MOST-AT-RISK ADOLESCENTS:
the evidence base for strengthening the HIV response in Ukraine

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FOREWORD

Preventing the spread of the human immunodeficiency virus is the key objective of the strategy to stop the HIV epidemic in Ukraine. The epidemic is currently concentrated among most-at-risk groups, including injecting drug users; orphaned children; homeless persons; juveniles detained within the state criminal justice system and in specialised institutions; children and adolescents from families in difficult living conditions; persons offering commercial sex services; and others.

The New All-State Targeted Programme on HIV Prevention, Treatment, Care and Support of the HIV-positive and People with AIDS for 2009–2013 envisages covering at least 60 per cent of representatives of most-at-risk groups with prevention interventions. Meeting this goal requires coordinated and comprehensive work on the part of the different ministries, agencies, organizations and individuals concerned with this issue. But it also requires in-depth knowledge of the causes and factors that contribute to the easy spread of infection within these groups and of the behavioural peculiarities of their representatives; of the barriers that hamper the access of such representatives to necessary information and services; and of the resources and interventions that are necessary to stop the HIV epidemic, especially among most-at-risk children and adolescents.

According to the Programme of Cooperation between the Government of Ukraine and the United Nations Children's Fund (UNICEF) for 2006–2010, the Government and UNICEF agreed to pay particular attention to work with most-at-risk adolescents. They would do this primarily by establishing a relevant evidence base and by collecting and analysing the data needed to develop programmatic approaches to work with adolescents.

The report presented below summarises the results of the study that Ukrainian specialists conducted with UNICEF's support. It provides reliable information about the factors pertaining to adolescents' vulnerability to HIV and about the risk behaviours of children and adolescents who live or work on the streets. It also offers an overview of policy and legislation on the provision of health and social services to most-at-risk children and adolescents and provides information about the social and demographic characteristics of this group.

The materials the report presents will be helpful to specialists, practitioners and policy and decision makers in the relevant area.

T. V. Kondratiuk
Deputy Minister of Family, Youth and Sports

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The main governmental partners of the UNICEF MARA Project in Ukraine are the Ministry of Family, Youth and Sports and the State Social Services for Families, Children and Youth (SSSFCY). Special thanks to both of them for providing essential support to the project. They deserve especial thanks for taking the lead in the country in acknowledging the publication's target populations as priority groups for HIV prevention and in working in partnership with UNICEF and other stakeholders in Ukraine to decide on how best to address these populations' needs.

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Research participants and others who contributed valuable time and effort:

Almost 1,600 adolescent boys and girls aged 10 to 19 in Ukraine and who are especially vulnerable to and most at risk of HIV infection participated in the research. The UNICEF MARA Project team is especially grateful to all of them for their willingness to participate in and contribute to the research, for their trust and for sharing with the researchers very personal details about their lives. Their doing so helped shed more light on their behaviour and on what determines it and on what services they use, so that adequate prevention interventions can be planned and programmed for them. This report is dedicated to all of these boys and girls.

The Project team would also like to thank the vast number of experts from all sectors of society in Ukraine who either supported or participated in the research and/or in the Project to date. They served as interview partners, focal points and participants in consultation meetings and took part in training workshops, strategic planning seminars and other events. They are too many to name, but the team is grateful to all of them for giving their valuable time and assisting in all possible ways.

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
BSS	Behavioural surveillance study
CAB	Community Advisory Board
CEE/CIS	Central and Eastern Europe and the Commonwealth of Independent States
CRC	Convention on the Rights of the Child
CSSFCY	Centres for Social Services for Families, Children and Youth
EVA	Especially vulnerable adolescents
FBO	Faith-based organization
FSW	Female sex worker
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
IDU	Injecting drug user
LSHTM	London School of Hygiene and Tropical Medicine
M&E	Monitoring and evaluation
MARA	Most-at-risk adolescents
MARPs	Most-at-risk populations
MoFYS	Ministry of Family, Youth and Sports of Ukraine
MoH	Ministry of Health of Ukraine
MSM	Men who have sex with men
NGO	Non-governmental organization
OSI	Open Society Institute
PMTCT	Prevention of mother-to-child transmission (of HIV)
RO	Regional Office
SMT	Substitution maintenance therapy
SSSFCY	State Social Services for Families, Children and Youth
STI	Sexually transmitted infection
SW	Sex worker
SWOT	Strengths, weaknesses, opportunities, threats
UISR after Olexander Yaremenko	Ukrainian Institute for Social Research after Olexander Yaremenko
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund

UN PAF	United Nations Project Acceleration Funds
USAID	United States Agency for International Development
VCT	Voluntary counselling and testing for HIV
WHO	World Health Organization

EXECUTIVE SUMMARY

A. Background

Adolescence is a time of increased vulnerability. Adolescents are undergoing many psychological and physical changes and are subject to increased peer pressure and prone to greater experimentation. Their personal identities are still forming and they are still developing confidence, knowledge and life skills. A supportive and enabling environment, positive relations with parents or an adult in the community and active involvement in public life can be critical to protecting adolescents from behaviours that can harm them, as well as from exploitative situations, such as trafficking, in which they cannot protect themselves.

In Ukraine, many adolescents grow up in circumstances and environments that do not offer them such protection. These young people suffer from the negative impact of Ukraine's years of political instability; from policy and legislation that make it hard to develop the services that adolescents need and to keep these services sustainable and accessible; from socioeconomic constraints that hit families, women and children the hardest; from depleted health care and social sectors; from high levels of human trafficking and sexual and labour exploitation; from widespread use of and easy access to alcohol and drugs; from the leftover Soviet practice of institutionalising orphans and children deprived of parental care; and from membership in groups that Ukrainian society marginalises and excludes.

All these factors can create situations in which an adolescent boy or girl starts to engage in risky behaviour, often as a coping mechanism. Such behaviour may include living, working or spending most of his/her time on the streets, early sexual activity with various sex partners and/or starting to use solvents, substances or drugs. Given that they live in the country with Europe's most rapidly developing HIV epidemic, these adolescents are especially vulnerable to HIV infection. Their risk of infection increases once they become engaged in so-called "most-at-risk" behaviours, such as unsafe injecting of drugs and unsafe sex with HIV-infected partners. These behaviours are often linked to selling sex or transactional[1] and exploitative sex.

Groups of especially vulnerable adolescents (EVA) and most-at-risk adolescents (MARA), including MARA living with HIV, often intermix in Ukraine. They can be found in many different settings. For example, they might live in families in crisis or they might live on the street. They might spend time in shelters for minors or in other child-care or penitentiary facilities, or they might go to school.

Living or working on the street creates particular risks for adolescent boys and girls. Qualitative research shows, for instance, that adolescents often live or spend time in groups within which behaviours that place them at risk of HIV infection are widespread. Social networks and peer pressure appear to strongly influence high-risk behaviour and the ways in which adolescents living and working on the street take it up. In addition, the street environment places adolescents at risk of abuse, exploitation, violence and crime. The latter may lead to detention or incarceration, during which the young person is additionally exposed to HIV risk. Meanwhile, the lack of adequate policy and legal frameworks and adequate enforcement mechanisms means that the young person's rights are not sufficiently defended. Furthermore, direct service providers are often negatively disposed to these adolescents and discriminate against them, while oppressive street raids on the part of the police create fear and distrust. The result is to discourage EVA and MARA boys and girls from seeking the services they need. Rather, they avoid the streets and go deeper into hiding, which makes them even harder to reach.

Official case registers are of limited use in understanding HIV incidence and prevalence among EVA and MARA boys and girls in Ukraine, because HIV testing rates are very low among these population groups. Official statistics most likely do not reflect the real situation. Data from a secondary analysis of adolescent injecting drug users (IDUs) and female sex workers (FSWs) aged 13 to 19 from sentinel surveillance studies among most-at-risk populations (MARPs) that the Ukrainian AIDS Prevention Centre carried out in 2006, as well as data on men who have sex with men (MSM) aged 15 to 24 from a bio-behavioural surveillance

[1] "Transactional sex" is used here to reflect the situation of adolescent boys and girls in Ukraine who may find themselves in situations in which they see no alternative but to exchange sex for money on which to live, for goods (including drugs) or for better living conditions.

study (BSS) conducted among MSM in 2007 with funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), showed that the HIV prevalence among MARA boys and girls is probably much higher than the official statistics indicate. Almost 40 per cent of adolescent IDU girls, 30 per cent of IDU boys, 11 per cent of adolescent FSWs and 4 per cent of young MSM had tested HIV positive in the above-mentioned studies.

The majority of the boys aged 15 to 19 in Ukraine who are officially registered with HIV infection contracted it through injecting drug use (65 per cent). Most of the HIV-positive girls of the same age contracted the infection through unprotected heterosexual contacts (89 per cent).

Existing social policies concerning housing, employment and social security benefits fail to balance out the social, psychological and health-related problems that EVA and MARA boys and girls face due to neglect, violence, deprivation and/or psychological distress. Ukraine's social and health care sectors are underfunded and lack political leadership. Nor are they a political priority. The results have been insufficient response capacity and facilities and institutions that languish in poor condition. Other factors that hinder provision of even a minimum package of high-quality services to MARA and EVA are the overcentralisation and over-specialisation of prevention and treatment services, the vertical service structure and a profusion of service access barriers. Alternative HIV prevention entry points, such as pharmacies, are underused. In addition, Ukraine has not yet sufficiently mainstreamed HIV prevention into non-HIV specific health care and social services, or into educational services, legal services and the State child protection and child-care systems. The findings of a comprehensive external evaluation of the national AIDS response conducted in 2007 and 2008 stressed that the present scale, scope and quality of HIV prevention, treatment, care and support services for EVA and MARA boys and girls in Ukraine are far too low to have an impact on the epidemic.

On the other hand, Ukraine's new National HIV/AIDS Programme 2009–2013 is setting an ambitious national prevention coverage target of 60 per cent for "at risk groups" (including EVA and MARA boys and girls, namely "IDUs, orphans, homeless children, children detained or incarcerated, children from families in crisis, sex workers, MSM, migrants and other similar groups"). How this can be achieved, however, remains a question that the new Programme fails to answer adequately.

Most of the HIV prevention and harm reduction services that non-governmental organizations (NGOs) provide to MARPs were primarily designed for adults and hard-core drug users. Governmental organizations have done little to provide services for EVA and MARA boys and girls. The Government also provides little financial support for HIV prevention work for these population groups (although it does support work among young IDUs and young people in penitentiary facilities). In addition, little is done to address and reduce stigma, discrimination and rights violations, even though these factors make EVA and MARA much more vulnerable. While the State is investing more in resocialisation and psychosocial rehabilitation programmes for young people, adequate drug rehabilitation programmes are still lacking. Legislation prevents minors from accessing substitution maintenance therapy (SMT) programmes, despite evidence that it is critical in preventing HIV among IDUs.

That relatively little has been known about EVA and MARA boys and girls until now has greatly hampered adequate planning and programming and an adequate prevention response for these population groups. The gaps in evidence and information help explain the lack of attention that decision makers, researchers and service providers have paid to EVA and MARA boys and girls and to their role in the epidemic.

A number of factors have prevented the collection and use of data on EVA and MARA. The most important is that "adolescent" is not a legal age category in Ukraine, which hinders planning and programming for those aged 10 to 19. This also explains why national reports have so far not referred to this age category. Other critical issues include:

- The absence of a centralised national monitoring and evaluation (M&E) system, one that would include a unit responsible for systematically collecting, processing, analysing and disseminating M&E data from different sources and sectors, and for different population groups.
- The lack of national and subnational estimates of the sizes of the different EVA and MARA sub-populations, estimates that would provide denominators for calculating programme coverage as well as for performing resource estimates and capacity planning.

- The lack of systematic and uniform disaggregation of data from sociological research, biological studies and BSSs (by age, sex, region, risk behaviour and population group) makes it more difficult to target interventions reliably; and standardised age breakdowns are not used.
- Until 2007, the samples for biological studies and BSSs in Ukraine were too small, which made conducting secondary analyses of the data for adolescent boys and girls, including by region, more difficult; also, there are no nationally agreed indicators for EVA and MARA boys and girls, nor a corresponding minimum set of data that service providers should collect, independent of ownership and sector.
- The qualitative data on EVA and MARA boys and girls are insufficient, so there are gaps in how well their social and sexual networks, their social status, their service-seeking behaviour and their behavioural determinants are understood; sound programmatic data are also lacking, because intervention research is very limited in Ukraine.

Since 2005, much has been done to improve Ukraine's national M&E system on HIV/AIDS and to address some of the issues highlighted above. But progress has been slow. In 2006, in light of the many difficulties pertaining to MARA boys and girls, UNICEF launched the multicountry project "HIV prevention in most-at-risk adolescents in Ukraine and South Eastern Europe" (UNICEF MARA Project), with support from the Government of Ireland. The goal was to support the efforts of various countries to strengthen their responses to HIV/AIDS and MARA boys and girls. Ukraine is one of seven countries participating in the project.

The UNICEF MARA Project includes such strategies as strengthening the knowledge base about EVA and MARA boys and girls and building the capacity of national M&E systems in this area; assessing legal barriers and developing policy and guidance concerning the legal and ethical aspects of HIV prevention among MARA boys and girls; supporting strategic planning processes at the national and subnational levels to improve strategic action plans for EVA and MARA boys and girls; and improving government and NGO capacity to programme and provide needs-based and high-quality services for EVA and MARA boys and girls, based on an agreed essential package of targeted interventions and service delivery models and on implemented and evaluated pilot projects.

The UNICEF MARA Project's main national partners in Ukraine are the Ministry of Family, Youth and Sports (MoFYS), the State Social Services for Families, Children and Youth (SSSFCY) and the Ukrainian Institute for Social Research after Olexander Yaremenko (UISR after Olexander Yaremenko). Key stakeholders have been involved with, and guide, the project's activities, working through those national and subnational multisectoral advisory boards that are linked to existing coordination structures. EVA and MARA boys and girls, meanwhile, have themselves participated in the project.

B. Research

There are many gaps in the evidence pertaining to EVA and MARA boys and girls in Ukraine. To rectify this, the MARA team sought to deepen its understanding of how these boys and girls behave, of what determines their behaviour, of their vulnerabilities and of how they use services. The team also wanted to create a sound basis for strengthening and more effectively monitoring the HIV prevention response as it affects these population groups. It therefore took a comprehensive research approach and conducted:

1. A comprehensive desk review on available evidence and services for EVA and MARA boys and girls in Ukraine.
2. A review of existing policy and legislation concerning service access barriers.
3. An analysis of gender-specific issues.
4. A secondary analysis of data on adolescent IDUs, FSWs and MSM from the 2007 (bio-) behavioural surveillance studies (Secondary Analysis).
5. A baseline behavioural study (Baseline Study) among adolescents living and working on the streets in Kyiv, Mykolaiv, Dnipropetrovsk and Donetsk. This was followed by focus groups with MARA boys and girls in each city to discuss the preliminary research findings.

6. An analysis of key EVA and MARA stakeholders in the four project sites and an assessment of their capacity needs as a basis for developing a sound capacity-building plan for each site, and for monitoring and evaluating the impact of capacity-building support.

The London School of Hygiene and Tropical Medicine (LSHTM) supported the Project team in the design, implementation and analysis of the Secondary Analysis and Baseline Study. The decision to pursue these research strategies was based on the understanding that Ukraine's HIV epidemic is young, and that there is therefore a real chance to intervene with EVA and MARA. Doing so would help blunt the epidemic's impact and reduce new HIV infections among these population groups. Another of the main aims of the research was to calculate a list of agreed core indicators for MARA boys and girls (see Annex 2 for a list of the Ukrainian indicators) that describe HIV risk behaviour, overlapping risk behaviour, sexual experience, behavioural determinants and vulnerabilities and service use (as a basis for calculating service coverage) in each of the seven countries participating in the Project. These indicators are meant to serve as a benchmark for future studies on MARA boys and girls.

The research team learned many valuable lessons during the research process. For instance, it learned about the importance of multisectoral cooperation and coordination. The latter not only helped create a supportive and enabling environment for the sensitive baseline research, but also provided a way to involve EVA and MARA boys and girls in the project. It created a context for conducting stakeholder analysis, fostering networking among service providers and initiating a multisectoral strategic planning process concerning EVA and MARA boys and girls in each region. Furthermore, it became clear during the research that resources for reaching out to and working with these two population groups are still very limited in Ukraine, and that the State child-care services have too limited a capacity and range to meet their needs.

Numerous child protection issues must be considered when research is being conducted among EVA and MARA boys and girls. When the research team conceived its project in 2007, however, no national ethical guidelines on carrying out research or programming for these population groups existed. The UNICEF Regional Office (RO) therefore helped the seven countries participating in the Project by developing draft ethical guidelines that it shared with key stakeholders at the national and subnational levels. The Sociological Association of Ukraine considered these guidelines and, on 9 December 2008, adopted ethical principles that will govern future research among EVA and MARA.

When it applied these ethical guidelines, the research team considered its target population's supplementary care needs, working through its advisory boards to establish sound partnerships with social services and non-governmental service providers. This was done to ensure that these needs were identified and discussed and that referral points and services were agreed, enabling the interviewers to refer adolescents to appropriate services or to take immediate action whenever needed.

C. Findings and discussion

Table C.1 provides an overview of the research samples of the Secondary Analysis and the Baseline Study.

Table C.1:

Secondary Analysis	Adolescent IDUs	Adolescent FSWs	Adolescent MSM
Total sample	259	281	212
Age group	13–19 years	13–19 years	15–19 years
Sex	66% boys (170) 34% girls (89) Ratio = 2:1		
Baseline Study	Adolescents living and working on the streets		
Total sample	805		
Age group	10–14 years = 38%	15–17 years = 44%	18–19 years = 18%
Sex	70% boys (565)	30% girls (240)	Ratio = 2:1

Table C.2 summarises and discusses the main findings of the Secondary Analysis and Baseline Study:

Table C.2:

MAIN FINDINGS	CONCLUSIONS
1. UNDERSTANDING THE SCOPE OF THE PROBLEM	
Secondary Analysis: Adolescent FSWs = 18% of the total 2007 FSW BSS sample Adolescent IDUs = 6% of the total 2007 IDU BSS sample Adolescent MSM = 12% of the total 2007 MSM BSS sample **Baseline Study:** Some 15.5% of adolescents reported having injected drugs, 10% of boys reported having had anal sex with a male and 28% of adolescents reported receiving money, gifts or drugs in exchange for sex at some point in their lifetimes (17% of boys, 57% of girls).	National and subnational estimations of the size of the EVA and MARA populations do not exist in Ukraine at this stage. They are critical, however, to understanding the problem's scope and to planning a prevention response that will have an impact on Ukraine's HIV epidemic. The research shows that the EVA and MARA population is considerable and any prevention response in Ukraine must pay it greater attention.
2. CONSIDERING THE INFLUENCE OF SOCIODEMOGRAPHIC CHARACTERISTICS – Selected evidence	
Gender Secondary Analysis: 22% of IDU girls and 35% of IDU boys reported consistently using condoms with their regular sex partners during the last year. **Age** Secondary Analysis: Condom use with clients in the last month was considerably lower among adolescent FSWs aged 13 to 17 (41%) than among those aged 18 to 19 (57%). Younger FSWs also reported more anal sex with clients (72% of those aged 13 to 17) than did their older counterparts (57% of those aged 18 to 19). Baseline Study: The research showed a clear trend for age. Younger age groups reported less lifetime experience with drugs than did older age groups, and respondents aged 18 to 19 were 6.7 times more likely to have injecting drug experience than those aged 10 to 14. Age was also associated with lower condom use among girls aged 10 to 14. **Marital status** Secondary Analysis: While the majority of MARA boys and girls are unmarried, a small proportion of them (20% of IDU girls, 11% of IDU boys, 13% of adolescent FSWs and 10% of adolescent MSM) reported living with partners, but without official marriage licenses. **Mobility and nationality** Baseline Study: Almost half of the adolescents living and working on the streets who were interviewed said that they came from other Ukrainian cities or regions to their places of current residence. Some 58% of the adolescents > 16 years lack passports, which include registration information.	The research demonstrates that sex and corresponding gender assumptions and relationships, age and social status differences influence the needs, behaviours, and relationships of EVA and MARA boys and girls. The youngest EVA and MARA need attention because risk behaviour starts early and is more common among adolescents than among adults. Younger people's lower knowledge, skill and confidence levels account for this. So does the fact that they are less covered by prevention services and use them more rarely. Another reason for making these children a priority is that the younger they are, the greater their vulnerability to HIV. On the other hand, their likelihood of having been exposed to HIV risk and vulnerability factors for long periods of time is smaller, so there is a window of opportunity for early prevention interventions. The data also stress the importance of taking into account the access barriers (such as registration) that confront migrating adolescents; of taking into account educational shortfalls, particularly among those adolescents living and working on the streets; and of understanding the disadvantaged economic situations of EVA and MARA boys and girls, and especially of adolescent FSWs; of understanding the situations of adolescents living and working on the streets who still sleep at home, as there are serious concerns about the capabilities of the relevant caregivers, the whereabouts of parents and the functioning of the child protection system; and of coming to terms with other significant differences that the research revealed (see report).

Living arrangement Baseline Study: 20% of adolescents living and working on the streets reported sleeping at home. Many stay with their grandparents. **Education level and employment status** Baseline Study: The majority of adolescents living and working on the streets aged 18 to 19 (86%) reported that they have not completed basic education, although doing so is obligatory in Ukraine. Four % said that they had never attended school. **Orphan status** Baseline Study: Almost 44% of the adolescents living and working on the streets reported being single orphans and about one third reported being double orphans or so-called "social" orphans, that is, children who do not know if their parents are still alive.	
3. INDIVIDUAL RISKS AND RISK BEHAVIOURS OF EVA AND MARA BOYS AND GIRLS	
3.1 MAIN FINDINGS OF THE SECONDARY ANALYSIS OF DATA ON ADOLESCENT IDUs, FSWs and MSM	
Sexual experience More than 80% of the adolescent IDUs reported having had sex (vaginal, oral, anal) at some point in their lives. Those reporting sex in the last 12 months had varying numbers of partners; almost half reported having had three or more sex partners in the last three months. Some 66% of adolescent MSM reported having had insertive anal sex (active) in the past six months, and 65.5% reported having had receptive anal (passive) sex. Some 71% reported having had heterosexual sex at some point in their lives; 53% of them reported having had heterosexual sex in the last six months and of these 23% reported having had more than three heterosexual sex partners. Some 99% of adolescent FSWs reported having had vaginal sex during the last year, while 94% reported having had oral sex and 62% reported having had anal sex. They reported on average three commercial sex partners per day and 15 per week. In addition, over half of them reported having a regular and/or casual sex partner in the last week, or more than one.	The majority of MARA boys and girls have sexual experience. They have relatively many sex partners for their age group. Consideration must be given to the different types of sex partners (regular, casual and commercial) that they have. It is noteworthy that the majority of adolescent MSM also reported having had heterosexual sex at some point in their lives. Their sexual relationships with females require more explanation.
Initiation of risk behaviour before the age of 15 Some 15.5% of the adolescent IDUs who had injected drugs reported that they started to inject drugs before turning 15, and 33% said they started having sex before turning 15. Some 50% of adolescent FSWs reported having sex before the age of 15. The data indicate that adolescent FSWs started to sell sex at 16, on average. Twelve was the lowest age at which they started to sell it, while 15% of them started selling it before 15.	A considerable proportion of adolescent IDUs, FSWs and MSM initiate risk behaviour before turning 15.

Risk behaviours Over 80% of adolescent IDUs reported using sterile injecting equipment the last time they injected drugs. However, 30% of them reported sharing needles/ syringes in the last month. Almost two thirds of them had done so with more than three other people. A third said that they inject daily and another third said that they inject between two and six times each week. Some 86% of IDU girls who reported selling sex used a condom the last time they did so. But consistency of condom use with clients in the last month was very low: only 33% of IDU girls used them consistently. Condom use with casual and regular partners is even lower (27% and 22%, respectively). Consistency among IDU boys was significantly higher with commercial sex partners, but also very low for regular and casual partners. Note: Adolescent FSWs were more consistent in their condom use with clients in the last month (52%) than were adolescent IDUs. But of the 62% of adolescent FSWs who reported having had anal sex with clients in the last year, only half said they always used condoms. Adolescent FSWs use condoms with their regular sex partners very rarely (25%), just as adolescent IDUs do. It was not possible to compare condom use among adolescent MSM with condom use among the other MARA, as the 2007 MSM-BSS did not assess condom use consistency.	Adolescent IDUs, FSWs and MSM widely practise behaviour that carries a high risk of HIV infection. Those who do, do so frequently. Interventions must focus on getting MARA boys and girls to use condoms more consistently, particularly during sex with regular and casual sex partners. Adolescent IDUs and FSWs who engage in anal sex need especial attention.
Overlapping risk behaviours Some 3% of adolescent IDU males and 25% of adolescent IDU females reported having transactional sex (vaginal/anal). In addition, 5% of IDU boys and girls reported buying sex (this group consisted primarily of boys). The data presented in the box above also show that a considerable proportion of adolescent IDUs engage in unsafe sex, doubling their risk of HIV infection. Injecting drug use is common among adolescent FSWs (19%), but less common among adolescent MSM (1.4%). It is also noteworthy that 14% of the adolescent MSM reported selling sex.	Overlapping risk behaviour is common among adolescent IDUs, FSWs and MSM. Adolescent IDUs demand particular attention.
Service use and coverage Almost 80% of IDU boys and girls could identify a HIV testing site, but only 14% of them had taken HIV tests in the past 12 months and know their results. Also, while over 80% of adolescent IDUs know of one formal source of condoms, only 47% had obtained condoms in the last month. Similarly, 71% of MSM could identify a voluntary counselling and HIV testing facility (VCT), but only 24% had been tested for HIV and know their results.	Many more MARA know about HIV/AIDS and the available HIV services than use the latter. This indicates the existence of serious access barriers.
Only somewhat over 30% of adolescent IDUs reported having been reached by HIV prevention programmes in the past 12 months. In comparison, 61% of adolescent FSWs and 45% of adolescent MSM had been reached. Only 28% of adolescent FSWs reported being covered with peer-driven interventions.	HIV prevention programme coverage is far too low to have an impact on the HIV epidemic, especially as it concerns adolescent IDUs and MSM. Evidence-based approaches for adolescent MARA, such as peer-driven interventions, remain underdeveloped.

3.2 MAIN FINDINGS OF THE BASELINE STUDY ON ADOLESCENT BOYS AND GIRLS LIVING AND WORKING ON THE STREET	
Sexual experience and initiation of risk behaviour Some 15.5% of adolescents reported having injected drugs, almost half of them before the age of 15. The majority of them reported having had sexual intercourse at some point in their lives, with 76% reporting initiating their sexual lives before the age of 15. Some 75% reported having casual sex partners in the last year. Only 37% reported having regular sex partners, while 56% of the girls and 11% of the boys reported having had commercial sex partners in the last 12 months. Almost 60% of the girls started to sell sex before the age of 15.	The number of MARA who live and work on the streets and intermix with EVA who live or work on the streets is considerable. This increases the risk that EVA boys and girls will start engaging in high-risk behaviour due to peer pressure, sexual relations with MARA, etc. The proportion of MARA on the streets who start to practise risk behaviour before the age of 15 is high. Consideration must be given to the different types of sex partners that they have.
Risk behaviours: **Unprotected sex:** Condom use is generally very low among these adolescents. Only 12% reported using them consistently with regular sex partners in the last year; 15% used them consistently with casual partners and 10% used them consistently with commercial partners. Some 57% of girls and 17% of boys selling or engaging in transactional sex said they used condoms consistently with their clients in the last year (8% said they "always" used them and 11% said they "never" did). The number of commercial sex partners that they had in the last year was relatively low, with 54% reporting > 6 partners (16%) or more than 10 partners (38%). Some 10% of boys reported having had anal sex with a male at some point in their lives, and 74% had had anal sex before the age of 15. Over half of the boys who had had anal sex had also sold or engaged in transactional sex. Condom use is very low. Only 4% of MSM boys used condoms consistently in the last year. Some 39% used them during their last incidences of anal sex with clients, and 36% used them the last time they had sex with non-commercial sex partners. Another indicator for what is generally very low condom use is the pregnancy rate and the rate of sexually transmitted infections (STIs) among adolescents on the streets. Some 18% of girls have been pregnant and 68% of these had abortions. Meanwhile, 27% of girls and 15% of boys reported STI symptoms. **Unsafe injecting practices:** Over 60% of adolescent street IDUs shared a needle/ syringe in the past month, even though 76% claimed to have used sterile injecting equipment the last time they injected.	MARA who live and work on the streets widely practise risk behaviour. Their sexual and reproductive health is also of great concern, and particular attention must be paid to EVA and MARA girls who have children, as 2% of those who participated in the Baseline sample do. Ukraine's current harm reduction services are insufficient to deal with the HIV infection risk associated with drug-scene trends. For example, adolescent IDUs, who widely use pre-filled syringes, lack access to substitution maintenance therapy before they turn 18. They also have only limited access to adequate psychosocial drug rehabilitation programmes, because provision of these services is characterised by large gaps. These young people therefore have few exit strategies. The Baseline Study also indicates that the MSM sex that boys practise appears to be less an expression of a homosexual identity than a form of transactional sex. It may even help boys to survive on the streets. Those planning HIV prevention interventions should take this into account, because it means that many boys engaging in MSM behaviour belong to no easily identifiable homosexual scene. They tend to congregate in other than homosexual communities.

Overlapping risk behaviours: Some 10% of IDU girls reported selling or engaging in transactional sex; 3% of street IDU boys reported MSM behaviour; 5% of adolescent street MSM reported selling or engaging in transactional sex; and, most strikingly, 1% of street IDU-MSM boys reported selling or engaging in transactional sex.	Overlapping risk behaviour is widespread among adolescents on the streets. Street IDUs are at particular risk of engaging in overlapping risk behaviour. MSM might be as well (this needs more investigation).
HIV/AIDS knowledge and service use: Fewer than 50% of adolescents were able to correctly answer questions about sexual HIV transmission or to identify a formal source of condoms. Over 50% were able to identify VCT sites or needle exchange points, but only 12% have taken HIV tests and know their results. In addition, 47% of those reporting STI symptoms did not seek help, but rather treated themselves.	Adolescents on the streets evince very low levels of knowledge about HIV/AIDS and available HIV prevention services. Such services do not cover adolescents widely, and adolescents do not much use them. The research showed that the scope and quality[2] of the available services can be greatly improved.
Behavioural determinants and vulnerabilities: Over 50% of girls and 11% of boys reported having been forced to have sex at some point in their lives; 37% of girls and 7% of boys reported experiencing forced sex in the last year. Some 83% of the boys and 58% of the girls reported having been stopped or harassed by the police at least once in their lives. Some 57% of adolescents have stayed in shelters for minors; 49% of them have stayed in a special room for children at a police department (57% of boys and 31% of girls); 33% of them have stayed in a pre-trial detention centre (38% of boys and 19% of girls); 11% of them have stayed in a remand centre (13% of boys and 7% of girls); and 8% of boys and 2% of girls have been incarcerated at some point in their lives. Physical violence and sexual abuse occurred in all the institutions and temporary facilities in which adolescents spent time.	These adolescents are exposed to a wide range of HIV vulnerability and risk factors. They inhabit a particularly risky and unsupportive environment in which they are often unable to protect themselves from significant harm or negotiate safer sex. Detention centres and other penitentiary facilities put all adolescents who enter them at increased risk of HIV infection. Cases of severe rights violations (physical violence and sexual abuse) were reported for all institutions/facilities listed in the research questionnaire. This underlines how urgent it is to protect the rights of these children and adolescents and to demonstrate zero tolerance towards the persecutors. Abuse at the hands of police officers, shelter and penitentiary facility workers, and other inmates and peers deserves special attention. That more than half of these adolescents reported having stayed in shelters for minors at some point in their lives highlights the need to review whether the State child-care system is adequate for EVA and MARA boys and girls. Short- and long-term care options and financing, which requires a needs-based approach, demand particular attention.
4. BEARING IN MIND ASSOCIATIONS BETWEEN SOCIODEMOGRAPHIC CHARACTERISTICS, RISK BEHAVIOURS AND OTHER VARIABLES	
LSHTM analysis[3] identified a link between adolescents' non-injecting drug use and their tendency to start injecting drugs. It also found that older respondents are more likely to inject drugs. In addition, it demonstrated that risk of unsafe sex is associated with being younger; having a regular (female) or casual sex partner (both sexes); having MSM sex; and using inhalants (both sexes). Age, having a regular partner and inhalant experience are commonly noted risk factors determining condom use.	These links need more investigation, but they indicate that prevention interventions must be targeted to the social and sexual networks that MARA boys and girls inhabit. Non-injecting drug users need special attention, to prevent them from starting to inject drugs, as do MARA boys' female sex partners, because the latter are exposed to a double risk: of HIV infection and of starting to inject drugs.

[2] "Quality" should be understood here as the accessibility, acceptability, appropriateness, effectiveness and affordability of services, as well as the extent of service coverage.

[3] The LSHTM conducted a separate analysis of the Baseline Study data, focusing on regional differences and bi-/multivariate analysis.

5. OVERCOMING BARRIERS TO SUSTAINING PROTECTIVE BEHAVIOUR AND SAFER PRACTICES	
The research also revealed that adolescent girls who practise unsafe sex, particularly those who are exploited for sex and who live in the street, find it especially hard to take up safer sex practices. Their regular sex partners may not want to use condoms consistently, they practise overlapping risk behaviours (such as sex work and injecting drug use), they have vast experience of forced sex in different settings and they lack police support and protection (indeed, the police often abuse them). They also have limited access to adequate health care services. Sufficient alternative entry points to prevention products and facilities (such as pharmacies and sexual and reproductive health care centres) are lacking.	Girls, especially adolescent FSWs and those who live or work in the street, face many barriers to sustaining protective behaviour and safer practices. Any prevention response must pay them particular attention. Their sex partners (whether commercial or non-commercial), whom interventions have to date excluded, will also require special attention. At the same time, prevention responses must also include the clients of FSWs. Research done among boys on the streets and adolescent IDUs engaged in selling or in transactional sex indicates that condom use greatly depends on the client's wishes.
6. TAKING ACCOUNT OF REGIONAL DIFFERENCES	
Baseline Study: The LSHTM analysis found that levels of unprotected sex (independent of the type of sex partner) differ from city to city. Mykolaiv shows the highest rates of such sex among the adolescents while Kyiv had the highest rates of condom use. The UNICEF MARA Research team's analysis found important differences in regards to living arrangements. More adolescents reported living at home in Dnipropetrovsk (28%) and in Donetsk (24%) than in the other two cities. This may explain why in Kyiv more adolescents (more than every fourth, or 29%) reported living in a temporary dwelling unsuited for habitation (such as an abandoned building). More research is needed to verify these significant differences by city and to identify the reasons behind them, as the age distribution was not consistent within each city. The findings may therefore simply be an artefact of the study or due to chance.	A regional analysis of Baseline Study data shows that significant regional differences may exist. More investigation is required. It will help in developing prevention interventions that address each city's or region's specific needs.

D. Recommendations

The following list provides a short summary of the main recommendations the report sets out. The importance of the matter requires that the Ukrainian Government take the lead:

1. In reducing legislative and normative barriers to service delivery and access and to sustaining safer behaviours. This will require political leadership for fostering HIV prevention programmes for EVA and MARA boys and girls; improving response management and enforcement of legislation (e.g. anti-discriminatory and zero tolerance policies) at all levels; legislative changes (e.g. adopting the age category of "adolescent" in Ukraine); abolishing legal contradictions with regard to providing medical services to children over 14 in the absence of a legal representative's consent; normative and legislative acts that support strategic planning processes; follow-up procedures for uncared-for HIV-positive EVA and MARA boys and girls; giving social workers in child-care institutions information about HIV infection; giving adolescents access to substitution maintenance therapy; and other initiatives. In parallel, the State care system for orphans and children deprived of parental care must be reformed so that EVA and MARA boys and girls who cannot be returned to their families have access to the short- and long-term care options they need. This will mean redirecting resources away from institutions and towards a wider range of community-based prevention and care services.

2. In coordinating the multisectoral response to EVA and MARA boys and girls, and in ensuring that EVA and MARA representatives take part in decision-making, planning, programming and M&E processes.

3. In developing, agreeing with stakeholders and overseeing the implementation and monitoring of multisectoral HIV/STI prevention strategic action plans for EVA and MARA boys and girls at the national and subnational levels for the years 2009 to 2013, based on the new national strategic HIV/AIDS and other relevant policy frameworks. A substantial increase in earmarked Government funding will be necessary to scaling up evidence-based prevention services for EVA and MARA to the point where they impact the HIV epidemic. This increase will also be necessary to make sure that local governments receive the support they need to address this urgent situation.

4. In addressing the current M&E system's weaknesses at the national, sectoral and subnational levels and in integrating EVA and MARA boys and girls into all relevant M&E systems. This means supporting efforts that are already underway. These include: systematically disaggregating behavioural and biological data by age and using a standardised age breakdown; calculating and agreeing national and subnational population size estimates for MARA and adolescents living and working on the streets; standardising data collection among direct service providers; agreeing a minimum set of data to be collected, independent of ownership, etc. M&E capacity will need to be built accordingly.

5. In ensuring the further development of the evidence base on EVA and MARA boys and girls as a basis for planning and programming. This can be done by, for example, working with stakeholders to develop multisectoral research plans at the national and subnational levels. These plans must pay particular attention to behavioural surveillance, to the M&E of service provision and to allocating and dispersing funds. They must also pay attention to operational research needs and to the need to close research gaps, particularly in qualitative research. Research capacity will need to be built accordingly.

6. In agreeing a national prevention intervention framework for EVA and MARA boys and girls. This report proposes a framework that establishes a series of prevention services tailored to EVA and MARA boys and girls' vulnerabilities and risks, and that takes into account various levels of intervention. It reflects the understanding that a prevention approach capable of impacting Ukraine's HIV epidemic needs to focus primarily on boys and girls most at risk of HIV infection, on those especially vulnerable to HIV and on those who already live with the virus. If these groups are not reached and adequately covered with prevention and harm reduction services, HIV will continue to spread rapidly and could jump to the general population. Adolescents living and working on the streets, detained or incarcerated adolescents and adolescents with overlapping risk behaviours demand special attention, because they are all at increased risk of infection.

   Implementing this framework will require a behaviour change intervention strategy that targets EVA and MARA boys and girls. It must cut across all prevention projects, programmes and services for these groups. It will require well-coordinated systems for developing and disseminating informational and education material and for procuring, disseminating and promoting HIV prevention products and methods. A comprehensive approach to HIV/STI prevention is also required. It would combine intervention methods and models that target EVA, MARA, their sex partners and those who belong to their social networks. It would involve peers, opinion leaders and professionals doing informational and educational work, as well as skills-building interventions (for example, on how to negotiate condom use) and counselling (for individuals, small groups and couples). The interventions must be sensitive to differences in age, gender, social status, population group, risk behaviour and setting, and should target places where risk behaviour occurs (an outreach approach must be used). They must also be coupled with targeted interventions that reduce stigma and discrimination, and with advocacy work.

7. In addressing and reducing discrimination against, and stigmatisation and criminalisation of, EVA and MARA boys and girls. The new National HIV/AIDS Programme 2009–2013 prioritises increasing tolerance. However, it envisages such little funding for this huge, difficult endeavour that the Ukrainian Government's seriousness in tackling these issues comes into question. Developing and implementing a comprehensive anti-stigma and anti-discrimination campaign in partnership with the affected communities and civil society should therefore be prioritised. The arrest, detention, defence and probation system for juveniles should be reviewed to make it more MARA-friendly and to mainstream HIV pre-

vention measures into it. Measures should also be taken to protect child victims from more abuse and to quickly and adequately punish the abusers.

8. In adopting prevention, treatment, care and support services to the needs of EVA and MARA boys and girls. This will require a comprehensive training and sensitisation programme for governmental and non-governmental service providers and decision makers alike. It will also mean implementing and maintaining quality standards in services; developing intervention materials; adopting HIV prevention as an essential component of client/patient service; and creating functioning referral systems. Outreach services will need to become MARA-friendly and take into account that EVA and MARA boys and girls rarely seek out services on their own. A list of MARA-friendly principles for service providers has been proposed (see report).

9. In implementing an essential, evidence-based package of prevention services for EVA and MARA boys and girls. Given the huge gaps and low coverage that characterise HIV/STI prevention services in Ukraine for EVA and MARA, major effort must go into rapidly scaling up a basic package of prevention services, particularly in places most affected by the epidemic. All available entry points for HIV/STI prevention for EVA and MARA boys and girls should be used. This will mean mainstreaming HIV prevention into the services of all direct service providers, including child-care and penitentiary facilities. Non-traditional entry points, such as pharmacies, should also play a role. Because little intervention research has been conducted to date in Ukraine, evidence on effective intervention models from other, and especially neighbouring, countries should be reviewed prior to programming.

10. In sustaining the prevention response. One way of doing this is to continue building the capacity of the State social services to carry out HIV/STI prevention work among EVA and MARA boys and girls. However, civil society organizations play a critical role in HIV prevention in Ukraine. Therefore, it is also important to develop mechanisms and supportive legislation that will let contracting civil society organizations provide services, thus lowering their dependence on donor funding. Furthermore, greater flexibility is needed to broaden the spectrum of services that civil society organizations can provide, and with regard to the mechanisms with which this can be done.

Research is only justified if its results are widely disseminated and utilised for a specific purpose. Within the frame of the UNICEF MARA Project a sound evidence base on EVA and MARA boys and girls was built, including baseline data and a list of core indicators, and UNICEF has initiated strategic planning processes at the national and subnational levels. These processes will establish a strategic framework for operational planning at the service-provider level, for capacity-building, for resource mobilisation and for implementing innovative and evidence-based service models for EVA and MARA boys and girls. The State social services play a critical role in this process, which is supported by the MoFYS. It is hoped that the process will kick-start Ukrainian Government efforts to meet the prevention needs of one of its most vulnerable and high-risk population groups, one that so far has been largely left out of the HIV/AIDS response; and to redirect the limited resources that exist towards supporting and implementing effective prevention models.

INTRODUCTION

Adolescence is when young people grow up and become more independent of their families. It is a period of physical and psychological change, one in which opinions form, attitudes develop, behavioural patterns emerge and experimentation begins. While experimenting in itself is critical to helping adolescents gain experience, learn and develop, some start to experiment with behaviours that are potentially harmful to them. That is, they practise risk behaviours.

Infection with the Human Immunodeficiency Virus (HIV), which causes Acquired Immunodeficiency Syndrome (AIDS), is one of the most harmful things that risk behaviour can lead to in Ukraine today.

The behaviours that place adolescent[4] boys and girls most at risk of HIV infection are :

- Injecting drugs using contaminated injecting equipment.
- Having unprotected[5] anal, vaginal or oral sex with an HIV-infected partner (this includes heterosexual sex as well as sex between males).
- Performing multiple unprotected sexual acts with an HIV-infected partner, a behaviour that is often linked with selling sex or transactional[6] sex.

Adolescents who engage in these behaviours are called "most-at-risk adolescents" (MARA)[7].

There are many vulnerability and risk factors for adolescent boys and girls. They can create situations in which a boy or girl is susceptible to engaging in HIV risk behaviour and/or is unable to protect himself or herself from exploitation that can lead to HIV infection. For instance, he or she might not be in a position to negotiate safer sex or the use of sterile injecting equipment.[8] Such factors can be medical and biological. For example, an adolescent who is infected with a sexually transmitted infection (STI) is more susceptible to HIV. Then there are the political, cultural and legislative factors that influence vulnerability and risk. These include religious and cultural norms that can shape people's attitudes and behaviours towards marginalised groups; the level to which social welfare systems target and provide adequate support to those in greatest need; and policies and laws that create barriers to service provision and access. At the community level, there are a wide range of socioeconomic and environmental factors that determine vulnerabilities and risks. These include being a member of a marginalised and socially excluded social group with limited access to prevention and support services; the pressures resulting from poverty and gender inequalities and peer pressure[9]; conflict and crisis within a family; the local drug scene; levels of human trafficking, exploitation and institutionalisation of children; levels of homelessness among adolescents; and the scale and quality[10], as well as the level of coordination of, community-based services. These as well as other factors can influence an individual's behaviour, personal risk awareness, confidence and level of knowledge and skill when it comes to reducing risk and preventing HIV.

The following table (Table 1) provides an overview of some of the key factors influencing adolescents' levels of vulnerability and risk[11].

[4] The World Health Organization (WHO) defines adolescents as "people aged 10 to 19 years".

[5] "Unprotected" means here: without the consistent and proper use of a high-quality condom.

[6] "Transactional sex" is used here to better reflect the situation of adolescent boys and girls in Ukraine who may find themselves in situations in which they see no alternative but to exchange sex for money on which to live, for goods (including drugs) or for better living conditions.

[7] Homans, H., "Manual on Programming to Prevent HIV in Most-at-risk Adolescents" (draft), UNICEF Regional Office for Central and Eastern Europe and the Commonwealth of Independent States, Geneva, November 2007.

[8] Ibid.

[9] Ibid.

[10] "Quality" should be understood here as the accessibility, acceptability, appropriateness, effectiveness and affordability of services, as well as the extent of service coverage, in line with: Ibid.

[11] Ukrainian Institute for Social Research after Olexander Yaremenko, British Council Ukraine and DFID, "Socio-economic consequences of the HIV/AIDS epidemic in Ukraine: new prognoses", Kyiv, 2003.

Table 1

Medical and biological factors	Political, cultural and legislative factors	Socioeconomic and environmental factors	Personal factors
Being male or female	Policies and legislation	Levels of poverty, unemployment, crime and violence in a community	Perception and awareness of risk
Presence of an STI infection	Cultural and religious norms, attitudes and expectations	Quality of services, information, programmes and leisure activities in a community	Skills
Type of virus	Levels of political and economic stability and growth	Living in an urban versus a rural area	Knowledge
Stage of infection	System of social welfare	Existing norms, stereotypes, social networks, and resulting pressures	Behaviour
	The width of the gap between the rich and the poor	Levels of stigma, discrimination and human rights violations	
	Level of solidarity between generations and within the society	Drug scene	
		Levels of mobility and migration	

Research shows that once adolescent boys or girls have started to engage in one risk behaviour, they are more likely to engage in others as well (this is known as overlapping risk behaviour). In some cases they may do this as a way to ensure themselves a livelihood, while in other cases they do so to support another risk behaviour, such as drug use.[12]

MARA boys and girls are not, however, an isolated population group. Their level of vulnerability and risk to HIV infection is the highest, but their sex partners are also at increased risk of it.

In addition, there is a group of adolescent boys and girls, the so-called "especially vulnerable adolescents" (EVA), who are one step away from engaging in risk behaviour and who live in risky situations. For example, adolescents who live on the streets, use non-injecting drugs and belong to a street group in which others are already injecting drugs are considered EVA. They are at increased risk of starting to inject drugs, as research shows.[13]

[12] WHO, Broadening the horizon: *Balancing protection and risk for adolescents,* Department of Adolescent Health and Development, Geneva, 2002.

[13] UNICEF and UNAIDS, *Risk and protective factors in the initiation of injecting drug use,* Kyiv, 2006.

Fig. 1

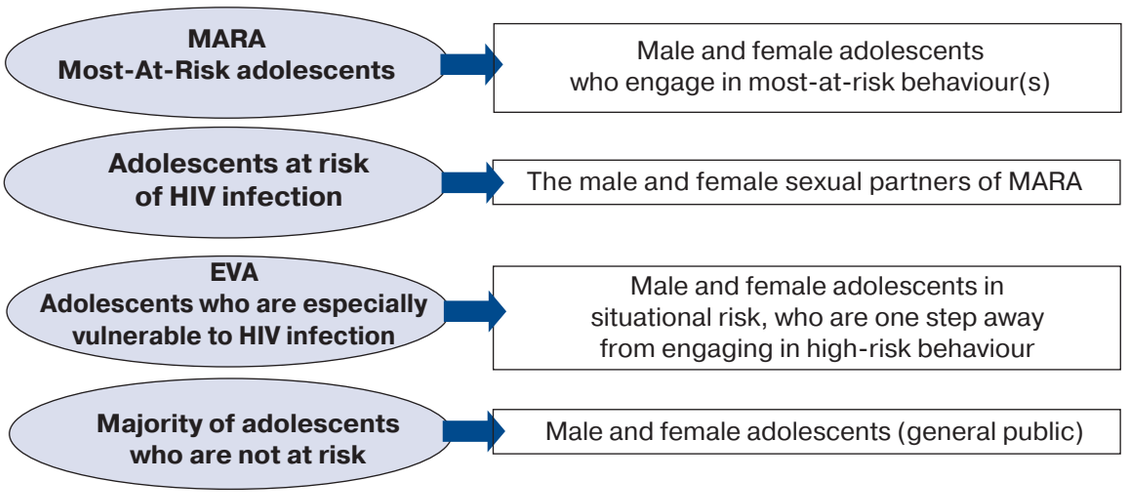


Figure 1. highlights the different stages of vulnerability and risk among adolescents[14].

MARA boys and girls and their sex partners and EVA boys and girls often intermix in the same groups. As research demonstrates, they can be found in many different settings, in particular living in families in crisis or on the streets; spending time in shelters for minors and other child-care institutions; or staying in detention centres and other penitentiary facilities and in psychosocial and drug rehabilitation centres. But they are also present in schools and in workplaces that employ persons 16 years of age and older. Sociological studies further show that EVA and MARA in Ukraine tend to access pharmacies frequently and to spend time in markets, Internet clubs and other places – places that are often linked to the purchase of substances and drugs.[15]

Various protective factors can lower vulnerabilities and risks[16] among adolescents. These include a positive relationship with parents or an adult in the community, a positive school environment, well-developed life skills and self-confidence, spiritual beliefs and active involvement in public life.[17]

Relatively little has been known about EVA and MARA boys and girls in Ukraine until now. This has hampered planning and programming for these population groups, as well as an adequate prevention response. The gaps in evidence and information have meant that decision makers, researchers and service providers have paid insufficient attention to EVA and MARA and to their role in the HIV epidemic. For instance, EVA and MARA were not recognised as groups in need of special attention until 2006 in Ukraine. Neither the Ukrainian National HIV/AIDS Concept for 2011 nor the National HIV/AIDS Programme 2004–2008 acknowledges them or sets out a response framework for them. Accordingly, national reports on HIV/AIDS, such as the 2006 Ukraine Report to the United Nations General Assembly Special Session on HIV/AIDS (UNGASS)[18], and national research reports on behavioural surveillance studies among most-at-risk population groups (MARPs) published from 2004 to 2007, presented no data on EVA and MARA boys and girls.

The situation started to change in late 2006. That was when the National *Road Map on Scaling-up Towards Universal Access to HIV/AIDS Prevention, Treatment, Care and Support in Ukraine by 2010 (Road Map)*

[14] Slightly revised figure based on a figure presented by Diane Widdus from UNICEF New York during the 2nd TSG (Technical Support Group) Global Consultation, Hanoi, 27–30 November 2007. Title of the presentation: Accelerating HIV Prevention Programming with and for Most-at-Risk Adolescents.

[15] UNICEF and UNAIDS, *Risk and protective factors in the initiation of injecting drug use, Kyiv, 2006; and:* AIDS Foundation East-West and UNICEF, *Children and young people living or working on the streets: the missing face of the HIV epidemic in Ukraine,* Kyiv, 2006.

[16] Homans, H., "Manual on Programming to Prevent HIV in Most-at-risk Adolescents" (draft), UNICEF Regional Office for Central and Eastern Europe and the Commonwealth of Independent States, Geneva, November 2007.

[17] Ibid.

[18] Ministry of Health of Ukraine, *National Report on the Follow-up to the UNGASS Declaration of Commitment on HIV/AIDS, Reporting Period: January 2003–December 2005,* Report prepared by the Ministry of Health of Ukraine in collaboration with the National Coordination Council on HIV/AIDS and with technical assistance from the International HIV/AIDS Alliance in Ukraine and the Joint United Nations Programme on HIV/AIDS (UNAIDS) in Ukraine, Kyiv, 2006.

for the first time officially recognised EVA and MARA as priority groups for the national response to the epidemic[19] . Most important, however, is that the new and improved National HIV/AIDS Concept[20] and National HIV/AIDS Programme 2009–2013[21] have acknowledged them as priority population groups for HIV prevention (both documents were prepared in 2008). The National HIV/AIDS Concept defines "risk groups" as "injecting drug users, orphans, homeless children, children detained or incarcerated, children from families in crisis, sex workers, men who have sex with men, migrants and other similar groups".

EVA and MARA boys and girls were recognised for the first time as a target population for the national AIDS response in 2006 by the Government and other national stakeholders.

In parallel to this official recognition, the Regional Office (RO) for Central Europe and the Commonwealth of Independent States (CIS) of the United Nations Children's Fund (UNICEF) continued to strengthen its activities in the area of HIV prevention for these population groups. With the Irish Government's support, it started a multicountry programme on "HIV prevention in most-at-risk adolescents in Ukraine and South Eastern Europe" (UNICEF MARA Project), with Ukraine being one of the priority countries.

The MARA Project's partners in Ukraine are the Ministry of Family, Youth and Sports (MoFYS), the State Social Services for Families, Children and Youth (SSSFCY) and the Ukrainian Institute for Social Research after Olexander Yaremenko (UISR after Olexander Yaremenko). In addition, the Project team is using an existing coordination mechanism to ensure that key national stakeholders stay involved in and guide project activities. Until May 2008, this mechanism was the informal Working Group on HIV Prevention, Treatment, Care and Support for At-risk Children. The Working Group was initiated by a multistakeholder group in 2007 to improve the coordination of activities related to HIV/AIDS and "at-risk children". It also agreed to act as a National Advisory Board for the MARA Project. It was co-chaired by the MoFYS and UNICEF and met several times in 2007 and 2008. At the end of May 2008, the Interdepartmental Committee on Childhood Protection of the Cabinet of Ministers of Ukraine[22] formalised the Working Group as an official sub-group of the Committee. However, since then, the Government has initiated no meeting.

Similar coordination mechanisms did not exist at the subnational level. As a result, the Project team established Regional Advisory Boards in all project sites. These are similar to the advisory board at the national level. They were then linked up to the existing Regional or City Coordination Councils on HIV/AIDS and Tuberculosis. In three of the four UNICEF MARA Project sites, the Regional Advisory Boards have by now become formal subgroups of the Regional or City Coordination Councils on HIV/AIDS and Tuberculosis.

These advisory boards make it a principle to consult with EVA and MARA representatives and involve them in their work. In particular, EVA and MARA boys and girls participate in working meetings and provide input into discussions through such mechanisms as focus groups and in-depth interviews.

The national and regional advisory boards consist of representatives of non-governmental and faith-based organizations (NGOs, FBOs) working in the HIV/AIDS field and/or with children and young people. Some of these representatives are former MARA boys and girls themselves. The boards include envoys from governmental organizations and institutions, in particular social services departments, departments for chil-

[19] UNAIDS, et al., *Road Map on Scaling-up Towards Universal Access to HIV/AIDS Prevention, Treatment, Care and Support in Ukraine by 2010,* Report prepared by a Multi-Stakeholder Working Group on Universal Access, based on the results of three national consultations, with technical assistance from the Joint United Nations Programme on HIV/AIDS (UNAIDS), Kyiv, 2006.

[20] National HIV/AIDS Concept *About the improvement of the Concept of the National Special Programme to ensure the prevention of HIV infection, and the treatment, care and support of HIV-infected persons and AIDS patients for the period of 2009–2013,* approved by the Cabinet of Ministers of Ukraine, # 728-r, 21 May 2008, Kyiv, 2008.

[21] For a copy, see the official website of the Ukrainian Parliament: www.zakon.rada.gov.ua.

[22] The Interdepartmental Commission for the Protection of Children was set up by Cabinet Decision No. 1200 as of 3 August 2000 in order to coordinate activities focusing on children in Ukraine. It is responsible for facilitating and coordinating state policies and legislation on child protection in cooperation with service providers, scientific institutions, local authorities and communities. The Commission includes the Head of the National Council of Children's Organizations Federation of Ukraine, the Ukrainian Parliament Commissioner for Human Rights, the UNICEF Representative in Ukraine and representatives of the Ministry of Family, Youth and Sports (Chair of the Commission), the Ministry of Health (Deputy Chair), the Ministry of Education and Science, Parliament and the Presidential Secretariat. It is supposed to meet at least quarterly.

dren, relevant child-care institutions such as shelters, the Criminal Police for Minors and local AIDS prevention centres and other medical establishments. The advisory boards also include representatives of legal services offices, the education sector and the Regional and/or City Coordination Councils on HIV/AIDS and Tuberculosis. Annex 1 provides an overview of planned and actual representation.

The main role of the advisory boards is:

- To advise and guide the UNICEF MARA Project team in all project-related activities.
- To give community representatives (EVA and MARA) the chance to participate in the discussion, planning, monitoring, undertaking and evaluation of the Project, as well as to establish a mechanism to keep them involved in the future.
- To influence in a positive way how the local community responds to EVA and MARA boys and girls.

Each advisory board has agreed terms of reference.

The following table provides an overview of Project objectives and the expected results for Ukraine (Table 2).

Table 2

UNICEF MARA Project objectives and expected results for Ukraine

Main Objectives	Expected Results
1. To strengthen the knowledge base on MARA boys and girls and to build the capacity of the national monitoring and evaluation system.	Sound MARA evidence base
2. To assess the legal barriers and to develop policy and guidance on the legal and ethical aspects of HIV prevention among MARA boys and MARA girls. 3. To build up partnership and cooperation with national and international stakeholders.	Enhanced protective environment and policy and legal frameworks for MARA boys and girls
4. To improve Government and NGO capacity to programme and provide needs-based and high-quality services for both MARA boys and girls. 5. To develop norms and standards for HIV prevention and support services for MARA boys and girls.	Strengthened capacity Established norms and standards
6. To ensure that MARA boys and girls have the best possible access to the targeted services, in order to reduce high-risk behaviours among them, in selected regions of Ukraine.	Strategic action plan for MARA boys and girls, including an essential package of targeted interventions and service delivery models, and implemented and evaluated pilot projects
7. To provide timely adjustments and to document good practices and lessons learned.	Documented results of monitoring, evaluation and intervention research

This report presents the key findings of the research that UNICEF and its project partners carried out in Ukraine during 2007 and 2008 (project objective No. 1). It discusses and interprets the results and the overall evidence base on EVA and MARA boys and girls in the context of the country's planning and programming needs with regard to HIV/AIDS, and in the context of current efforts to develop one national HIV/AIDS monitoring and evaluation (M&E) system. It also sets out a framework for HIV prevention interventions for EVA and MARA boys and girls based on current response capacities, identifies priority groups and unmet needs and provides recommendations for strengthening the prevention response to EVA and MARA at all levels within the context of the HIV epidemic.

1. BACKGROUND

As of 1 January 2008 there were 5,616,683 adolescent boys and girls aged 10 to 19 in Ukraine. That is, adolescents constitute 12.1 per cent of the country's total population.[23] While there have been no national or sub-national population size estimates for EVA and MARA boys and girls in Ukraine, hampering planning and programming at all levels, an analysis of the situation and of available statistics indicates that their number is considerable, and that they are exposed to a wide range of vulnerability and risk factors .

So far, there have been no national or sub-national population size estimates for EVA and MARA boys and girls in Ukraine, hampering planning and programming at all levels

1.1. Vulnerability and risk factors

Ukraine remains one of the European region's poorest countries. During the last seven years the poverty rate has hovered around 28 per cent[24]. As in many other countries, large families, single parent families and women and children under the age of 18 are most strongly affected by chronic poverty. While the unemployment rate has decreased in Ukraine in the last five years, unemployment among young people is higher than it is for the rest of the labour force.[25] Many of those without jobs are young first-time job seekers. This phenomenon is linked to rapid labour turnover and widespread short-term employment. Unemployment is greater among young women than among young men.[26]

Poverty and unemployment can create situations in which both adolescent boys and girls, but particularly girls[27], are tempted to engage in transactional sex or to sell sex as means to provide a livelihood. Widespread gender inequality increases girls' vulnerability . This inequality expresses itself in the education and employment opportunities available to girls. Ukraine at present lacks empowerment programmes for the latter.[28]

The vulnerability of girls to HIV is increased by widespread gender inequality in Ukraine.

There is no national consensus estimate of the size of the adolescent sex worker population in the country, but data from social research performed in Ukraine and Eastern Europe suggest that a significant proportion of female sex workers (FSWs) on the streets in Ukraine may be under the age of 18.[29] A report on sex work published in 2005 by the Open Society Institute (OSI) also indicates that a considerable number of sex workers in the Eastern European region have children who in most cases live in poverty, face stigma and social discrimination if their mothers' behaviour is known and have a greater-than-average likelihood of being exposed to HIV risk behaviour.[30]

[23] State Statistical Committee of Ukraine: statistics as of 1 January 2008, see at www.ukrstat.gov.ua.

[24] Based on Libanova, E.M., "Mechanism of social risks minimization in society in the context of the social security of the country", unpublished research report, Kyiv, 2007.

[25] World Bank, *Development and the Next Generation, World Development Report 2007,* Washington D.C., 2007, see at http://www.worldbank.org/wdr2007.

[26] International Labour Organization, *Global Employment Trends for Youth,* Geneva, 2006.

[27] AIDS Foundation East-West and UNICEF, *Children and young people living or working on the streets: the missing face of the HIV epidemic in Ukraine,* Kyiv, 2006.

[28] UNAIDS, *Assessing Gender Equality and Equity as Critical Elements in National Responses to HIV: Cambodia, Honduras and Ukraine. Presentation of policy guidance to address gender issues,* 20th Meeting of the UNAIDS Programme Coordinating Board, Geneva, 25–27 June 2007.

[29] ECPAT International and Ukrainian Institute of Social Research, "The situation of children in Ukraine and their vulnerability to commercial sexual exploitation", Kyiv, 2003; see also: Open Society Institute (OSI) and Central and Eastern European Harm Reduction Network, Sex Work, *HIV/AIDS, and Human Rights,* Central and Eastern European Harm Reduction Network, Lithuania, 2005.

[30] OSI and Central and Eastern European Harm Reduction Network, Sex Work, *HIV/AIDS, and Human Rights,* Central and Eastern European Harm Reduction Network, Lithuania, 2005.

The socioeconomic consequences of the transition phase through which Ukrainian society has been passing have not, however, spared males. Stereotypes about manhood are common in the country . It is widely assumed that men are "more knowledgeable and experienced about sex" than women, that they "have more sex partners" than women and that they should "dominate women and not show emotions or…seek help".[31] In addition, drinking alcohol is considered "manly", as much advertising in the country suggests. Many men, especially younger ones, employ risk behaviours as a coping strategy. This has resulted in a marked difference in average life expectancy between men and women (62.5 years for males versus 74.2 years for females). Men die on average 12 years earlier than females do and there are many female-headed households (49 per cent of all households in Ukraine).[32] The phenomenon of using risk behaviour as a coping strategy might also explain why, since 2003, the mortality rate of boys aged 15 to 17 has been twice as high as that of girls the same age.[33]

The vulnerability of boys to HIV is increased by widespread male stereotypes that support risk behaviours among males in Ukraine. The mortality rate of adolescent boys is twice as high as that of girls of the same age.

Then there is sex between men, which is one of the most stigmatised behaviours in Ukraine. It forces many boys and men to hide their sexual preferences, often in a marriage. The result is to increase their own and their spouses' vulnerability to and risk of HIV infection.[34]

Social benefits are still below the official subsistence level in the country, which means that those most in need receive insufficient support.[35] In 2005, 2.6 million children and adolescents in Ukraine were living in families with an income below the subsistence minimum. At the end of 2006, 113,681 families were registered with the State social services as "families in crisis"[36], which is recognised as a key vulnerability factor.[37] As of 1 July 2008, the State social services had registered 61,419 families "in crisis". Some 122,983 children were living in these families.[38]

Most of these families experienced crisis due to the disability of a parent or a child (21.9 per cent); due to serious problems in relations among family members (19.4 per cent) or to the use of alcohol, substances or drugs by a family member (18.4 per cent); due to unemployment of family members (13.5 per cent); due to orphanhood (10.5 per cent); due to domestic violence (2.7 per cent); due to the incarceration (2.6 per cent)

[31] Rivers, K., Aggleton, P., *Men and the HIV Epidemic, Gender and the HIV Epidemic,* United Nations Development Programme (UNDP), HIV and Development Programme, New York, 1999.

[32] State Statistics Committee: statistics as of 1 January 2008, see at http://www.ukrstat.gov.ua.

[33] Moiseenko, R.O., The health of children and adolescents: needs, priorities and challenges, presentation by the Head of the Department on maternity and child health of the Ministry of Health of Ukraine at the UNICEF mid-term review meeting, Kyiv, 1 November 2008.

[34] Based on an analysis of the results of the 2007 bio-behavioural surveillance study conducted among MSM in Ukraine; see: Balakireva, O.M., et al., *Monitoring of the behaviour of men who have sex with men. Analytical report on the research results,* International HIV/AIDS Alliance in Ukraine, Kyiv, 2008; on a written interview with Svjatoslav Sheremet, President of the Gay Forum of Ukraine in 2007, and on: Nash Mir (Our World) Gay and Lesbian Centre, "Report on the Situation of Homosexuals in Ukraine in 2006", Kyiv, 2006.

[35] State Institute for Family and Youth Development and Ministry of Family, Youth and Sports of Ukraine, "National Report on implementation of the decisions of the final outcome document of the Special Session of the UN General Assembly on Children (2002) and Action Plan "A World Fit for Children", Kyiv, 2007.

[36] A "family in crisis" in this context is commonly created by situations such as severe family financial problems. These lead to other problems, such as a breakdown in communication between parents, or to a parent starting to engage in unsafe or illegal activities; a general breakdown or the absence of any meaningful communication between parents and children, often linked to a lack of emotional support within the family; disasters such as a serious illness or the death of one or more members of the family, with which the family does not cope well; labour migration of one or both parents, leaving some children uncared for and unattended for long periods of time; domestic violence and abuse; or the excessive use of substances or drugs, including alcohol, leaving children without proper care; etc.

[37] State Institute for Family and Youth Development and Ministry of Family, Youth and Sports of Ukraine, "National Report on implementation of the decisions of the final outcome document of the Special Session of the UN General Assembly on Children (2002) and Action Plan "A World Fit for Children", Kyiv, 2007.

[38] Speech of Yury Pavlenko, Minister of Family, Youth and Sports, at All-Ukrainian meeting on social support for families, see at http://www.kmu.gov.ua/sport/control/uk/publish/article;jsessionid=BD14295B9A81656801A602B039CE6F61?artid=99659&cat_id=99860.

or migration (1.3 per cent) of a family member; and due to HIV infection (0.8 per cent). In addition, 7.1 per cent of families have several problems simultaneously.[39]

Abandonment, neglect and abuse of children and adolescents are also serious vulnerability and risk factors in Ukraine. This suggests that many children and adolescents live in unsafe environments. In 2006, 23,069 families with a total of 48,432 children were registered to receive, and did receive, services to help them prevent child abandonment.[40] Official warnings related to domestic violence and abuse of women and children were issued to 73,200 people in Ukraine in the first six months of 2008.[41] Domestic violence is considered to be one of the fundamental causes of children and adolescents running away and starting to engage in risk behaviour in Ukraine.[42] For six months of 2008 the Ministry of the Interior was informed that 2,223 children went missing. Less than 5 per cent of them reunited with their parents.[43]

Domestic violence and family crisis are two of the fundamental reasons why children and adolescents run away from home and start to engage in risk behaviour, often as a coping mechanism.

Another indication that adolescents are living in unsafe environments are the 2007 mortality statistics for adolescents. They show that almost 63 per cent of adolescents aged 15 to 17 died of accidents, including traumas and poisoning.

In 2007, over 20,000 children and adolescents passed through Ukraine's 95 State-run temporary shelters. Of these children, 11,324 (almost 55 per cent) had been living on the streets.[44] There is no official figure for the overall number of adolescent boys and girls who are living and working on the streets. The street environment is particularly risky, rendering adolescents vulnerable to sexual and labour exploitation and violence, as well as to HIV risk behaviours and HIV infection.[45] Many adolescents on the streets also find themselves excluded from education, health care, legal and social services.[46]

The number of children and adolescent boys and girls in Ukraine who are without parental care and who are institutionalised remains large . As of 10 March 2008, there were 101,354 orphans and children and adolescents without parental care. Most of them live in institutions.[47] Institutionalisation as such can be a vulnerability factor, as few child-care institutions in Ukraine have the capacity to provide the individualised and intensive care and support that especially EVA and MARA boys and girls require. The result is adolescents and young people who, upon graduating from the facility, lack the necessary life skills to cope with the world outside, and who are especially vulnerable to being trafficked for labour or sexual exploitation.[48] Coverage

[39] Ibid.

[40] State Institute for Family and Youth Development and Ministry of Family, Youth and Sports of Ukraine, "National Report on implementation of the decisions of the final outcome document of the Special Session of the UN General Assembly on Children (2002) and Action Plan "A World Fit for Children", Kyiv, 2007.

[41] The Ministry of Family, Youth and Sports of Ukraine: statistics for the first six months of 2008, see at http://www.kmu.gov.ua.

[42] UN Human Rights Committee, "International Covenant on Civil and Political Rights. Consideration of reports submitted by state parties under Article 40 of the Covenant, concluding observations of the Human Rights Committee on Ukraine", Eighty-eighth session, Geneva (16 October–3 November 2006), Geneva, 28 November 2006.

[43] The Ministry of Interior of Ukraine, statistics for the first six months of 2008, see at http://mvs.gov.ua.

[44] Data provided by the State Institute for Family and Youth Development of the Ministry of Family, Youth and Sports in March 2007 to UNICEF Ukraine.

[45] Kissing, D.M., et al., "HIV seroprevalence in street youth in St. Petersburg, Russia", *AIDS* 2007, Vol. 21 No. 17, pp. 2333–2340, and: AIDS Foundation East-West and UNICEF, *Children and young people living or working on the streets: the missing face of the HIV epidemic in Ukraine,* Kyiv, 2006.

[46] AIDS Foundation East-West and UNICEF, *Children and young people living or working on the streets: the missing face of the HIV epidemic in Ukraine,* Kyiv, 2006.

[47] The Ministry of Family, Youth and Sports: statistics as of 10 March 2008, see at http://www.kmu.gov.ua.

[48] UNICEF, et al., *Trafficking in Ukraine. An Assessment of Current Responses,* Kyiv, 2005; and: Kyiv International Institute of Sociology, "Analytical report based on survey results. Assessment of initial knowledge, attitudes and practices among social workers and management of child-care institutions and children living in such institutions about the personal, social and psychological needs of children living in care institutions", Kyiv, December 2005.

with alternative, for instance family-based, care options remains insufficient.[49] The same holds true for services geared to prevent institutional placement. Ukraine has a very limited range of short-term care options for children from families in crisis. The range does not include respite and day-care centres, short term stays in foster families and so on. In addition, efforts made to reintegrate children, where possible, with their own families are insufficient in light of the apparent size of the problem. This insufficiency is mainly the result of insufficient support capacity.[50]

The number of adolescents without parental care who are institutionalised is large in Ukraine. Research shows that institutionalisation can be a vulnerability factor in the country. For instance, it can lead to trafficking for labour or sexual exploitation.

Adolescent boys and girls living with HIV or an AIDS-related disease, or who are personally affected by HIV (for instance, who were orphaned by AIDS), face similar problems when they are institutionalised, in addition to the stigma to which they are often exposed within and outside the institution.[51] Those who live at home with their families not only suffer from psychological distress, but also often lack consistent responsive care and face economic hardship, loss of inheritance, stigma, discrimination, isolation and more.[52] According to a socioeconomic impact study published in 2006[53], the number of children orphaned by HIV/AIDS and children affected by HIV/AIDS continues to grow in Ukraine .

The number of children orphaned and affected by HIV/AIDS is growing in Ukraine.

Ukraine has one of Europe's highest incarceration rates. According to data of the State Penitentiary Department of Ukraine, as of 1 October 2006, 1,500 adolescents were in pre-trial detention centres; 8,000 were registered on the books of the Criminal Executive Inspection sub-units (they were convicted without incarceration); and 2,500 were in penitentiary facilities (they were convicted and incarcerated). Of those in the latter, most were aged 16 to 18 (72 per cent). More than a third had not been to school prior to conviction, over half were from single-parent families, 21 per cent were orphans, and 8 per cent had previously been educated in special educational facilities. Detention centres and other penitentiary facilities, meanwhile, are settings that are additional determinants of HIV vulnerability. An inmate of such a facility faces a greater likelihood of being infected with HIV through injecting drug use or anal sex (either forced and by consensus).[54]

Ukraine is also a country of transit, origin and destination for different migration flows, including many undocumented migrants.[55] Qualitative research among children of labour migrants[56] aged 12 to 17 indicates that quite a few of the adolescent boys and girls belonging to this population experience psychological problems. It also indicates that some of them start engaging in risk behaviours because they receive insufficient care and support from their temporary caregivers, educational institutions and/or social services. Furthermore, trafficking is becoming more common in Ukraine. The vast majority of cases involve young women trafficked for sexual exploitation, which increases the risk of HIV infection.[57]

[49] Gudbransson, M., "Children in institutions: prevention and alternative care. Final report", Working Group on Children at Risk, approved by the European Committee for Social Cohesion at its 12th meeting in Strasbourg, 17–19 May 2004.

[50] Bilson, A. and Carter, R., "Strategy development for the reform of the state care system for children deprived of parental care living in state institutions", report for UNICEF Ukraine, June 2008.

[51] UNICEF, *Prevention of HIV Infection in Infants: Documenting and Learning from the Ukraine Experience,* Kyiv, 2007.

[52] UNAIDS, UNICEF, et al., *The Framework for the Protection, Care And Support of Orphans and Vulnerable Children Living in a World with HIV/AIDS,* Geneva, July 2004.

[53] World Bank, et al., *Socioeconomic impact of HIV/AIDS in Ukraine,* Kyiv, 2006.

[54] UNAIDS, *Intensifying HIV Prevention,* Geneva, 2006; and: Leinikki, P., "Draft Summary Report, Technical Issue: 1.1.3 Prisoners and 2.6.4 State Penitentiary Department", draft report prepared in 2007 within the frame of the Comprehensive External Evaluation of the National AIDS Response in Ukraine, UNAIDS (2007–2008), unpublished.

[55] Pribytkova I. and Gromovs J., *Migration Trends 2004–2006,* Soderkoping Process Countries, European Commission, 2007.

[56] Ukrainian Institute for Social Research after Olexander Yaremenko and La Strada-Ukraine International Women's Rights Centre, *Problems of children of labour migrants: an analysis of the situation,* Kyiv, 2006.

[57] International Organization for Migration, *Needs Assessment for Reintegration Assistances For Trafficked Males,* Kyiv, 2006.

The size of the mobile population groups in the country is significant, too. One of the biggest groups is the Roma population. There is anecdotal evidence that a considerable number of children of Roma families are working on the streets to help earn livings for their families.[58] But there are also other mobile populations, such as truck drivers and mariners, many of the members of which are young men who use commercial sex services[59].

Being displaced and being a refugee can also increase an adolescent's vulnerability to HIV. However, displaced persons and refugees are relatively few in Ukraine, and evidence indicates that their HIV vulnerability so far appears to be no higher than that of the country's general population.[60]

The following constitute serious vulnerability and risk factors for adolescents in Ukraine: widespread use of and easy access to alcohol, substances and drugs; high levels of human trafficking and of incarceration; living or working on the streets; the migration of one or both parents; belonging to a highly mobile or socially marginalised population group; and being personally affected by HIV/AIDS.

Another major vulnerability factor is the widespread use of alcohol, substances and drugs in Ukraine. These are relatively cheap and easily accessible to all age groups. The current situation in the country is characterised by a rapid increase in substance and drug use.[61] Data from different organisations and agencies suggest that the majority of injecting drug users (IDUs) are males.[62] Based on the results of behavioural surveillance studies (BSSs) conducted in past years in Ukraine, it is estimated that young people under the age of 25 may constitute between 42 to 58 per cent of the drug-injecting population in Ukraine.[63] Taking the national consensus estimate of the size of the IDU population in Ukraine as of 2007 as the denominator (325,000 to 425,000 IDUs)[64], there might therefore be between 136,500 (low estimate) to 246,500 (high estimate) IDUs in Ukraine who are under 25 .

There could be between 136,500 (low estimate) to 246,500 (high estimate) IDUs in Ukraine who are under the age of 25 (based on 2007 IDU population size estimates).

The age of injecting drug use initiation in Ukraine is estimated to be around 18. It is assumed to be dropping. Non-injecting drug use seems in most cases to precede the first injection, which appears to be an unplanned event for the majority of IDUs under 18. Few of the minors buy and prepare their first injections by themselves. Having a spouse or sex partner who is injecting drugs and drinking alcohol more or less regularly appears to be an important factor in the initiation of girls and young women .[65]

Having a spouse or sexual partner who is injecting drugs and drinking alcohol more or less regularly appear to be important factors in the initiation of injecting drug use among girls and young women.

It is also noteworthy that many IDUs have completed their secondary education or are still in school.[66]

[58] UNICEF, et al., *Trafficking in Ukraine. An Assessment of Current Responses,* Kyiv, 2005.

[59] Araujo I. and Roberts-Hatcher J., "Draft Summary Report, Technical Issue 1.1.5.2 Migrants and Mobile Populations", draft report prepared in 2007 within the frame of the Comprehensive External Evaluation of the National AIDS Response in Ukraine, UNAIDS (2007–2008), unpublished.

[60] Homans, H., "Draft Summary Report, Technical Issue 1.1.5, "Refugees and asylum seekers in Ukraine", draft report prepared in 2007 within the frame of the Comprehensive External Evaluation of the National AIDS Response in Ukraine, UNAIDS (2007–2008), unpublished.

[61] UNICEF and UNAIDS, *Risk and protective factors in the initiation of injecting drug use*, Kyiv, 2006.

[62] UNICEF and UNAIDS, *A review of work with injecting drug users in Ukraine in the context of the HIV/AIDS epidemic,* Kyiv, 2005.

[63] UNICEF and UNAIDS, *Risk and protective factors in the initiation of injecting drug use,* Kyiv, 2006.

[64] Ukrainian AIDS Prevention Centre, World Health Organization, et al., "National Consensus Estimates", overview table, Kyiv, 2007.

[65] UNICEF and UNAIDS, *Risk and protective factors in the initiation of injecting drug use,* Kyiv, 2006.

[66] Ibid.

Adolescents whose parents use alcohol or substances and drugs can easily come to perceive this behaviour as "normal", and there is some evidence from Ukraine that children of parents who are using alcohol have a higher risk of starting to use substances and drugs than do their peers. This is especially true if an otherwise protective and supportive environment is missing, as is particularly the case in areas of the country that are severely deprived socially and economically.[67]

Last, Ukraine continues to have high rates of STIs, which can accelerate sexual HIV transmission. Data suggest that members of MARPs are more vulnerable to STIs than are their counterparts in the general population.[68] However, EVA and MARA boys and girls, particularly boys, are insufficiently targeted by reproductive and sexual health services in Ukraine, and few of the existing youth-friendly clinics that offer STI counselling services reach them.[69]

1.2. The policy and legislation frameworks

In order to ensure an effective response to the HIV epidemic, policies and legislation need to create a supportive and enabling environment. The UNICEF MARA Project team therefore analysed existing policies and legislation concerning service access barriers for adolescents and the provision of HIV-related medical and social services to children and youth most at risk of HIV infection.

Because youth aged 18 to 19 possess full legal capacity, the analysis focused on 10- to 18-year-olds. This latter group has partial and incomplete civil legal capacity, which can create barriers to its members receiving high-quality medical and social services.

In general, Ukraine's national legislation corresponds with widely accepted international legislation, including legal documents of the European Council. However, in practice, the prevailing legal culture and the manner in which decision makers interpret laws create problems. The following summarises the main problems that the policy and legislation review identified.

There are contradictions between how Ukrainian legislation and different international organizations define the terms "children", "adolescents" and "youth". International documents, for instance, use the term "adolescents" to mean people aged 10 to 19. Ukrainian legislation, on the other hand, uses the term "adolescents" but does not define it, which means that "adolescents" are not considered a legal age category. Ukrainian legislation does use and define the term "children" (people under 18) and "youth" (people aged 14 to 35). Consequently, in the context of the Ukrainian legislation, when one speaks about "adolescents" aged 10 to 19, one must differentiate between two different groups: (1) those aged 10 to 18, who are "children" and lack complete legal capacity; and (2) those aged 18 and 19, who are "adults" and possess full legal capacity. Furthermore, Ukrainian legislation differentiates between children younger and children older than 14. Until they turn 14, children are considered "very young" and have very limited legal capacity. Children aged 14 to 18, meanwhile, are considered "minors" and have legal capacity that, though incomplete, is greater than that of children under 14 (Article 6, Family Code of Ukraine).

In terms of access to medical services in Ukraine, one important issue to consider is how accessible voluntary HIV counselling and testing (VCT) are to 10- to 18-year-old children (particularly those most at risk of HIV infection) who lack a legal representative's consent. Article 7 of the Law of Ukraine On Prevention of Acquired Immunodeficiency Syndrome (AIDS) and on Social Protection of the Population (AIDS Law) states the following: "Medical examinations of minors under the age of 18, and of people who have incomplete legal capacity, can be performed upon request or with the consent of their legal representatives, who

[67] Ibid.

[68] Ministry of Health of Ukraine, *National Report on the Follow-up to the UNGASS Declaration of Commitment on HIV/AIDS, Reporting Period: January 2003–December 2005*, Report prepared by the Ministry of Health of Ukraine in collaboration with the National Coordination Council on HIV/AIDS and with technical assistance from the International HIV/AIDS Alliance in Ukraine and the Joint United Nations Programme on HIV/AIDS (UNAIDS) in Ukraine, Kyiv, 2006; AIDS Foundation East-West and UNICEF, *Children and young people living or working on the streets: the missing face of the HIV epidemic in Ukraine,* Kyiv, 2006; and: Homans, H., "Manual on Programming to Prevent HIV in Most-at-risk Adolescents" (draft), UNICEF Regional Office for Central and Eastern Europe and the Commonwealth of Independent States, Geneva, November 2007.

[69] Based on discussions with the UNICEF and United Nations Population Fund (UNFPA) offices in Ukraine in July 2007.

have the right to attend the examinations". In practice, this Law is being interpreted in different ways. Many physicians who provide HIV testing services understand the Law as a strict order. They consider that the presence of a child's legal representative during examination is mandatory, and that they cannot give a child aged 14 to 18 an HIV test without his or her representative's request and consent. Thus, some health care facilities do not give HIV tests to children who arrive without a legal representative. However, the AIDS Law can be interpreted differently, as stipulating the following: a 14- to 18-year-old does not need the presence of a legal representative to undergo HIV-related medical examinations, as the Law does not specifically mandate this. (The situation concerning children under 14 years will be addressed later on in this sub-chapter.) In other words, children under 18 can be tested for HIV upon request and with the consent of their legal representative, but children aged 14 to 18 years can also be tested based on their personal consent alone. This interpretation is additionally supported by Part 3 of Article 284 of the Civil Code of Ukraine, which says that 14- to 18-year-olds can receive medical examinations and care upon their own consent.

It is therefore clear that a child older than 14 can undergo medical examination, including HIV diagnostics, without the consent or presence of a legal representative. The latter can, however, request that a child be examined. In such a case, the representative would have the right to be present during the examination.

According to current Ukrainian legislation, children under 14 (including those aged 10 to 14) cannot undergo medical examination without the request and consent of a legal representative, who has the right to be present during the examination. However, applying this rule to EVA and MARA under 14 creates a problem, as EVA and MARA often find themselves in situations in which their legal representatives are, for a variety of reasons, either absent or unable/unwilling to request or consent to a medical examination, and/or to be present. The negative and even irreparable consequences of the delays in diagnosing HIV infection that this can cause are obvious. Ukrainian legislation fails to address this issue.

> The Ukrainian legislation does not provide clear guidance on HIV testing for children without parental care, particularly for MARA, children living on the streets and children under the age of 14.

Another problem is the provision of high-quality follow-up care and support services to HIV-positive EVA, MARA and children under 14, particularly services that NGOs provide.

It must also be noted that the Order on *Procedures of Health Care Services for Children in Shelters for Minors of the Services for Children and in Psychosocial Rehabilitation Centres for Children* (approved by the MoFYS and the Ministry of Health of Ukraine (MoH) as of 28 September 2006, № 3297/645) contradicts Part 3 of Article 7 of the AIDS Law. At issue are the 2006 Order's requirements about performing mandatory HIV tests among children entering these facilities. The Order requires that HIV test results be provided to the facilities' pedagogical staffs, thereby violating two points in the AIDS Law. First, Part 2 of Article 8 of that Law stipulates that HIV test results be provided "in cases envisaged by the laws of Ukraine". But the 2006 Order is not a law, but rather just what it claims to be: a sectoral order. Second, pedagogical staffers who work at shelters for minors and psychosocial rehabilitation centres are not among the people who can receive such information, according to Part 2 of Article 8 of the Law. There are no clear recommendations on who should provide HIV test result information or on what other steps (diagnostics, treatment and so on) should be taken after it is provided. Nor are there clear recommendations about how the information should be provided, in what form it should be provided, on what legal grounds it should be based, under what conditions all this should be done and so on. In addition, the AIDS Law specifies no follow-up activities for HIV-infected children who were not born to HIV-infected mothers, nor does it establish procedures for counselling these children's parents or legal representatives. It does, however, establish procedures for the parents or legal representatives of children born to HIV-infected mothers.

In parallel to this report's publication, various changes to the existing AIDS Law are being discussed. Some of these changes would rectify the above-mentioned issues.

Ukraine's legislation does not much concern itself with informing the population about HIV/AIDS and HIV-related services. There is no comprehensive HIV/AIDS information, education and communication strategy at the national or subnational level. Informing people is done reactively, not proactively. No policy exists to spread information about how HIV is transmitted or how to prevent it, or about the scope of HIV-

related services. NGOs primarily target adult risk populations (IDUs, FSWs, MSM) or the general population. Those organizations who work with risk populations lack a sufficiently large network of outreach workers, and so rely on the service-seeking behaviour of their target populations. Few of them work with children and adolescents outside of the formal education sector.

The access of minors to social services, as provided for by Ukrainian legislation, appears at first sight unproblematic. However, the legislation does not specify which mechanisms will ensure access. Various issues remain unaddressed. First, there is no explanation of how children will be informed about existing social services. Second, it is unclear how social services can be made acceptable for children and adolescents (that is, how they can be made to work according to youth-friendly approaches). Third, there is no explanation of how to ensure that children have access to psychosocial rehabilitation and re-socialization services. There are gaps between the implementation of the social service provision policy, the effective monitoring of the policy's implementation, and the use of M&E results for strategic planning purposes.

NGOs providing social services rarely work with children under 18. Also, as mentioned before, they lack outreach capacity and the capacity to work with children who do not attend school, especially EVA and MARA.

Last, it must be stressed that Ukraine is still in the process of developing a juvenile justice system. Current legislation has many gaps pertaining to juvenile justice. A great number of documents address issues related to children and adolescents, and this poses an additional challenge.

1.3. Strategic planning and programming

Existing policies and legislation hinder the development of services, of service access and of systems for safeguarding the rights of EVA and MARA boys and girls. Meanwhile, there are no national and subnational multisectoral HIV prevention strategies and action plans for these population groups. The result has been service provision that is highly fragmented, uncoordinated and generally insufficient[70]. The lack of such strategies explains why such little attention is paid to these groups in HIV-related research, national AIDS response monitoring, and national and subnational resource allocation. Indeed, it explains why Government pays such little regard to these groups in general. In addition, it explains why there are no agreed prevention service packages and evidence-based service delivery models for the various EVA and MARA sub-populations [71] and why research and programming for them has been uninformed by ethical principles.[72] It should be noted, however, that the Sociological Association of Ukraine adopted precisely such ethical principles on 9 December 2008. They are based on guidelines that the UNICEF RO drafted for the UNICEF MARA Project countries in 2007.

> The absence of a multisectoral HIV prevention strategy and action plan for EVA and MARA boys and girls at all levels has resulted in highly fragmented, uncoordinated and insufficient service delivery.

While much data on HIV/AIDS and on related issues is being collected in Ukraine, a number of issues have so far prevented using it to programme for EVA and MARA. In particular these issues are[73]:

[70] Teltschik, A. , "Draft Summary Report, Technical Issue: 1.1.4 MARA and MARY, Technical area: 1. Prevention / 1.1 Most-at-Risk Populations", draft report prepared in 2007 within the frame of the Comprehensive External Evaluation of the National AIDS Response in Ukraine, UNAIDS (2007–2008), unpublished.

[71] Note that while the Road Map sets out an overall minimum package of prevention services for "children and adolescents at risk", the package does not take into account the differing needs of the various sub-populations of EVA and MARA boys and girls and does not reflect the various settings in which they live.

[72] UNICEF, "Desk Research Report. A review of the evidence on HIV/AIDS and most-at-risk adolescents (MARA) and young people (MARY) in Ukraine", internal working document, UNICEF Ukraine, Kyiv, 2008.

[73] UNAIDS, "Comprehensive External Evaluation of the National AIDS Response in Ukraine: Consolidated Report (zero draft)", Kyiv, June 2008; and: Hoppenbrouwer, J., "Draft Summary Report, Technical Issues: 8.1.1-8.1.12 National M&E Plan, National indicators/reporting, Databases and information management, National programme M&E, Oblast and Sectoral M&E, Research, studies and ethics, Data use, GFATM M&E, World Bank M&E and other M&E , Technical area: 8. Monitoring and Evalu-

a. The absence of a centralised national M&E system. This system should have a unit responsible for maintaining a national HIV/AIDS database and library and for systematically collecting, processing, analysing and disseminating M&E data from different sources and sectors, and for different population groups, including EVA and MARA. The lack of such a system makes it hard to access data, as data sets and reports need to be requested individually from various organizations and agencies[74].

In 2008, efforts intensified to establish one national M&E centre on HIV/AIDS.

b. Up until 2008, data collected in Ukraine within the frame of sociological research and biological and behavioural surveillance studies were not systematically disaggregated for the younger age groups by sex, region, social status, risk behaviour and population group. This made it harder to target interventions reliably.[75] Data disaggregation and the age breakdown used also vary between and within sectors. National HIV/AIDS reports, for instance, have to date presented data primarily on young people under 25, or on those aged 15 to 24. They did not consider adolescents aged 10 to 19 to be a separate group. The reports were therefore less useful for planning and programming for EVA and MARA boys and girls than they might have been.[76]

During a retreat in August 2008, the national M&E Working Group on HIV/AIDS[77], which was established under the auspices of the National Council for the Prevention of the Spread of Tuberculosis and HIV/AIDS (formerly the National Coordination Council on HIV/AIDS) in April 2007 in Ukraine, came to a conclusion. It decided that the systematic disaggregation of national data on HIV/AIDS by age will be an important aspect of the one national M&E system on HIV/AIDS in Ukraine, which is in development. The importance of systematic disaggregation of national and subnational data by age was also stressed in the Resolution of the Fourth National Conference on "Changing the national system of monitoring and evaluation of measures to fight the HIV/AIDS epidemic in Ukraine"[78] (Resolution). It will also be reflected in a new M&E guidance document for the subnational level, produced by Constella Futures[79].

c. As mentioned before, the age category "adolescents" is not a legal one in Ukraine. This constitutes a serious obstacle to planning and programming for those aged 10 to 19, and explains why national reports do not refer to such a category.

d. Also, national and subnational estimates of EVA and MARA sub-population sizes are lacking. There is no information about the proportion of adolescents among MARPs, or estimates of how many adolescents live or work on the streets. Yet such estimates are critical to calculating programme coverage, estimating resources and planning capacity.[80]

ation, 8.1 National M&E Systems", draft report prepared in 2007 within the frame of the Comprehensive External Evaluation of the National AIDS Response in Ukraine, UNAIDS (2007-2008), unpublished.

[74] See also: UNICEF, "Desk Research Report. A review of the evidence on HIV/AIDS and most-at-risk adolescents (MARA) and young people (MARY) in Ukraine", internal working document, UNICEF Ukraine, Kyiv, 2008; and: UNAIDS, "Comprehensive External Evaluation of the National AIDS Response in Ukraine: Consolidated Report (zero draft)", Kyiv, June 2008.

[75] World Health Organization Regional Office for Europe, *European strategy for child and adolescent health and development,* Regional Committee for Europe, fifty-fifth session, Bucharest, 12–15 September 2005, Copenhagen, 2005.

[76] Ministry of Health of Ukraine, *Ukraine National Report on Monitoring Progress Towards the UNGASS Declaration of Commitment on HIV/AIDS, Reporting Period: January 2006–December 2007,* Kyiv, 2008.

[77] The working group includes representatives of different ministries, research institutions, international and bilateral organizations and civil society organizations, including people living with HIV. It serves as an open forum in which all partners involved in various aspects of research, monitoring and evaluation can facilitate the coordinated planning, collection and dissemination of national data and operational research and support the development of one national M&E system; for more information, see for instance: Ibid.

[78] The Conference took place from 24–27 September 2008 in Yalta, Ukraine, and the Resolution was published by the Ministry of Health of Ukraine, UNAIDS and the International HIV/AIDS Alliance.

[79] Constella Futures is an international company currently implementing a USAID-funded HIV/AIDS capacity project in Ukraine.

[80] UNAIDS, *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations,* Geneva, 2007.

The Resolution of the Fourth National M&E Conference in Ukraine confirms the need to estimate regularly how many MARPs, MARA and children live on the streets.[81] The International HIV/AIDS Alliance in Ukraine, within the frame of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) Project, also confirms this need. A new project has been recently launched to estimate population sizes of MARPs at the subnational level, making sure to account for proportions of adolescents.

e. Until 2007, samples of biological and behavioural surveillance studies in Ukraine were too small to enable secondary analyses of the data for adolescent boys and girls, and by region.

In 2007, the International HIV/AIDS Alliance (which is largely funding the studies through the GFATM grants to Ukraine), in cooperation with the implementing research team from the UISR after Olexander Yaremenko, and with Constella Futures providing additional financial support, decided to increase the samples for the younger age groups to the point where a secondary analysis was possible. In 2008, the International HIV/AIDS Alliance, in cooperation with the UISR after Olexander Yaremenko, also issued guidelines[82] for monitoring the HIV epidemic in Ukraine. They stress the importance of including sufficiently large samples (minimum: n=300) for adolescents in the overall sample, and of conducting a separate analysis of the data for adolescents under 19.

f. There is no agreed minimum set of data to be collected by service providers (independent of ownership) on EVA and MARA boys and girls, nor is there a set of agreed indicators for these population groups at the national and subnational levels.

Different sectors have, however, made efforts in the last year to standardise data collection and agree on a minimum set of data. For instance, the International HIV/AIDS Alliance, within the frame of the GFATM project, developed a system called SYREX for its non-governmental sub-grantees. It collects a minimum set of data about clients of HIV prevention and harm reduction projects. Also, the SSSFCY introduced a new system called PIK in 2008. While this is a start, the Comprehensive External Evaluation[83] of the National AIDS Response in Ukraine 2004–2008, which was carried out in late 2007 to early 2008 (External Evaluation), made a good point. It noted that these systems not only face various problems in their implementation, but that they have also been created primarily as internal management information tools, and have yet to be aligned with systems that other sectors and organizations use.[84]

g. Qualitative data on EVA and MARA boys and girls is insufficient. There are many gaps in the understanding of their social and sexual networks, their diversity, their health-seeking behaviour and their behavioural determinants.

h. Programmatic data for EVA and MARA boys and girls is almost non-existent, as is intervention research data[85].

To start rectifying this situation, the UNICEF MARA Project is supporting the development of prevention strategies and action plans for MARA boys and girls at the national and subnational levels. These efforts are based on a complex analysis of the situation of these boys and girls in Ukraine and on the research that this report presents.

[81] Ministry of Health of Ukraine, UNAIDS and International HIV/AIDS Alliance in Ukraine, Resolution of the Fourth National Conference on "Changing the national system of monitoring and evaluation of measures to fight the HIV/AIDS epidemic in Ukraine", Yalta, 24–27 September 2008.

[82] Balakireva, O.M., et al., *Methodological recommendations on conducting research for monitoring the HIV epidemic in Ukraine,* International HIV/AIDS Alliance in Ukraine, Kyiv, 2008.

[83] UNAIDS, "Comprehensive External Evaluation of the National AIDS Response in Ukraine: Consolidated Report (zero draft)", Kyiv, June 2008.

[84] Hoppenbrouwer, J., "Draft Summary Report, Technical Issues: 8.1.1-8.1.12 National M&E Plan, National indicators/reporting, Databases and information management, National programme M&E, Oblast and Sectoral M&E, Research, studies and ethics, Data use, GFATM M&E, World Bank M&E and other M&E, Technical area: 8. Monitoring and Evaluation, 8.1 National M&E Systems", draft report prepared in 2007 within the frame of the Comprehensive External Evaluation of the National AIDS Response in Ukraine, UNAIDS (2007–2008), unpublished.

[85] See also: UNICEF, "Desk Research Report. A review of the evidence on HIV/AIDS and most-at-risk adolescents (MARA) and young people (MARY) in Ukraine", internal working document, UNICEF Ukraine, Kyiv, 2008; and: UNAIDS, "Comprehensive External Evaluation of the National AIDS Response in Ukraine: Consolidated Report (zero draft)", Kyiv, June 2008.

1.4. HIV prevalence and incidence

An estimated 1.64 per cent of Ukraine's population aged 15 to 49 is living with HIV. The country has the most severe HIV epidemic in the European region. An estimated half a million people of reproductive and productive age may be infected with HIV.[86]

According to the case register of the Ukrainian AIDS Prevention Centre, only 493 adolescents aged 15 to 17 and 16,513 young people aged 18 to 24 were officially registered as HIV positive as of 1 January 2008. The majority of these were most at risk of HIV infection. HIV prevalence among MARA boys and girls may, however, be much higher than the official statistics indicate. Such is suggested by the results of a secondary analysis[87] of data on adolescent IDUs and FSWs aged 15 to 19 from sentinel surveillance studies among MARPs that were carried out in 2006 by the Ukrainian AIDS Prevention Centre, as well as of data on MSM aged 15 to 24 from a bio-behavioural surveillance study among MSM in 2007. For both, see Table 1.4.1.

HIV prevalence among MARA boys and girls in Ukraine appears to be much higher than official statistics suggest.

Table 1.4.1:

2006 Sentinel Surveillance Study		
Target group	**Total tested**	**% tested HIV positive**
Female IDUs, aged 15 to 19 years	54	39%
Male IDUs, aged 15 to 19 years	116	29%
FSWs, aged 15 to 19 years	99	11%
2007 Bio-Behavioural Surveillance Study		
Target group	**Total tested**	**% tested HIV positive**
MSM, aged 15 to 24 years	137	4%

Despite the limitations of the official HIV case register in Ukraine, the available statistics on new HIV infections per year clearly show that HIV continues to spread fast among all the country's age groups. In 2007, adolescents aged 15 to 19 made up 2.8 per cent of all newly registered HIV cases (0.8 per cent boys and 5.6 per cent girls)[88]. However, coverage with VCT is very low among this age group, so these figures might not reflect the actual situation .

While HIV continues to spread fast in Ukraine, low coverage with HIV testing among EVA and MARA boys and girls implies that the official statistics on new HIV infections among this group do not represent the actual situation.

While the HIV epidemic is still concentrated among MARPs in Ukraine, and HIV is still mostly transmitted through injecting drug use, the risk of a generalised epidemic continues to grow. The number of HIV-infected women of childbearing age is rapidly increasing, as is the number of children born to HIV-positive mothers.[89] Data for 2007 from the Ukrainian AIDS Prevention Centre suggest that while the majority of officially registered males aged 15 to 19 contracted HIV through injecting drug use (65 per cent), most girls the same age contracted it through unprotected heterosexual contact (89 per cent). As there is insufficient information available on the sex partners of the HIV-infected girls, it is difficult to say whether or not these

[86] Ministry of Health of Ukraine, *Ukraine National Report on Monitoring Progress Towards the UNGASS Declaration of Commitment on HIV/AIDS,* Reporting Period: January 2006–December 2007, Kyiv, 2008.

[87] UNICEF, "Desk Research Report. A review of the evidence on HIV/AIDS and most-at-risk adolescents (MARA) and young people (MARY) in Ukraine, internal working document", UNICEF Ukraine, Kyiv, 2008.

[88] Ukrainian AIDS Prevention Centre/Ministry of Health of Ukraine, et al., "HIV infection in Ukraine", Information Bulletins No. 29, Kyiv, 2007; and: Ukrainian AIDS Prevention Centre, "A summary of HIV statistics on adolescents aged 15 to 17 years provided to UNICEF upon request in 2007 and 2008", internal working document , 2007.

[89] Ministry of Health of Ukraine, *Ukraine National Report on Monitoring Progress Towards the UNGASS Declaration of Commitment on HIV/AIDS, Reporting Period: January 2006–December 2007,* Kyiv, 2008.

girls contracted HIV from sex partners who are IDUs. The results of a Seroconversion study[90] presently being carried out in Ukraine may shed more light on this question.

1.5. HIV and other support services

Ukraine's housing, employment and social security benefits do not compensate for the social, psychological and health-related problems that EVA and MARA boys and girls face due to neglect, violence, deprivation and/or psychological distress. The country's health care and social sectors remain underfunded and lack political leadership, and they are not a political priority. This has resulted in insufficient response capacities and in many facilities and institutions being in poor condition.[91] In addition, overcentralisation and overspecialisation of prevention and treatment services, the vertical service structure and many service access barriers all add to the difficulties that exist in providing even a minimum package of high-quality services to MARA and EVA.[92]

The External Evaluation's findings provide more evidence that the present scale, scope and quality of HIV prevention, treatment, care and support services for EVA and MARA boys and girls are far too low to have an impact on the HIV epidemic.[93]

> The present scale, scope and quality of HIV prevention, treatment, care and support services for EVA and MARA boys and girls in Ukraine are far too low to have an impact on the HIV epidemic. Governmental organizations are insufficiently involved in the provision of prevention services.

While the new National HIV/AIDS Programme 2009–2013 is setting an ambitious national coverage target of 60 per cent for at-risk groups (including EVA and MARA boys and girls, or more specifically "injecting drug users, orphans, homeless children, detained or incarcerated children, children from families in crisis, sex workers, men who have sex with men, migrants and other similar groups"), governmental organizations are insufficiently involved in service provision. The Government is providing very little financial support for HIV prevention interventions beyond those for young people in penitentiary facilities and young IDUs.

> The new National HIV/AIDS Programme 2009–2013 sets an ambitious national prevention coverage target of 60 per cent for at-risk groups.

Important progress has been made in scaling up HIV prevention and counselling services for young IDUs. The SSSFCY have created a country-wide network of 217 targeted counselling points. These points also help clients undertake self-help measures. These points are still largely based on a drop-in approach. Young IDUs who do not seek services are therefore not being reached and covered.[94]

[90] International HIV/AIDS Alliance in Ukraine, Analysis of risk factors for HIV infection related to sexual practices and injecting drug use, presentation on the preliminary results of the Polaris Seroconversion Study (2006–2008) conducted in Ukraine, Kyiv, undated; see also at http://www.hivpolaris.org and: International HIV/AIDS Alliance in Ukraine (2005), "Monitoring and Evaluation Plan for Phase Two of the Programme "Overcoming the HIV/AIDS Epidemics in Ukraine" (2005–2008)", funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria in support of the National Response to HIV/AIDS in Ukraine, Kyiv, March 2006.

[91] State Institute for Family and Youth Development and Ministry of Family, Youth and Sports of Ukraine, "National Report on implementation of the decisions of the final outcome document of the Special Session of the UN General Assembly on Children (2002) and Action Plan "A World Fit for Children", Kyiv, 2007; Gudbransson, M., "Children in institutions: prevention and alternative care. Final report", Working Group on Children at Risk, approved by the European Committee for Social Cohesion at its 12th meeting in Strasbourg, 17–19 May 2004; and: Kyiv International Institute of Sociology, "Analytical report based on survey results: Assessment of initial knowledge, attitudes and practices among social workers and management of child-care institutions and children living in such institutions about the personal, social and psychological needs of children living in care institutions", Kyiv, December 2005.

[92] UNAIDS, "Comprehensive External Evaluation of the National AIDS Response in Ukraine: Consolidated Report (zero draft)", Kyiv, June 2008.

[93] Ibid.

[94] Ibid.

HIV prevention work in penitentiary facilities for young people has been scaled up as well, but not all facilities consistently provide it. There are other problems. For example, peer-driven intervention approaches and the possibilities that pre-release programmes offer for HIV prevention are underutilised. Also, penitentiary facilities offer no harm reduction services (even though risk behaviour is prevalent in them) and post-release programmes are scarce, especially for young people from other regions.[95]

Efforts are underway to build and strengthen HIV prevention capacity among staff working in State-run shelters and psychosocial rehabilitation centres. But all other child-care facilities and institutions, such as boarding schools, have yet to mainstream these interventions into their service portfolios. The same is true for social aide services for "families in crisis", a vulnerability reduction programme the Government supports.

Also, interventions to address and reduce existing stigma, discrimination and rights violations are in short supply. Zero tolerance policies either do not exist or are not sufficiently enforced in services that are directly in touch with MARA and EVA boys and girls, such as the health care, education, child protection, law enforcement and judicial services.[96]

Facilitating exit for MARA is a lengthy, time-consuming and rather expensive process. The State, while increasingly investing in re-socialisation and psychosocial rehabilitation programmes, has passed legislation making it harder for minors to access substitution maintenance therapy (SMT) programmes. It has done this despite existing evidence that SMT is one of the most critical HIV prevention interventions for IDUs.[97] There is, furthermore, a major gap in evidence-based inpatient and outpatient psychosocial drug rehabilitation programmes for adolescent boys and girls.

A 2006 research report published by UNICEF and the United Nations Joint Programme on AIDS (UNAIDS)[98] that discussed initiation of injecting drug use (particularly among young people) and suggested strategies to address this issue called interventions to prevent this initiation crucial. Yet these interventions have not yet been implemented in Ukraine.

Adolescent FSWs and MSM receive no prevention services from the Government. NGOs almost solely provide them these services. However, most of the available HIV prevention and harm reduction services for IDUs, FSWs and MSM are designed for adults and do not cater to the special and complex needs of EVA and MARA boys and girls.[99] Few offer, for instance, a low threshold and comprehensive set of services based on a "one-stop-shop"[100] client management and outreach approach.[101]

HIV prevention programmes targeting other EVA or MARA sub-populations, such as adolescent male sex workers, clients of adolescent sex workers or the sex partners of MARA are almost non-existent. So are peer-

[95] Ibid.

[96] Ibid.

[97] Ibid., and: UNICEF and UISR after Olexander Yaremenko, *The current situation concerning policy and legislation on medical and social services for children and adolescents most at risk of HIV infection,* analytical report, Kyiv, 2008.

[98] UNICEF and UNAIDS, *Risk and protective factors in the initiation of injecting drug use,* Kyiv, 2006.

[99] Homans, H., "Manual on Programming to Prevent HIV in Most-at-risk Adolescents" (draft), UNICEF Regional Office for Central and Eastern Europe and the Commonwealth of Independent States, Geneva, 2007; and: Socis-CSPR and International HIV/AIDS Alliance, "Situation analysis. Operational Research. Evaluation of Coverage of IDUs and FSWs with Harm Reduction Programs", Kyiv, 2006.

[100] By "a low threshold and comprehensive set of services based on a "one-stop-shop" client management and outreach approach" are meant services that have reduced the need for referrals to other services to the minimum extent possible. The result is that the multiple needs of a client who has come to the service either via the attached outreach services or through his/her own initiative can be met in one place (a one-stop shop). Social, psychological, legal, skills-building and health care services are provided in an integrated manner. In addition, a client manager is appointed to work out an individual support and care plan with a client. The manager also accompanies the client, or at least follows up with the client, if he or she has to be referred to another service. These are evidence-based approaches. See for example: Homans, H., "Manual on Programming to Prevent HIV in Most-at-risk Adolescents" (draft), UNICEF Regional Office for Central and Eastern Europe and the Commonwealth of Independent States, Geneva, November 2007; WHO, *Preventing HIV/AIDS in young people: a systematic review of the evidence from developing countries,* UNAIDS Inter-Agency Task Team on Young People, WHO Technical Report Series No. 938, Geneva, 2006; or: http://www.effectiveinterventions.org/go/interventions.

[101] UNAIDS, "Comprehensive External Evaluation of the National AIDS Response in Ukraine: Consolidated Report (zero draft)", Kyiv, June 2008.

driven interventions and community mobilisation, empowerment and high-quality behavioural change intervention programmes.[102]

Besides HIV-service organizations, there are various other NGOs and FBOs in Ukraine that provide services specifically to EVA boys and girls, especially to those living on the streets, or within the context of humanitarian programmes – for instance for migrants, refugees, the Roma or people who have been trafficked. As the External Evaluation highlights, very few of these NGOs and FBOs have mainstreamed HIV prevention and harm reduction into their service portfolio in general and for adolescents in particular, even though they represent important entry points to HIV prevention and other services.[103]

HIV prevention has yet to be mainstreamed into the activities of the State care system for children deprived of parental care and of humanitarian and other programmes. Alternative entry points for HIV prevention, such as pharmacies, are underused.

Other underutilised resources and entry points for HIV and STI prevention, treatment and care services for EVA and MARA boys and girls in Ukraine are the existing VCT, services that prevent mother-to-child-transmission (PMTCT), and sexual and reproductive health care services. Access is greatly restricted for these population groups[104], and many of these services have yet to incorporate youth-friendly approaches and principles into their work. A similar situation exists with regard to pharmacies, which are often privately owned in Ukraine, and which can also play an important role in HIV prevention for EVA and MARA boys and girls. For the latter, pharmacies are often providers of medication for self-treatment and of means of prevention, but they can also be places to acquire substances and drugs. This suggests that governmental control needs urgently to be increased.[105]

Little data is available on the effectiveness of existing programmes for EVA and MARA boys and girls. BSSs among MARPs carried out in past years indicate that while knowledge rose and protective behaviours become more widespread among programme clients, they did so more among people older than 25 than among people younger. This is linked to the low service coverage among those younger than 25. Most service providers blame legal barriers for this, as well as lack of capacity and of experience in working and communicating with EVA and MARA boys and girls.[106]

As highlighted in sub-chapter 1.2 on policy and legislation frameworks, EVA and MARA boys and girls face a range of political and legislative barriers to service access and provision. Qualitative research studies also identified a variety of other service development and access barriers, in particular[107]:

- Limited knowledge and understanding of the special service needs and service-seeking behaviour of these population groups among decision makers and service providers. This results in service gaps and

[102] Ibid.

[103] Ibid.

[104] Teltschik, A., "Draft Summary Report, Technical Issue: 1.1.4 MARA and MARY, Technical area: 1. Prevention / 1.1 Most-at-Risk Populations", draft report prepared in 2007 within the frame of the Comprehensive External Evaluation of the National AIDS Response in Ukraine, UNAIDS (2007–2008), unpublished; and: Thorne, C., and Malyuta, R., "Draft Summary Report, Technical Issue: 1.6.2 PMTCT and 7.1.5 PMTCT epidemiology and surveillance, Technical area: 1. Prevention / 1.2 General Population / 7. Epidemiology", draft report prepared in 2007 within the frame of the Comprehensive External Evaluation of the National AIDS Response in Ukraine, UNAIDS (2007–2008), unpublished.

[105] UNICEF, "Desk Research Report, "A review of the evidence on HIV/AIDS and most-at-risk adolescents (MARA) and young people (MARY) in Ukraine", internal working document, UNICEF Ukraine, Kyiv; AIDS Foundation East-West and UNICEF, *Children and young people living or working on the streets: the missing face of the HIV epidemic in Ukraine, Kyiv, 2006; and:* WHO, *Preventing HIV/AIDS in young people: a systematic review of the evidence from developing countries,* UNAIDS Inter-Agency Task Team on Young People, WHO Technical Report Series No. 938, Geneva, 2006.

[106] Stressed during discussions with service providers during round tables held within the frame of the UNICEF MARA Project, for instance on 12 June 2008 and on 10 August 2008, Kyiv.

[107] AIDS Foundation East-West and UNICEF, *Children and young people living or working on the streets: the missing face of the HIV epidemic in Ukraine,* Kyiv, 2006; and preliminary results of qualitative research (in-depth interviews and focus groups) conducted among MARA boys and girls in Dnipropetrovsk, Donetsk, Mykolaiv and Kyiv during the summer of 2008, within the frame of the UNICEF MARA Project.

insufficient technical, financial and human resource capacities for addressing their multiple and complex needs.

- Low health-seeking behaviour among EVA and MARA boys and girls. This appears to be founded in distrust or in previous negative experiences, such as of unofficial payment requests at service entry points or of discrimination. In addition, these groups seem not to value health very highly. Qualitative data also suggests that they seek health care services mainly in emergencies and usually revert to self-treatment first. Their knowledge of available services is rather low and often depends on the level of knowledge of the peer leaders they trust.
- Low service coverage, especially outside of the bigger cities. This forces EVA and MARA boys and girls to pay for transport to access services. Many either cannot or are unwilling to pay transport costs.
- Absence of an adequate service network and service referral system, including a client management approach. This creates the risk that EVA and MARA boys and girls get "lost in the system".

1.6. Interests and relations among different stakeholders

Within the frame of the UNICEF MARA Project, an analysis of the key stakeholders and a capacity needs assessment of selected service providers were carried out in the four project sites (see sub-chapter 2.5 for more details on the research and the research process). Stakeholders invited to join the research included, first and foremost, MARA boys and girls, all existing and potential direct service providers (independent of sector and ownership), relevant decision and policy makers and representatives of grant-managing and/or international organizations. The results underline many of the issues that previous chapters of this report have presented. While the findings cannot be exhaustive, given that only four sites were involved in the research, they offer an interesting insight into the interests of and relations between stakeholders at the sub-national level. They also offer insight into relations between stakeholders at the national level; the adequateness of available support services for EVA and MARA; the skills and knowledge levels of the organizations providing direct services; some of the main challenges inherent in addressing the needs of EVA and MARA; and the strengths, weaknesses, opportunities and threats (SWOT) of governmental and non-governmental service providers with regard to service delivery for these boys and girls (see Table 1.6.1).

The assessment demonstrated, for instance, that almost all the direct service providers lack organizational strategies for EVA and MARA. The stakeholders stressed that, in particular, the information, medical, pedagogical, social welfare and legal support services that are provided in their localities are not sufficiently targeted to the needs of these adolescents. EVA and MARA are not a priority for most of the stakeholders. The latter explained this by citing the lack of national-level targeted policies and legislation that could provide a supportive framework for service delivery. They also pointed out that harm reduction and most other HIV-specific prevention services are not registered to work with children and that most major international donors do not consider EVA and MARA to be priority groups.

A national supportive framework for working with EVA and MARA boys and girls is lacking, and many harm reduction and HIV-specific services in Ukraine are not registered to work with children.

The analysis cited other serious barriers to service delivery. For example, conflicts of interest occur between:

- Decision makers and service providers

Stakeholders said that decision makers are driven by political ambitions and considerations keyed to upcoming elections, and that their main interest is in reporting successes, rather than in improving matters. They said service providers want to meet and monitor their clients' needs and strengthen their own response capacities, projects for which the following are needed: supportive policies and legislation, adequate and earmarked budgets and willingness among decision makers to support or initiate the necessary changes.

- The governmental and the non-governmental sector

Conflicts of interest between those sectors are primarily linked to existing tensions, the stakeholder analysis made clear. They have arisen in the HIV/AIDS sphere because international donors chiefly provide financial and technical support to civil society, while building and/or strengthening the governmental sector's capacity has not been a priority in Ukraine. Suspicions on each side about the quality of the services that the other sector provides also create tensions, as does the absence of national service provider standards independent of service ownership. In addition, there is still no sound mechanism in place to sustain evidence-based non-governmental services with governmental funding.

The tensions between the two sectors often hinder multisectoral referral systems, where they exist. NGOs also stressed their lack of power to influence decisions, as multisectoral coordination mechanisms have primarily advisory functions. Service providers in general said that they are in no position to hold decision makers accountable, which often has serious consequences for their own work and their clients.

- Organizations within the non-governmental sector

The absence of a sustained governmental funding mechanism for NGOs, and the dependency of NGOs on donor funding, has created a situation in which NGOs tend to compete with each other and are secretive about their finances and plans. This hinders cooperation, joint strategic planning and programming. It may also explain how little NGOs knew about each other's activities, resources and plans during the assessment. (They also know little about government organizations, and vice versa.)

- The Criminal Police for Minors and MARA boys and girls

Oppressive raids aimed at removing children from the streets, as well as the criminalisation of the lifestyles of MARA boys and girls and serious rights violations by police, have had this effect: MARA deeply distrust the police and all authority. This is a major obstacle to HIV prevention and harm reduction. An increasing number of EVA and MARA boys and girls have gone into hiding and are very hard to reach.

All of the above-mentioned (potential) conflicts of interest hamper multisectoral cooperation and coordination at the subnational level. But such cooperation and coordination is critical to developing a sound prevention response.

The stakeholder analysis also revealed a gap in information about the policy and legislative framework for providing services to EVA and MARA. Nor are their national guidelines helping stakeholders to interpret and apply national policies and strategies at the local level.

The analysis also shows that stakeholders have yet to acknowledge the critical role that EVA and MARA should play in planning, programming and M&E. Formal involvement mechanisms are not in place at this stage .

> Formal involvement mechanisms for EVA and MARA boys and girls in planning, programming and M&E are not yet in place in Ukraine.

It is noteworthy that the stakeholders came up with a common list of areas in which human resource capacities could improve. They stressed that they have few staffers qualified to communicate and work with EVA and MARA boys and girls and that direct service providers must become familiar with evidence-based service delivery models. They said that there must be adequate funding for training and that there should be a modern human resource management system incorporating adequate incentives and ongoing support for direct service providers. They called for establishing and sustaining outreach teams and using peer educators.

Stakeholders also said that the lack of one single database of their clients was degrading the efficiency of their work. That MARA indicators are not integrated into a functioning M&E system on HIV/AIDS at the subnational level is also a liability.

The following table (Table 1.6.1) summarises the results of a SWOT analysis of governmental and non-governmental service providers in terms of service provision for EVA and MARA, from the perspective of the stakeholders who participated in the research:

Table 1.6.1

ANALYSIS OF SERVICE PROVIDERS' COMPETENCE AND POTENTIAL

How can weaknesses be mitigated and risks minimised?

Governmental institutions	Non-governmental organizations
Strengths	**Strengths**
Personal: working experience, optimism, humanity, motivation. **Professional:** specialists are trained at the cost of the state budget; the workforce is sustainable. **Material and technical:** information base is sufficient, a client database is in place, methodological literature is available. **Legal:** have the right to provide services in compliance with the regulatory framework. **Structural:** sustainable budgets.	**Personal:** enthusiasm, personal interest, initiative, optimism. **Professional:** ability to adjust to new conditions and implement innovative approaches, as well as ability to establish partner and donor relations easily. **Material and technical:** a client database is in place. **Structural:** operate outside the bureaucratic system; MARA have more trust in NGOs, for example because NGOs do not have to officially register them.
Weaknesses	**Weaknesses**
Professional: insufficient budgeting skills, lack of experience in providing direct services to MARA and in the HIV sphere. **Material and technical:** poor technical support, insufficient material incentives for employees. **Legal:** legal restrictions, for example on provision of services to MARA without registration.	**Professional:** burnout is widespread; professionalism is questioned and not universally accepted; issues concerning legal status. **Legal:** NGO services are often provided in a legal "grey" area, given that not all of their activities are properly regulated by the State. **Structural:** no sustained funding sources, dependence on donor funding, lack of adequate mechanisms for contracting social services.
Opportunities	**Opportunities**
Legal: make more effective use of legal powers to positively impact the situation. **Structural:** increase funding and improve the support they receive and the pertinent legislation.	**Personal:** continue to increase operational efficiency utilising the intrinsic motivation of the employees. **Professional:** provide targeted social assistance and support, introduce innovative service delivery models for MARA, utilise good relations with MARA to increase coverage and expand peer-driven interventions, and more.
Risks	**Risks**
Social and cultural: lack of information on MARA. Stigmatization of MARA by the public and media. **Political:** MARA are not a political priority; a lack of political stability and staff changes hinder planning and advocacy. **Legal:** legislation does not take into account the specific needs of MARA. **Structural:** negative impact of the "black market" and of existing criminal structures on MARA.	**Social and cultural:** lack of information on MARA. Stigmatization of MARA by the public and media. **Political:** MARA are not a political priority; a lack of political stability and staff changes hinder planning and advocacy. **Structural:** dependence on donor funding; lack of adequate mechanisms for contracting social services; risk of services being interrupted or stopped and clients and jobs lost.

Table 1.6.1 demonstrates that governmental and non-governmental organizations can complement each other in many areas. However, it also shows that NGOs depend greatly on government leadership and on a policy and legislation framework that adequately addresses the situation and needs of EVA and MARA. These things are just as important for the work of NGOs as are NGOs' own sustainability and quality standards .

Civil society work depends on government leadership, which ensures an adequate and supportive policy, legislation and strategic framework for service development, provision and sustainability.

2. RESEARCH

The UNICEF MARA Research Team took a comprehensive research approach towards building the evidence base on EVA and MARA boys and girls in Ukraine. This included desk research and a review of existing policy, legislation and gender-specific issues, as well as behavioural research on EVA and MARA boys and girls and an analysis of key stakeholders. There then followed a capacity needs assessment, as mentioned in the previous chapter.

The following sub-chapters describe the different research projects conducted .

Building the evidence on EVA and MARA boys and girls in Ukraine by taking a comprehensive research approach:

1. Desk research
2. Policy and legislation review
3. Gender analysis
4. Stakeholder analysis and capacity needs assessment
5. Behavioural research

2.1. Desk Research

A comprehensive desk research project on EVA and MARA and HIV/AIDS in Ukraine was carried out in 2007. The overall aim was to review available data and information on these population groups, their behaviour, their behavioural determinants and their service coverage. It was also to identify knowledge gaps and to review the key achievements, strengths, weaknesses and shortcomings of the national HIV/AIDS response to EVA and MARA boys and girls.

The results of the desk research were compiled into an internal working document. The Research Team consulted on the first draft of this document with UNICEF MARA Project partners and other United Nations (UN) agencies. Key findings from the final document have been incorporated into this report. The final working document[108] was shared after completion in early 2008 with all Project partners, relevant UN agencies and selected stakeholders.

The desk research was limited by the absence of a centralised national database and library on HIV/AIDS, including data and information on different population groups. Other restrictions were the slow responses of some stakeholders to requests for data and survey reports and the inaccessibility of some data sets and reports. The inaccessibility was primarily explained by the fact that some surveys were still in progress and that much data had not yet been analysed and officially published.

2.2. Policy and legislation review

UNICEF commissioned a comprehensive policy and legislation review in 2007. The aim was to review existing policy and legislation in Ukraine with regard to service development and delivery and access for MARA boys and girls. It was also to identify barriers and gaps and to develop a set of recommendations for improving the national legislation and harmonising it with international laws and policies. This review became necessary because the desk review demonstrated the lack of any such appraisal with regard to the specific situation of MARA boys and girls.

The review contained an extensive desk research and interviews with lawyers working in the governmental and non-governmental sectors and with practitioners and other key stakeholders. It also included two mul-

[108] UNICEF, "Desk Research Report. A review of the evidence on HIV/AIDS and most-at-risk adolescents (MARA) and young people (MARY) in Ukraine", internal working document, UNICEF Ukraine, Kyiv, 2008.

tisectoral round tables at the national level, during which the findings were presented and discussed. A final report was compiled and published in June 2008.[109]

The policy and legislation review's main findings were presented in sub-chapter 1.2 of this report.

2.3. Gender situation analysis

Building on the results of the gender assessment of Ukraine's National HIV/AIDS Programme, which was published by UNAIDS in 2007[110], the UNICEF RO supported UNICEF Ukraine in conducting a targeted situation analysis of the gender issues relating to MARA boys and girls. The analysis involved desk research and interviews with key informants. It was also based on the results of discussions held during a series of MARA gender training workshops. Decision makers, researchers and service providers in Ukraine participated in these workshops, which took place in 2007 and 2008.

The outcomes of the analysis have been incorporated into different chapters of this report.

2.4. Behavioural research

Based on the findings of the desk research, with support from the London School of Hygiene and Tropical Medicine (LSHTM)[111], and in consultation with the National Advisory Board of the UNICEF MARA Project, the research team decided to combine two research strategies to learn more about EVA and MARA risk and protective behaviours:

1. A secondary analysis of data on MARA boys and girls from the 2007 BSSs among MARPs[112] in Ukraine (Secondary Analysis).
2. A baseline behavioural study among adolescent boys and girls aged 10 to 19 who are living and working on the streets in Ukraine (Baseline Study).

The decision to pursue these research strategies was also based on the understanding that the HIV epidemic in Ukraine is young. This means that there is a real chance to intervene with EVA and MARA, thus blunting the epidemic's impact and lowering the number of new HIV infections among these population groups.[113]

The Secondary Analysis and the Baseline Study's overall research objectives were to strengthen the evidence base on EVA and MARA in Ukraine; to deepen understanding of their behaviours, their behavioural determinants and their use of services; and to create a basis for strengthening and more effectively monitoring the HIV prevention response for them. Another shared objective was to use the findings as an advocacy tool[114]. Such a tool can help create a more supportive environment for EVA and MARA boys and girls in Ukraine. It would increase their access to services and foster development and enforcement of service models, standards and corresponding ethical codices.

[109] UNICEF and UISR after Olexander Yaremenko, *The current situation concerning policy and legislation on medical and social services for children and adolescents most at risk of HIV infection,* analytical report, Kyiv, 2008.

[110] UNAIDS, *Assessing Gender Equality and Equity as Critical Elements in National Responses to HIV: Cambodia, Honduras and Ukraine, presentation of policy guidance to address gender issues,* 20th Meeting of the UNAIDS Programme Coordinating Board, Geneva, 25–27 June 2007.

[111] The LSHTM was contracted by the UNICEF Regional Office to support the baseline research among EVA and MARA boys and girls in the seven UNICEF MARA Project countries.

[112] Balakireva, O.M., et al., *Monitoring of the behaviour of men who have sex with men,* analytical report on the research results, International HIV/AIDS Alliance in Ukraine, Kyiv, 2008; Balakireva, O.M., et al., *Monitoring the behaviour of injecting drug user*, analytical report on the research results, International HIV/AIDS Alliance in Ukraine, Kyiv, 2008; and: Balakireva, O.M., et al., *Monitoring the behaviour of female sex workers,* analytical report on the research results, International HIV/AIDS Alliance in Ukraine, Kyiv, 2008.

[113] Homans, H., "Manual on Programming to Prevent HIV in Most-at-risk Adolescents" (draft), UNICEF Regional Office for Central and Eastern Europe and the Commonwealth of Independent States, Geneva, November 2007.

[114] An advocacy toolkit on MARA boys and girls was developed within the frame of the UNICEF MARA Project. For a copy, contact the UNICEF office in Kyiv.

Two of the main research objectives of the Secondary Analysis of 2007 behavioural surveillance data on MARA boys and girls, and of the Baseline Study among EVA and MARA living and working on the streets, were to add depth to the understanding of their behaviours and behavioural determinants, vulnerabilities and service use, and to create a basis for strengthening and for better monitoring the HIV prevention response to these population groups.

The seven countries participating in the Project also agreed to collect and analyse sex and age disaggregated empirical data. This would allow calculation of a list of agreed core indicators for MARA boys and girls (see Annex 2 for a summary of the Ukrainian core indicators) that describe their HIV risk behaviour, overlapping risk behaviour, sexual experience, behavioural determinants and vulnerabilities and service use in each of the seven countries. These indicators should serve as a benchmark for future MARA studies. The core MARA indicators were submitted to the MoFYS and publicly presented, discussed and agreed in Ukraine at a round table that the MoFYS and UNICEF chaired in Kyiv on 12 June 2008.

2.4.1. Secondary analysis

Ukraine by now has an established system of biological and behavioural surveillance in the HIV/AIDS field. In recent years, behavioural surveillance is increasingly being combined with HIV-prevalence studies. These studies have some weaknesses. For instance, they have so far taken place primarily in regions with relatively high HIV prevalence, and "bridge populations"[115] have not been studied.[116] Still, they presently provide the most reliable data that is obtainable in Ukraine on knowledge, attitudes, behaviours, and behavioural determinants. They also provide good data on service coverage of MARPs (IDUs, FSWs and, since 2007, also MSM), youth and two especially vulnerable population groups: prisoners and members of the uniformed services.[117]

Because of this situation, the research team decided that it is unnecessary to conduct additional behavioural research on adolescent IDUs, FSWs or MSM in Ukraine to calculate core MARA indicators . Instead, the research team carried out a secondary analysis of the existing data on MARA boys and girls (data on IDUs and FSWs aged 13 to 19 and data on MSM aged 15 to 19) in early 2008. It derived the data from the overall data sets of the 2007 behavioural (FSWs) and bio-behavioural (IDUs and MSM) surveillance studies.

The list of core MARA indicators calculated within the frame of the UNICEF MARA Project can serve as a benchmark for future studies on MARA boys and girls in Ukraine.

It is noteworthy that this was the first time that a secondary analysis of data on adolescents based on an existing data set was performed in Ukraine. Also, the issues that are preventing the proper use of data in Ukraine, which were listed in sub-chapter 1.3 of this report, significantly influenced the research process. They presented themselves as issues that will need to be addressed urgently in order to ease future research, planning and programming among EVA and MARA in Ukraine.

The results of the Secondary Analysis were widely shared and discussed with UNICEF MARA Project partners and key stakeholders. Chapter 3 of this report sets out its main findings.

[115] "Bridge populations" are populations that have links to both the general public and to MARA boys and girls. For instance, a married truck driver buying sex on the street from an adolescent FSW is considered a member of a bridge population.

[116] Hoppenbrouwer, J., "Draft Summary Report, Technical Issues: 8.1.1-8.1.12 National M&E Plan, National indicators/reporting, Databases and information management, National programme M&E, Oblast and Sectoral M&E, Research, studies and ethics, Data use, GFATM M&E, World Bank M&E and other M&E, Technical area: 8. Monitoring and Evaluation, 8.1 National M&E Systems", draft report prepared in 2007 within the frame of the Comprehensive External Evaluation of the National AIDS Response in Ukraine, UNAIDS (2007–2008), unpublished.

[117] UNAIDS, "Comprehensive External Evaluation of the National AIDS Response in Ukraine: Consolidated Report (zero draft)", Kyiv, June 2008.

2.4.2. Baseline survey

As the research team conducted the desk research, it became obvious that there was a major gap in the evidence on adolescent boys and girls who are living and working on the streets. Qualitative research[118] indicates, however, that their vulnerabilities and risks with regard to HIV infection are high and that coverage with HIV services is very low, while the size of the population as a whole appears to be considerable. In its sixth-round proposal to the GFATM, Ukraine estimated the size of the population of "street children" aged 10 to 18 and in need of HIV services to be around 115,000.[119] Qualitative research also shows that adolescents often live or spend time in groups within which behaviours that place them most at risk of HIV infection are widespread. Social networks and peer pressure are key factors in influencing high-risk behaviour and its initiation among adolescents living and working on the streets. In addition, the street environment places them at risk of abuse, exploitation, violence and crime. The latter may lead to detention or incarceration, adding the additional risk of exposure to HIV in detention and other penitentiary facilities. Meanwhile, the lack of adequate policy and legal frameworks and their enforcement hampers rights protection. Furthermore, negative attitudes and discrimination on the side of service providers, in particular in the health care sector, and oppressive street raids by the police, create fear and distrust, affecting service-seeking behaviour.[120]

This situation was discussed with the National Advisory Board of the UNICEF MARA Project and the LSHTM. The MARA research team subsequently decided to design and carry out a baseline study in addition to the Secondary Analysis. It would collect data on the HIV risk behaviour, overlapping risk behaviour, behavioural determinants, vulnerabilities and service use of boys and girls aged 10 to 19 who live and work on the streets. The team collected data in five research sites that represent Ukraine's five main geographic areas (East, West, Central, South and North).

The Baseline Study's study protocol (see Annex 3) was shared with and reviewed by the MoFYS, as well as by a group of researchers who belong to the National Advisory Board. After the consultation process the protocol was submitted to the Ukrainian Sociological Association for ethical approval. That approval was provided on 28 November 2007.

2.4.2.1. Eligibility criteria for the research target population

The research target population was adolescent boys and girls aged 10 to 19[121] who live and work on the streets. The eligibility criteria were defined as follows:

(a) Adolescent boys and girls aged 10 to 19 who have lived at least three months on the streets, do not attend school regularly and spend at least 50 per cent of their time on the streets.

(b) Adolescent boys and girls aged 10 to 19 years who have lived at least three months on the streets, have no regular work, attend no vocational or any higher education facility and spend at least 50 per cent of their time on the streets.

[118] AIDS Foundation East-West and UNICEF, *Children and young people living or working on the streets: the missing face of the HIV epidemic in Ukraine,* Kyiv, 2006.

[119] Ukrainian Government, "Ukraine 6th Round Proposal to the Global Fund to Fight AIDS, Tuberculosis and Malaria", Kyiv, 2006.

[120] LSHTM, "Investigating HIV risk behaviours amongst most-at-risk adolescents in Ukraine", submitted in partial fulfilment for the award of Master of Science, Demography & Health, University of London, by Clea Meynell, September 2008, unpublished; AIDS Foundation East-West and UNICEF, *Children and young people living or working on the streets: the missing face of the HIV epidemic in Ukraine,* Kyiv, 2006; and: Goodwin, R., Kozlova, A., Nizharadze, G., Polyakova, G., "High-risk behaviours and beliefs and knowledge about HIV transmission among school and shelter children in Eastern Europe", Sex Transm Dis. 2004 Nov; 31(11):670–5, 2004.

[121] The age range for adolescents used is consistent with the definition WHO provides, as mentioned earlier in this report. It reflects a Ukrainian situation in which adolescents and young people, particularly aged 19 or slightly older, are often members of groups of adolescents who are living and working on the streets and tend to have a strong influence on younger group members, especially in terms of HIV risk behaviour. For supportive evidence, see: AIDS Foundation East-West and UNICEF, *Children and young people living or working on the streets: the missing face of the HIV epidemic in Ukraine,* Kyiv, 2006.

"Living on the streets" was defined as:

- When boys and girls have no contact with their families and live in temporary dwellings (such as abandoned buildings) or else have no permanent dwelling and sleep in a different place every night.
- When boys and girls maintain contact with their families and/or caregivers but, due to poverty or other reasons, such abuse or neglect, spend at least 50 per cent of their days, and occasionally nights, on the street.
- When boys and girls reside in temporary shelters and lived on the streets prior to entering them (criteria (a) or (b))[122].
- When boys and girls technically reside in state boarding schools, psychosocial rehabilitation centres or other child-care facilities, but for one reason or another have run away and now live on the streets (criteria (a)).

In order to better understand the approximate proportion of EVA to MARA on the streets (the assumption was that any given group of young people contained both EVA and MARA), the Baseline Study did not use "risk behaviour" as an eligibility criterion. The eligibility criteria were applied to all members of the social networks of adolescent boys or girls eligible for the Baseline Study. These boys or girls were asked to refer members of his/her social networks.

2.4.2.2. Selection of research sites

Selection criteria were established for choosing research sites. The criteria included:

1. The site had to have enough adolescent boys and girls aged 10 to 19 who live and work on the streets that a proper sample size could be arrived at.
2. The site had to have medium to high HIV prevalence, and that prevalence had to be increasing.
3. Governmental and non-governmental organizations had to be providing services (health, social, education, legal, others) to the population groups on the site. These organizations can serve as "gatekeepers"[123] through which the groups can be accessed.
4. The site had to be cost-effective.
5. Local authorities had to show interest in using the research findings to strengthen the local HIV prevention response to EVA and MARA.

The research team also consulted on this matter with UNICEF MARA Project partners, service providers and the National Advisory Board. It chose the following five research sites for the Baseline Study:

1. Kyiv city.
2. Donetsk city.
3. Dnipropetrovsk city.
4. Mykolaiv city and oblast.
5. Rivne city and oblast (pilot site).

[122] There are two main ways that adolescents enter temporary shelters: either they access them voluntarily or they are taken to them by authorities. According to the Law of Ukraine (20/95-BP) on Services and Institutions for Minors, when the police pick up children, i.e. persons under the age of 18, on the street they have to report them to the child protection services (departments for children). The police may transfer a child to a temporary shelter if a child has no other place to go to, cannot be taken back to his or her family or needs medical attention – if he or she has overdosed, for example. After a child has been reported, the departments for children, usually in cooperation with the State social services, start working with the family and the child. It should, however, be noted that quite a few of the children transferred to temporary shelters escape and return to the streets. For supporting evidence, see: AIDS Foundation East-West and UNICEF, *Children and young people living or working on the streets: the missing face of the HIV epidemic in Ukraine,* Kyiv, 2006.

[123] A "gatekeeper" means in this context an organization with direct contact with the research target population. The organization is in a position to help in accessing and recruiting target population members.

Rivne was selected at the request of key stakeholders who were present during the consultation with members of the National Advisory Board. The main reason it was chosen was to ensure an optimal representation of the situation across Ukraine. However, the agreement was to add Rivne only as a pilot site for research, as available data indicated that the numbers of boys and girls who live and work on the streets in the city and oblast are very small.

2.4.2.3. Research objective

The Baseline Study's main objective was to collect data about risk and protective behaviours, about factors determining behaviour or constituting vulnerabilities and about service use. The goal was to estimate service coverage and to calculate HIV indicators for MARA, based on the list of core MARA indicators that was agreed among the seven countries who participated in the Project.

2.4.2.4. Sampling and fieldwork

Each research site was mapped with the support of the Regional Advisory Boards. The goals were to identify and map out locations where the target populations gather and/or live, to estimate population sizes in the particular locations and to mark key groups and locations. During the mapping process, priority locations for the provision and possible scale-up of targeted HIV prevention interventions were also noted down, and a risk assessment was conducted. The latter took into account the safety of both the adolescents and the fieldworkers/interviewers.

In the absence of national and subnational population size estimates, overall target numbers (Table 2.4.2.4.1) for the survey were calculated based on available MoFYS statistics on children accessing shelters for minors in 2005 and 2006. The majority of children living in shelters previously lived in the street. In 2005 and 2006, around 25 to 30 per cent of the children in the shelters were girls.[124] A cross-sectional sample from four cities was recruited and, in total, 843 adolescents living and working on the streets were interviewed within the frame of the survey. Of them, 598 were boys (70 per cent) and 245 were girls (30 per cent).[125]

Table 2.4.2.4.1:

Locality	Target number	Number interviewed
Kyiv city	200 in total: 140 boys + 60 girls	202: 142 boys + 60 girls
Donetsk city	200 in total: 140 boys + 60 girls	200: 140 boys + 60 girls
Dnipropetrovsk city	200 in total: 140 boys + 60 girls	201: 141 boys + 60 girls
Mykolaiv city/oblast	200 in total: 140 boys + 60 girls	202: 142 boys + 60 girls
Rivne city/oblast	100 in total: 70 boys + 30 girls	38: 33 boys + 5 girls
TOTAL	900 in total: 630 boys + 270 girls	843 in total: 598 boys + 245 girls

A quota had to be prescribed for girls in the study (30 per cent), based on the available statistics on sex distribution among adolescent boys and girls living and working on the streets in Ukraine.[126] Sex distribution is therefore uniform across research sites and the study sample is most likely not representative.

The approaches used for recruiting the target populations included a location-based and network sampling approach. Snowball sampling was used to refer entire networks.

Interviewees were given an incentive for participating in the study. The incentive was discussed and agreed with the Regional Advisory Boards and differed slightly from research site to research site. The incentives included, for instance, food and/or warm socks (it was winter). Interviewees would also be given lists of local support services, with information about locations, working hours, etc.

[124] State Institute for Family and Youth Development of the MoFYS, Statistics on children in shelters and psychosocial rehabilitation centres in Ukraine in 2005 and 2006, Kyiv, 2007. Statistics were provided to the UNICEF office in Ukraine in 2007.

[125] Note that Rivne was excluded from calculation of the core MARA indicators (see Annex 2) to avoid bias. This means that the total sample of adolescents used for calculating these indicators was 805.

[126] AIDS Foundation East-West and UNICEF, *Children and young people living or working on the streets: the missing face of the HIV epidemic in Ukraine,* Kyiv, 2006.

In each research site a group of five interviewers was supervised by one fieldwork manager. The national network of researchers of the UISR after Olexander Yaremenko provided these fieldwork managers. "Gatekeepers" in turn supported the interviewers and managers during the mapping and recruitment process, in cooperation with the Regional Advisory Boards. Eligibility criteria were established for choosing gatekeeping organizations. They included how much of the target population they covered; the characteristics of clients they served (the clients had to be similar to the research's target population); whether they provided direct services to the target population, including outreach services, drop-in centres and similar low threshold services; and whether they had previous experience with research studies (although this was not mandatory).

The fieldwork team was briefed and trained prior to starting its work, and received interview and fieldwork guidelines. The training focused especially on ethical, gender and safety issues.

2.4.2.5. Research instrument and data analysis

The LSHTM developed two standardised questionnaires, one for girls and one for boys. It was based on the agreed list of core indicators for MARA boys and girls, and adapted for the local context by all research teams participating in the UNICEF MARA Project. The questionnaires used in Ukraine were in Russian and Ukrainian. The research instrument was tested twice in Ukraine, as it required extensive changes with regard to the language.

SPSS version 15 software was used for data entry and analysis. The LSHTM helped the UISR after Olexander Yaremenko analyse the data. The two organizations held a joint analysis workshop in Kyiv. In addition, a Masters student at the LSHTM performed another analysis, with a particular focus on regional differences[127].

Data analysis focused on two high-risk behaviours: reported lifetime experience of injecting drugs and unprotected sex. The variables used in the analysis are listed in Annex 4.

Answers falling into the category of "no answer/I don't know/I cannot remember" have been excluded from the analysis, unless interviewees were responding to a knowledge-related question, as it is not possible to establish the reason behind their response. The excluded responses did not amount to more than 10 per cent of the total sample size. For all variables relating to injecting drug use, those who had never injected drugs were excluded from analysis. The same was done for all variables concerning sexual practices. Those who had never had vaginal or anal sex were excluded from analysis.[128].

In the statistical analysis, $p \leq 0.05$ was taken as the significance level. The Mann and Whitney U test was employed to verify the significance level of the results for both sub-samplings (for example, by sex). The Kruskal Wallis H-test was applied for the greater number of samplings (by age groups, cities and others). Both tests are incorporated into the standard SPSS package. Statistical significance of p less than 0,001 ($p<0.001$) means that differences are maximally significant; $p<0,01$ means very significant; $p=0,05$ means significant; and $p>0,001$ means insignificant.

Including Rivne as a pilot site proved challenging, because the target population in the city and oblast proved smaller than expected. Also, very few organizations there provide direct services to and have experience with this population group. In the end, the agreed target numbers for the research could not be met, and after performing a preliminary analysis of the data from all research sites, the research team excluded Rivne data from the overall data analysis to avoid bias.

After the Baseline Study was completed, the research team conducted focus groups among MARA living and working on the streets. They did this to ensure that the young people would stay involved in the research process and to discuss the findings with them. Chapter 3 of this report incorporates the focus groups' results.

[127] LSHTM, "Investigating HIV risk behaviours amongst most-at-risk adolescents in Ukraine", submitted in partial fulfilment for the award of Master of Science, Demography & Health, University of London, by Clea Meynell, September 2008, unpublished.

[128] Ibid.

2.4.2.6. Ethical considerations

In 2007, when the UNICEF research team designed the Baseline Study, national ethical guidelines and principles for research and programming for EVA and MARA boys and girls did not exist in Ukraine . The research team therefore developed its ethical approach and corresponding guidelines for fieldworkers by relying on the *Draft ethical guidelines for conducting quantitative research among MARA boys and girls*[129]. This is a guidance paper that the UNICEF RO specially produced for all the countries that took part in the UNICEF MARA Project. The version adapted for Ukrainian fieldworkers put particular focus on child protection issues. In addition, the research team, with the help of advisory boards and project focal points, established partnerships with relevant national and local authorities while it planned its work. All procedures that the fieldworkers' guidelines prescribe are in line with existing Ukrainian policies and legislation. The research team also gave each fieldworker an information package, including a list of local service providers. Team members were trained on how to use the package and how to refer an adolescent to the appropriate service. The appointed project focal points helped ensure that adolescents had access to adequate services in the locality.

Until 2008, there were no national ethical guidelines and principles for research and programming for EVA and MARA boys and girls in Ukraine. In November 2008, the Ukrainian Sociological Association developed national ethical principles for research among these population groups, based on draft guidelines issued by the UNICEF Regional Office, which it adopted officially on 9 December 2008.

The study's design and approach received ethical approval from the Ukrainian Sociological Association, as mentioned previously.

2.4.2.7. Strengths and limitations of the baseline study

Strengths

The Baseline Study's overall design proved practicable and appropriate for collecting data on the risk behaviour, behaviour determinants and vulnerabilities and service use of its target population.

The individual interviews were useful, and both interviewers and interviewees felt comfortable with the study method. Interviewers and fieldworkers liked being paired off with each other, because it made them feel more secure, while the interviewees did not have a problem with dealing with two people at once.

Interviews were held in the places where the adolescents lived and hid out by night or spent time by day. Some of the adolescents whom "gatekeepers" recruited preferred to talk on the premises of the "gatekeeper", who was usually a direct service provider. This sort of flexibility, informed by the principle of outreach to the young people, was practical and gave interviewers a more in-depth understanding of the environments in which the target young people live and work.

Another of the methodology's important strengths was the involvement of the "gatekeepers", who provide direct services to the target population. They knew a lot about the local communities in question and about the structure and availability of services. In addition, they have good access to different sub-populations of the target group and have earned their trust. This contributed to the success of the study and was optimal for addressing sensitive topics and studying EVA and MARA.

The sampling approach, based on previous experience that had been gained during formative research among the target population and behavioural surveillance among MARPs in Ukraine, also proved appropriate. The snowball sampling helped the interviewers access hard-to-reach sub-populations and social networks, including adolescents who have no contact with services. It is, however, not a random sample, and therefore it might not be truly representative of the study population.

[129] Homans, H., "Guidance: Ethical issues in conducting quantitative research with adolescents engaging in HIV risk behaviour" (draft), UNICEF CEE/CIS, July 2007.

The research team developed its methods and instruments in accordance with national HIV/AIDS policy and legislation. These methods and instruments will contribute to planning and programming for EVA and MARA boys and girls in the future.

The research brought together key stakeholders from different sectors at the national and subnational levels. It provided an important forum for networking, coordination and forging new partnerships.

Limitations

Given the research's sensitivity, the research team encountered some difficulties in recruiting interviewers. More time than had been anticipated had to be spent on supporting and supervising the interviewers and other fieldworkers.

Recruiting the target population brought various challenges and took more time than expected, too. The team tried to better understand these challenges by consulting with the fieldworkers and advisory boards. The following possible reasons for the problems could be identified:

1. It was winter, which generally slows down research, given that the target population spends more time than usual in warm hideouts or in temporary shelters.
2. The outreach capacity of the existing direct service providers was limited. Often, outreach is an "add-on" to a person's job and few providers appear to have received proper training in outreach. As a result, people sometimes were afraid to access hideouts (even in pairs, as the research guidelines required) or to interview young people in the evening.
3. Some members of the target population are reluctant to speak to any adult. This testifies to deep distrust of adults, and possibly to past negative experiences with them. It is also, however, an expression of low service coverage.
4. Target population members were sometimes fearful when members of their groups or networks were recruited for research. During the research period, the Criminal Police for Minors performed street raids more frequently, which is one possible reason for this fear. Another may be that more and more adolescents living and working on the streets are being "organized" by adults, who are usually members of criminal structures. The latter may explain why there seem to be markedly fewer adolescents on the streets than there was a year ago, when UNICEF conducted explorative research among the same target population in the cities of Kyiv and Odessa.[130] Whether there really are fewer, or their being subject to this sort of adult organization just makes it seem as if there are, the research could not resolve.
5. As expected, more males than females were located during the mapping and recruitment process, forcing the research team to introduce a quota for females.

The location-based research, while accommodating the target population's needs and ensuring access to hard-to-reach groups, involved some risks for the fieldworkers. While few encountered dangerous situations, there were sometimes interruptions and distractions.

2.4.2.8. Lessons learned

During the research many important lessons were learned .

Some of the main lessons learned during the research:

1. The importance of multisectoral cooperation and coordination
2. Ongoing involvement of EVA and MARA boys and girls in the research process is critical
3. Possible research barriers need to be anticipated, in particular as they relate to informed consent, child protection and supplementary care needs and stigmatisation of and discrimination against the research population.

[130] AIDS Foundation East-West and UNICEF, *Children and young people living or working on the streets: the missing face of the HIV epidemic in Ukraine,* Kyiv, 2006.

The importance of multisectoral cooperation and coordination

The role of multisectoral advisory boards during research is critical. This is not only because they are well-acquainted with their own localities, but also because they can create a supportive and enabling environment for sensitive research in their communities. For instance, to make sure the research, including the mapping process results, stayed confidential, and to reduce data misuse, Regional Advisory Board members signed terms of reference and confirmation letters that affirmed ethical principles based on those set out in the UNICEF Regional Office's *Draft ethical guidelines for conducting quantitative research among MARA boys and girls*[131], mentioned earlier in this report.

The research helped strengthen multisectoral cooperation and local ownership among advisory board members. That creates a sound basis for the next step in the UNICEF MARA Project: strategic planning and programming for EVA and MARA boys and girls.

Working with the advisory boards can also help avoid duplication of research results. Furthermore, working through the links established with the local coordination councils on HIV/AIDS and tuberculosis can help ensure that the evidence base and all planning and programming efforts for EVA and MARA boys and girls are fully embedded in the regional and national HIV/AIDS planning processes.

Involving EVA and MARA boys and girls

Involving EVA and MARA in designing the research and discussing the findings is essential. However, the research also showed that mechanisms for including EVA and MARA in planning and programming on a regular basis have to be institutionalised, and that getting MARA who are living with HIV involved is crucial. As research among a similar population in Russia further demonstrates, EVA and MARA who live and work on the streets are often considered a "single dispossessed mass that has fallen through support networks in various risk scenarios", while researchers, planners and service providers overlook that many of them have developed social capital, are resourceful, have become integrated into new social groups and may even have found substitute families on the street.[132]

Anticipating possible research barriers

Research among EVA and MARA boys and girls who are minors implies a "double sensitivity" – one that relates to their risk behaviour and vulnerabilities, as well as to their ages and corresponding issues of child protection. In addition, barriers to service access for EVA and MARA boys and girls that service providers encounter during their work and during programming also apply to research. These barriers are, in particular:

a. Informed consent

The capacity of adolescents to understand the risks and benefits of participating in research is often limited by low levels of education, lack of development opportunities or intoxication. Many adolescents on the streets use substances and drugs frequently, including solvents and alcohol.[133] This had to be taken into account during research planning and implementation, and in several cases it required repeated visits to meeting places in order to receive informed consent and interview the boy or girl in question.

b. Child protection and supplementary care needs

According to the Ukrainian Law on *Social Protection of Orphans and Children Without Parental Care*, any person encountering a minor without parental care is obliged to inform the authorities. Furthermore, cases of child abuse and exploitation should also be reported to relevant authorities. The research team ensured compliance with these obligations by working with project focal points among the national and local au-

[131] Homans, H., "Guidance: Ethical issues in conducting quantitative research with adolescents engaging in HIV risk behaviour" (draft), UNICEF CEE/CIS, July 2007.

[132] Stephenson S., "Street children in Moscow: using and creating social capital", The Editorial Board of The Sociological Review, Malden, MA, 2001.

[133] AIDS Foundation East-West and UNICEF, *Children and young people living or working on the streets: the missing face of the HIV epidemic in Ukraine,* Kyiv, 2006.

thorities. It also consulted with the authorities and other key stakeholders through the advisory boards, and got these stakeholders and the authorities involved. At each research site, partnerships were developed with the Centres for Social Services for Families, Children and Youth (CSSFCYs) and, wherever possible, with the Criminal Police for Minors and the departments for children. In addition, the target population's possible supplementary care needs were identified and discussed with the advisory boards and referral points and services were agreed. This enabled the interviewers to refer adolescents to the appropriate services or take immediate action when needed.

There are four main reasons why the supplementary care needs of a target population such as EVA and MARA have to be considered during research planning and implementation, as was done in the Baseline Study. First, there is concern for the welfare of adolescents, who may be sick and in urgent need of medical care. Second, situations arise in which adolescents are in acute danger and need rescue. Third, researchers often encounter grave injustices during their work, as when they meet adolescents deprived of even the most basic support. Fourth, by taking part in such research, adolescents entrust aspects of their well-being to the researcher.[134] All this means that researchers have supplementary care obligations to the research participants, obligations that go beyond what the research requires. There is no national-level guidance concerning these obligations in Ukraine today, just as there are no ethical guidelines.

However, while considering supplementary care needs was important, it was also important to be realistic about local response capacities and researchers' roles. As has been stressed previously, client management, referral systems and service networks are still underdeveloped in the country. Also, there are many gaps in services, many service providers are not trained to work with adolescents and many child-care facilities lack the capacity to meet the multiple needs of EVA and MARA. Alternative care options are almost non-existent.[135]

c. Stigma and discrimination

EVA and MARA boys and girls experience stigma and discrimination everywhere they go and in many forms. This makes them highly distrustful.[136] For instance, adolescents often have to pay unofficially for medical services or are simply refused service, in contravention of medical ethics.[137] Criminalisation of drug or syringe possession, even near needle exchange points[138], the perception of IDUs as "potential criminals", the absence or lack of enforcement of zero tolerance policies and insufficient coverage with youth-friendly legal services also create major access barriers to services and to research, as mentioned before.

The research team had to remain aware of the risk that focusing on these population groups could call down on them more stigmatisation and discrimination. The team tried to reduce this risk by working closely with the advisory boards.

[134] Participants in the 2006 Georgetown University Workshop "Ancillary Care Obligations of Medical Researchers Working in Developing Countries" (2008), "The ancillary-care obligations of medical researchers working in developing countries", in: *PLoS Med* 5(5): e90. doi:10.1371/journal.pmed.0050090

[135] AIDS Foundation East-West and UNICEF, *Children and young people living or working on the streets: the missing face of the HIV epidemic in Ukraine*, Kyiv, 2006; and: Gudbransson, M., "Children in institutions: prevention and alternative care. Final report", Working Group on Children at Risk, approved by the European Committee for Social Cohesion at its 12th meeting in Strasbourg, 17–19 May 2004.

[136] All-Ukrainian Coalition of non-government organizations Unite for Children, "Alternative report on the implementation of the Optional Protocol to the UN Convention on the Rights of the Child, on the Sale of Children, Child Prostitution and Child Pornography", Kyiv, 2006; Human Rights Watch, *Rhetoric and Risk: Human Rights Abuses Impeding Ukraine's Fight against HIV/AIDS,* 2006, see at http://hrw.org/reports/2006/ukraine0306/2.htm; and UN Committee on the Rights of the Child (8 June 2007) Forty-fifth session, "Consideration of Reports Submitted by States Parties under Article 12 (1) of the Optional Protocol to the Convention on the Rights of the Child, on the Sale of Children, Child Prostitution and Child Pornography, concluding observations: Ukraine".

[137] AIDS Foundation East-West and UNICEF, *Children and young people living or working on the streets: the missing face of the HIV epidemic in Ukraine,* Kyiv, 2006.

[138] Human Rights Watch, *Rhetoric and Risk: Human Rights Abuses Impeding Ukraine's Fight against HIV/AIDS,* 2006, see at http://hrw.org/reports/2006/ukraine0306/2.htm.

2.5. Stakeholder analysis and capacity needs assessment

2.5.1. Purpose and objectives

One of the UNICEF MARA Project's objectives was to create a sound basis for strategic planning and programming for EVA and MARA boys and girls, including the development of essential service packages and intervention models. It was therefore indispensable not only to map places where EVA and MARA congregate, live or work, but also to identify priority locations for providing and scaling up targeted prevention interventions. Thus, the overall research approach involved a stakeholder analysis and a capacity needs assessment of potential service providers for EVA and MARA boys and girls. This approach was implemented in Kyiv, Donetsk, Dnipropetrovsk and Mykolaiv. The analysis and assessment were agreed with the advisory boards prior to implementation. In none of the four sites had such an analysis and assessment been conducted previously.

The objectives of the stakeholder analysis were to survey who the relevant stakeholders are; what they think of the situation; which interests and what stake they have in interventions for EVA and MARA; what power they possess to influence these interventions, and how important they are for them; how they relate to and cooperate with each other; how they perceive the response capacity in their localities; in what political, economical, social and technological environment they function; how these factors may influence prevention interventions; and what the risk and vulnerability factors are for EVA and MARA in the selected sites.

The aim of the complementary capacity needs assessment of (potential) service providers for EVA and MARA boys and girls, which followed the stakeholder analysis, was to assess the capacity of a selected number of potential service providers from all sectors; to identify capacity-building needs as a basis for developing a capacity-building plan (an integral component of a strategic action plan for EVA and MARA); and to monitor and evaluate the impact of capacity-building support within the frame of the UNICEF MARA Project and other projects targeting EVA or MARA in the same site.

2.5.2. Key steps and methods

The stakeholder analysis and capacity needs assessment are primarily qualitative in their approaches, even though some of the data they generate can be used as a quantitative baseline as well, in order to track progress in organizational development. The research comprised mapping of stakeholders in the selected research sites; an assessment of their interests and an analysis of their influence and importance; a review of response capacities (SWOT-analysis); an agreement with stakeholders on strategies required to generate interest in and to reduce barriers to involvement, building capacity and alliances; a risk assessment; and an institutional appraisal of selected service providers.

As this is a relatively new approach and method in Ukraine, the research team could not fall back on existing instruments. It had to develop new ones based on international models and experience, as well as on similar research instruments that have been tested and then used within the context of HIV/AIDS and/or among non-governmental and other civil society organizations abroad.[139] The research team developed the following instruments for the analysis and assessment: a stakeholder analysis guideline for a participatory and facilitated group discussion with the Regional Advisory Boards; and a semi-structured questionnaire for in-depth interviews with the potential service providers (the list of these providers was discussed and agreed with the advisory boards) for assessing each organization's profile, as well as an evaluation matrix for estimating the level of competence in different areas. The capacity needs assessment considered 11 areas[140]

[139] Main sources used: Homans, H., "Capacity assessment tool for organizations working with most-at-risk adolescents" (draft for field testing), UNICEF, January 2008; International HIV/AIDS Alliance, *CBO Capacity Analysis. A toolkit for assessing and building capacities for high-quality responses to HIV,* UK, 2007; McKinsey & Company, *Effective Capacity Building in Nonprofit Organizations,* prepared for Venture Philanthropy Partners, Reston, VA, 2001; World Health Organization, online presentation, 1-2. "Stakeholder Analysis, Transforming Health Priorities into Projects, Health Action in Crisis", date unknown; Schmeer K. and Abt Associates Inc. (1999), *Guidelines for Conducting a Stakeholder Analysis,* Health Reform Tools Series, A Partnership for Health Reform Publication, Bethesda, MD.

[140] Strategic planning, financial management, governance, human resource management, organizational infrastructure, programming, monitoring and evaluation, experience in HIV/AIDS and in working with EVA and MARA boys and girls, network-

of capacity. All tools were tested prior to their use in Ukraine. The main findings of the stakeholder analysis and the capacity needs assessment have been incorporated into previous chapters of this report.

2.5.3. Strengths, limitations and lessons learned

The strengths of the participatory stakeholder analysis are that it involves all key stakeholders in a given locality and facilitates a guided discussion among them on issues that are rarely openly discussed within coordination mechanisms. These issues include conflicts of interest; power relations; the subnational response, as compared to individual responses by each organization; and others. Its main limitation is that inherent in all group discussions is the risk that very sensitive issues will not be raised, even if they constitute major threats to interventions.

The capacity needs assessment's most important limitation is that it was perceived by many organizations as an intrusion into their internal matters and as an instrument of control that can be misused if the results become accessible to anyone outside the research team. Its main strength is the way the instrument is designed. It focuses on facilitating self-assessment by the organization in question and opportunities for learning. It also provides a tool that the respondent can use in the future for measuring organizational development and monitoring progress.

As expected, the research team faced difficulties in getting the potential service providers to sit for in-depth interviews. One reason was the length of the interview. But another was the fear, mentioned above, that the results could be misused and that the assessment was a way to control their performance, rather than to assess their capacity needs with their help. This fear persisted despite the fact that confidentiality was ensured and research objectives communicated.

ing, advocacy and involvement of the community and clients.

3. RESEARCH FINDINGS

As mentioned in the previous chapter of this report, the UNICEF MARA Project team decided to combine two research strategies: a secondary analysis of data on adolescents most at risk of HIV infection from the 2007 BSSs among MARPs with a baseline behavioural surveillance study among adolescents who are living and working on the streets in Ukraine (see sub-chapter 2.4). The structure of this chapter includes four sub-chapters presenting the social and demographic characteristics of the survey respondents, different aspects of risk behaviour (relating to sexual behaviour, injecting drug use and overlapping risks), behavioural determinants and vulnerabilities (knowledge about HIV/AIDS, experience of forced sex, and so on) and service use and coverage.

3.1. Social and demographic characteristics

Secondary analysis of behavioural surveillance data on MARA (IDUs, FSWs and MSM)

It is important to monitor behaviour and behavioural patterns among MARA in order to better understand the HIV epidemic and the role these population groups play in it.

Within the frame of the 2007 BSSs among IDUs, FSWs and MSM[141], the following were interviewed: 4,143 IDUs from 14 regions of Ukraine, including 256 adolescents; 1,602 FSWs from 12 regions of Ukraine, including 278 adolescents; and 1,764 MSM from 12 regions of Ukraine, including 212 adolescents.

It was the first time in Ukraine that a team of researchers (the UNICEF MARA Project team) carried out a secondary analysis of data on adolescents (under the age of 20) derived from BSSs among MARPs (IDUs, FSWs, MSM). This was possible because special efforts had been made to reach the younger age groups (under the age of 18) within the frame of the 2007 BSSs.

The research employed the "snowball" sampling technique (for FSWs) and the "respondent-driven sampling" technique (for IDUs and MSM), in which the respondents themselves direct and realise the sampling.

The distribution of MARA by region is presented in Table 3.1.1 and the distribution of the respondents by sex is presented in Table 3.1.2.

Distribution of MARA by region

Table 3.1.1

Distribution of MARA by region and number of people interviewed

Region	Number of people interviewed		
	Adolescent IDUs 13–19 years	Adolescent FSWs 13–19 years	Adolescent MSM 15–19 years
Autonomous Republic of Crimea	24	29	30
Volyn	4	16	24
Dnipropetrovsk	15	7	
Donetsk	31	18	10
Ivano-Frankivsk			15
Kyiv City	37	32	24
Kirovohrad	25		
Luhansk	17		30
Mykolaiv	14	5	21

[141] The 2007 BSSs were funded by the International HIV/AIDS Alliance in Ukraine within the framework of the implementation of the GFATM programme "Overcoming the HIV/AIDS Epidemics in Ukraine" and by the company Futures Group International and the USAID-funded Health Policy Initiative Project.

Odessa	18	18	21
Poltava	5	7	
Sumy	13	22	
Kharkiv	27	25	
Kherson	10	55	27
Cherkassy	19	47	10
Total number of MARA	259	281	212
Total sample (MARPs)	4,143	1,602	1,764

Distribution of MARA by sex

Table 3.1.2

Distribution of MARA by sex, %

	Adolescent IDUs		Adolescent FSWs		Adolescent MSM	
	Number of respondents	%	Number of respondents	%	Number of respondents	%
Boys	170	66			212	100
Girls	89	34	281	100		
Total	259	100	281	100	212	100

Distribution of MARA by age groups

The minimum age of IDU and FSW respondents is 13 years old, while the minimum age of MSM respondents is 15 (see Table 3.1.3). Younger respondents were not identified during the sampling process.

The average age of the respondents is 18 (IDUs, FSWs and MSM). Adolescents who are 18 to 19 years old form the largest proportion in the three target groups (IDUs, FSWs and MSM). Girls who use injecting drugs predominate among IDU respondents aged 18 to 19.

Table 3.1.3

Distribution of MARA boys and girls by age groups, %

	Adolescent IDUs			Adolescent FSWs	Adolescent MSM
	Among all	Boys	Girls		
Under 14 years	1	2	0	1	
15–17 years	34	36	29	33	28
18–19 years	65	62	71	66	72

Distribution of MARA by marital status

At the moment of the survey 2 per cent of adolescent IDUs were officially married, girls more often than boys. Among FSWs, 2 per cent of respondents were officially married. Fifteen per cent of adolescent IDUs, 13 per cent of adolescent FSWs and 10 per cent of adolescent MSM live with a partner, but without official registration (see Table 3.1.4). The majority of respondents of all three MARA target groups are not married officially to their sex partners and do not live with them (83 per cent of adolescent IDUs, 85 per cent of adolescent FSWs and 90 per cent of adolescent MSM).

Table 3.1.4

Distribution of MARA boys and girls by marital status, %

	Adolescent IDUs			Adolescent FSWs	Adolescent MSM
	Among all	Boys	Girls		
Officially married	2	1	5	2	
Not married officially, but live with sex partner	15	11	20	13	10
Not married and do not live with sex partner	83	88	75	85	90

Distribution of MARA by educational level

The obtained data testify to a rather low educational level among members of the risk groups. Seventeen per cent of adolescent IDUs and FSWs who had achieved the age of 15 at the moment of the survey did not have basic secondary education.

Thirty-nine per cent of adolescent IDUs and FSWs aged 18 to 19 had not completed their secondary education before reaching adulthood.

The education level of MSM corresponds to the standard level of education received by the majority of young people in Ukraine.

Distribution of MARA by employment status

Half of the surveyed MARA boys and girls are pupils and students (see Table 3.1.5). Among adolescent IDUs, 50 per cent are pupils at secondary schools and students at vocational schools and higher educational institutions of different levels of accreditation. Of FSWs, 53 per cent are female adolescent students. Fifty-seven per cent of those in the MSM group are students.

Almost one third of adolescent MSM are regularly or irregularly employed (31 per cent). Among adolescent IDUs, 23 per cent of the respondents are working. Thirteen per cent of adolescent FSWs are regularly or irregularly employed.

Table 3.1.5

Distribution of MARA boys and girls by educational level and employment status, %

		Adolescent IDUs		Adolescent FSWs		Adolescent MSM	
Pupils and students	Secondary school pupils	9	50	13	53	8	57
	Vocational school students	16		13		9	
	Students of higher educational institutions of I–II levels of accreditation	13		13		13	
	Students of higher educational institutions of III–IV levels of accreditation	12		14		27	
Employed	Have regular work	7	23	2	13	12	31
	Have irregular work	16		11		19	
Neither study nor work	Unemployed	24	27	30	34	11	12
	Involved in running household	2		4		1	
	Disabled (invalids)	1					

Distribution of MARA by mobility

The interviewed MARA boys and girls are not very mobile. As a rule, they live in the cities in which they were born (see Table 3.1.6).

Table 3.1.6

Distribution of responses from MARA boys and girls to the question: How long have you been living in this city?, %

		Adolescent IDUs		Adolescent FSWs		Adolescent MSM	
Natives	Was born and live here	84		61		72	
Commuting	Don't live permanently in this city, come to the city from time to time	4		9		9	
Non-residents	Have lived less than 1 year in the city	2	12	11	30	6	19
	Have lived from 1 to 5 years in the city	5		16		9	
	Have lived from 6 to 10 years in the city	2		2		2	
	Have lived more than 10 years in the city	3		1		2	

Conclusions

- The proportion of MARA boys and girls in the total sampling of the 2007 BSSs is 6 per cent among IDUs, 18 per cent among FSWs and 12 per cent among MSM.
- There is a two to one proportion of boys to girls among adolescent IDUs. Boys are more involved in injecting drug use, as the results of the 2007 IDU BSS show.
- The average age of the MARA respondents in the 2007 MARP BSSs was 18.
- Eighty-four per cent of IDUs, 85 per cent of FSWs and 90 per cent of MSM adolescents are not married to their sex partners and do not live with them. A fifth of all IDU girls (20 per cent) live with their sex partners without official marriage registration, while 11 per cent of IDU boys do.
- The majority of respondents are either pupils or students. Almost one third of the respondents (27 per cent among adolescent IDUs and 34 per cent among adolescent FSWs) neither study nor work.
- The majority of the respondents of the three target groups (adolescent IDUs, FSWs and MSM) are natives of the cities where the survey was conducted.

Baseline study among adolescents living and working on the street

The project team analysed interviews with 805 respondents in four cities (see Table 3.1.7). A location-based and network sampling approach was used to recruit members of the target populations. Snowball sampling was used for referral of entire networks.

Distribution of adolescents living and working on the streets by research site

Table 3.1.7

Distribution of adolescents living and working on the streets by research site and number of people interviewed

Research site	Number of people interviewed
Dnipropetrovsk	201
Donetsk	200
Kyiv	202
Mykolaiv	202
TOTAL	805

Distribution of adolescents living and working on the streets by age group

Adolescents aged 15 to 19 were most highly represented (they comprised 62 per cent of the adolescents). In Mykolaiv they made up 64 per cent of the adolescents surveyed, while in Dnipropetrovsk and Kyiv they made up 51 and 49 per cent, respectively. In Donetsk they made up a little bit more than one third of them (36 of the respondents) (see Table 3.1.8).

Table 3.1.8

Distribution of adolescents living and working on the streets by age group and research site, %

Research site	Age group		
	10–14 years	15–17 years	18–19 years
Dnipropetrovsk	27	20	31
Donetsk	31	26	10
Kyiv	26	24	25
Mykolaiv	16	30	34
Total	38	44	18

Distribution of adolescents living and working on the streets by sex

The Baseline Study prescribed a quota for girls. Girls therefore represented 30 per cent of the adolescents interviewed and the sex distribution is uniform across the four research sites. The data array contains the responses of 240 girls and 565 boys.

Distribution of adolescents living and working on the streets by place of birth and nationality

Fifty-two per cent of the respondents indicated that they had been born in the city where the survey was conducted. The rest of the respondents (48 per cent) were born in other settlements. More than half of the respondents indicated that they were born in oblast centres (see Table 3.1.9). The same tendency is traced in the distribution of the respondents by sex and age. In Mykolaiv city 6 per cent of adolescents did not know where they had been born. In Kyiv 13 per cent of them did not know. The adolescents included persons not only from other cities but also from other countries, namely the Russian Federation, the Republic of Moldova, Belarus, Kazakhstan, Georgia and Chechnya (2.5 per cent). The majority of respondents (93 per cent) were born in Ukraine. The remaining 4 per cent of the respondents do not know in what country they were born.

Table 3.1.9

Distribution of the birth places of adolescents living and working on the streets by type of settlement and research site, %

Type of settlement	Among all respondents	Research site (p=0.163)			
		Dnipropetrovsk	Donetsk	Kyiv	Mykolaiv
Oblast centre	62	60	57	60	70
City	24	24	31	23	19
Town	1	2	2	0	1
Village	4	5	2	4	4
Don't know	9	9	8	13	6

Sixty-eight per cent of the interviewed adolescents identified themselves as Ukrainians, 18 per cent as Russians and 4 per cent as other nationalities, such as Moldavians, Roma, Azerbaijanis, Armenians, Belarusians, Greeks, Jews, Tatars, Georgians, Koreans and Chechens. Another 10 per cent do not know their nationalities.

Distribution of adolescents living and working on the streets by orphan status

More than half of the adolescents (59 per cent) are double orphans (15 per cent) or single orphans (either the mother or father is alive) (44 per cent) (see Table 3.1.10). Almost every fifth adolescent is unaware if his or her parents are alive. The sex difference is statistically insignificant.

Table 3.1.10

Distribution of responses of adolescents living and working on the streets by age group to the question: "Are your parents alive?", %

	Sex (p=0.501)		Age group (p=0.663)			Among all respondents
	Boys	Girls	10–14 years	15–17 years	18–19 years	
Both parents are alive	22	26	25	24	17	23
One parent is alive (single orphan)	42	47	42	46	42	44
Both parents are dead (double orphan)	16	12	10	15	24	15
Don't know ("social" orphan)	20	15	23	15	17	18

Distribution of adolescents living and working on the streets by living arrangement

The majority of the respondents (67 per cent) live with their parents (23 per cent with both parents and 44 per cent with one of them) (see Table 3.1.11). Boys live apart from their parents more often than girls do. Older respondents (18–19 years old) reported not living with their parents more often than did younger respondents (10–17 years old).

Fifty-two per cent of adolescents who live apart from their parents (55 per cent of boys and 45 per cent of girls, p=0.006) live with friends. A statistically significant difference is observed between age groups. Respondents aged 15 to 17 live mostly with friends (59 per cent), while 46 per cent of 10- to 14-year-olds and 48 per cent of 18- to 19-year olds do (p=0.004).

On the whole, 41 per cent of the respondents live with adults. Half of 10- to 14-year-olds do (50 per cent); 40 per cent of 14- to 15-year-olds do; and less than a third (30 per cent) of 18- to 19-year olds do (p<0.001). The sex difference is statistically insignificant.

Table 3.1.11

Distribution of responses of adolescents living and working on the streets by age group to the question: "Who do you live with?", %

	Sex (p=0,024)		Age group (p=0,043)			Among all respondents
	Boys	Girls	10–14 years	15–17 years	18–19 years	
With both parents (including foster parents)	22	26	25	24	17	23
With one parent (including foster parents)	42	46	42	46	42	44
Not with parents	36	28	33	30	41	33

The street and railway or bus stations are the main places in which adolescents dwelled during the three months leading up to the survey (36 per cent). Almost one fourth of them live in temporary places unfit for habitation, while 20 per cent reported that they live at home (Fig. 3.1.1).

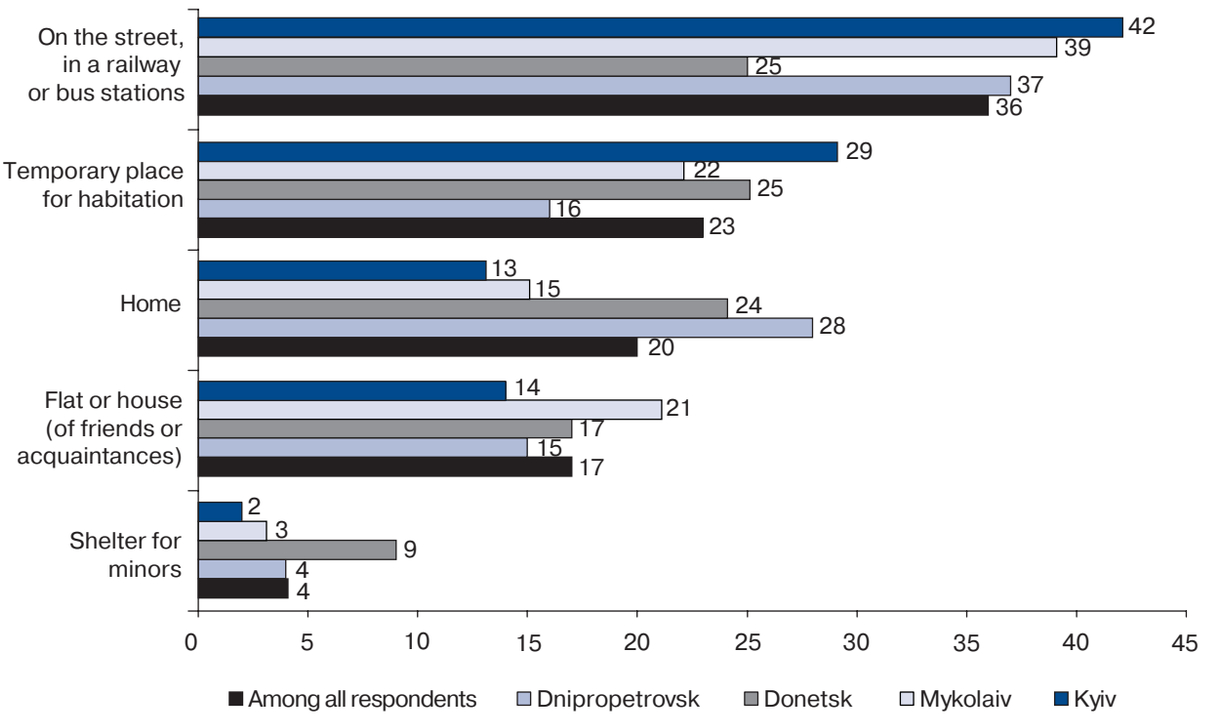


Fig. 3.1.1. Distribution of adolescents living and working on the streets by living arrangement in the last 3 months and research site, % (p=0.003)

In each city, the largest proportions of the adolescents interviewed live on the street: 42 per cent of them in Kyiv, for example, and 37 per cent of them in Dnipropetrovsk. In Dnipropetrovsk and Donetsk relatively more live at home (28 and 24 per cent of the respondents, respectively). In Kyiv and Mykolaiv 13 and 15 per cent live at home, respectively. In Kyiv more than every fourth respondent lives in a place unfit for habitation, while in Dnipropetrovsk only 16 per cent of respondents do.

Distribution of adolescents living and working on the streets by mobility

According to the survey results, 48 per cent of the adolescents are non-residents who came from other regions of Ukraine or from other CIS countries. The other 52 per cent are natives of the cities in which the survey was conducted (see Table 3.1.12).

Table 3.1.12

Distribution of responses of adolescents living and working on the streets by research site and age group to the question: "How long have you been living in this city?", %

	Research site (p=0.002)				Sex (p=0.547)		Age group (p=0.087)			Among all respondents
	Donetsk	Dnipro-petrovsk	Kyiv	Mykolaiv	Boys	Girls	10–14 years	15–17 years	18–19 years	
Born in this city	52.5	56	41	59	51	54	51	52	55	52
Living here less than a year	10	19	15	10	14	13	17	12	11	14
Have lived 1-3 years in this city	18	9	21	14	15	17	19	15	9	15
Have lived more than 3 years in this city	18	15.5	22	17	19	15	12	21	25	18
Don't remember/don't know	1.5	0.5	1	0	1	1	1	0	0	1

The largest proportion of non-resident adolescents is in Kyiv (59 per cent). Every fifth such adolescent (22 per cent of the respondents) has been in Kyiv for more than three years.

No essential difference related to sex was established. The length of time that adolescents live in a city is statistically significant by age. One fourth of the respondents (25 per cent) aged 18 to 19 and 12 per cent of those aged 10 to 14 have lived in cities for more than three years ($p<0.05$).

Fourteen per cent have lived in the city of survey for less than one year.

Distribution of adolescents living and working on the streets by educational level

The majority of adolescents living and working on the street have not received educations appropriate to their ages. For example, only 14 per cent of those aged 18–19 had completed secondary education, only half (52 per cent) had received basic compulsory secondary education and only 28 per cent had finished the first eight grades.

Four per cent of them never attended school (the youngest respondents form the largest proportion in this group). Boys and adolescents of Ukrainian nationality constitute the majority in this group.

Among respondents who were aged 18–19 at the moment of the survey, 86 per cent lack secondary education. Fifty-seven per cent of 15-year-old respondents lack it as well (see Table 3.1.13).

Table 3.1.13

Distribution of adolescents living and working on the streets by educational level, age group and research site, %

	Among all respondents	Age group ($p<0.001$)			Research site ($p=0.004$)			
		10–14 years	15–17 years	18–19 years	Donetsk	Dnipro-petrovsk	Kyiv	Mykolaiv
Never attended school	4	6	2	3	6	4	3	2
Attending forms 1–3	13	30	3	2	16	16	17	5
Primary education completed	6	10	5	1	6	6	2	10
Attending forms 5–8	50	54	57	28	54	34	52	59
Basic secondary education completed	24	-	32	52	16	38	23	18
Completed secondary education	3	-	1	14	2	2	3	6

The largest proportion of 18- to 19-year-old adolescents with a complete basic secondary education proved to be in Mykolaiv (20 per cent) and the smallest was in Dnipropetrovsk (7 per cent). Sixty-three per cent of adolescents interviewed in Dnipropetrovsk and 17 per cent of them interviewed in Mykolaiv had achieved a basic secondary education by age 15. In Kyiv and Donetsk 28 per cent and 27 per cent of respondents 15 and older, respectively, had received a basic secondary education.

Three fourths of those interviewed indicated that they did not attend any educational institution during the school year that started in September 2007. The remaining 25 per cent attended school, but not regularly. They went to school one or two days a week at most, or else not every day.

Distribution of adolescents living and working on the streets by availability of official, mandatory documents

In compliance with Ukrainian law, every person must have a full list of mandatory documents identifying them. These include a birth certificate, a Ukrainian citizen passport and an assigned identification number document[142]. The distribution of responses about the availability of these documents is presented in Table 3.1.14. More than half of the respondents (58 per cent) older than 16 lack passports and every second respondent (53 per cent) lacks a medical card or does not know where it is.

No statistically significant differences were identified between the cities in the survey.

[142] Required for schoolchildren after ninth grade or after receiving a school leaving certificate; see at http://20minut.ua/news/74909.

Table 3.1.14

Distribution of affirmative responses of adolescents living and working on the streets by age group to the question: "Which of the following documents do you presently have?", %

	Age group			Among all respondents	Asymp. Sig. (p)
	10–14 years	15–17 years	18–19 years		
Birth certificate	77	83	72	78	0.010
Identification number	19	31	54	31	<0.001
Medical card	39	50	58	47	<0.001
Passport (certificate about its loss, certificate about release from detention centre, other)		29 (among 16–17-year-olds)	60	42 (among 16–19-year-olds)	<0.001
Education certificates, such as school leaving certificate, diploma, etc.	0	24	51	20	<0.001
Single ticket (ticket issued to orphans under the age of 18 for free travel on public transport)	4	6	7	6	0.340
Other (certificate from boarding school, Chernobyl certificate)	1	1	2	1	0.331

Conclusions

- Adolescents living and working on the streets aged 15 to 19 comprised the largest group in the survey sample.
- Due to the quota for girls, the sex distribution is one to two: girls account for 30 per cent and boys for 70 per cent of respondents.
- Fifty-two per cent of the respondents indicated that they were born in the city where the survey was conducted, while the other 48 per cent indicated that they were born in other settlements, mostly within the same oblast.
- Sixty-eight per cent of the respondents indicated that they were Ukrainians, 18 per cent that they were Russians and 4 per cent that they were representatives of other nationalities.
- Fifty-nine per cent of the respondents are orphans (15 per cent) or half-orphans (either the father or mother is alive) (44 per cent).
- Streets and a railway or bus stations were the most popular dwelling places for the adolescents during the three months leading up to the survey (36 per cent), and almost one fourth (23 per cent) live in temporary places unfit for habitation.
- Forty-eight per cent of the adolescents came from other oblasts of Ukraine or from other CIS countries, while the rest (52 per cent) are natives of the cities in which they took the surveys.
- Four per cent of the respondents never attended school (those aged 10 to 14 were particular prone not to have attended it).
- The majority of the respondents, even those older than 15, lack documents pertaining to education (school leaving certificate, diploma and so on).
- More than half (58 per cent) of respondents lack passports after the age of 16.
- Every second adolescent on the streets (53 per cent) lacks a medical card or does not know where it is.

3.2. Risky and safe MARA behaviour

3.2.1. Sexual behaviour

Secondary analysis of behavioural surveillance data on adolescent IDUs

Sexual experience

Eighty-three per cent of all respondents report having experience of vaginal, oral or anal intercourse (80 per cent of boys and 90 per cent of girls, p=0.018). Sixty-eight per cent of 13- to 17-year-old adolescent IDUs had sexual experience. Ninety-one per cent of 18- to 19-year-old adolescent IDUs did (p<0.001).

Age of first sexual intercourse

Thirty-three per cent of adolescent IDUs had their sexual debuts before the age of 15 and 99 per cent of respondents had experienced sexual contact before reaching adulthood. The average age of sexual debut is 15 (there is no statistically significant difference between boys and girls). Among adult IDUs (those 20 years and older) it is 16 (p<0.001).

Types of sex partners

Sex-based variations are evident when it comes to sex partners. Half of all interviewed adolescent IDUs (50 per cent) had a *regular* sex partner in the three months prior to the survey. Forty-two per cent of these were boys and 61 per cent were girls (p<0.001).

Seventy-four per cent of boys and 57 per cent of girls reported having *casual* sex partners (p<0.001). On the whole 67 per cent of sexually active respondents had them.

As for *commercial* sex partners, 5 per cent of all respondents paid for sex services (6 per cent of boys and 3 per cent of girls) and 12 per cent sold sex (3 per cent of boys and 25 per cent of girls). Twenty-six per cent of the adolescent IDUs selling sexual services were 14–17 and 74 per cent were 18–19.

Number of sex partners by different type of sex partner

Regular partners

The majority (76 per cent) of respondents who had regular sex partners during the three months prior to the survey had one partner. Every fifth adolescent IDU (20 per cent) had two or three partners during this period (see Table 3.2.1.1) and 4 per cent of respondents had more than four.

Casual partners

Thirty per cent of those who had casual partners had one such partner, 33 per cent had two or three, 32 per cent had from four to 10 and 5 per cent had 11 or more.

Commercial partners

Six out of nine adolescent IDUs who reported buying sex had one to three commercial sex partners.

Of 23 adolescent IDUs reporting selling sex, nine had from four to 10 commercial partners, seven had one and another seven had 11 or more.

Table 3.2.1.1

Number and types of sex partners of adolescent IDUs (who had ever had a regular, casual or commercial sex partner) in the last 3 months, %

	Regular sex partner N=96		Commercial sex partner, buying sex N=9		Commercial sex partner, selling sex N=23		Casual sex partner N=132	
	number	%	number	%	number	%	number	%
1 partner	73	76	6		7		39	30
2–3 partners	19	20					44	33
4–10 partners	4	4	1		9		42	32
11 and more partners			2		7		7	5

Total number of sex partners

More than one third (34 per cent) of sexually active adolescent IDUs had one sex partner during the three months before the survey, and almost every fifth (18 per cent) had two (see Fig. 3.2.1.1). About a quarter of the respondents (23 per cent) had from three to five partners, while 14 per cent had from six to 10. Having 11 and more sex partners is typical for 11 per cent of adolescent IDUs.

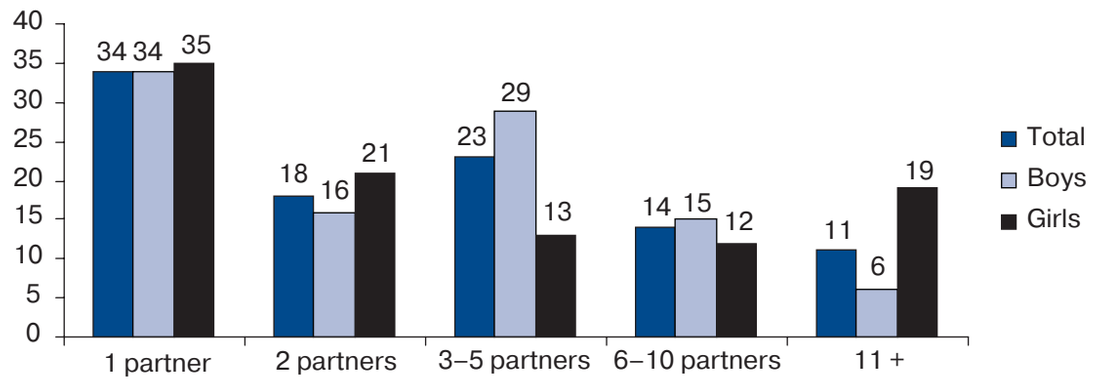


Fig. 3.2.1.1. Total number of sex partners of sexually active adolescent IDU boys and girls in the last 3 months (p=0.089), N=196

Girl IDUs typically had many sex partners during the period in question: 19 per cent of the sexually active girls interviewed reported having had 11 and more partners. Six per cent of boy IDUs reported the same record ($p<0.001$).

Girls' involvement in commercial sex explains why they have so many partners. Only 2 per cent of girls who are not involved in commercial sex reported having more than 11 partners, but 52 per cent of girls who are involved in it did ($p<0.001$).

Condom use

Eighty-three per cent of adolescent IDUs reported having used condoms the last time they had sexual intercourse with a commercial partner while 54 per cent of them reported having used condoms with a regular partner (see Table 3.2.1.2).

Table 3.2.1.2

Condom use with regular/casual/commercial partners during last incidence of sex among adolescent IDU boys and girls & consistent condom use in the last year, %

% IDUs using a condom during last incidence of sex…						
	Number	%		Number	%	p
with a regular partner (N =94)	51	54	boys	28	57	0.001
			girls	23	51	
with a casual partner (N =112)	75	67	boys	48	64	0.003
			girls	27	73	
with a commercial partner (N = 30)	25	83	boys	7	78	0.807
			girls	18	86	
% IDUs who always used condoms in the last year…						
	Number	%		Number	%	p
with a regular partner (N =95)	27	28	boys	17	35	<0.001
			girls	10	22	
with casual partners (N =131)	50	38	boys	38	44	<0.001
			girls	12	27	
with commercial partners (N =29)	12	41	boys	5	63	0.531
			girls	7	33	

Indicators of regular condom use during the last year are essentially lower: 28 per cent of all interviewed adolescent IDUs used condoms with a regular partner (35 per cent of boys and 22 per cent of girls), 38 per cent used condoms with a casual partner (44 per cent of boys and 27 per cent of girls) and 41 per cent used condoms with a commercial partner (63 per cent of boys and 33 per cent of girls). So a tendency towards more frequent use of condoms with non-regular partners can be observed.

Forty-four per cent of adolescent IDUs reported that they did not use condoms the last time they had sexual intercourse with a regular partner because it "decreased sensuality" and because they "did not think it necessary" with a casual partner (32 per cent). Another reason was because they were "under the influence of drugs" (30 per cent). The main reason for not using condoms with commercial partners was "the desire of the partner" (60 per cent).

Conclusions

- Eighty-three per cent of adolescent IDUs reported lifetime experience of vaginal, oral or anal sexual contact (80 per cent of boys and 90 per cent of girls).
- Adolescent IDUs began their active sex lives on average when they are 15, which is one year younger than the age at which IDUs over 20 (adult IDUs) began them. More than one third (33 percent) of adolescent IDUs reported having sexual intercourse for the first time before 15, while 99 per cent of the respondents who had reached adulthood had already had their sexual debuts. This proves that prevention programmes must be implemented earlier.
- Having a regular sex partner is more typical for girl IDUs: 61 per cent of girls had regular sex partners during the three months prior to the survey, while 42 per cent of boys did. The situation with casual partners is the reverse: about three fourths (74 per cent) of boys had such a partner while 57 per cent of girls did. On the whole, girl IDUs are more inclined to have many sex partners than are boys. This is related to involvement in commercial sex services.
- Twelve per cent of adolescent IDUs reported selling sex at some point in their lifetimes (25 per cent of girls and 3 per cent of boys). This index is two times higher than that for adult IDUs. Six per cent of IDUs aged 20 and older have provided sex services for a reward.

- Adolescent IDUs use condoms with commercial or casual partners more often than they do with regular partners. During their last acts of sexual intercourse with commercial or casual partners, 83 and 67 per cent of respondents, respectively, used condoms. Fifty-four per cent used them the last time they had sex with regular partners. However, such a high percentage does not indicate consistent condom use. During the three months leading up to the survey, only about one third (28 per cent) of the respondents always used condoms with regular partners, 38 per cent always used them with casual partners and 41 per cent always used them with commercial partners.

Secondary analysis of behavioural surveillance data on adolescent FSWs

Selling different types of sex

During the last year 99 per cent of adolescent FSWs reported having sold vaginal sex (the age difference is insignificant), 94 per cent provided oral sex services (the age difference is insignificant) and 62 per cent provided anal sex services (72 per cent of 13- to 17-year-old and 57 per cent of 18- to 19-year-old girls, $p<0.001$).

Age of first incidence of sexual intercourse and of initiation of commercial sex

The average age of sexual debut in this risk group is 14 (the minimal age is seven and the maximal age is 18). Among adult FSWs (20 years of age and older) it is 16 ($p<0.001$). Half of the interviewed girls (50 per cent) had their first sexual experience before 15 and another 50 per cent had it when they were between 15 and 17.

The average age of commercial sex debut is 16 (the minimal age is 12 and the maximal age is 19). Among adult FSWs (20 years of age and older) it is 20 ($p<0.001$). The majority of the respondents (70 per cent) began to provide sex services when they were between 15 and 17. Another 15 per cent started in commercial sex before they were 15 and the remaining 15 per cent started when they were 18 or older.

The overwhelming majority of adolescent FSWs began to provide sex services within one or two years of their sexual debuts (32 per cent for each option, respectively). Respondents who had their sexual debuts before 15 began to provide sex services on average almost one year later than those who had their sexual debuts after 16 ($p<0.05$)(see Table 3.2.1.3).

Table 3.2.1.3

Average number of years between first incident of sexual intercourse and initiation of commercial sex among adolescent FSWs by age group ($p<0.05$)

Age of 1st incidence of sexual intercourse	Average number of years between 1st incidence of sexual intercourse and initiation of commercial sex	N =	Standard deviations
7–13 years	2.1	50	1.29
14–15 years	1.6	141	1.08
16–17 years	1.2	49	0.85

Number of sex partners

On the last working day

Adolescent FSWs have many sex partners. On their last working day more than a third (37 per cent) of girls had three to five commercial partners and more than a fourth (26 per cent) had two. Twenty-four per cent of girls had one sex partner a day (see Fig. 3.2.1.2). The average number of commercial partners a day is three (no difference between adolescent FSWs and adult FSWs is observed).

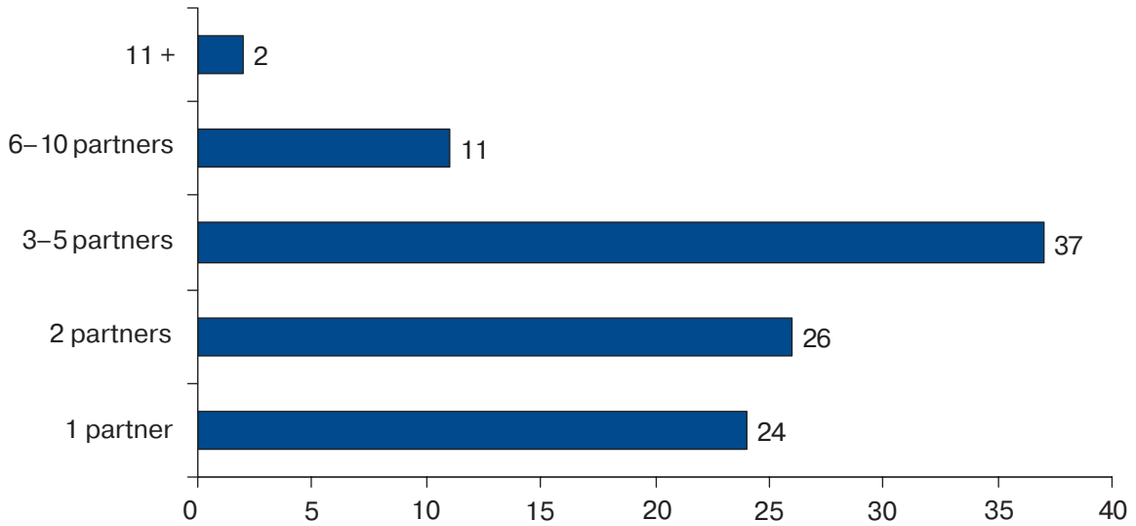


Fig. 3.2.1.2. Number of commercial sex partners of adolescent FSWs on last working day, %

In the last week

Fifty-seven per cent of the interviewed adolescent FSWs had non-commercial sex partners during the last week. The majority (56 per cent of those who had such partners) had one non-commercial partner and almost one fourth (23 per cent) had two (see Table 3.2.1.4). On average, both adolescent and adult FSWs had one non-commercial partner.

Respondents' answers about the number of commercial sex partners they had during the last week were distributed as follows: almost one fourth (23 per cent) of the girls had between one and five, almost one third (29 per cent) had six to 10, 23 per cent of respondents had 11 to 20 and one fourth (25 per cent) of the girls had more than 20. One per cent of the girls had one partner. The average number of such partners for the last week was 15. For adult FSWs it is 13 ($p<0.001$).

During the last week about one third (27 per cent) of the respondents had from six to 10 partners in total. The same number of respondents reported that they had had 21 sex partners or more. Twenty-six per cent of the girls reported having 11 to 20 partners and 16 per cent reported three to five partners. One per cent of girls had one partner and 3 per cent had two partners. The average number of sex partners was 16. For adult FSWs it is 14 ($p<0.001$)).

Table 3.2.1.4

Number of commercial and non-commercial sex partners of adolescent FSWs in the last week, %

	Non-commercial sex partners (for the last week) N=126	Commercial sex partners (for the last week) N=281	Total sex partners (for the last week) N=281
1 partner	56	1	1
2 partners	23	6	3
3–5 partners	18	16	16
6–10 partners	3	29	27
11–20 partners		23	26
21 partners and more		25	27

Condom use

Respondents in this risk group reported condom use with commercial partners more often. Seventy-six per cent used condoms during last incidence of sexual intercourse with such partners while 51 and 25 per cent used them with casual and regular sex partners, respectively ($p<0.001$).

About half of the interviewed adolescent FSWs (52 per cent) always used condoms with clients in the month before the survey. The rest (48 per cent) took risks and did not use them (and 1 per cent of girls never used them) (see Fig. 3.2.1.3).

Sixty-two per cent of adult FSWs (20 and older) reported consistent condom use ("always") with clients in the last month and 38 per cent reported inconsistent use. One per cent said that they had never used a condom in the last month with a client.

Girls aged 13 to 17 take more risks than girls aged 18 to19: 41 per cent of the former and 57 per cent of the latter reported that they always used condoms with clients during the last month ($p<0.05$).

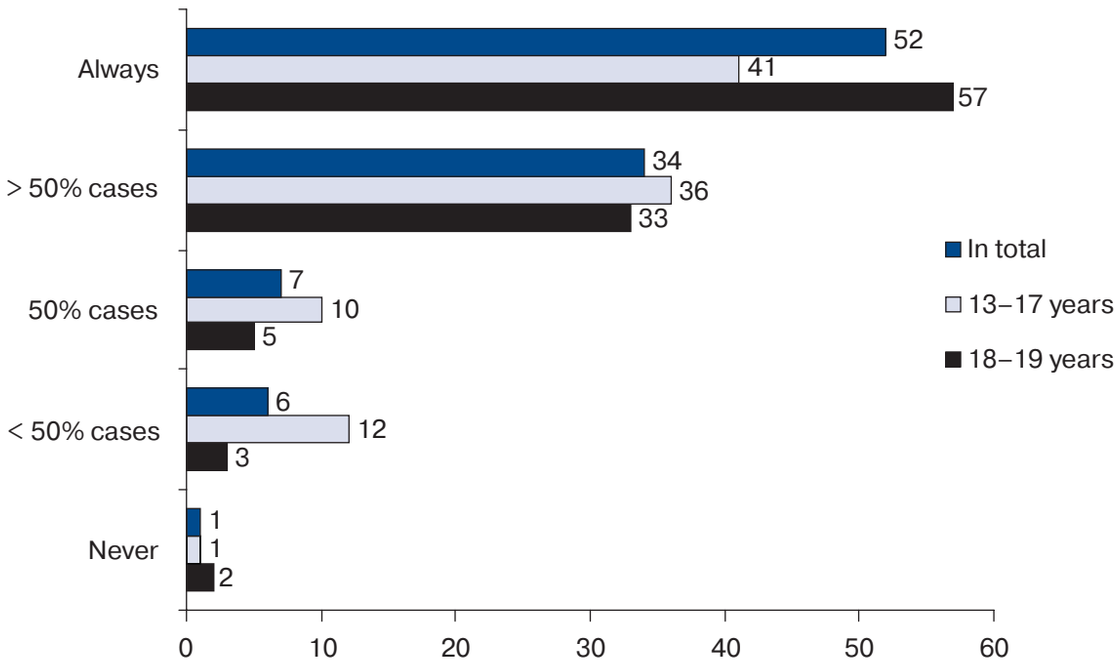


Fig. 3.2.1.3. Distribution of responses of adolescent FSWs who had ever had a commercial sex partner by age group to the question: "When you had sex with a client in the last month, how often did you use a condom?", % (p=0.012)

The majority of the adolescent FSWs (61 per cent) used condoms with clients for vaginal sex during the last year. Half (50 per cent) of the respondents used them for anal sex and more than one third (37 per cent) used them for oral sex (see Fig. 3.2.1.4). One per cent of girls never used condoms for vaginal sex during the last year, 6 per cent used them for anal sex and one third (33 per cent) used them for oral sex.

In comparison, condom use with clients by adult FSWs (above the age of 20) breaks down as follows. Sixty-nine per cent reported always using them during vaginal intercourse. None reported never using one. Sixty-two per cent reported consistent condom use during anal sex and 2 per cent reported never using them during anal sex. Fifty-three per cent said they always used condoms for oral sex and 17 per cent said they never did.

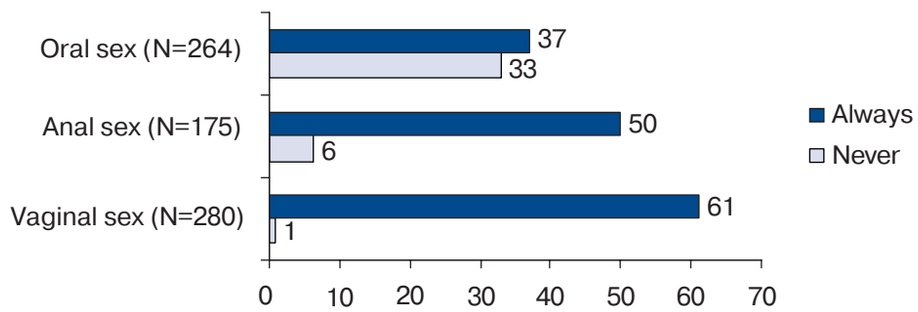


Fig. 3.2.1.4. Distribution of responses "Always" and "Never" of adolescent FSWs to the question: "How often did you use condoms in the last 12 months during sexual intercourse?", by type of sexual intercourse, %

Age differences were observed in terms of condom use for vaginal sex: 52 per cent of 13- to 17-year-olds and 65 per cent of 18- to 19-year-old girls always used condoms for it during the last year ($p<0.05$).

Higher indicators of condom use for vaginal than for anal sex (61 per cent versus 50 per cent, respectively, $p<0.05$) might be attributed to the condom's utility in contraception rather than to a perception among adolescent FSWs that anal sex is less risky.

The majority of adolescent FSWs consider sex without condoms permissible for extra payment (39 per cent versus 25 per cent of adult FSWs, $p<0.05$). Forty-five per cent of girls approve of unprotected sex with a regular partner whom they know and trust. Among adult FSWs this percentage is 38 per cent ($p<0.05$). Thirty-two per cent of adolescent and 47 per cent of adult FSWs say that there are no circumstances in which sex without a condom would be possible ($p<0.05$).

Adolescent FSWs are more vulnerable than adult FSWs to infection because they do not use condoms consistently for all kinds of sexual contact. This is most likely a function of their insufficient experience in sex work and of their lesser knowledge about safe practices and why they are needed.

Conclusions

- Adolescent FSWs began their sex lives and provision of sex services for reward earlier than adult FSWs. Their average age of sexual debut is 14 years, while for commercial sexual debut it is 16 years. At the same time, the average age of sexual debut of adult FSWs (20 years and older) is 16 years and for commercial sexual debut it is 20 years.
- The overwhelming majority of adolescent FSWs began to provide sex services within one or two years of their sexual debuts. Girls who had their sexual debuts before 15 began to provide sex services on average one year later than those who had their sexual debuts after.
- Adolescent FSWs are characterised by intense sexual activity. More than half (57 per cent) of the girls had non-commercial sex partners (regular or casual) as well as commercial ones in the previous week. Adolescent FSWs had 16 total partners on average. Adult FSWs had 14.
- Condoms are more frequently used with commercial and casual partners than with regular partners. More than three fourths (76 per cent) of the respondents reported that they had used condoms during their last act of sexual intercourse with a commercial partner, 65 per cent said they used them with casual partners and 25 per cent said they used them with regular partners. Consistency indices for safer sex practices are essentially lower – adolescents take more risks than adult FSWs do. A bit more than half (51 per cent) of the respondents always had safer sex during the last month while 62 per cent of adult FSWs did.
- During the last year 62 per cent of girl FSWs provided anal sex services. Fifty per cent of them reported using always condoms during anal sex with clients.

Secondary analysis of behavioural surveillance data on adolescent MSM

Type of sexual intercourse

The majority (92 per cent) of the interviewed adolescent MSM reported having had oral sex during the last six months. Sixty-six per cent assumed the insertive (active) role in anal sex and 65.5 per cent played the receptive (passive) role.

Seventy-one per cent of adolescent MSM have had sex with women. Fifty-three per cent of them had had sex with at least one woman during the six months prior to the survey.

Types of male sex partners

During the six months prior to the survey, 66 per cent of the interviewed adolescent MSM had sex with regular sex partners, 77 per cent had it with casual partners and 14 per cent had it with commercial partners (adolescent MSM either provided sex services to men or paid for sex services themselves) (see Fig. 3.2.1.5).

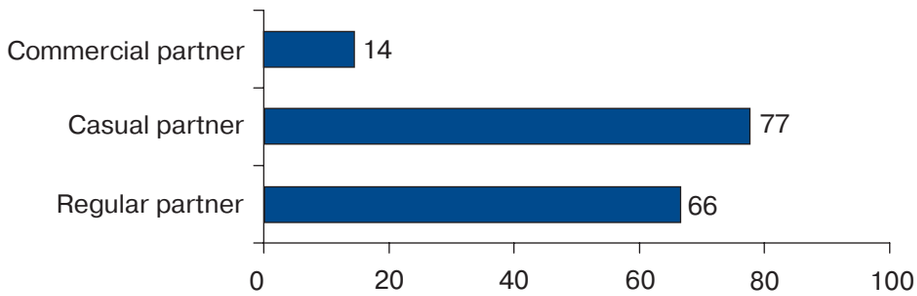


Fig 3.2.1.5. Types of male sex partners of adolescent MSM in the last six months, %

Number of oral sex partners

Among adolescent MSM who had oral sex, 84 per cent (N=191) had it with two and more partners. More than half (53 per cent) of the respondents had more than four partners in the last six months. The data reflect those of the survey conducted among the adult MSM population, which indicated that 80 per cent had had oral sex with two or more partners. However, 40 per cent of those who had had oral sex with two or more partners had had between four and 10 partners. Twenty per cent of adult and 16 per cent of adolescent MSM had one partner.

Number of anal sex partners

The majority of the respondents had from two to 10 sex partners in both insertive (43 per cent) and receptive (36 per cent) roles in the last six months. The age difference is insignificant (see Table 3.2.1.5).

Table 3.2.1.5

Number of anal sex partners of adolescent MSM in the last six month by insertive/receptive role, %

Number of partners	Insertive role (N=207)	Receptive role (N=206)
1 partner	16	23
2–3 partners	22	20
4–10 partners	21	16
11 partners and more	7	6
No partners	34	35

Condom use

Seventy-two per cent of MSM respondents used condoms during their last act of sexual intercourse with a regular partner. Seventy-eight per cent used them during their last act with a casual partner and 75 per cent used them during their last act with a commercial partner (see Fig. 3.2.1.6).

Adolescent MSM overwhelmingly reported that they use condoms with commercial, casual and regular partners. However, one fourth of them expose themselves to risk of HIV infection by having unprotected sex with commercial and regular partners (25 and 28 per cent, respectively). Among the reasons they cite for not using condoms with different partners are these: "decreased sensuality," "didn't think it necessary" and "didn't think about it at all." The main reason for not using a condom is that a commercial partner might not want to.

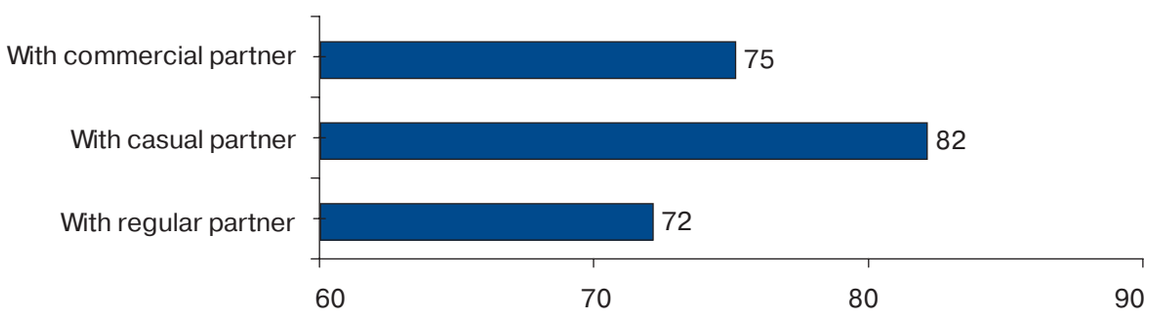


Fig. 3.2.1.6. Condom use by adolescent MSM with regular/casual/commercial partners during last sex act, %

Conclusions

- During the six months prior to the survey, 92 per cent of the interviewed adolescent MSM had oral sex, 66 per cent played an insertive (active) role in anal sex and 65.5 per cent played a receptive (passive) role in anal sex.
- Of those who had oral sex, 84 per cent had contacts with two and more partners in the last six months; 50 per cent of those who played the insertive role in anal sex had two and more partners and 41 per cent of those who played the acceptive role had two and more partners.
- Seventy-one per cent of adolescent MSM reported having had heterosexual sex at some point in their lifetimes.
- In the six months previous to the survey, 66 per cent of the interviewed adolescent MSM had sex with regular sex partners and 77 per cent had it with casual partners.
- Fourteen per cent of the respondents comprise a double risk group: adolescent MSM involved in commercial sex (they either provide commercial services or pay for them).
- In the six months previous to the survey, adolescent MSM had on average four or five sex partners.
- Seventy-two per cent of adolescent MSM reported using condoms during their last sex acts with regular partners, 78 per cent reported using them during their last sex acts with casual partners and 75 per cent reported using them during their last sex acts with commercial partners. However, such high indicators do not testify to sustained safer sex behaviour[143].

Baseline study among adolescents living and working on the street

Sexual experience

Seventy-four per cent of the total number of interviewed adolescents living and working on the street reported ever having had vaginal intercourse (70 per cent of boys and 82 per cent of girls) (see Table 3.2.1.6).

Table 3.2.1.6

Distribution of sexually active adolescents living and working on the streets reporting ever having had vaginal intercourse by age group and research site, %

	Sex (p<0.001)		Age group (p<0.001)			Research site (p<0.001)				Total
	Boys	Girls	10–14 years	15–16 years	17–18 years	Dnipro-petrovsk	Donetsk	Kyiv	Mykolaiv	
% ever having had vaginal intercourse	70	82	43	90	99	61	66	87	88	74

Forty-three percent of respondents from the youngest age group (10–14 years) reported experience of vaginal sex.

Mykolaiv and Kyiv had the largest proportions of sexually active adolescents (88 per cent and 87 per cent, respectively).

Twenty-six per cent of the respondents (21 per cent of boys and 38 per cent of girls, p<0.001) said that they had had anal sex during heterosexual intercourse at some point in their lifetimes.

[143] The questionnaire for the 2007 BSS on MSM did not contain a question – such as "In the last month/last three months/last year, how often did you use condoms during sexual intercourse?" – about the consistency of condom use.

Age of first sexual intercourse

Sexual debut before age 15 is typical: 76 per cent of all interviewed adolescents had their first sexual experience before that age. Ninety-nine per cent of them had their first sexual experience before reaching majority age. The average age of sexual debut is 13. Sex difference is insignificant here.

Types of sex partners

During the year prior to the survey, 37 per cent of sexually active respondents had *regular* partners (34 per cent of boys and 44 per cent of girls, p<0.001).

Eighty per cent of boys and 65 per cent of girls (p<0.001) had *casual* sex partners over the last 12 months (75 per cent of the respondents in general had them).

During the year prior to the survey 17 per cent of boys and 57 per cent of girls were involved in *commercial* sex by either buying (boys) or selling (girls) sex services.

Eleven percent of respondents who had regular partners reported that they had regular partners who were injecting drug users. Eight per cent of the boys and 16 per cent of the girls had regular IDU sex partners (p<0.001). It is worth mentioning that 79 per cent of the respondents who had regular IDU sex partners reported injecting drugs themselves (89 per cent of boys and 70 per cent of girls, p<0.001).

Number of sex partners

Regular partner

More than half of the boys (54 per cent) who reported having regular partners had one such partner in the last 12 months. One fourth (25 per cent) had two regular sex partners (see Table 3.2.1.7).

Table 3.2.1.7

Number and type of sex partners of adolescents living and working on the streets reporting sex with regular, casual and/or commercial partners in the last 12 months, %

	Regular partners (among boys)* N=122	Casual partners (p<0.001)			Commercial partner (selling sex) (among girls) N=89
		boys N=287	girls N=110	Total N=397	
1 partner	54	19	15	17	8
2 partners	25	22	26	23	25
3–5 partners	16	38	28	36	19
6–10 partners	3	13	23	16	18
11 partners and more	2	8	8	8	30

* Girls were not asked about the number of their regular partners.

Casual partners

More than one third (36 per cent) of respondents who had casual partners had from three to five of them (38 per cent of boys and 28 per cent of girls). Almost one fourth (23 per cent) had two casual partners for the last year. Seventeen per cent had one casual partner and 16 per cent had from six to 10.

Commercial partners

Girls involved in commercial sex mostly had more than 11 commercial partners during the last year (30 per cent of girls had 11 or more commercial partners). One fourth of girls (25 per cent) provided sex services to two partners during the last year. Almost every fifth girl (19 per cent) had from three to five such partners and another 18 per cent of girls had from six to 10. Eight per cent of girls had one commercial partner during the last year.

Total number of sex partners

During the year prior to the survey, 20 per cent of adolescents living and working on the streets had one or two partners. About one third of the respondents (31 per cent) had from three to five partners (see Table 3.2.1.8). Almost every fifth adolescent (18 per cent) had sex with six to 10 partners and 11 per cent had sex with more than 10.

The number of a young person's sex partners also depends on his or her age and sex. Girls reported having "6 to10 partners" or "more than 10 partners" more often than boys did. Some 20 per cent and 24 per cent of girls reported these numbers, respectively, while 17 per cent and 9 per cent of boys did, respectively.

Table 3.2.1.8

Total number of sex partners of sexually active adolescents living and working on the streets in the last year by age group, % (N=525)

Among sexually active adolescents (N=525)	Sex (p=0.001)		Age group (p=0.002)			Among all respondents
	boys	girls	10–14 years	15–17 years	18–19 years	
1 partner	20	21	25	17	21	20
2 partners	21	18	25	21	15	20
3–5 partners	33	27	30	35	25	31
6–10 partners	17	20	16	17	23	18
11 partners and more	9	14	4	10	16	11

The youngest adolescents living and working on the streets (10–14) typically have the least sex partners and the oldest (18–19 years) typically have the most. Twenty-five per cent of 10- to 14-year olds and 15 per cent of 18- to 19-year-olds had two partners for the last year, while 4 per cent of 10- to 14-year-olds and 16 per cent of 18- to 19-year-olds had more than 10.

MSM behaviour

Ten per cent of the male adolescents living and working on the street reported having sex with boys/men.

The numbers of adolescents who are MSM differ from city to city ($p<0.001$). The largest MSM group is in Mykolaiv (where MSM are 12 per cent of male adolescents living and working on the streets) and the smallest is in Donetsk (where they were 2 per cent of them). In Kyiv and Dnipropetrovsk MSM account for 10 and nine per cent, respectively, of their total number.

Seventy-four per cent of the respondents had sex with a male before they turned 15. Ninety-six per cent had male sex experiences before they turned 18.

Fifty-four per cent of boys had their last anal sex with a boy/man during the month prior to the survey.

Half (52 per cent) of the interviewed boys reported that they had anal sex experience and had anal sex with one partner. Thirty-seven per cent said they had it with two partners and 11 per cent said they had it with more than three partners (see Table 3.2.1.9).

Table 3.2.1.9

Number of male sex partners of boys living and working on the street in the last month/last year, %

In the last month	
1 partner	52
2 partners	37
3 and more partners	11

In the last year	
1 partner	44
2 partners	19
3–5 partners	20
6–10 partners	12
More than 11 partners	5

Half of the boys who had sex with men during the last year (52 per cent of the total MSM group, or 5 per cent of all respondents) reported receiving money, various goods, drugs, food or clothes for sex at some point in their lifetimes.

Thirty-nine per cent of boys reported using a condom during their last incidence of anal sexual intercourse. Thirty-six per cent of boys reported using condoms with non-commercial male partners.

Irrespective of the type of partner (regular, casual or commercial), 4 per cent of boys living and working on the street reported consistent condom use in the last year. Boys reported that they use condoms if clients wish. Sometimes "clients buy mineral water to clean the sex organs" (boy MSM, 15 years old, Donetsk).

On the whole, MSM contact among boys appears to be less a manifestation of sexual identity than a way of surviving on the street. Clients are "mostly wealthy men who approach on four wheels" (boy MSM, 15 years old, Donetsk). Sometimes "adults come and propose sex, then treat [me] with alcohol and food and provide money" (boy MSM, 15 years old, Mykolaiv).

Commercial and transactional sex

Almost one third (28 per cent) of the interviewed adolescents living and working on the street had experience in providing sex services for a reward (money, food, clothes, drugs and other things). Fifty-seven per cent of girls sold sex services and 17 per cent of boys bought them.

The number of adolescents living and working on the streets involved in commercial sex differs from surveyed city to surveyed city ($p<0.001$). Commercial sex is more widespread among adolescents in Mykolaiv and Kyiv: 35 and 23 per cent of the total number of respondents, respectively, had commercial sex in the last 12 months prior to the survey. Thirteen per cent of the adolescents interviewed in Dnipropetrovsk and 10 per cent in Donetsk sold or bought sex services.

More than half (57 per cent) of girls who had experience in commercial sex began providing sex services for reward before turning 15 and 95 per cent of the respondents began before reaching majority age. The average age of commercial sex debut is 14.

It is noteworthy that boys who use commercial sex do not necessarily begin their sex lives early. The distribution of boys of both groups (both those involved and those not involved in commercial sex) by average sexual debut age did not show significant differences between responses (see Table 3.2.1.10). Among girls, on the contrary, the respondents not involved in commercial sex began their sex lives on average one year earlier than those respondents involved in it.

Table 3.2.1.10

Level of involvement in commercial sex of adolescents living and working on the streets by average age of first sexual intercourse, in years

	Boys		Girls ($p<0.001$)	
	Use commercial sex (N=96)	Don't use commercial sex (N=469)	Involved in commercial sex (N=137)	Not involved in commercial sex (N=103)
Average age of 1st incidence of sexual intercourse	13	13	13	14
N	74	312	128	60
Std. deviation	1.9	1.9	1.6	1.8

The majority of girls living and working on the streets began to provide sex services at the same age as when they had their sexual debut (39 per cent) or in the year after that (34 per cent). Sixteen per cent of girls show a difference of two years between their sexual debut and their first participation in commercial sex. The rest (11 per cent) began to provide sex services three and more years after their sexual debuts.

Girls living and working on the streets stressed that providing sex services is a means of survival for them. Focus group research shows that commercial sex is viewed as a more effective way of raising income than begging or rough labour. For example, one of the respondents from Mykolaiv, an 18-year-old girl, said: "Many girls start doing this [commercial sex] for money." On the other hand, a reward may take the form

not only of money but also of food, alcohol, drugs or anything else. The majority of boys and girls who participated in the focus groups stated that provision of sex services is not occasional, but rather a well-organized business. Some girls are involved in organized structures headed by a male or female pander, while others organize their own groups.

Girl, 17 years old, Mykolaiv: "There are female panders who invite you to their places; a girl pays her for a client and that's it";

Girl, 16 years old, Mykolaiv: "Some girls live at the place of a female pander and go with her (…) many are united into groups and rent flats."

Condom use

Adolescents living and working on the street more often used condoms during their last sexual acts with commercial partners (65 per cent) than during their last sexual acts with casual ones (47 per cent) (see Table 3.2.1.11).

Indicators of consistency of condom use are essentially lower: 12 per cent of the respondents always used condoms with regular partners during the last year, 15 per cent used them with casual ones and 10 per cent used them with commercial ones.

Table 3.2.1.11

Condom use of adolescents living and working on the streets with regular/casual/commercial sex partners during last sex/in the last year, %

% of adolescents reporting the use of condoms for their last sex act			
With regular partner (N =74)	43 (among girls)		
With casual partner (N =342, p=0.462)	47	boys	46
		girls	50
With commercial partner (N =128, p<0.001)	65	boys	64
		girls	65

% of adolescents reporting that they always used condoms during the last year			
With regular partner (N =204, p=0.001)	12	boys	9
		girls	18
With casual partner (N =431, p=0.806)	15	boys	16
		girls	11
With commercial partner (N =155, p<0.001)	10	boys	15
		girls	8

Girls always used condoms with regular partners more often than boys did: 18 per cent of the former and 9 per cent of the latter always used them during the last year. But boys used them more often than girls when it came to casual and commercial partners: 16 per cent of boys and 11 per cent of girls always used them with casual partners while 15 per cent of boys and eight per cent of girls always used them with commercial partners.

On the whole, during the last year, 12 per cent of all respondents always used condoms with regular partners, 15 per cent always used them with casual partners and 10 per cent always used them with commercial partners.

Unprotected sexual intercourse is more typical of the sexual behaviour of adolescents in Mykolaiv: 91 per cent of respondents there had unprotected sex with casual partners. As for the rest of cities, 88 per cent of respondents in Kyiv reported that they did not use condoms in sex with casual partners, as did 87 per cent in Donetsk and 70 per cent in Dnipropetrovsk (p<0.001).

Pregnancies

Almost every fifth girl living and working on the streets (18 per cent of all interviewed girls) was pregnant. The most (55 per cent) pregnancy cases are among 18- to 19-year old respondents. Sixty-four per cent of the pregnant girls were pregnant for the first time and one fourth (23 per cent) of them were in their second pregnancies. Thirteen per cent of them had been pregnant three and more times.

Abortions

The majority of girls (68 per cent) who were pregnant had their pregnancies terminated. All respondents in the youngest age group (10–14) had had their pregnancies terminated. In the middle (15–17) and older (18–19) age groups 69 and 61 per cent of girls had, respectively. Almost two thirds of girls (63 per cent of

all the girls who had had pregnancies terminated) did it once, 17 per cent did it twice and 20 per cent did it three times and more.

Miscarriages

Almost half of the girls with pregnancy experiences (43 per cent) had had miscarriages. Sixty-eight per cent of them had had one miscarriage and 32 per cent had had two miscarriages.

Children

Two per cent of girls living and working on the streets, or 11 per cent of those who were pregnant, have children.

Sexually transmitted infections

Eighteen per cent of the respondents reported having experienced STI symptoms. Almost one third of girls (27 per cent) and 15 per cent of boys answered in the affirmative to the question "Have you ever had genital sores, ulcers or unusual genital discharges?" ($p<0.001$). Such symptoms are more typical of the oldest age group. One third (30 per cent) of 18- to 19-year-old respondents had had such symptoms while 19 per cent of 15- to 17-year-olds and 12 per cent of 10- to 14-year-olds had ($p<0.001$).

Experience of forced sex in institutions[144]

The respondents reported cases of being forced into sexual intercourse in all of the sorts of institutions into which adolescents living and working on the streets are placed. There were single cases in distribution centres for minors (one adolescent out of 161 placed there), regional police departments (two adolescents out of 44), special rooms for children in police departments (three adolescents out of 292) and in penitentiary facilities (three adolescents out of 24). All adolescents placed in special centres for homeless people reported cases of being forced into sexual intercourse (36 adolescents out of 36). Every tenth adolescent who had ever been in a pre-trial detention centre or a remand centre reported experience of sexual abuse (18 adolescents out of 233 and nine adolescents out of 84, respectively).

Girls more often than boys were forced into sexual intercourse in pre-trial detention centres (out of 18 sexual abuse cases, 16 involved girls and two involved boys) and in remand centres (out of nine sexual abuse cases, seven involved girls and two involved boys). Boys were more often thus victimised in special centres for homeless people (out of 36 sexual abuse cases, four involved girls and 32 involved boys).

The youngest respondents (10- to 14-year-olds) faced sexual abuse in shelters for minors more often than older respondents (15 to 19-year-olds) did. Out of nine sexual abuse cases here seven involved adolescents from the 10- to 14-year-old group and two involved adolescents from the 15- to 19-year-old group. Older adolescents more often faced sexual abuse in special centres for homeless people. Of 36 cases in such shelters, 17 involved adolescents from the 15- to 17-year-old group and 14 involved adolescents from the 18- to 19-year-old group.

Conclusions

- The sexual behaviour of adolescents living and working on the streets is characterised by its starting early. More than three fourths (76 per cent) start having sex before 15. The average age of sexual debut is 13. On the whole, 74 per cent of all respondents are sexually active.
- Adolescents living and working on the streets do not have extraordinarily high numbers of sex partners. During the last year the majority (40 per cent) of respondents had one or two of them. Casual partners prevail: 75 per cent of sexually active adolescents had casual partners during the last year and 37 per cent had regular partners.
- Eleven per cent of respondents who had regular partners (16 per cent of girls and 8 per cent of boys) had regular partners who were IDUs, girls more often than boys. It is noteworthy that the majority (79 per cent) of adolescents in this group are injecting drug users themselves.
- In general, male adolescents living and working on the streets do not sell MSM sex very often. But they do it "when money is needed" or "when a drug dose is a problem (drugs are more expensive in the spring)."

[144] The research instruments did not include a question about a type of persecutor in the institutions.

- Five per cent of boys reported being engaged in commercial or transactional MSM sex, making them a double risk group: MSM involved in commercial or transactional sex.
- In the focus groups that the project team held following the quantitative survey, boys said they received money, various goods, drugs, food and clothes from men in return for sex services.
- More than half (52 per cent) of the boys had one male sex partner during the month prior to the survey.
- Thirty-nine per cent of adolescent MSM living and working on the streets used condoms with commercial partners and 36 per cent used them with non-commercial partners.
- Twenty-eight per cent of all respondents are involved in providing commercial sex services: 57 per cent of girls sell and 17 per cent of boys buy sex services. This increases HIV infection risk.
- Adolescents living and working on the streets mainly have unprotected sex. Only 12 per cent of the respondents always used condoms for sex with regular partners, 15 per cent always used them for sex with casual partners and 10 per cent always used them for sex with commercial partners.
- Almost every fifth girl (18 per cent) said that she had been pregnant at some point in her lifetime. Sixty-eight per cent of girls who had been pregnant had had their pregnancies interrupted once or twice. Eighteen per cent of all respondents had had symptoms of sexually transmitted diseases: 27 per cent of girls and 15 per cent of boys.
- The research made clear that young people are forced into sexual intercourse in all the state institutions in which children living and working on the streets are placed (distribution centres for minors, shelters for minors, remand centres and others). They are thus exposed to an additional risk of HIV infection.

3.2.2. Injecting drug use

Secondary analysis of behavioural surveillance data on adolescent IDUs

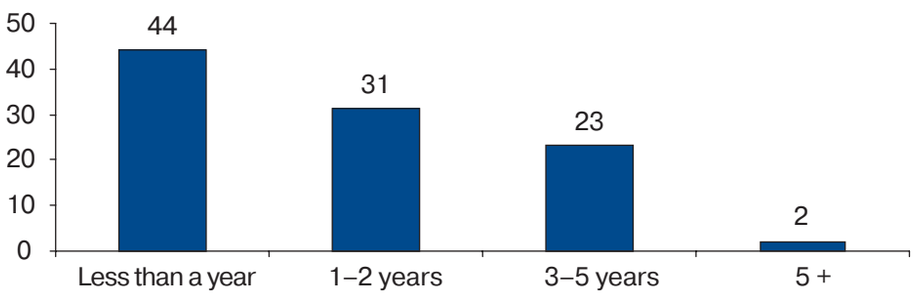
Age of initiation

Some 15.5 per cent (21 per cent of boys and 4 per cent of girls, $p<0.001$) of adolescent IDUs reported starting injecting drugs before turning 15, while 86 per cent ($p>0.05$) of adolescent IDUs started before gaining majority age.

Some 44 per cent of adolescent IDUs reported that they had been injecting drugs for less than a year and 31 per cent reported that they had been doing so for one to two years (13–24 months).Twenty-three per cent had used drugs for three to five years and 2 per cent for more than five years (Fig. 3.2.2.1).

Fig. 3.2.2.1. Length of time adolescent IDUs had used injecting drugs (N=259), %

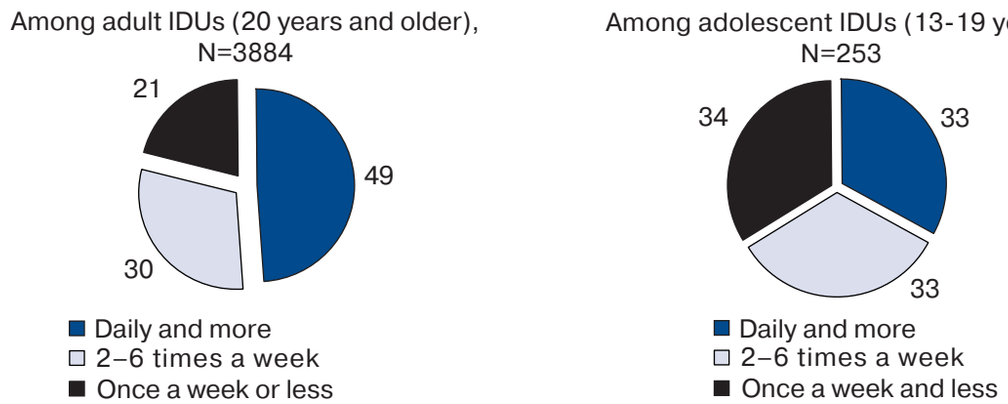
Frequency of injecting drug use



Daily use of injecting drugs was reported by 33 per cent of adolescent IDUs. Thirty-three per cent reported using them between two and six times a week and 34 per cent reported using them once a week and more rarely (Table 3.2.2.1). Comparing adolescent IDUs (13 to 19 years old) with older IDUs (20 and older) shows that daily drug use is more widespread among the latter: 49 per cent of them reported that they used drugs every day (Fig. 3.2.2.2).

Table 3.2.2.1

Frequency of injecting drug use among adolescent IDU boys and girls in the last 30 days by age group, %



	Sex (p=0.013)		Age (p=0.015)	
	Boys, N=165	Girls, N=88	13–17-year-olds, N=89	18–19-year-olds N=164
Daily and more often	33	30	30	34
2–6 times week	34	32	32	34
1 time a week and less	33		38	32

Fig. 3.2.2.2. Frequency of injecting drug use among adolescent and adult IDUs in the last 30 days, % *(p<0.001)*

Unsafe injecting

During the last 30 days, 30 per cent of adolescent IDUs shared needles and injecting equipment. More than four fifths (83 per cent) of them reported that they had practised at least one of the listed behaviours that place themselves or others at risk of HIV infection (Fig. 3.2.2.3).

Moreover, 24 per cent of adult IDUs (20 and older) had shared injecting equipment during the last 30 days. The research traced considerable differences in needle-sharing between adolescent IDUs (13–19 years old) and adult IDUs, with 66 per cent of the former sharing as against 79 per cent of the latter (p<0.001). There are also differences when it comes to lending or passing along used needles or syringes, with 30 per cent of adolescent IDUs and 24 per cent of adult IDUs reporting such practices (p<0.001).

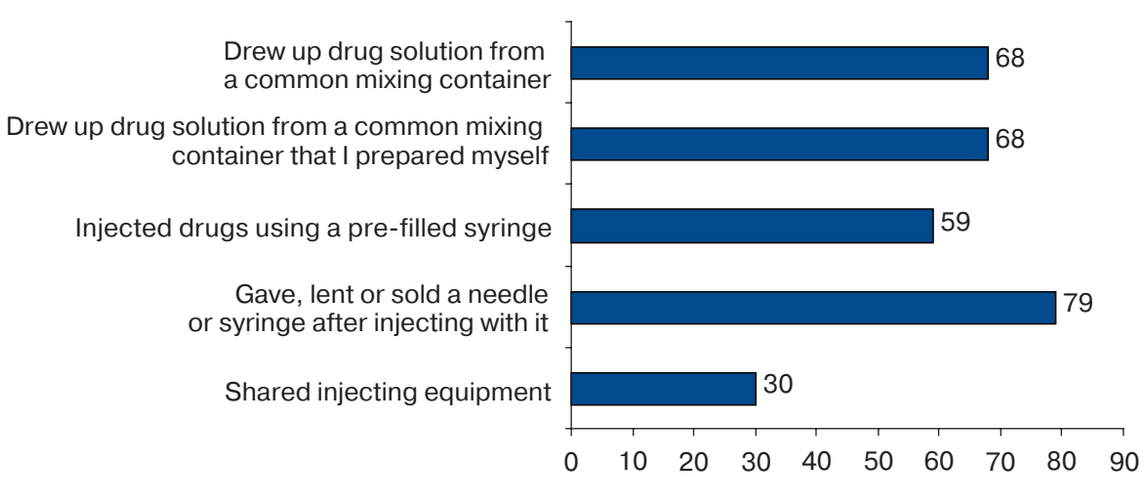


Fig. 3.2.2.3. Different types of sharing reported by adolescent IDUs in the last 30 days, %

Use of sterile injecting equipment (at last injection)

Eighty-one per cent of adolescent IDUs and 87 per cent of adult IDUs (20 and older) reported that they used sterile equipment during their last injection ($p<0.05$). The sex difference is insignificant.

Number of sharing partners

Adolescent IDUs commonly share injecting equipment with other people. The majority of them shared it with three to five partners during the month previous to the survey. Adults more typically share with one (34 per cent) or two (22 per cent) partners (Table 3.2.2.2).

Table 3.2.2.2

Number of sharing partners of adolescent and adult IDUs in the last month, *% (p=0.002)*

	Adolescent IDUs (13–19 years), N=67	Adult IDUs (20 years and older), N=820
1 partner	21	34
2 partners	13	22
3–5 partners	43	32
6–10 partners	18	8
More than 10 partners	5	4

Conclusions

- Of adolescent IDUs under 15, some 15.5 per cent have tried injecting drugs; 86 per cent of those under majority age have tried them.
- Forty-four per cent of adolescent IDUs have injected drugs for less than one year.
- One third (30 per cent) of adolescent IDUs and less than one fourth (24 per cent) of adult IDUs (20 and older) share injecting equipment.
- During the last month, adolescent IDUs mostly shared equipment with three to five partners (43 per cent). Adults mostly shared it with one or two (56 per cent).

Secondary analysis of behavioural surveillance data on adolescent FSWs

Adolescent FSW-IDUs account for 19 per cent of the interviewed adolescent FSWs. The adolescent FSW-IDUs are distributed as follows by age: 43 per cent are 15 to 17 years old and 57 per cent are 18 to 19 years old.

Frequency of injecting drug use

Daily use of injecting drugs was reported by 45 per cent of adolescent FSWs who used injecting drugs during the last 30 days. Thirty-one per cent of adolescent FSWs used injecting drugs between two and six times a week and 24 per cent used them once a week or more rarely (Table 3.2.2.3).

Table 3.2.2.3

Frequency of injecting drug use of adolescent FSWs in the last 30 days, *%*

	Among adolescent FSW-IDUs, N=54
Every day	45
2–6 times a week	31
Once a week and more rarely	24

Conclusions

- Almost every fifth adolescent FSW (19 per cent) reported that she had used injecting drugs and almost half of the respondents (45 per cent) reported daily use of injecting drugs. It is therefore possible to

distinguish a double risk group, "Adolescent FSW-IDUs", which combines commercial sex and injecting drug use.

Secondary analysis of behavioural surveillance data on adolescent MSM

Injection drugs are used by 1.4 per cent of adolescent MSM.

Frequency of injecting drug use

Sixty-seven per cent of MSM who use injecting drugs use them once a week or more rarely.

Conclusions

- Injecting drug use does not appear to be much of a risk for the majority of adolescent MSM. Not many MSM use injecting drugs (1.4 per cent do). In most cases use is episodic.

Baseline study among adolescents living and working on the streets

Some 15.5 per cent of adolescents living and working on the streets had used injecting drugs (Table 3.2.2.4). As this age cohort grows older, more of its members start to use such drugs.

Table 3.2.2.4

Lifetime experience of injecting drug use among adolescents living and working on the streets by age group (N=805, 565 boys and 240 girls), %

	Among all	Sex (p=0.364)		Age group (p<0.001)		
		Boys	Girls	10–14 years	15–17 years	18–19 years
Have injected drugs in their lives	15.5	16	14	5	19	29

The percentages of IDUs among the adolescents vary depending on where the survey was conducted (p=0.005): from 23 per cent in Kyiv to 11 per cent in Donetsk. In Mykolaiv and Dnipropetrovsk injecting drugs are used by 16 and 13 per cent of respondents, respectively.

Focus groups held in Kyiv, Dnipropetrovsk, Donetsk and Mykolaiv identified certain peculiarities that characterise injecting drug use by adolescents living and working on the streets. Different groups of adolescents display different attitudes to injecting drug use and different levels of involvement with it. Specifically, some groups do not support use, and even disapprove of it: "I'm sure that people use them, but our group does not support that" (boy, 16 years old, Dnipropetrovsk).

Using injecting drugs is typical for some members of other groups of adolescents living and working on the streets: "Not everybody uses drugs, but every group has some IDUs" (focus group member, Mykolaiv); "Out of 10 members of the group, six are sure to be drug users: four boys and two girls" (boy, 18 years old, Kyiv); "I can say that half of our group uses injecting drugs – more boys (five of them) than girls (two of them)…" (girl, 17 years old, Kyiv).

There are groups in which injecting drug use is not just a habitual practice but a factor that holds the group members together: "All 12 members of the group are injecting drug users" (boy, 19 years old, Kyiv); "We are all on the needle" (boy, 17 years old, Donetsk).

The research also traced tendencies related to the ages of the adolescents. In most cases it is the older adolescents (18 to 19 years old) that are involved in drugs. By the age of 17 or 18 practically all are linked to the problem in one way or another, either because they are themselves involved or because they have friends or acquaintances who are IDUs.

Girls (10 per cent) who provide sex services and use injecting drugs and the 3 per cent of boys who engage in MSM behaviour and inject drugs are exposed to a double risk. Another 1 per cent is a triple risk group – boy MSM involved in commercial sex and injecting drug use.

The double risk group "IDU involved in commercial sex" accounts for 7 per cent of the sample in Mykolaiv, 5 per cent of the samples in Kyiv and in Dnipropetrovsk and 2 per cent of the sample in Donetsk ($p<0.001$).

Sources for buying drugs

Focus group results indicate that adolescents raise money for drugs either by working some sort of job or by begging: "Lately we work only to get doses, we don't even have money for food" (boy, 15 years old, Donetsk); "We buy drugs without resorting to theft" (girl, 19 years old, Kyiv).

Adolescents either buy injection drugs from dealers or prepare them from ingredients purchased at pharmacies.

Drugs for users in a group are usually prepared by a leader or an older person. Most often, syringes are filled from a common mixing container by the same people who prepare the drug.

Age of initiation of injecting drug use

Forty-five per cent of adolescents living and working on the streets who had ever used injecting drugs started using them before turning 15 (41 per cent of the boys and 56 per cent of the girls, $p<0.001$). By the time they reach the age of 18 this indicator is 98 per cent (the sex difference is insignificant).

Most of the interviewed adolescents living and working on the street start using injecting drugs at age 15.

Frequency of injecting drug use

Daily use of injecting drugs among those who used them during the last 30 days was reported by 11 per cent of adolescents, while 55 per cent of the respondents reported that they used them from two to six times a week and 34 per cent reported that they used them every week or more rarely (Table 3.2.2.5).

Table 3.2.2.5

Frequency of injecting drug use among adolescent IDU boys and girls in the last 30 days by age group, % (N=113)

	Among all, N=113	Sex (p=0.340)		Age groups (p=0.011)		
		Boys, N=80	Girls, N=33	10–14 years, N=12	15–17 years, N=65	18–19 years, N=42
Daily	11	10	13	50	4	12
2–6 times a week	55	61	40	0	52	68
Weekly or less	34	29	47	50	44	20

Unsafe injecting

Sixty-one percent of adolescents living and working on the streets reported sharing injecting equipment the last time they used drugs (the sex difference is insignificant). As a cohort grows older, its members share equipment more often Fig. 3.2.2.4).

Adolescents from Donetsk and Mykolaiv appear to be at a higher risk: more than every second IDU (57 per cent of boys and 52 per cent of girls) shared equipment during the month prior to the survey. Forty-six per cent of adolescents in Dnipropetrovsk and 37 of adolescents in Kyiv shared it ($p=0.013$).

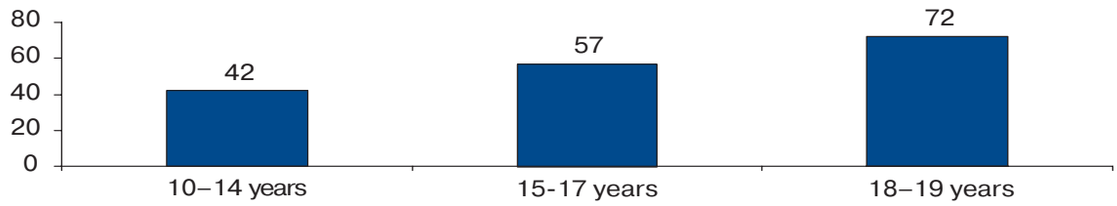


Fig 3.2.2.4. Percentage of adolescent IDUs living and working on the streets reporting the use of a needle/syringe that had been previously used by someone else in the last month, by age group (p=0.031)

In the last 30 days, 22 per cent of the respondents reported using a syringe after someone else had squirted drugs into it from his or her own syringe in the last 30 days; 37 per cent used syringes filled from a "working" syringe; 34 per cent used drugs from a pre-filled syringe; 17 per cent used a filter or cotton that someone else had previously used to draw up drugs; and 47 per cent drew up the drug solution into their syringe from a common mixing container (Table 3.2.2.6). Sex and age difference is insignificant.

Table 3.2.2.6

Different types of unsafe injecting practices in the last 30 days among adolescent IDUs, %

Risk behaviours	
Injecting drug using a syringe after someone else squirted drugs into it from their syringe	22
Injecting drug using a syringe that had been filled from a "working" syringe	37
Injecting drug using a pre-filled syringe	34
Using a filter or cotton that someone else had previously used to draw up drugs	17
Drawing up the drug solution into a syringe from a common mixing container	47

Of adolescent IDUs living and working on the streets and sharing injecting equipment with other people, 17 per cent shared it with one partner, 37 per cent shared it with two partners, 34 per cent shared it with three to five partners, 8 per cent shared it with six to 10 partners and 4 per cent shared it with more than 10 partners (Table 3.2.2.7).

Table 3.2.2.7

Number of sharing partners of adolescent IDUs living and working on the streets in the last 30 days (N=24), %

1 partner	17
2 partners	37
3–5 partners	34
6–10 partners	8
More than 10 partners	4

Use of sterile injecting equipment and sources for obtaining injecting equipment

Seventy-six per cent of the adolescents who had used injecting drugs at least once in their lifetimes reported using sterile equipment the last time they injected. This was the case for 77 per cent of boys and 71 per cent of girls.

Some 42 per cent of adolescent IDUs reported obtaining syringes from an official source.

The majority (69 per cent) of adolescents who at least once used injecting drugs usually obtain syringes from IDU friends. More than half get them in the place where they use drugs or buy them at a pharmacy (56 per cent and 55 per cent, respectively). More than one fourth (26 per cent) of adolescents get them from their sex partners and almost every fifth collects syringes on the streets or in the entrance halls of buildings (18 per cent). Syringes were also obtained from non-IDU friends, stolen from pharmacies, hospitals or shops,

obtained at needle exchange points or from social workers or taken from family members or hospitals (Fig. 3.2.2.5).

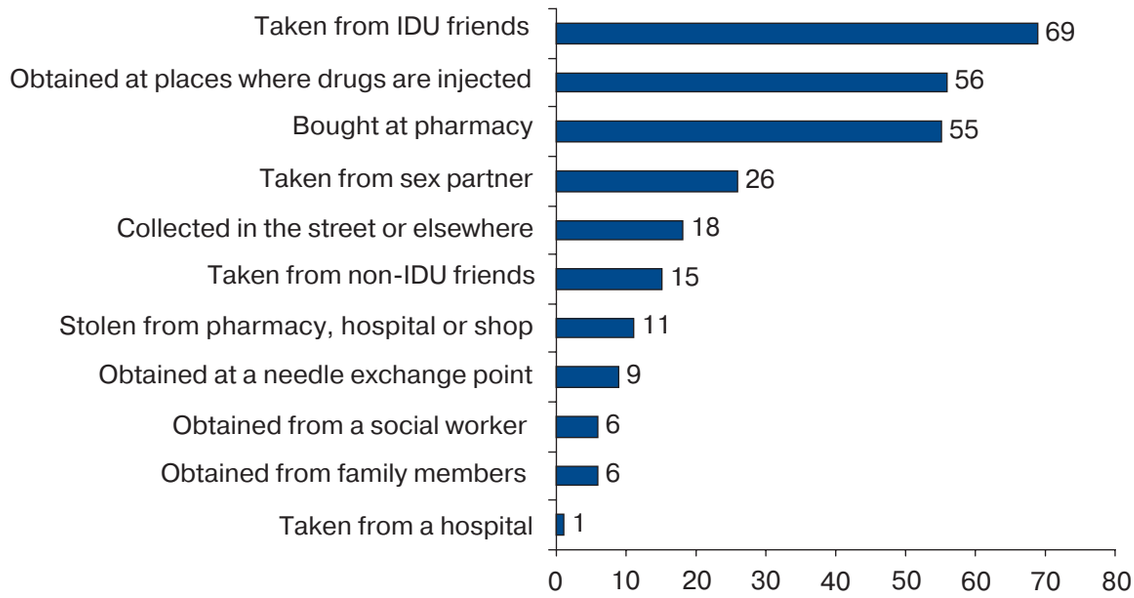


Fig. 3.2.2.5. Places from which adolescent IDUs living and working on the streets usually obtain needles/syringes, %

Injecting drug use in institutions

Injecting drug use also took place in institutions in which adolescents were placed (Table 3.2.2.8).

Almost half (46 per cent) of adolescents who had ever used injecting drugs did so in institutions. One third (30 per cent) of these incidences of drug use happened in juvenile colonies, 25 per cent happened in remand centres and one fifth (20 per cent) happened in special centres for homeless people. Drug use is less widespread but still occurs in shelters for minors, regional police departments, pre-trial detention centres, distribution centres and special rooms for children in police departments.

Table 3.2.2.8

Number and percentage of adolescents who had ever injected drugs reporting injecting drug use in institutions in which they reported staying at some point in their lifetimes

	Number	%
Institutions		
Shelter for minors, N=65	8	12
Special room for children in a police department, N=63	4	6
Juvenile colony, N=10	3	30
Other penitentiary facilities, N=11	5	46
Remand centre, N=39	10	26
Special centres for homeless people, N=15	3	20
Regional police department, N=9	1	11
Pre-trial detention centre, N=69	6	9
Distribution centre for minors, N=39	3	8

Conclusions

- The research indicates that injecting drug use among adolescents living and working on the streets is rather common – practically every sixth respondent (15.5 per cent) reported having injected at least once.
- Adolescents living and working on the streets start injecting early. Forty-five per cent of the respondents who had injected drugs said they had used them for the first time before turning 15. Ninety-eight per cent of the respondents said they had used them for the first time before reaching majority age.
- The indicator for sharing injecting equipment and other risk behaviour patterns related to injecting drugs is high among these adolescents. During the last month more than one third (61 per cent) of the respondents among adolescent IDUs living and working on the streets had shared equipment.
- More than two thirds (69 per cent) of the adolescents in this target group get equipment from IDU friends. More than half (55 per cent) of the respondents buy it at a pharmacy.
- Injecting drug use occurs in all the public institutions in which these adolescents are placed. It is most common in juvenile colonies and other penitentiary facilities in which adolescents reported staying at some point in their lifetimes (30 and 46 per cent of the respondents who stayed in such institutions, respectively).
- Ten per cent of girls living and working on the streets reporting transactional/selling sex also reported injecting drugs.
- Three per cent of boys living and working on the streets and engaged in MSM behaviour also reported injecting drugs, while 1 per cent constitutes a triple risk group: these are boy MSM who are involved in commercial sex and who inject drugs.

3.3. Factors influencing adherence to risk practices

The 2007 BSSs among MARPs also studied behavioural determinants and vulnerabilities, such as knowledge about how HIV is transmitted and of how to prevent it. The Baseline Study among adolescents living and working on the streets looked at vulnerability factors as well. These included institutionalisation (in police departments, shelters for minors, distribution centres and other facilities) and experience of forced sex and physical abuse in institutions.

The 2007 MARP BSSs did not contain a special question about forced sex. However, one of the reasons that MARP representatives gave for not using condoms was: "I was a victim of sexual abuse." This sub-chapter uses that data as an indication that forced sex was a reality among these population groups.

The next sub-chapter considers services and the extent to which they are accessible to EVA and MARA boys and girls. How accessible these services are has an impact on the formation of the risk behaviour patterns of these surveys' subjects.

Secondary analysis of behavioural surveillance data on MARA (IDUs, FSWs and MSM)

Correct knowledge of HIV transmission

Adolescent IDUs

When asked about how HIV is transmitted, adolescent IDUs demonstrate a high level of knowledge (Table 3.3.1).

Table 3.3.1

Distribution of correct answers of adolescent and adult IDUs to the question: "To what extent do you agree with the following statements about HIV/AIDS?", %

	Adolescent IDUs (13–19 years) N=259	Adult IDUs (20 years and older) N=3882	Asymp. Sig. (p)
Correct statements			
HIV infection can be prevented if you have sex with one faithful, uninfected partner	75	80	0,040
The risk of HIV infection can be reduced by using condoms correctly and consistently (i.e. each time you have sex)	66	75	<0,001
A healthy-looking person may be HIV-infected	74	83	<0,001
You can contract HIV by using a needle/syringe that someone else used before	91	95	0.002
Wrong statements			
HIV may be contracted through mosquito bites	73	83	0.123
A person may contract HIV by sharing a glass of water with an HIV-infected person	72	86	0.069
A person may contract HIV by sharing a toilet, swimming pool or sauna with an HIV-infected person	74	84	0.030

Ninety-one per cent of adolescent IDUs know that HIV can be transmitted by a used needle. Sixty-eight per cent can correctly identify sexual means of HIV transmission.

The question that concerned catching HIV by using a used needle generated the most correct answers. The statement "The risk of HIV infection can be reduced by using condoms correctly and consistently (i.e. each time you have sex)" generated the fewest correct answers (66 per cent).

Eighty-one per cent of the interviewed adolescent IDUs know about official sources at which condoms can be obtained. Ninety-three per cent of them indicated places where sterile equipment can be had.

Adolescent FSWs

Adolescent FSWs are highly knowledgeable about how HIV is transmitted. Eighty-three percent of them correctly identified methods of sexual HIV transmission and 96 per cent of them know how HIV can be contracted through needle use.

The statements "The risk of HIV infection can be reduced by using condoms correctly and consistently (i.e. each time you have sex)" and "You can contract HIV by using a needle/syringe that someone else used before" generated the most correct answers (from 99 per cent and 96 per cent of respondents, respectively) (see Table 3.3.2).

Table 3.3.2

Distribution of correct answers among adolescent and adult FSWs to the question: "To what extent do you agree with the following statements about HIV/AIDS?%

	Adolescent FSWs (13–19 years)	Adult FSWs (20 years and older)	Asymp. Sig. (p)
Correct statements			
HIV infection can be prevented if you have sex with one faithful, uninfected partner	84	80	0.208
The risk of HIV infection can be reduced by using condoms correctly and consistently (i.e. each time you have sex)	99	99	

A healthy-looking person may be HIV-infected	59	73	<0.001
You can contract HIV by using a needle/syringe that someone else used before	96	97	0.948
Wrong statements			
HIV may be contracted through mosquito bites	59	75	0.003
A person may contract HIV by sharing a glass of water with an HIV-infected person	83	87	0.429
A person may contract HIV by sharing a toilet, swimming pool or sauna with an HIV-infected person	76	84	0.926

The statements "A healthy-looking person may be HIV-infected" and "HIV may be contracted through mosquito bites" generated the fewest correct answers (59 per cent of the answers for each statement were correct).

Adolescent FSWs are somewhat less aware about these issues than are adult FSWs. For example, the statement "A healthy-looking person may be HIV-infected " generated correct answers from 59 per cent of adolescent FSWs and 73 per cent of adult FSWs, and the statement "HIV may be contracted through mosquito bites" generated correct answers from 59 per cent of adolescent FSWs and 75 per cent of adult FSWs.

Adolescent MSM

The results show that adolescent MSM are highly aware about how HIV spreads: through sexual intercourse and through human blood during needle use (90 and 91 per cent, respectively) (see Table 3.3.3). Adult MSM are also highly aware (93 per cent for each option) when it comes to these matters. A difference between adult MSM and adolescent MSM awareness emerges only in responses to the statement "HIV may be contracted through mosquito bites."

Table 3.3.3

Distribution of correct answers among adolescent and adult MSM to the question: "To what extent do you agree with the following statements about HIV/AIDS?", %

	Adolescent MSM (13–19 years)	Adult MSM (20 years and older)	Asymp. Sig. (p)
Correct statements			
HIV infection can be prevented if you have sex with one faithful, uninfected partner	79	76	0.492
The risk of HIV infection can be reduced by using condoms correctly and consistently (i.e. each time you have sex)	90	93	0.159
A healthy-looking person may be HIV-infected	78	83	0.152
You can contract HIV by using a needle/syringe that someone else used before	91	93	0.156
Wrong statements			
HIV may be contracted through mosquito bites	71	83	0.007
A person may contract HIV by sharing a glass of water with an HIV-infected person	73	83	0.355
A person may contract HIV by sharing a toilet, swimming pool or sauna with an HIV-infected person	67	77	0.912

Forced sex as a reason for being unable to use condoms

The answers that adolescent IDUs gave to the question about why they do not use condoms indicate that minimal evaluation of sex abuse among them is 2 per cent. It is 1 per cent for both adolescent FSWs and adolescent MSM.

Conclusions

- Sixty-eight per cent of adolescent IDUs know how HIV is transmitted sexually and 91 per cent of them know about how it is transmitted through injection of drugs.
- Eighty-three per cent of adolescent FSWs correctly identified ways in which HIV is transmitted sexually and 96 per cent of them know about how it is spread through injection.
- Ninety per cent and 91 per cent of adolescent MSM know about sexual and injecting methods of HIV transmission, respectively.
- The answers that adolescent IDUs gave to the question about why they do not use condoms indicate that minimal evaluation of sex abuse among them is 2 per cent. It is 1 per cent for both adolescent FSWs and adolescent MSM.

Baseline study among adolescents living and working on the streets

Correct knowledge of HIV transmission

Less than half (46 per cent) of the adolescents (40 per cent of the boys and 50 per cent of the girls, p=0.033) correctly identify how HIV is transmitted sexually. Fewer than two thirds of the respondents (61 per cent) are familiar with how it is transmitted through injection drug use (there are no differences by sex).

The statements "The risk of HIV infection can be reduced by using condoms correctly and consistently (i.e. each time you have sex)" and "You can contract HIV by using a needle/syringe that someone else used before" generated the largest number of correct answers – 63 per cent and 61 per cent of all respondents, respectively (see Table 3.3.4).

Table 3.3.4

Distribution of correct answers of adolescents living and working on the streets to the question: "To what extent do you agree with the following statements about HIV/AIDS?", %

	Among all respondents
Correct statements	
HIV infection can be prevented if you have sex with one faithful, uninfected partner	55
The risk of HIV infection can be reduced by using condoms correctly and consistently (i.e. each time you have sex)	63
A healthy-looking person may be HIV-infected	53
You can contract HIV by using a needle/syringe that someone else used before	61
Wrong statements	
HIV may be contracted through mosquito bites	41
A person may contract HIV by sharing a glass of water with an HIV-infected person	37
A person may contract HIV by sharing a toilet, swimming pool or sauna with an HIV-infected person	39

The statements "A person may contract HIV by sharing a glass of water with an HIV-infected person" and "A person may contract HIV by sharing a toilet, swimming pool or sauna with an HIV-infected person" received the fewest correct answers – 37 per cent and 39 per cent, respectively.

In general, only 9 per cent of adolescents (there were no differences by sex) gave correct answers for all the statements about HIV/AIDS. Five per cent of 10- to 14-year-old respondents, 14 per cent of 15- to 17-year-old respondents and 9 per cent of 18- to 19-year-old respondents gave correct answers (p<0.001).

Experience of being stopped or harassed by the police

Seventy-six per cent of all respondents reported having at some point been stopped or harassed by the police (83 per cent of boys and 58 per cent of girls, p<0.001). Older respondents have more experience with this sort of treatment: 78 per cent of 15- to 17-year-olds and 85 per cent of 18- to 19-year-olds had at some point been stopped or harassed by the police, while 68 per cent of 10- to 14-year-olds had been (p<0.001).

Frequency of being stopped or harassed by the police

During the last year almost one third of adolescents living and working on the streets (27 per cent of all respondents) reported having been stopped or harassed by the police between three and five times (see Table 3.3.5.). Every fifth respondent was stopped or harassed once or twice (20 and 21 per cent, respectively).

Girls were stopped or harassed less frequently than boys were. For example, 17 per cent of boys and 30 per cent of girls reported having been stopped or harassed during the last year, while 13 per cent of boys and 5 per cent of girls said that this had happened to them 20 and more times. No statistically significant differences by age were observed.

Table 3.3.5

Distribution of responses of adolescents living and working on the streets with lifetime experience of being stopped or harassed by the police by age group to the question: "How many times have you been stopped or harassed by the police in the last year?", % (*N=608*)

	Among adolescents who had been stopped or harassed by the police N=608	Sex (p<0.001)		Age groups (p=0.042)		
		Boys N=468	Girls N=140	10–14 years N=206	15–17 years N=275	18–19 years N=127
Once	20	17	30	24	19	17
2 times	21	18	32	22	19	23
3–5 times	27	29	21	32	25	22
6–10 times	12	13	9	10	14	10
11–20 times	9	10	3	4	11	14
21 +	11	13	5	8	12	14

Respondents from Mykolaiv reported being stopped or harassed by the police the most: 83 per cent of all interviewed adolescents had experienced such treatment, while in Kyiv, Donetsk and Dnipropetrovsk 79, 70 and 58 per cent had, respectively (p<0.001).

Reasons for being stopped or arrested by the police

Police in most cases stopped or arrested adolescents for begging or for break-ins (61 per cent of all respondents) and for petty theft (45 per cent). They also stopped or arrested them during police raids (40 per cent) and under other circumstances (see Table 3.3.6).

Boys were stopped or arrested for petty theft and robbery more often than girls were. Fifty-one and 38 per cent of boys, respectively, and 23 and 16 per cent of girls, respectively, were stopped or arrested for these reasons.

Three times more boys (33 per cent) than girls (11 per cent) were charged with disorderly conduct. Almost every fourth (24 per cent) girl was stopped or arrested for prostitution.

Different age groups were stopped for different reasons. For example, 29 per cent of 18- to 19-year-old and 22 per cent of 15- to 17-year-old adolescents were stopped or arrested for infliction of bodily injury. Eight per cent of 10- to 14-year-old adolescents were stopped or arrested for that reason.

Table 3.3.6

Distribution of responses by age group of adolescents living and working on the streets with lifetime experience of being stopped or harassed by the police to the question: "What charges were brought against you when you were stopped or arrested?", % (N=608)

	Among respondents who had been stopped or arrested by the police, N=608	Sex (p<0.001)		Age groups (p<0.001)		
		boys N=468	girls, N=140	10–14 years, N=206	15–17 years, N=275	18–19 years, N=127
Begging or break-ins	61	64	50	61	65	50
Petty theft	45	51	23	46	43	47
Stopped or arrested during police raids: don't know the reason	40	40	36	45	34	43
Suspicious behaviour	39	41	31	34	38	48
Robbery	33	38	16	29	33	40
Disorderly conduct, plunder	28	33	11	21	30	34
Drinking alcohol in public places	25	28	15	18	27	33
Infliction of bodily harm	19	22	8	9	22	29
Drug use	15	15	12	8	16	15
Drug storage	7	8	4	2	7	15
Prostitution	6	1	24	4	7	9
Selling drugs	3	3	2	3	2	3
Preparation of drugs (offering residential space for this activity and other activities)	1	1	2	2	1	2

Experience of institutionalisation among adolescents living and working on the streets

More than half (57 per cent) of the adolescents living and working on the streets had been placed in shelters for minors at least once. A little fewer than half (49 per cent) of the respondents were placed in special rooms for children at police departments, one third (33 per cent) were placed in pre-trial detention centres and one fourth (25 per cent) were placed in distribution centres for minors (see Table 3.3.7).

Girls were placed almost half as often as boys in special rooms for children at police departments (57 per cent of boys and 31 per cent of girls), in pre-trial detention centres (38 per cent of boys and 19 per cent of girls) and in remand centres (13 per cent of boys and 7 per cent of girls). Three times more boys were placed in distribution centres for minors (31 per cent of boys and 10 per cent of girls).

The youngest respondents reported having been placed in shelters for minors more frequently than older ones did: 60 per cent of 10- to 14-year-olds and 41 per cent of 18- to 19-year-olds had stayed in such institutions at least once. On the other hand, 10- to 14-year-olds were more rarely put into pre-trial detention centres or remand centres (17 and 2 per cent of 10- to 14-year-olds and 58 and 31 per cent of 18- to19-year-olds had had this experience, respectively).

Table 3.3.7

Distribution of responses of adolescents living and working on the streets by age group to the question: "Have you ever stayed in one of the following institutions?", %

	Among all respondents	Sex			Age group			
		Boys	Girls	p	10–14 years	15–17 years	18–19 years	p
Shelter for minors	57	63	44	< 0.001	60	61	41	< 0.001
Special room for children at a police department	49	57	31	< 0.001	50	52	40	0.035
Pre-trial detention centre	33	38	19	< 0.001	17	35	58	< 0.001
Distribution centre for minors	25	31	10	< 0.001	21	26	28	0.247
Remand centre	11	13	7	0.012	2	10	31	< 0.001
Special centre for homeless people	6	7	2	0.002	4	5	10	0.016
Regional police department	6	5	8	0.061	2	5	14	< 0.001
Juvenile colonies and other penitentiary facilities	6	8	2	0.003	2	4	21	< 0.001

There are big differences from city to city in the proportions of adolescents placed in shelters for minors. The proportions range from 70 per cent in Donetsk to 45 per cent in Dnipropetrovsk. As for other cities, 65 per cent of Kyiv and 49 per cent of Mykolaiv adolescents reported having stayed in such shelters at least once ($p< 0.001$).

Experience of physical abuse in institutions

Physical abuse at the hands of staff took place in all the institutions in which adolescents living and working on the street were placed. Almost two thirds (65 per cent of those who stayed in these institutions) suffered physical abuse in remand centres and 64 per cent suffered it in regional police departments (see Fig. 3.3.1). Among those who were put in pre-trial detention centres or in other penitentiary facilities, 59 and 60 per cent, respectively, suffered physical abuse. Occasions of physical abuse at the hands of staffers of shelters for minors took place much more rarely: 16 per cent of the respondents reported such experiences.

Girls were exposed to physical abuse in distribution centres for minors and shelters for minors more rarely: 32 and 18 per cent of boys and 18 and 9 per cent of girls, respectively, suffered from physical abuse in these institutions ($p< 0.001$).

Almost half (49 per cent) of the older adolescents had suffered from physical abuse in distribution centres for minors while less than one third (27 per cent) of 10- to 14-year-olds had ($p< 0.001$).

Forced sex

Almost one fourth (23 per cent) of all interviewed sexually active adolescents had been forced into sexual intercourse during their lifetimes (11 per cent of boys and 52 per cent of girls, $p< 0.001$). During the last year, 15 per cent of adolescents (7 per cent of boys and 37 per cent of girls, $p< 0.001$) had been exposed to sexual abuse. No statistically significant differences by age were identified.

Among adolescent MSM living and working on the street, only one respondent (N=54) had been forced into sexual intercourse. Another had been sexually abused.

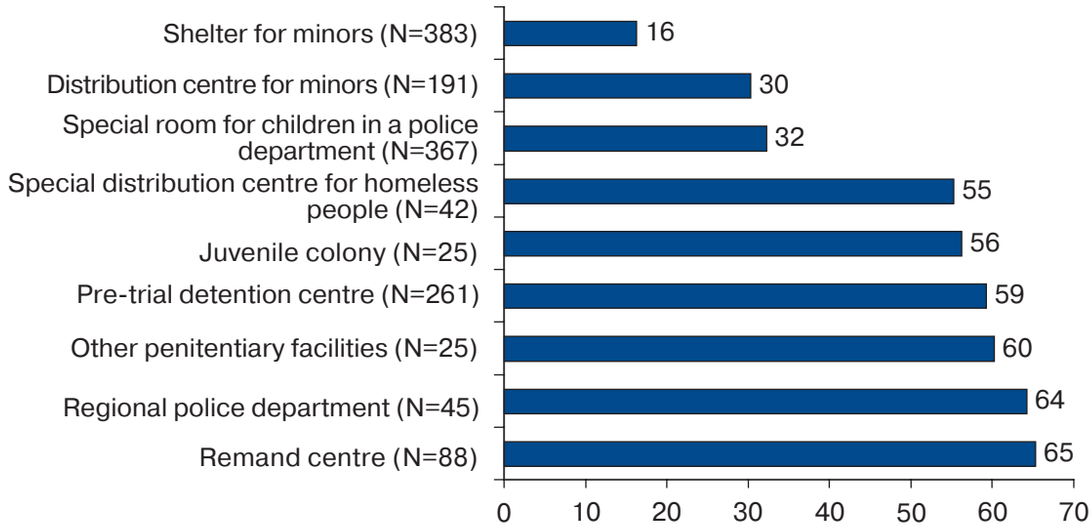


Fig. 3.3.1. Distribution of affirmative responses of adolescents living and working on the streets with experience of staying in an institution to the question: "Have you ever been exposed to physical abuse from staff working in any of the following institutions?", %

Experience of forced sex in institutions

Respondents reported occasions of being forced into sexual intercourse in all the institutions in question. There were isolated occasions of abuse in distribution centres for minors (one adolescent out of the 161 placed there), in regional police departments (two adolescents out of 44), in special rooms for children at police departments (three adolescents out of 292) and penitentiary facilities (three adolescents aged 18 to 19 out of 24). But all adolescents placed in special centres for homeless people reported having been forced into sexual intercourse (36 adolescents out of 36). Almost every tenth adolescent put into a pre-trial detention centre or remand centre experienced sexual abuse (18 adolescents out of 233 and nine adolescents out of 84, respectively).

Girls more often than boys were forced into sexual intercourse in pre-trial detention centres (out of 18 cases of forced sex there were 12 girls and two boys) and in remand centres (out of nine cases of forced sex there were seven girls and two boys). Boys were more often exposed to sexual abuse in special centres for homeless people (out of 36 cases of forced sex there were four girls and 32 boys).

The youngest respondents (10- to 14-year-olds) were exposed to sexual abuse in shelters for minors more often than were older respondents (15- to 19-year-olds). Out of nine cases there were seven adolescents from the younger group and two from the older. Older adolescents were more often exposed to sexual abuse in special centres for homeless people (17 adolescents from among 15- to 17-year-olds and 14 adolescents from among 18- to 19-year-olds out of 36 cases in such institutions).

Conclusions

- Adolescents living and working on the street have a rather low level of knowledge about HIV/AIDS. Only 9 per cent of the respondents gave correct answers in response to all the statements they were given about ways of transmitting and preventing HIV transmission. Forty-six per cent of adolescents (40 per cent of boys and 50 per cent of girls) correctly identified methods of sexual HIV transmission. However, fewer than two thirds of the respondents (61 per cent) are familiar with ways in which HIV can be transmitted through injecting (there were no differences by sex).
- The majority of adolescents (76 per cent) have been stopped or harassed by the police at least once in their lifetimes (83 per cent of boys and 58 per cent of girls). During the last year more than one fourth of the respondents (27 per cent of all respondents) had had such an experience. During the specified time period adolescents as a rule were stopped or harassed between three and five times (27 per cent of

all respondents). The most common reasons for being stopped or arrested were begging or break-ins (61 per cent of all respondents), petty theft (45 per cent) and police raids (40 per cent).

- Twenty-three per cent of all sexually active adolescents have been forced into sexual intercourse during their lives (11 per cent of boys and 52 per cent of girls).
- More than half (57 per cent) of adolescents living and working on the street have been placed in shelters for minors at least once. A little fewer than half (49 per cent) were placed in special rooms for children at police departments, one third (33 per cent) were placed in pre-trial detention centres and one fourth (25 per cent) were placed in distribution centres for minors. Occasions of physical and sexual abuse at the hands of staffers occurred in all the institutions into which these adolescents were placed.

3.4. Accessibility level of prevention services

Secondary analysis of behavioural surveillance data on adolescent IDUs

Knowledge of a formal source of condoms and sterile injecting equipment

Ninety-three per cent of adolescent IDUs indicated formal sources at which sterile injecting equipment could be obtained and 81 per cent of them know of at least one formal source at which condoms can be obtained. Sex and age differences are insignificant.

Obtaining sterile needles/syringes and condoms

Some 53 per cent of adolescent IDUs reported obtaining sterile injecting equipment at needle exchange points and under outreach programmes during the month prior to the survey. For adult IDUs (over the age of 20) this indicator is 70 per cent ($p<0.001$).

Forty-seven per cent of adolescent IDUs reported that they had obtained condoms from outreach workers or under various programmes during the month prior to the survey. By contrast, only 63 per cent of adult IDUs had ($p<0.001$) (Table 3.4.1).

Table 3.4.1

% of adolescent IDUs reporting obtaining sterile needles/syringes and condoms free of charge in the month prior to the survey

Prevention measures	All interviewed adolescent IDUs	Sex	
		Boys	Girls
Obtained sterile needles/syringes free of charge ($p<0.001$)	53	57	45
Obtained condoms free of charge ($p=0.053$)	47	47	46

Coverage with prevention programmes

A number of indicators will now be analysed in order to assess coverage of IDUs with prevention programmes (Table 3.4.2).

Prevention programmes cover 31 per cent of adolescent IDUs (30 per cent of boys and 32 per cent of girls). They cover considerably more adult IDUs (over the age of 20): 47 per cent of them ($p<0.001$).

During the last 12 months, 94 per cent of adolescent IDUs applied for help to NGOs. For 30 days, this indicator was 76 per cent. The majority of those who applied for services received everything they needed (86 per cent). In 13 per cent of cases, they got some but not all of the desired services. One per cent of respondents reported that they received none of the services they requested.

Table 3.4.2

Coverage of adolescent IDU boys and girls with prevention programmes in the last 12 months, %

Interventions	All interviewed adolescent IDUs	Sex		
		Boys	Girls	p
Coverage with prevention programmes	31	30	32	0.809
Applied for help to NGO	94	94	93	0.736
Coverage with peer-driven interventions	37	40	33	0.320
Received free-of-charge condoms	47	47	46	0.053
Received free-of-charge sterile needles/syringes	53	57	45	0.117
Were tested for STIs	27	23	36	

Thirty-seven per cent of adolescent IDUs (40 per cent of boys and 33 per cent of girls) reported having been reached in the last 12 months by peer-driven interventions.

Twenty-seven per cent of adolescent IDUs (23 per cent of boys and 36 per cent of girls) were tested for STIs. Of adult IDUs, 36 per cent were tested for STIs ($p<0.01$).

Voluntary HIV counselling and testing

Seventy-seven per cent of adolescent IDUs (the sex difference is insignificant) reported that they know where to get HIV counselling and testing. For adult IDUs this indicator is 88 per cent ($p<0.01$).

Fourteen per cent of adolescent IDUs had been tested for HIV and know the results (the sex difference is insignificant). Thirty per cent of adult IDUs had ($p<0.001$). (Table 3.4.3).

Table 3.4.3

HIV counselling and testing among adolescent IDUs, %

VCT	All interviewed adolescent IDUs
Can identify where VCT is available	77
Were tested for HIV and know their results	14

Conclusions

- The majority of adolescent IDUs are aware of formal sources at which they can obtain sterile needles/syringes (93 per cent) and condoms (81 per cent). During the last month almost half of them received sterile injecting equipment and condoms free of charge (47 per cent and 53 per cent, respectively). Indicators for using these services are higher in the adult IDU group.
- Prevention services cover very few adolescent IDUs. The integrated indicator for their coverage with prevention services is 31 per cent.
- Over two thirds (77 per cent) of the interviewed adolescent IDUs know where to get HIV counselling and testing. However, only 14 per cent had been tested for HIV in the last 12 months and know their results.

Secondary analysis of behavioural surveillance data on adolescent FSWs

A number of indicators assess coverage of FSWs with prevention services, including accessibility of condoms and of HIV testing (see Table 3.4.4).

Accessibility of condoms

Sixty-six per cent of all interviewed adolescent FSWs had received condoms free of charge from NGOs during the prior 12 months.

Table 3.4.4

Coverage in the prior 12 months and knowledge of prevention services among adolescent FSWs, %

% of affirmative replies	
Received condoms free of charge	66
Applied for help to NGO	50
Covered with peer-driven interventions	28
Were tested for STIs	67
Know where to get an HIV test	82
Were tested for HIV and know their results	41

On the whole, adolescent FSWs are highly aware of where to buy or otherwise obtain condoms. Ninety-nine per cent of girls know at least one formal condom source.

Adolescent FSWs tended to buy condoms in pharmacies (60 per cent of all respondents) or shops (54 per cent). Thirty-seven per cent of the respondents received condoms free of charge at needle exchange points and 34 per cent received them from NGO representatives. Almost every fifth girl (19 per cent) received condoms from harm reduction projects and 16 per cent of the respondents received them from social workers.

Coverage with prevention programmes

Sixty-one per cent of adolescent FSWs had been covered with prevention programmes during the year prior to the survey.

Half of the interviewed adolescent FSWs (50 per cent) and 62 per cent of adult FSWs ($p<0.01$) applied to NGOs for help during that period. The majority of girls (75 per cent) who applied to NGOs reported that they received the services they requested in total.

More than one fourth (28 per cent) of girls reported coverage with peer-driven interventions. It is noteworthy that a higher percentage of adult FSWs reported being covered by such services: 40 per cent of all interviewed FSWs 20 and older ($p<0.01$).

Voluntary HIV counselling and testing and STI diagnostics

Adolescent FSWs' levels of knowledge about HIV counselling and testing services are indications of what they value when it comes to their health.

Awareness about institutions that offer HIV counselling and testing is rather high. The indicator states that 82 per cent of all interviewed girls are aware of them. For adult FSWs this indicator is somewhat higher – 92 per cent ($p<0.05$). Eighty per cent of adolescent FSWs and 89 per cent of adult FSWs say that they have access to HIV testing ($p<0.05$).

The most common reasons that adolescent FSWs gave for why HIV testing was inaccessible were these: "inconvenient location of the institution" (49 per cent of the respondents), "don't know the location of the institution" (28 per cent), "have no money for testing" (16 per cent) and "afraid that my HIV status will be disclosed" (16 per cent).

During the year prior to the survey, 41 per cent of girls got tested for HIV and know the results. For 13- to 17-year-old girls this indicator is 34 per cent and for 18 to 19-year-old girls it is 44 per cent ($p<0.01$).

During the year prior to the survey 67 per cent of girls got tested for STIs. Of 13- to 17-year-old girls 59 per cent did, and of 18- to 19-year-old girls 71 per cent did ($p<0.001$).

Conclusions

- Adolescent FSWs typically have good access to condoms. Ninety-nine per cent of them know of at least one formal place at which to buy or otherwise obtain them. More than half (66 per cent) of adolescent FSWs received free-of-charge condoms during the year prior to the survey and 73 per cent of adult FSWs (20 years and older) did.

- Sixty per cent of adolescent FSWs buy condoms at the pharmacy.
- Prevention programmes cover more than half of the interviewed adolescent FSWs (61 per cent). However, only 28 per cent of adolescent FSWs reported coverage with peer-driven interventions, while they cover 40 per cent of adult FSWs (20 years and older).
- During the year prior to the survey 67 per cent of girls had been tested for STIs and less than half of the girls (41 per cent) had been tested for HIV and knew their results.

Secondary analysis of behavioural surveillance data on adolescent MSM

Eighty-three per cent of the interviewed adolescent MSM know of at least one formal source at which to obtain condoms.

Coverage with prevention programmes

Equally important are prevention programmes covering such groups as adolescent MSM (see Table 3.4.5). Their level of coverage with prevention programmes is 45 per cent. Adult MSM (20 years and older) have a 51 per cent coverage level ($p<0.01$).

Seventy-two per cent of adolescent MSM had never applied to an NGO for help. Their coverage with peer-driven interventions in the prior year was low (20 per cent).

Table 3.4.5

Coverage of adolescent MSM with prevention programmes in the prior 12 months, %

Applied for help to NGO	28
Coverage with peer-driven interventions	29
Received condoms free of charge	54
Were tested for STIs	27
Know where to get an HIV test	71
Were tested for HIV and know their results	24

This MARA group evinces a rather high degree of knowledge of where to obtain HIV counselling and testing. Almost three fourths of adolescent MSM (71 per cent) are knowledgeable in this regard. However, HIV testing rates are low. Over the last 12 months only 24 per cent of adolescent MSM were tested for HIV and know the results.

Testing rates for STIs are also low among adolescent MSM. Only 27 per cent of the respondents took STI tests.

Conclusions

- Almost half (45 per cent) of adolescent MSM are covered with prevention programmes.
- Adolescent MSM demonstrate a rather high level of knowledge about HIV counselling and testing (71 per cent). However, only about one fourth (24 per cent) of boys were tested for HIV in the year prior to the survey.
- Over the last year, 27 per cent of adolescent MSM were tested for STI.

Baseline study among adolescents living and working on the streets

Knowledge of a formal source of condoms

Adolescents are not highly aware about places at which they can obtain condoms (either by buying them or getting them free). Only 46 per cent know where to find such places. The youngest adolescent age group (10 to14 years old) had the largest proportion of members who are ignorant in this regard.

Knowledge of formal sources at which sterile injecting equipment can be obtained

Of the 15.5 per cent of adolescents who inject drugs, only a bit more than half (58 per cent) know where to buy or otherwise obtain sterile injecting equipment free of charge.

STI treatment strategies

Eighteen per cent of adolescents reported that they have had genital sores, ulcers or unusual genital discharges and 47 per cent of them treated themselves. Thirty-one per cent of the respondents sought help from medical institutions, undergoing examinations and receiving treatment, 8 per cent sought advice from social workers and 1 per cent called helplines. These low percentages might be attributed to the fact that this target group lacks knowledge about services that non-governmental and governmental organizations provide to children and young people.

There are, however, differences in how young people of different genders and ages choose counselling and treatment strategies (see Table 3.4.6.).

Table 3.4.6

Distribution and ranking of responses to STI treatment strategies of adolescents living and working on the streets who reported having had STI symptoms by age group, % (N=145)

	Sex (p<0.001)		Age groups (p<0.001)		
	Boys	**Girls**	**10–14 years**	**15–17 years**	**18–19 years**
1 rank group (over 31%)	1. Self-treatment (57%) 2. Bought medicine at a pharmacy (48%)	1. Self-treatment (34%) 2. Asked advice of a social worker (34%) 3. Was treated at a medical centre (33%)	1. Abstained from sex (42%)	1. Applied to a healer for treatment (55%) 2. Was treated at a private polyclinic (55%)	1. Applied to a healer for treatment (48%) 2. Self-treatment (39%) 3. Abstained from sex (36%)
2 rank group (10-30%)	1. Was treated at a medical centre (28%) 2. Abstained from sex (22%)	1. Was treated at a private polyclinic (22%) 2. Abstained from sex (11%)	1. Was treated at a medical centre (22%) 2. Applied to a healer for treatment (22%) 3. Self-treatment (14%)	1. Abstained from sex (29%) 2. Called a helpline (19%)	1. Asked advice of a social worker (27%) 2. Applied to an anonymous testing and counselling site (“Dovira”) (18%)
3 rank group (below 10%)	1. Asked advice of a social worker (6%) 2. Was treated at a private polyclinic (1%) 3. Applied to a healer for treatment (1%) 4. Called a helpline (1%)	1. Applied to a healer for treatment (9%) 2. Bought medicine at a pharmacy (2%) 3. Called a helpline (2%) 4. Applied to an anonymous testing and counselling site (“Dovira”) (1%)	1. Was treated at a private polyclinic (8%) 2. Called a helpline (2%)	1. Self-treatment (5%) 2. Asked advice of a social worker (5%) 3. Applied to an anonymous testing and counselling site (“Dovira”) (5%) 4. Was treated at a medical centre (1%) 5. Bought medicine at a pharmacy (1%)	1. Called a helpline (5%) 2. Was treated at a private polyclinic (2%)

Both boys (57 per cent of them) and girls (34 per cent) reported undergoing self-treatment. However, girls more often seek advice of a social worker (34 per cent) than boys do (6 per cent). Girls living and working on the streets also turned to private polyclinics for treatment (22 per cent). Only 1 per cent of boys did. Almost half (48 per cent) of the boys bought medicine at pharmacies while only 2 per cent of the girls did.

Respondents from the youngest age group (10 to 14) in most cases abstained from sex (42 per cent). In the middle age group (15 to 17) it is common to seek treatment at a private medical institution or from a healer (55 per cent for each strategy). Older adolescents (18 to 19) also often turn to healers (48 per cent). However, self-treatment (39 per cent) and abstaining from sex (36 per cent) were also reported. Older adolescents more often apply to social workers (27 per cent) or to anonymous testing and counselling sites ("Dovira") (18 per cent) than do 15- to 17-year-olds (5 per cent). No such strategies were identified among 10- to 14-year-olds.

Use of services

Seventeen per cent of the interviewed adolescents living and working on the streets reported having applied to NGOs for help in the 12 months prior to the survey.

These adolescents demonstrate very low knowledge about where to find HIV counselling and testing. Only half of the respondents (51 per cent) know where such counselling and testing is available and only 10 per cent were tested for HIV during the 12 months prior to the survey, and know the result. Twenty per cent of all the respondents interviewed in Donetsk were tested for HIV and know the result. In Mykolaiv, 6 per cent were. In Kyiv and Dnipropetrovsk 13 and 10 per cent of the respondents were, respectively ($p<0.001$).

Conclusions

- Forty-six per cent of adolescents living and working on the streets know of at least one formal source at which to buy or otherwise obtain condoms free of charge, while 58 per cent of those who inject drugs know formal places at which they can obtain sterile injecting equipment.
- Eighteen per cent of the respondents said that they have had genital sores, ulcers or unusual genital discharges. Forty-seven per cent of them resorted to self-treatment.
- Service-seeking behaviour among adolescents on the streets appears to be very low. Seventeen per cent of the respondents applied to NGOs for help in the last year.

Based on the key research findings, the project team calculated core MARA indicators for behaviour, behavioural determinants and vulnerabilities and use of services (see Annex 2).

The next chapter discusses the research findings and sets out recommendations and strategies for effectively planning and programming a HIV prevention response for MARA boys and girls.

4. DISCUSSION AND RECOMMENDATIONS

This chapter's aim is to discuss the findings of the research that the UNICEF MARA Project conducted in the context of Ukraine's HIV prevention response. It explores EVA and MARA boys' and girls' unmet needs and establishes a framework for HIV prevention interventions that target them. It also makes recommendations about how to strengthen the prevention response for them.

4.1. Understanding the scope of the problem

As this report demonstrates, EVA and MARA boys and girls need special attention from Ukraine's HIV/AIDS response. Like all Ukrainians, they have a right to high-quality services, to participate in planning and programming and to information. As most of them are still children, they also have a right to a special level of protection. In addition, this report demonstrates that their needs differ from those of their older counterparts. This is because adolescents occupy a different developmental stage, tend to be strongly influenced by peer and family norms and have less awareness and lower knowledge and skills levels because of their ages and because their access to information and services is limited. In addition, they are particularly affected by the consequences of economic instability and conflicts within families.[145] It is thus critical to understand the scope of the problem if a prevention response that can impact the HIV epidemic is to be devised.

> Using population size estimates for EVA and MARA boys and girls to understand the size of the problem is crucial if a prevention response that can have an impact on the HIV epidemic in Ukraine is to be planned.

However, Ukraine has yet to produce population size estimates for EVA and MARA boys and girls at any level. The results of the Secondary Analysis and of the Baseline Study (that is, the proportion of MARA boys and girls among the MARP samples (BSSs 2007) and among the Baseline Study sample of adolescents living and working on the streets) indicate that their number is considerable, particularly in the oblasts most affected by the HIV epidemic. Adolescent FSWs made up almost 18 per cent of the overall 2007 street-based FSW BSS sample. Adolescent IDUs comprised 6 per cent of the 2007 IDU BSS sample, and 12 per cent of the 2007 MSM BSS sample were adolescent MSM. In the Baseline Study, almost 16 per cent of the boys and girls reported having used injecting drugs, 10 per cent of the boys reported having had anal sex with men and 28 per cent reported having received money, gifts or drugs in exchange for sex (17 per cent of the boys and 57 per cent of the girls).

4.2. Considering the influence of sociodemographic characteristics and social status

To plan and programme an adequate prevention response for EVA and MARA boys and girls, it is vital to understand the target populations' sociodemographic profile. Their genders and corresponding assumptions and relationships, their ages and their differences in social status – these things influence their roles, norms and values, needs, expectations, behaviours and relationships. They also influence how resources should be distributed when planning responses that take these young people into account.[146]

4.2.1. Gender

A general trend analysis of the HIV epidemic shows that the male-female ratio among people living with HIV continues to narrow and that the epidemic is becoming increasingly feminised.[147] However, Ukraine's

[145] Homans, H., "Manual on Programming to Prevent HIV in Most-at-risk Adolescents" (draft), UNICEF Regional Office for Central and Eastern Europe and the Commonwealth of Independent States, Geneva, November 2007.

[146] Ibid.

[147] Costigan, A., "Know Your Epidemic in Gender Terms: Most-At-Risk Adolescents (MARA) and HIV/AIDS in Ukraine", draft report, unpublished, 2007.

prevention services do not generally take account of the differing risks and needs of EVA and MARA boys and girls.[148] Harm reduction services especially tend to target adult hardcore male drug users.[149] The Secondary Analysis' results confirm this, showing that being older and being male make one more likely to be reached by needle-exchange and peer-driven prevention programmes.

The Secondary Analysis highlights many other areas where boys and girls differ from one another. IDU girls, for instance, have more regular sexual relationships than IDU boys do. They also take more risks with their regular sex partners. For example, they use condoms less often (22 per cent of IDU girls reported consistent condom use with regular partners in the last year versus 35 per cent of IDU boys). IDU boys, on the other hand, reported having more casual sex and using condoms more consistently (44 per cent of them reported consistent condom use with a casual partner in the year prior to the survey while only 27 per cent of IDU girls did). The preliminary results of the ongoing Seroconvertion study[150] in Ukraine have produced similar findings for IDU males and casual sex. Other studies[151] demonstrate that condom use among MARP members when they have sex with regular partners is generally lower than it is when they have sex with casual partners. This may be because they perceive lower risk levels when they have sex with regular sex partners and are under the impression that they know each other well enough to trust in each others' fidelity.[152] Another explanation, cited by 44 per cent of the adolescent IDUs interviewed in the Secondary Analysis, was that condoms "decrease sensuality." When asked why they did not use condoms with casual partners, 32 per cent of the adolescent IDUs said they "did not consider it necessary" and 30 per cent said they were often "intoxicated" during sex acts.

A representative study among young IDUs in 2006 revealed, furthermore, that male adolescent IDUs are likely to deliberately decide to inject drugs, while females inject drugs more spontaneously, under the influence of sex partners and/or alcohol.[153] The study also shows that young females are more likely than males to inject drugs to relieve psychological distress or stimulate sexual activity. More young males than females take their first injection under the impression that drugs are better than alcohol. They inject more frequently than young females do because it is "cool".

Gender studies also suggest that gender norms influence drug use in Ukraine. These support the idea that risk-taking is a sign of "masculinity ". Girls and young women, on the other hand, have a higher level of dependency than men do and usually earn less than men, which is just one of the many reasons why girls and young women resort to selling sex.[154] They are also more prone to be trafficked for sexual exploitation than

[148] Teltschik, A., "Draft Summary Report, Technical Issue: 1.1.4 MARA and MARY, Technical area: 1. Prevention / 1.1 Most-at-Risk Populations", draft report prepared in 2007 within the frame of the Comprehensive External Evaluation of the National AIDS Response in Ukraine, UNAIDS (2007–2008), unpublished.

[149] UNAIDS, "Comprehensive External Evaluation of the National AIDS Response in Ukraine: Consolidated Report (zero draft)", Kyiv, June 2008; and: Homans, H., "Manual on Programming to Prevent HIV in Most-at-risk Adolescents" (draft), UNICEF Regional Office for Central and Eastern Europe and the Commonwealth of Independent States, Geneva, November 2007.

[150] International HIV/AIDS Alliance in Ukraine, "Analysis of risk factors for HIV infection related to sexual practices and injecting drug use", presentation on the preliminary results of the Polaris Seroconversion Study (2006–2008) conducted in Ukraine, Kyiv; see also at http://www.hivpolaris.org and: International HIV/AIDS Alliance in Ukraine (2005), "Monitoring and Evaluation Plan for Phase Two of the Programme "Overcoming the HIV/AIDS Epidemics in Ukraine" (2005–2008)", funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria in support of the National Response to HIV/AIDS in Ukraine, Kyiv, March 2006.

[151] See list of references provided in: LSHTM, "Investigating HIV risk behaviours amongst most-at-risk adolescents in Ukraine", submitted in partial fulfilment for the award of Master of Science, Demography & Health, University of London, by Clea Meynell, September 2008, unpublished. The list is displayed as Annex 5 to this report.

[152] LSHTM, "Investigating HIV risk behaviours amongst most-at-risk adolescents in Ukraine", submitted in partial fulfilment for the award of Master of Science, Demography & Health, University of London, by Clea Meynell, September 2008, unpublished.

[153] UNICEF and UNAIDS, *Risk and protective factors in the initiation of injecting drug use,* Kyiv, 2006.

[154] Costigan, A., "Know Your Epidemic in Gender Terms: Most-At-Risk Adolescents (MARA) and HIV/AIDS in Ukraine", draft report, unpublished, 2007, and: UNAIDS (2007), *Assessing Gender Equality and Equity as Critical Elements in National Responses to HIV: Cambodia, Honduras and Ukraine, presentation of policy guidance to address gender issues, 20th Meeting of the UNAIDS Programme Coordinating Board,* Geneva, 25–27 June 2007.

adolescent males.[155] The Secondary Analysis underlines that adolescent FSWs tend to be in disadvantaged economic positions. Only 13 per cent of the girls interviewed reported having a job (whether permanent or temporary).

Research suggests that gender norms and stereotypes influence drug use, and that adolescent girls and young women appear to be injecting drugs rather spontaneously, particularly under the influence of a sex partner and/or alcohol.

The needs of male adolescents living and working on the streets and female adolescents living and working on the streets also differ, as the Baseline Survey's results reveal. Due to the quota prescribed for girls, however, these results have to be considered with caution.

Girls generally had more sexual experience than boys (82 per cent of girls versus 70 per cent of boys reported having had sex, with 38 per cent of the girls having had anal sex, versus 21 per cent of the boys). Girls also reported more frequent sex with regular partners than boys did (44 per cent of girls versus 34 per cent of boys) and more frequent sex with commercial partners (57 per cent of girls versus 17 per cent of boys). This may also explain why girls reported having been picked up by the police for selling sex more often than boys did, as well as why they reported higher levels of experience with sexual violence (52 per cent of girls and 11 per cent of boys reported lifetime experience of sexual violence, and 37 per cent of the girls and 7 per cent of the boys reported experience of it in the last year). Also, more girls than boys said their sex partners were IDUs. The latter means that more girls are at risk of starting to use injecting drugs, which will intensify their already high risk of sexual HIV transmission.[156]

The Baseline Study shows that boys who are living or working on the streets appear to start sex earlier than girls, and have more frequent casual sex.

The data show that the boys start having sex at an earlier age than girls do, and that the boys had more frequent sex with casual partners in the last year than girls did (80 per cent of boys versus 65 per cent of girls). Boys were stopped or harassed by the police more often than the girls (83 per cent of the boys versus 58 per cent of the girls), and 8 per cent of the boys had incarceration experience versus 2 per cent of the girls. A 2006 explorative study among Ukrainian children and young people living and working on the streets brought to light similar gender differences.[157]

4.2.2. Age

A prevention response must be more than gender-sensitive. It must also be age-specific, taking into consideration adolescents' developmental stages and confronting evidence that shows that the younger EVA and MARA boys and girls happen to be, the less likely they are to have been exposed to risk factors for long, and the more crucial it is that they be targeted by early prevention interventions .

The younger EVA and MARA boys and girls are, the greater their vulnerability to HIV. On the other hand, the likelihood of their having been exposed to HIV risk factors for long periods of time is smaller. Their relative youth therefore provides a window of opportunity for early prevention interventions.

The Baseline Study showed a clear trend for age. Younger age groups reported less lifetime drug use than older age groups did, and respondents aged 18 to 19 were 6.7 times more likely to have lifetime injecting

[155] UNICEF, "Desk Research Report. A review of the evidence on HIV/AIDS and most-at-risk adolescents (MARA) and young people (MARY) in Ukraine", internal working document, UNICEF Ukraine, Kyiv, 2008, and: Costigan, A., "Know Your Epidemic in Gender Terms: Most-At-Risk Adolescents (MARA) and HIV/AIDS in Ukraine", draft report, unpublished, 2007.

[156] UNICEF and UNAIDS, *Risk and protective factors in the initiation of injecting drug use,* Kyiv, 2006.

[157] AIDS Foundation East-West and UNICEF, *Children and young people living or working on the streets: the missing face of the HIV epidemic in Ukraine,* Kyiv, 2006.

experience than those aged 10 to 14. That older respondents had been exposed for longer to the drug scenes in their localities explains this.[158]

Age was also associated with lower condom use among 10- to 14-year-old girls, which may be due to their earlier exposure to sexual violence. In addition, the younger the boys and girls in the Baseline Study were, the less knowledge of HIV/AIDS they reported. For example, only 5 per cent of 10- to 14-year-olds were able to correctly answer questions about HIV/AIDS, versus 14 per cent of 15- to 17-year-olds. Low levels of HIV prevention coverage for these younger adolescents explain their extremely low knowledge levels. Also, the younger the respondents were, the less sexual experience they had (43 per cent of 10- to 14-year-olds said they had had vaginal sex versus 90 per cent of the 15- to 17-year-olds and almost 100 per cent of the 18- to 19-year-olds).

The Secondary Analysis betrayed similar trends. The younger the interviewed MARA boys and girls were, the less they knew about HIV/AIDS and the less service use and access to prevention means they reported. Condom use was, for instance, significantly lower among adolescent FSWs aged 13 to 17 than among those aged 18 to 19 (41 per cent of the adolescent FSWs aged 13 to 17 versus 57 per cent of those aged 18 to 19 reported condom use with clients in the previous month). An explanation for this may be that confident, self-protective behaviours increase with age and exposure to sex work. Younger FSWs also reported more anal sex with clients than their older counterparts did (72 percent of those aged 13 to 17 reported anal sex with clients as compared to 57 per cent of those aged 18 to 19). Fears of unwanted pregnancy, requests for anal sex from older sex partners or the attitude among clients that younger FSWs will do whatever is asked of them may all explain this. Additional research is required to shed more light on this high risk behaviour among younger age groups.

Comparing adolescent MARA with their adult counterparts, it is noteworthy that the adolescents reported more high-risk behaviours than their adult counterparts did. This may be linked to their lower knowledge, skill and confidence levels and to lower coverage with prevention services. For instance, 39 per cent of adolescent FSWs said that they are ready to sell sex without a condom if the client pays more, versus 25 per cent of their older counterparts. In addition, 32 per cent of adolescent FSWs versus 47 per cent of their older counterparts stressed that they would never have sex without condoms. That adolescent FSWs have more limited exposure to the sex business and less awareness of the risks attached to anal sex may help explain their vulnerability.

These findings underline that Ukraine's prevention response must pay greater attention to EVA and MARA boys and girls. The younger members of these populations deserve especial care, and interventions must start as early as possible. As the research shows, risk behaviours start early among these groups, and by the later stages of adolescence they are firmly established. The data also demonstrate that the younger EVA and MARA boys and girls are, the greater the number of vulnerability factors to which they are exposed. This is especially true of girls.

4.2.3. Social status

Research tends to characterise EVA and MARA populations as homogeneous. This ignores the significance of the differences in social status that exist between and within these groups. These differences, it hardly needs saying, impact on the programming that is necessary.

The Baseline Study reviewed the following factors related to the social status of adolescents living and working on the streets: their mobility levels, their nationalities, their living arrangements, their educational levels, their employment status, their orphan status and their experience of institutionalisation. The 2007 BSS among MARPs, which formed the basis for the Secondary Analysis, considered marital status, mobility levels, educational levels and employment status.

[158] LSHTM, "Investigating HIV risk behaviours amongst most-at-risk adolescents in Ukraine", submitted in partial fulfilment for the award of Master of Science, Demography & Health, University of London, by Clea Meynell, September 2008, unpublished.

4.2.3.1. Marital status

Evidently, the social and sexual networks in which MARA boys and girls exist imply increased risk of HIV infection and make it more likely that risk behaviours will crop up. This is especially true when it comes to non-injecting drug users and the female sex partners of male IDUs.[159] Therefore, it is important to a service provider if an adolescent is married to or is living with a sex partner. If he or she is, that spouse or partner can also be integrated into prevention efforts. In addition, paying attention to such situations can help service providers see possible bridge populations more clearly.

> It is important to understand and reach the sexual and social networks of EVA and MARA boys and girls with prevention interventions, as they are at increased risk of initiating HIV risk behaviour, and of HIV infection.

As the Secondary Analysis shows, the majority of adolescent IDUs (83 per cent), FSWs (85 per cent) and MSM (90 per cent) are unmarried and are not living with their sex partners. A small proportion of them (20 per cent of IDU girls, 11 per cent of IDU boys, 13 per cent of adolescent FSWs and 10 per cent of adolescent MSM) are living with sex partners, but without official marriage licenses. Because of its design, the MSM BSS 2007 could not establish if the adolescent MSM interviewed were living with female or male partners. This is, however, important information. If an adolescent MSM is living with a female partner, she would not only be at increased risk of HIV infection, but her mere presence could indicate that the MSM in question fears being open about his homosexual activities or bisexuality.[160]

The Baseline Survey did not address the marital status of the adolescents living and working on the streets because previous surveys among this population group in Ukraine demonstrate that the majority are unmarried.[161]

4.2.3.2. Mobility and nationality

The Desk Research identified migration as a potential vulnerability factor for EVA and MARA boys and girls in Ukraine, especially for those lacking identification documents, including registration information. The Baseline Study revealed that health care and other support services in Ukraine often require that adolescents provide identifying documents if they want access to services. This restricts service access for migrating adolescents, who, research shows, are usually unregistered in a particular locality and lack identification documents (58 per cent of the adolescents over 16 said they had no passport, for instance). The External Evaluation[162] also identified this as a serious access barrier.

The Secondary Analysis revealed that adolescent IDUs, FSWs and MSM may, however, not be as mobile as their adult counterparts. The majority of the respondents claimed to have been born in the cities in which they were interviewed. Adolescent FSWs demonstrated the highest level of mobility among the three groups, with 39 per cent having come to their cities of current residence from other places. That FSWs are generally a rather mobile population group is in line with findings of other social research conducted in Ukraine.[163]

The picture is quite different for adolescents who are living and working on the streets. Almost half of those interviewed within the frame of the Baseline Study said that they came from other cities or regions

[159] UNICEF and UNAIDS, *Risk and protective factors in the initiation of injecting drug use*, Kyiv, 2006.

[160] International HIV/AIDS Alliance in Ukraine and the Centre of Social Expertise, *Population survey results. Report. Behaviour monitoring of men having sex with men, as a component of second generation surveillance,* Kyiv, 2004.

[161] See for instance: AIDS Foundation East-West and UNICEF, *Children and young people living or working on the streets: the missing face of the HIV epidemic in Ukraine,* Kyiv, 2006; and: Postupniy, O.M., et al., "Prevention of addictive behaviour among street children in Ukraine", in: Drug abuse prevention: organizational and methodical aspects. Concluding materials of the international project, Finart, Kharkiv, 2002.

[162] Araujo, I. and Roberts-Hatcher J., "Draft Summary Report, Technical Issue: 1.1.5.2 Migrants and Mobile Populations, Technical area: 1. Prevention / 1.1 Most-at-Risk Populations", draft report prepared in 2007 within the frame of the Comprehensive External Evaluation of the National AIDS Response in Ukraine, UNAIDS (2007–2008), unpublished.

[163] OSI and Central and Eastern European Harm Reduction Network, *Sex Work, HIV/AIDS, and Human Rights*, Central and Eastern European Harm Reduction Network, Lithuania, 2005, and: UNICEF and UNAIDS, *Risk and protective factors in the initiation of injecting drug use*, Kyiv, 2006.

in Ukraine to their places of current residence. Seasonal mobility is also common among this population group. Most of the migration seems to take place within Ukraine, as only 2.5 per cent of the adolescents interviewed reported having come to Ukraine from abroad, primarily from neighbouring countries, such as the Russian Federation, the Republic of Moldova, Belarus, Georgia, Chechnya and Kazakhstan. In addition, over 90 per cent of the adolescents interviewed were born in Ukraine. It is also noteworthy that 4 per cent of the adolescents reported that they do not know in which country they were born.

Adolescents living and working on the streets are highly mobile. Most of their migration appears to take place within Ukraine. This makes them hard to track and prone to exclusion from services, due to the widespread practice among health care providers in particular of requesting registration/identification documents.

4.2.3.3. Living arrangement

The Baseline Survey considered the living arrangements of adolescents who are living and working on the streets. The finding that 20 per cent of the adolescents responded that they are still sleeping at home and are staying primarily with their grandparents raises serious questions about the functioning of Ukraine's social service and child protection system. The data indicate that the grandparents and other relatives with whom the adolescents are staying apparently lack the capability to take adequate care of the adolescents, and do not seem to know where to turn for help and support. Such living arrangements raise the question of the whereabouts of the parents and the capacities of social and child protection services to provide adequate support to families in crisis, as well as to children without parental care .

Twenty per cent of adolescents living and working on the streets reported sleeping at home. Many stay with their grandparents. This raises serious concerns about the capability of the caregivers, the whereabouts of the parents and the functioning of the child protection system.

According to the Baseline Survey, another 17 per cent of the adolescents interviewed are living in the flats of friends. This is an important finding as well, as these adolescents may provide an entry point to a wider social network.

4.2.3.4. Educational level and employment status

Lack of education, incomplete education, unemployment and a lack of a permanent job are all significant vulnerability factors for EVA and MARA boys and girls, greatly impacting their lives, their health, their development and their behaviour.

The level of education among MARA boys and girls, as the Secondary Analysis demonstrates, is relatively low. Few of them have permanent work and over half of them are still in school or vocational school or are studying at college or university. Among adolescent IDUs, FSWs and MSM, adolescent MSM demonstrated the highest level of education, the lowest levels of unemployment and the highest levels of employment (permanent and temporary).

Evidence shows that life skills-based HIV education in schools is ineffective[164] for MARA boys and girls, but Ukraine's formal education and business sectors still have a potential role to play in HIV prevention for them. For instance, they can support efforts to increase access to services for MARA by providing targeted information about community-based prevention, treatment, care and support services[165] to their pupils and

[164] Homans, H., "Manual on Programming to Prevent HIV in Most-at-risk Adolescents" (draft), UNICEF Regional Office for Central and Eastern Europe and the Commonwealth of Independent States, Geneva, November 2007; and: WHO, *Preventing HIV/AIDS in young people: a systematic review of the evidence from developing countries,* UNAIDS Inter-Agency Task Team on Young People, WHO Technical Report Series No. 938, Geneva, 2006.

[165] Costello, J., "Draft Summary Report, Technical Issue: 1.2.3 Workplace, Technical area: 1.2 General Population", draft report prepared in 2007 within the frame of the Comprehensive External Evaluation of the National AIDS Response in Ukraine, UNAIDS (2007-2008), unpublished, and: Teltschik, A., "Draft Summary Report, Technical Issue: School-based HIV education: schools 1.2.1.1, PTUs 1.2.1.2 and universities/institutes 1.2.1.3, Technical area: 1.2 General Population", draft report prepared in 2007 within the frame of the Comprehensive External Evaluation of the National AIDS Response in Ukraine, UNAIDS (2007–2008), unpublished.

employees. They can do this by using peer educators and psychosocial and medical in-house services, which can also make service referrals. This role is currently underdeveloped in Ukraine, due to a lack of relevant training programmes and limited capacities.

The Baseline Study shows that the education level of adolescents who are living and working on the streets is very low. The majority of the adolescents aged 18 to 19 (86 per cent) reported that they have not completed basic education, although it is obligatory in Ukraine. And despite an overall very high official school attendance rate in Ukraine[166], most of the adolescents do not attend school. Four per cent (most of them aged 10 to 14) even reported that they had never attended school .

EVA and MARA boys and girls often lack educational levels appropriate to their ages. Partnerships between NGOs, the education sector and the business sector are needed to provide adolescents with the chance to reintegrate into the formal education and work systems and to access appropriate support services.

That so many adolescents living and working on the streets have lower educational levels than their ages would suggest has consequences for development and provision of prevention services and informational and educational materials. Such services and materials, after all, need to match the level of education, rather than age, of their target audience. They also require close cooperation between out-of-school service providers, the formal education system and the business sector. Such cooperation is critical to re-integrating adolescents into the formal education system and providing them with job opportunities once more urgent issues, such as homelessness and health concerns, have been addressed adequately.[167]

4.2.3.5. Orphan status

That orphans (orphans in general as well as children orphaned by HIV/AIDS) are particularly vulnerable to HIV infection is a confirmed fact.[168] Almost 44 per cent of the adolescents living and working on the streets who were interviewed within the frame of the Baseline Study reported being single orphans. Approximately one third said they were double orphans or so-called "social" orphans, who do not know if their parents are still alive .

The Baseline Survey shows that the number of single, double and "social" orphans is high among adolescents living and working on the streets.

4.2.3.6. Experience of detention and incarceration

As this report stressed earlier, detention and incarceration put an adolescent at an increased risk of HIV infection. The Baseline Study shows that half of the adolescents living and working on the streets have been detained or incarcerated at least once in their lives .

According to the Baseline Survey, half of street adolescents have been detained or incarcerated.

[166] UNICEF (2008), Information by country, Ukraine statistics 2008 (updated 2008; cited 2008 21/07/08), available from: http://www.unicef.org/infobycountry/ukraine_statistics.html#42.

[167] Haldenby, A.M., et al., "Homelessness and Health in Adolescents", in: *Qual Health Res* 2007; 17/9; 1232-1244, Sage Publications, November 2007.

[168] Richter, L., et al., "Social and community risk factors that predispose children to risk of HIV infection in South Africa", International Conference on AIDS (15th: 2004: Bangkok, Thailand), Int Conf AIDS 2004, Jul 11–16;15; Kang, M., et al. "Maternal versus paternal orphans and HIV/STI risk among adolescent girls in Zimbabwe", *AIDS Care* 2008, vol. 20, n 2, pp. 214–217 [4 page(s) (article)] (1/4 p.); Kissin, D.M., et al., "HIV seroprevalence in street youth in St. Petersburg, Russia", *AIDS* 2007, Vol. 21 No. 17, pp. 2333–2340; and: UNAIDS, et al., *The framework for the protection, care and support of orphans and vulnerable children living in a world with HIV and AIDS,* July 2004.

4.3. Individual risks and risk behaviours of EVA and MARA boys and girls

The Secondary Analysis and the Baseline Survey paint a grim picture. High-risk behaviours start early. A substantial proportion of adolescents are already engaged in them or are likely to engage in them in the near future, due to their being exposed to a variety of personal and environmental vulnerability and risk factors. On top of that, the research revealed that high-risk behaviour is more common among adolescent MARA than among their adult counterparts. This is mainly because adolescents have lower levels of knowledge, skills and confidence, and less prevention service coverage. On the other hand, the research results indicate that the earlier an intervention takes place among these population groups, the greater the chance to prevent risk behaviour or harm.

All of this calls for an urgent and immediate HIV prevention response at the national and subnational levels in Ukraine. But while all EVA and MARA boys and girls are in great need of HIV prevention interventions, as well as of other prevention, support and care services, there are distinct differences in the risks that various EVA and MARA groups take, and in the protective behaviours they practise. Any prevention response must take into account these differences. Several other issues also require special attention:

EVA and MARA boys and girls are in great need of HIV services. Special attention needs to be paid to:

1. Associations between risk behaviours, sociodemographic characteristics and other variables
2. Consistent condom use and barriers to implementing and sustaining safer sex practices
3. Unsafe injecting behaviour
4. Boys living and working on the streets engaged in MSM behaviour
5. Overlapping risk behaviours
6. The sexual and reproductive health of EVA and MARA boys and girls
7. Social and sexual networks of MARA
8. Early interventions
9. HIV prevention, child protection and the State child-care system
10. The street environment
11. Service use and service quality and coverage
12. Service access barriers
13. Regional differences

a. Associations between risk behaviours, sociodemographic characteristics and other variables

A separate analysis of the Baseline Survey's data conducted by a Masters student of the LSHTM[169], including a bivariate and multivariate analysis[170], highlights possible associations and relationships between risk behaviours, sociodemographic characteristics and various independent variables. It indicates, for instance, that the risk of injecting drugs is associated with lifetime experience of non-injecting drug use among adolescents who are living and working on the streets, and that older respondents have increased odds of having injected drugs. Other studies have found similar results, even though research is divided on this issue.[171]

The risk of unsafe sex, on the other hand, seems to be associated with being younger; with having a regular sex partner (for females); with having a casual sex partner (for both sexes); with having MSM sex; and with having lifetime experience of using inhalants (for both sexes). Age, having a regular sex partner and inhalant

[169] LSHTM, "Investigating HIV risk behaviours amongst most-at-risk adolescents in Ukraine", submitted in partial fulfilment for the award of Master of Science, Demography & Health, University of London, by Clea Meynell, September 2008, unpublished.

[170] That means analysing possible associations and crude relationships between different variables.

[171] See list of references provided in: LSHTM, "Investigating HIV risk behaviours amongst most-at-risk adolescents in Ukraine", submitted in partial fulfilment for the award of Master of Science, Demography & Health, University of London, by Clea Meynell, September 2008, unpublished. The list is displayed as Annex 5 to this report

experience are commonly noted risk factors determining condom use.[172] The LSHTM analysis also identified having correct knowledge about HIV/AIDS as a protective factor for females, but not for males. As this is contrary to recent research quoted in the LSHTM analysis, it may require more investigation.

The LSHTM analysis also found possible associations between safer sex with a casual sex partner and being involved in sex work (females); between having a regular sex partner (males) and using condoms with casual partners; and between having experience of forced sex (males) and condom use. Various factors could explain the first of those associations. For example, the LSHTM analysis mentions that FSWs are more aware of the risks of unprotected sex and act accordingly in their relations with casual sex partners; that they are better at negotiating condom use because of their work; and that their casual partners request the use of a condom if they know that their sex partner is engaged in sex work. The last of those associations (forced sex and condom use) is contrary to the current research that the LSHTM references. That research indicates that those with histories of forced sex are more likely to engage in risky behaviours.[173]

The LSHTM analysis identified MSM-IDUs who are living and working on the streets as a population group at particular risk of HIV infection. The results showed that adolescent males living and working on the streets who report MSM behaviour were twice as likely to inject drugs as those who do not report MSM behaviour. While the numbers were small and therefore need to be considered with caution, this is still an interesting finding. It suggests that this population group practises overlapping risk behaviours. When the increased risk of unsafe sex among MSM is taken into account, this places this group at very high risk of HIV infection. The LSHTM analysis provides some possible explanations for the overlapping risk behaviour. For example, it refers to previous studies that indicate that both MSM and IDUs are highly marginalised and often forced underground, and that there might therefore be potential for overlap between them; and that in Ukraine and other countries IDU females and males frequently sell sex to fund their drug habits.

b. Consistent condom use and barriers to implementing and sustaining safer sex practices

The Secondary Analysis and Baseline Survey reveal that while condom use during the last incidence of sex appears to be relatively high among adolescent MARA boys and girls, consistency of condom use remains in question. Unsafe sex practices are widespread and the response to the question about condom use during last incidence of sex may be socially biased.

According to the Secondary Analysis, the MARA population groups in need of special attention with regard to behaviour change interventions such as condom promotion are adolescent IDU boys and girls and adolescent FSWs who practise anal sex. Adolescent IDU boys and girls appear to use condoms least consistently, while adolescent FSWs who practise anal sex use condoms for it far less often than they do for vaginal sex.

Additionally, programming must take into account barriers to implementing and sustaining safer sex practices. The Secondary Analysis, for instance, hints that lack of knowledge about HIV/AIDS and low risk perception possibly explain why adolescent MSM do not use condoms.

The Secondary Analysis and Baseline Survey also reveal that adolescent girls who practise unsafe sexual behaviour, particularly those who are exploited for sex and who live on the streets, face especially high barriers to implementing and sustaining safer sex practices. Such barriers include the role that regular sex partners appear to be playing with regard to condom use; high levels of overlapping risk behaviour (sex work and injecting drug use); vast experience of forced sex in different settings; lack of protection and support from the police and police violence; limited access to adequate health care services; and the underdeveloped role of alternative entry points to prevention commodities and means, such as pharmacies and sexual and reproductive health care services.

Another interesting finding is that boys who live and work on the streets and who are exploited for sex by men pointed out in focus groups that the will of the client greatly determines condom use. Social research in other countries[174] and the Secondary Analysis for IDU boys and girls have pointed out the same thing. The

[172] Ibid.

[173] Ibid.

[174] See for instance research cited in: Homans, H., "Manual on Programming to Prevent HIV in Most-at-risk Adolescents" (draft), UNICEF Regional Office for Central and Eastern Europe and the Commonwealth of Independent States, Geneva, November

majority (60 per cent) of IDU boys and girls reported that they did not use condoms with clients because the clients did not wish it. Work with clients is completely underdeveloped at this stage in Ukraine.[175]

These findings have implications for more than prevention interventions. They are also important for the national M&E system, as it is questionable how adequately a national indicator reporting condom use during last incidence of sex describes the real situation.

c. Unsafe injecting behaviour

Ukraine's dominant harm reduction approach is currently needle and syringe exchange, which has the goal of increasing the use of sterile injecting equipment. This approach is coupled with counselling about safer behaviours and condom distribution. Looking at the findings of the Secondary Analysis and the Baseline Study, it is important to note that while exchange represents a critical approach and while Ukraine offers a basic package of services, harm reduction services fall short of tackling the HIV infection risk that is associated, for instance, with the widespread purchase and use by adolescent IDUs of pre-filled syringes.[176] Nor do harm reduction services work sufficiently with the social networks of adolescent IDUs, even though a 2006 study of injecting drug use initiation in Ukraine found that 64 per cent of the IDUs interviewed said that they had received their first injections from friends or acquaintances.

d. Boys living and working on the streets engaged in MSM behaviour

As the Baseline Study indicates, the MSM behaviour of boys who are living and working on the streets appears to be less an expression of a homosexual identity than a form of transactional sex. It can, for example, ensure survival on the streets. This has implications for planning and programming HIV prevention interventions because these adolescent boys belong to no homosexual scene that prevention interventions could target, and they congregate in different settings than homosexual communities. [177]

e. Overlapping risk behaviours

Prevention services in Ukraine do not, as of today, sufficiently address overlapping risk behaviours.[178] This report's data have clearly illustrated that such behaviours are generally common among adolescent IDUs, most of whom are sexually active and who do not use condoms often enough; among adolescent IDU girls, many of whom sell or engage in transactional sex; among adolescent FSWs, who inject drugs; and possibly among MSM-IDUs.

It is also noteworthy that risk factors and vulnerability factors overlap. For instance, the use of substances and drugs often acts as a vulnerability factor that contributes to adolescent homelessness.[179]

f. The sexual and reproductive health of EVA and MARA boys and girls

The Baseline Study also addressed the sexual and reproductive health of EVA and MARA boys and girls. The data show that almost every fifth girl living on the streets has been pregnant at least once. Sixty-four per cent of those reporting pregnancies said that they had been pregnant once, 23 per cent reported being pregnant twice and 13 per cent had been pregnant three or more times. Most of these pregnancies ended in abortion (68 per cent). All pregnancies among girls aged 10 to 14 apparently ended in abortion. Among girls aged 15

2007.

[175] UNAIDS, "Comprehensive External Evaluation of the National AIDS Response in Ukraine: Consolidated Report (zero draft)", Kyiv, June 2008.

[176] Needle, R., "Draft Summary Report, Technical Issue: 1.1.1 Injecting Drug Users, Technical area: 1.1 Most-At-Risk Population", draft report prepared in 2007 within the frame of the Comprehensive External Evaluation of the National AIDS Response in Ukraine, UNAIDS (2007–2008), unpublished.

[177] LSHTM, "Investigating HIV risk behaviours amongst most-at-risk adolescents in Ukraine", submitted in partial fulfilment for the award of Master of Science, Demography & Health, University of London, by Clea Meynell, September 2008, unpublished.

[178] UNAIDS, "Comprehensive External Evaluation of the National AIDS Response in Ukraine: Consolidated Report (zero draft)", Kyiv, June 2008.

[179] Mallett, S., et al., "Young people, drug use and family conflict: Pathways into homelessness", *Journal of Adolescence,* 28, 185-199, 2005.

to 17, sixty-nine per cent did, and among those aged 18 to 19, sixty-one per cent did. Many girls said that they had experienced miscarriages.

Eleven per cent of the girls who reported having been pregnant also reported having children. That amounts to 2 per cent of the Baseline Study's entire female sample. Given the circumstances in which these young mothers and their children live and grow up, and given the increased risk of HIV among the children of FSWs, special attention must be paid to pregnant girls and adolescent mothers living and working on the streets.

The relatively high level of pregnancies and abortions is not surprising given the low level of condom use among EVA and MARA boys and Ukraine's overall high abortion rate. The repeat pregnancy phenomenon (23 per cent of girls reported having been pregnant twice and 13 per cent three times or more) and the high abortion rate indicate that the HIV prevention interventions that the reproductive health care sector and abortion clinics practise are ineffective when it comes to this population group – where they exist at all. There is room for improvement, a fact that the External Evaluation also took care to stress.[180]

The Baseline Study results also demonstrate that the role that existing sexual health care services play in HIV prevention remains underdeveloped. These services do not sufficiently cover and reach out to those most at risk of STIs and HIV infection, such as EVA and MARA. Only 31 per cent of the sexually active boys and girls reporting STI symptoms (18 per cent of the total sample) went to health care services for diagnostics and treatment. Forty-seven per cent, on the other hand, reported self-treatment (57 per cent of the boys and 34 per cent of the girls).

g. Social and sexual networks of MARA

The research shows that IDU sex partners play a crucial role in the initiation of injecting drug use among MARA girls. But as the 2006 IDU Initiation Study proved[181], not only sexual relationships but also social relations and peer pressure place adolescents at increased risk of starting to inject, of sharing needles and, consequently, of HIV infection. More attention therefore must be paid to the social and sexual networks in which IDU boys and girls exist, independent of the settings in which they congregate and live. Prevention programmes aimed at preventing initiation of injecting drug use also demand more attention.

Another critical finding is that adolescent MSM have sexual relations with girls and young women. It is not possible to establish on the basis of the Secondary Analysis of the MSM BSS 2007 what role females play in the risk behaviour of adolescent MSM. This question requires more research. So do the sexual and social networks of adolescent MSM who report transactional sex, as mentioned above.

h. Early interventions

As this report has noted, HIV and STI prevention interventions must start earlier than they currently do, to ensure that EVA and MARA are reached before they commence risk behaviour or just after they have done so. Until now, however, most of Ukraine's HIV and STI prevention and harm reduction service providers have targeted primarily adults. They target secondary and tertiary prevention measures to MARA who have already been practising risk behaviour for considerable periods of time, but do not address EVA boys' and girls' primary prevention needs (that is, their need for interventions that will keep them from becoming MARA).

A United States-based study has demonstrated the importance of reaching EVA and MARA living and working on the streets during transitional stages. This can be done during the early stages of street life. It is then that the young people are under great stress to meet basic needs. Moreover, they feel like outsiders, a situation that either leads to them leaving the street or forces them to "acculturate" to it. Acculturation is usually accomplished with the help of "street mentors" (mostly adolescents who have already lived for some time on the streets and lead groups of youths) who teach the newcomer survival skills. It can also happen during later

[180] De Knocke, H., "Draft Summary Report, Technical Issue: 1.2.7 Sexual & Reproductive Health, Technical area: 1.2 General Population", draft report prepared in 2007 within the frame of the Comprehensive External Evaluation of the National AIDS Response in Ukraine, UNAIDS (2007–2008), unpublished.

[181] UNICEF and UNAIDS, *Risk and protective factors in the initiation of injecting drug use,* Kyiv, 2006.

stages, when young people undergo crisis and may be more open to outside help.[182] Early-stage work calls for offering comprehensive services first, that is, services that meet basic needs (for health, food, hygiene, safety, and so on). After providing these services, outreach workers should focus on an adolescent's HIV prevention needs. They should also target street mentors, exploring options for involving them in prevention work as volunteers, peer educators or advocates. Later-stage work, with young people undergoing crises, requires service providers to learn more about what can trigger a crisis and what the signs of crisis are.

i. HIV prevention, child protection and the State child-care system

A prevention response that aims to address the various needs of Ukraine's EVA and MARA boys and girls must take into account child protection and child-care considerations. The research findings provide evidence concerning the sexual and physical violence that EVA and MARA boys and girls experience, particularly on the streets but also in child-care and penitentiary facilities.

The evidence is insufficient for estimating either the scale of these rights violations or the child protection and child-care system's failure to protect institutionalised children and adolescents from discrimination, abuse and exploitation. Still, even the little data that is available raise concerns about the system. (These concerns were also raised in the reports to and the statements of the Committee on the *Convention of the Rights of the Child*, henceforth the *CRC* Committee).[183] Rights violations are major barriers to sustainable safe behaviour among EVA and MARA, and not only among those who are institutionalised. They indicate the widespread stigma with which EVA and MARA live in Ukraine, and the discrimination that they face, even from professionals in the system. They stimulate boys and girls to avoid services, shun authority and in effect go into hiding. This became clear during the research process (see, for instance, sub-chapter 2.4.2.7) and during the focus groups in which MARA boys and girls discussed the research's findings. They stressed that the Criminal Police for Minors' oppressive and increasingly common street raids lead them to avoid the streets more and more. They are retreating to better hideouts, making them harder to reach.

Furthermore, the criminalization of syringe/needle possession[184] remains a barrier to providing high-quality needle-exchange services for the populations in question.

Employees of the Criminal Police for Minors and other governmental agencies and institutions are not shy about expressing their negative attitudes towards EVA and MARA in interviews and discussions[185]. They consider them "potential criminals" rather than the victims that they often are. Their attitudes, the research shows, are sometimes reflected in their behaviour towards them. This behaviour can include physical or sexual violence, which demonstrate a disrespect for the young people that should never be tolerated and calls for zero tolerance policies among all direct service providers. But it can also include police harassment, which results in situations in which high numbers of EVA and MARA boys and girls are stopped and even arrested by officers in the street. The Baseline Studies show that most EVA and MARA have been stopped or harassed at least once in their lives (76 per cent have been in total, including 83 per cent of the boys and 58 per cent of the girls; and every fifth boy or girl reported being stopped or harassed once or twice in the last year).

[182] Auerswald, C.L., and Eyre, S.L., "Youth homelessness in San Francisco: A life cycle approach", *Social Science & Medicine* 54 (2002) 1497–1512, USA.

[183] See for instance: UN Human Rights Committee, "International Covenant on Civil and Political Rights, Consideration of Reports submitted by States Parties under Article 40 of the Covenant, Concluding Observations of the Human Rights Committee on Ukraine", Eighty-eighth session, Geneva (16 October–3 November 2006), Geneva, 28 November 2006; All-Ukrainian Coalition of non-government organizations Unite for Children, "Alternative report on the implementation of the Optional Protocol to the UN Convention on the Rights of the Child, on the Sale of Children, Child Prostitution and Child Pornography", Kyiv, 2006; or: UN Committee against Torture, "Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Consideration of reports submitted by States Parties under Article 19 of the Convention. Fifth periodic report of Ukraine", Thirty-eight session, Geneva (8 May 2007), Summary Record of the 765th meeting held at the Palais Wilson, Geneva, 21 May 2007.

[184] Human Rights Watch, *Rhetoric and Risk: Human Rights Abuses Impeding Ukraine's Fight against HIV/AIDS*, 2006, see at: http://hrw.org/reports/2006/ukraine0306/2.htm.

[185] See for instance: AIDS Foundation East-West and UNICEF, *Children and young people living or working on the streets: the missing face of the HIV epidemic in Ukraine,* Kyiv, 2006. Related comments were also made by some representatives of the Criminal Police for Minors, departments for children, social services and child-care facilities during the strategic planning process that UNICEF initiated at the MARA Project sites in 2008.

Boys and girls living on the streets said the police stopped or arrested them for committing criminal or administrative offences to secure a living. These included begging or break-ins (61 per cent) and petty theft (45 per cent). On the other hand, young people could be stopped just for "suspicious behaviour" (39 per cent). To a much lesser degree they reported being stopped or arrested for selling sex (24 per cent of girls but only 1 per cent of boys), for drinking alcohol in public places (28 per cent of boys and 15 per cent of girls), for drug use (15 per cent of boys and 12 per cent of girls), for drug storage (8 per cent of boys and 4 per cent of girls) and for selling drugs (3 per cent of boys and 2 per cent of girls).

As this report stressed before and as the research findings indicate, arrests and detentions are vulnerability and risk factors for adolescents. It should be noted that in Ukraine adolescents can be detained prior to and during trial for up to one or two years[186].

The recent decision to set aside special rooms in police stations ("green rooms") for arrested minors is a positive step. It improves the quality of child protection and makes law enforcement more youth-friendly. Green rooms could also become important spaces for providing HIV prevention information. It is also noteworthy that the police have in recent years received some training in community policing and restorative justice and that the Criminal Police for Minors have adopted a more youth-friendly approach nationally. They have been visiting schools, organising campaigns about domestic violence and cooperating with civil society organizations. Still, the role that the police play in HIV prevention has yet to be clearly defined and developed. That role should be an essential part of a comprehensive programme of primary and secondary prevention for EVA and MARA, including those at risk of being offenders,.

There are other barriers to a comprehensive prevention approach in Ukraine. Some are inherent in the Ukrainian policy on child protection. For example, as the findings of the Stakeholder Analysis presented in sub-chapter 1.6 show, there is a major conflict of interest between EVA and MARA who are living and working on the streets, on the one hand, and the Criminal Police for Minors and departments for children, on the other. This conflict arises because the latter are legally obliged to protect children from harm and "rescue" them from street life. That is, they are to remove them from the street (if necessary by force) and either return them to their families, or – where this is not possible – place them in childcare. State policy supports this so-called "child rescue" approach. The children's interests, however, are often not consistent with that approach. Many have lost trust in adults in general and governmental services in particular and prefer to remain on the street and in their street groups, which often become "substitute families" for them.[187] Removing them forcibly from the street results frequently in adolescents running away from child-care institutions. The Baseline Study showed, for example, that a lot of the adolescents living and working on the streets have previously stayed in shelters for minors. This finding underscores the lack of alternative child-care options for this particular population group, options that would better meet their needs and are acceptable to them.[188] In particular, young people who use substances and drugs are ending up on the streets again. This is due not only to the absence of adequate care options, but also to minors' low coverage with high-quality inpatient and outpatient psychosocial drug rehabilitation programmes. These latter are critical to HIV prevention and harm reduction, and are often a pre-condition for transferring a child to child-care facilities.

The role of social services and outreach workers in the above-mentioned conflict of interest is also a difficult one. Evidence-based prevention approaches for working with EVA and MARA clearly show that outreach, in combination with low threshold support and MARA-friendly health care services, is an effective way to help these adolescents reduce their risks, prevent harm and find a possible exit.[189] However, an outreach approach is inconsistent with the child-rescue approach mentioned above. This is because its focus is not on

[186] See Criminal Code of Ukraine, Article 156.

[187] See for instance: AIDS Foundation East-West and UNICEF, *Children and young people living or working on the streets: the missing face of the HIV epidemic in Ukraine,* Kyiv, 2006; and: Stephenson, S., "Street children in Moscow: using and creating social capital", The Editorial Board of The Sociological Review, Malden, MA, 2001.

[188] See also: AIDS Foundation East-West and UNICEF, *Children and young people living or working on the streets: the missing face of the HIV epidemic in Ukraine,* Kyiv, 2006; and: Gudbransson, M., "Children in institutions: prevention and alternative care. Final report", Working Group on Children at Risk, approved by the European Committee for Social Cohesion at its 12th meeting in Strasbourg, 17–19 May 2004.

[189] See for example: WHO, *Preventing HIV/AIDS in young people: a systematic review of the evidence from developing countries,* UNAIDS Inter-Agency Task Team on Young People, WHO Technical Report Series No. 938, Geneva, 2006; or: Homans, H., "Manual

removing the child immediately from his or her environment (although if a child wants to be removed or is in acute danger, the outreach approach can remove him.). It is rather on first establishing trust with the child and reducing harm as a basis for helping the child when he or she is ready to cooperate in finding a way to escape his or her lifestyle. This approach makes success more realistic.

All of these issues have yet to be adequately addressed in Ukraine or considered in the HIV prevention context.

j. The street environment

EVA and MARA boys and girls living and working on the streets face unique challenges. Living without proper homes violently affects their development, health and overall well-being, and places them in environments full of unpredictable risks and characterised by significant disadvantages.[190] Homeless girls are especially at risk of being sexually exploited, abused and/or trafficked, and therefore are one of the most-at-risk sub-populations on the street.[191] However, the Baseline Survey shows that a small but substantial number of homeless boys also start engaging in survival and transactional sex while living on the streets.[192] Consequently, these adolescent boys and girls are more likely to be involved in high-risk sexual activities.[193] Moreover, the Baseline Survey confirms the findings of other quantitative surveys in Ukraine[194] that the majority of EVA and MARA boys and girls living and working on the streets use solvents or substances and drugs, increasing their likelihood of becoming engaged in high-risk injecting practices.[195] The Baseline Survey also reveals a lower level of HIV/AIDS-related knowledge among this group than among other MARPs in Ukraine, and very low levels of protective behaviour (such as safer sex and safer injecting).

Studies in other countries suggest that these adolescents are six to 12 times more likely to become infected with HIV than any other group of adolescents. They are also more likely to contract an STI. They therefore require particular attention from a prevention response.[196]

k. Use of services and service quality and coverage

One of the most notable findings of the Secondary Analysis is that there is a big gap between what MARA know about services and means of protection (such as condoms and sterile needles/syringes) and their actual access to them. This means that it is critical to understand and address the access barriers that confront these young people. As has been pointed out, Ukraine lacks behaviour change interventions and corresponding strategies that cut across all the available prevention services, particularly when it comes to MARA. Giving members of this population group a basic package of outreach services is not enough to change their behaviour. It does not address the vulnerability factors that play a role in changing behaviour, factors such as social pressures, motivations, lack of skills or gender roles.

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on Programming to Prevent HIV in Most-at-risk Adolescents" (draft), UNICEF Regional Office for Central and Eastern Europe and the Commonwealth of Independent States, Geneva, November 2007.

[190] See: AIDS Foundation East-West and UNICEF, *Children and young people living or working on the streets: the missing face of the HIV epidemic in Ukraine,* Kyiv, 2006; and: Panter-Brick, C., "Street children, human rights and public health: A critique and future directions", *Annual Review of Anthropology*, 31, 147–171, 2002.

[191] Research abroad shows similar findings, see for instance: Ensign, J., Panke, A.., "Barriers and bridges to care: Voices of homeless female adolescent youth in Seattle, Washington, USA", *Issues and Innovations in Nursing Practice,* 25, 166–172, 2002.

[192] Again, similar findings abroad, see for example: Rew, L., et al., "Planning a sexual health promotion intervention with homeless adolescents", *Nursing Research,* 51(3), 168–174, 2002.

[193] See for instance: Johnson, T. P., et al., "Self-reported risk factors for AIDS among homeless youth", *AIDS Education and Prevention,* 8, 308–322, 1996.

[194] AIDS Foundation East-West and UNICEF, *Children and young people living or working on the streets: the missing face of the HIV epidemic in Ukraine,* Kyiv, 2006.

[195] For similar results from other countries, see for instance: Dematteo, B. A., et al., "Toronto street youth and HIV/AIDS: Prevalence, demographics, and risk", *Society for Adolescent Medicine,* 25, 358–366, and: Walters, A.S., "HIV prevention in street youth", *Journal of Adolescent Health,* 25, 187–198, 1999.

[196] Rotheram-Borus, Song, J., et al., "Reductions in HIV risk among runaway youth", *Prevention Science*, 4(3), 173–187, 2003; and: Shields, S. A., et al., "Prevalence and correlates of chlamydia infection in Canadian street youth", *Society of Adolescent Medicine*, 34, 384–390, 2004.

Prevention coverage is particularly low for IDU boys and girls, as the Secondary Analysis shows. There are, furthermore, marked differences with regard to age, sex, population group and risk behaviour. The likelihood of having been reached with prevention interventions increases, for example, with age (31 per cent of the adolescent IDUs said they had been covered with outreach services versus 47 per cent of the adult IDUs).

The Secondary Analysis also demonstrates that harm reduction services (such as needle exchange, outreach and peer-driven interventions) reached fewer IDU girls than boys. Yet fewer IDU boys than girls reported having been tested for STIs. Adolescent FSWs had the highest testing rate for STIs (almost 70 per cent), which may be due to higher STI risk awareness among this population group than among other groups. Less than one third of MSM and IDUs had been tested for STIs. Perhaps following logically from the above, more adolescent FSWs (66 per cent) reported having obtained free condoms from outreach workers or needle-exchange points in the last 12 months, versus 47 per cent of adolescent IDUs. It is noteworthy that over 50 per cent of adolescent MSM had obtained condoms in the last 12 months. However, prevention interventions had reached fewer than a third of them, suggesting that adolescent MSM may be purchasing most of their condoms by themselves.

Additionally, the Secondary Analysis reveals that peer-driven interventions are much less likely to reach adolescent FSWs and MSM than they are to reach adolescent IDUs. The main reason for this may be that such interventions for FSWs and MSM are relatively new to Ukraine.[197]

While almost all the respondents from the three MARA populations explained that they know where to go to get tested for HIV, less than one third had actually been tested for it and knew their result. The percentage was especially low among adolescent IDUs, of whom only 14 per cent had been tested and knew their results. In focus groups, adolescent FSWs said that the main reason their group was disinclined to take HIV tests was that the testing sites are inconveniently located. Young people also cited lack of knowledge about where to get tested, lack of testing sites in their communities and fears of disclosure as reasons.

The Baseline Survey demonstrates that hardly any EVA and MARA who live and work on the streets have taken HIV tests and know their results (only 12 per cent). The data indicate that their use of services and their service coverage is in general extremely low.

These findings highlight the need to rapidly develop and scale up prevention and harm reduction services and behaviour change interventions for EVA and MARA boys and girls. Differences in sex, age, population group, risk behaviour and social status must be kept in mind when these things are being done.

There is insufficient research data to allow drawing firm conclusions about the scope and quality of the services that EVA and MARA boys and girls receive. There is some evidence, however, that there are issues with regard to both that deserve attention. These issues, such as the above-mentioned lack of gender- and age-sensitive services and overall low coverage, relate to more than just HIV/STI prevention and harm reduction services. They also relate to the services that child-care and penitentiary facilities provide. They must be viewed in light of evidence of rights violations (see the previous sub-chapter about child protection and the State child-care system for more details), the number of adolescents who were previously institutionalised and are now back on the streets and the number of those who are still technically institutionalised but who spend most of their time on the streets.

l. Service access barriers

The Baseline Survey and the Secondary Analysis point out the various service access barriers that EVA and MARA boys and girls face, such as harassment by the police (Baseline Survey) and low service use and coverage (both surveys). They indicate that some of the sub-populations have a low perception of risk (Secondary Analysis) and have suffered negative experiences during institutionalisation (Baseline Survey), and that these are reasons why EVA and MARA avoid services. Another reason why EVA and MARA are not using services is that facilities that could provide them with alternative prevention entry points, such as pharmacies and sexual and reproductive health care services, are underused. But as the results of the Desk Research (see sub-chapter 1.5) and the Policy and Legislation Review (sub-chapter 1.2) indicate, many more access

[197] UNAIDS, "Comprehensive External Evaluation of the National AIDS Response in Ukraine: Consolidated Report (zero draft)", Kyiv, June 2008.

barriers than these exist in Ukraine, including some unrelated to service providers (such as criminalisation of drug and syringe possession, even near harm reduction service sites[198]). These require sound strategies if they are to be overcome. If they are not overcome, they will continue to hamper the prevention response, even if services are rapidly scaled up.

m. Regional differences

As this report stressed earlier, national BSS samples for MARPs have been so small up to now that it has been impossible to conduct regional analysis of the data. The Baseline Study ensured that the samples from each research site were large enough that analysis by city was possible. However, the age distribution is not consistent within each city, so the findings need to be considered with caution.

The LSHTM's analysis of the Baseline Study data found that respondents in Mykolaiv were more likely to have unprotected sex with every type of sex partner (regular, casual and commercial) than were respondents from the other three research sites. On the other hand, adolescents living and working on the streets in Kyiv, and in some instances Donetsk, reported the highest condom use.[199] Whether this is due to higher prevention service coverage in Kyiv and Donetsk or is simply an artefact of the study or due to chance, could not be established. The question demands deeper investigation.

The UNICEF MARA Research team's analysis demonstrated that in Dnipropetrovsk (28 per cent) and Donetsk (24 per cent) substantially more adolescents still live at home even while spending most of their time on the street. The corresponding numbers for Kyiv (13 per cent) and Mykolaiv (15 per cent) were smaller. In Kyiv more adolescents (29 per cent) reported living in temporary dwellings that were unfit for living (such as abandoned buildings) than they did in Dnipropetrovsk (16 per cent). The analysis also showed that a considerably larger number of adolescent girls in Mykolaiv (35 per cent) and Kyiv (23 per cent) are engaged in transactional sex than in Dnipropetrovsk (13 per cent) and Donetsk (10 per cent). But again, additional research is needed to verify these differences by city and to identify the reasons behind them. That research will be useful in developing prevention interventions that address each city and region's specific needs.

4.4. Behaviour determinants and vulnerability factors

As the Desk Research reveals especially, many factors determine the behaviour and vulnerability of EVA and MARA girls and boys. Since this report's previous sub-chapter discussed most of the individual risks that EVA and MARA face, this chapter will focus on the medical, biological, political, cultural, legislative, socioeconomic and environmental vulnerability factors that the Secondary Analysis and the Baseline Survey revealed. It will also examine what they mean for planning and programming a prevention response at the national and subnational levels.

Medical and biological vulnerability factors

The Secondary Analysis could not ascertain how biologically susceptible MARA populations are to STI infections, because the BSSs among MARPs assessed only STI testing coverage. They did not ask whether or not the respondent ever had an STI. The Baseline Survey did ask this question, however[200]. It substantiates what other assessments stress: Ukraine remains a country with high child STI levels. This indicates that this population group fails to follow safer sex practices to the extent necessary.[201]

[198] Human Rights Watch, *Rhetoric and Risk: Human Rights Abuses Impeding Ukraine's Fight against HIV/AIDS,* 2006, see at: http://hrw.org/reports/2006/ukraine0306/2.htm.

[199] SHTM, "Investigating HIV risk behaviours amongst most-at-risk adolescents in Ukraine", submitted in partial fulfilment for the award of Master of Science, Demography & Health, University of London, by Clea Meynell, September 2008, unpublished.

[200] Almost a third of the girls and 15 per cent of the boys living and working on the streets reported having had symptoms of STIs.

[201] Ministry of Health of Ukraine, *National Report on the Follow-up to the UNGASS Declaration of Commitment on HIV/AIDS, Reporting Period: January 2003–December 2005*, Report prepared by the Ministry of Health of Ukraine in collaboration with the National Coordination Council on HIV/AIDS and with technical assistance from the International HIV/AIDS Alliance in Ukraine and the Joint United Nations Programme on HIV/AIDS (UNAIDS) in Ukraine, Kyiv, 2006; AIDS Foundation East-West

Socioeconomic, environmental, political, cultural and legislative vulnerabilities

Earlier chapters of this report already mentioned most of the socioeconomic, environmental, political, cultural and legislative vulnerability factors that the research revealed. These factors include pressures resulting from gender inequalities, particularly for adolescent females (see sub-chapter 1.1); the service access barriers that existing policy and legislation create (sub-chapter 1.2); the lack of a targeted prevention strategy at all levels plus the HIV/AIDS M&E system's weaknesses (sub-chapter 1.3); and the policies governing institutionalisation of children and the child protection system (sub-chapters 1.1 and 4.3). Other important vulnerability factors are:

- The absence of adequate housing policies and alternative housing and child-care options for MARA boys and girls, such as halfway homes[202] or specialised foster families.
- The inaccessibility of substitution maintenance therapy for minors.
- The decentralised financing system for State social services, which puts them too often at the mercy of local political considerations; and the vertical structures of the health care and other support systems, which necessitate exquisite cooperation and networking from service providers from all sectors, not to mention referral systems that work (both the financing system and the support system structures are in their infancies in Ukraine[203]).

One of the most visible vulnerability factors is EVA and MARA boys and girls' limited access to and coverage with good prevention and support services, as the Secondary Analysis and Baseline Research indicate (see sub-chapter 4.3). Peer pressure also plays an important role in the initiation of risk behaviour, particularly among IDU communities and on the streets. The studies this report presents have also identified vulnerability factors such as widespread sexual exploitation and police harassment and physical abuse. These factors create an unprotective and unsupportive environment for EVA and MARA, placing them in situations in which they cannot protect themselves from harm or negotiate safer sex. Data from other research projects and assessments conducted within the last two years among Ukraine's MARPs and EVA substantiate these claims.[204]

> The research has shown that EVA and MARA boys and girls live in an unprotective and unsupportive environment in Ukraine, placing them in many situations in which they are unable to protect themselves from significant harm and to negotiate safer sex.

The Secondary Analysis could not determine the extent to which MARA boys and girls are exposed to forced sex. It should be noted, though, that a small percentage of MARA boys and girls said that they had not used condoms because they had been forced to have sex (2 per cent of adolescent IDUs, 1 per cent of adolescent FSWs and another 1 per cent of adolescent MSM). The Baseline Study, on the other hand, did assess forced sex as a vulnerability factor and indicates that 23 per cent of the respondents who are sexually active reported having experienced forced sex at some point in their lives. Asked if they had suffered sexual violence in the last 12 months, 15 per cent responded that they had.

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and UNICEF, *Children and young people living or working on the streets: the missing face of the HIV epidemic in Ukraine,* Kyiv, 2006; and: Homans, H., "Manual on Programming to Prevent HIV in Most-at-risk Adolescents" (draft), UNICEF Regional Office for Central and Eastern Europe and the Commonwealth of Independent States, Geneva, November 2007.

[202] "Halfway homes" are safe houses for people with various kinds of problems or psychological distress. Some may be leaving penitentiary facilities; others may have been trafficked or have experienced domestic violence; yet others may be recovering from substance abuse. These homes offer a structured living and support programme, helping the individual to re-integrate into society. Some offer medium-term care and accommodation (for a year or more), while others provide long-term care and housing, especially to EVA and MARA boys and girls who are deprived of parental care and for whom adoption or fostering is not an option. For more information, see http://en.wikipedia.org/wiki/Halfway_house or http://www.friendofbills.com/halfway-houses.htm.

[203] See also: UNAIDS, "Comprehensive External Evaluation of the National AIDS Response in Ukraine: Consolidated Report (zero draft), Kyiv, June 2008.

[204] For instance: Human Rights Watch, *Rhetoric and Risk: Human Rights Abuses Impeding Ukraine's Fight against HIV/AIDS,* 2006, see at: http://hrw.org/reports/2006/ukraine0306/2.htm; or: OSI and Central and Eastern European Harm Reduction Network, *Sex Work, HIV/AIDS, and Human Rights*, Central and Eastern European Harm Reduction Network, Lithuania, 2005.

As this report stressed above, the Baseline Survey shows that sexual and physical violence also occurs in the various institutions in which the adolescents in question reported staying at some point in their lives. The findings suggest that penitentiary facilities present acute problems in this regard (three adolescents aged 18 to 19 out of 24 in total who had been incarcerated said they had experienced sexual violence). So might specialised shelters for homeless people, in which every adolescent who entered reported sexual violence (36 adolescents in total: 32 boys and four girls). Then there are pre-trial detention centres and remand centres. Every tenth adolescent who spent time in one of these said he or she had experienced sexual violence. Shelters for minors are also scenes of sexual violence, and a majority of the surveyed adolescents reported having stayed in one at some point.

The adolescents cited the following facilities as particularly prone to physical violence: penitentiary facilities, in which 60 per cent of the adolescents aged 18 to 19 years who had stayed in them had experienced violence; remand centres, in which 65 per cent had; regional police departments, in which 64 per cent had; and specialised shelters for homeless people, in which 55 per cent had. The adolescents also mentioned shelters for minors. Sixteen per cent of them reported suffering physical violence at the hands of the shelters' staffers.

4.5. Recommendations

In light of the research findings, and considering the overall strategic framework for action that the new National HIV/AIDS Concept and National HIV/AIDS Programme 2009–2013 provide, the project team recommends doing the following to improve the prevention response to EVA and MARA boys and girls at the national and subnational levels:

I. Reduce legislative and normative barriers to service delivery and access and to sustaining safer behaviours

As the research demonstrates, many barriers prevent the delivery of adequate prevention interventions for EVA and MARA boys and girls. Other barriers block these young people's access to these services and their ability to practise safer behaviours in a sustainable way. In sum, they represent serious vulnerability factors for the population groups in question, as sub-chapters 1.1 and 1.2 of this report describe. While Ukrainian policy and legislation have created some of these barriers, others are a function of poor management and of the absence of governmental leadership and political stability. Ukrainian policy and law frequently change, for example, meaning that professionals working with these population groups lack up-to-date information and guidelines. Often they are unsure about how to handle such issues as, for example, giving minors condoms. The result can be that some services are simply not delivered.

The following recommendations are meant to address those barriers that require the most urgent attention:

a. Strengthen political leadership in HIV prevention among EVA and MARA boys and girls and improve the management of the response at all levels.[205]

b. Overcome legislative and normative barriers.

The following recommendations, most of which are directed at policy and decision makers, are consistent with the recently-published final policy and legislation review report[206]. Developing and enforcing them will require partnerships with civil society organizations and the affected population groups:

- Make EVA and MARA priorities when policies, legislation and national and subnational programmes relating to children and youth are being conceived. These should reflect the young people's specific vulnerabilities, risks and needs, including their gender-specific needs. Implementing them may require

[205] The comprehensive external evaluation of the national AIDS response carried out in 2007-08 has sufficiently addressed the lack of political leadership and poor management that have characterised Ukraine's national AIDS response. That document also contains specific proposals to improve the situation. See UNAIDS, "Comprehensive External Evaluation of the National AIDS Response in Ukraine: Consolidated Report (zero draft), Kyiv, June 2008.

[206] UNICEF and UISR after Olexander Yaremenko, *The current situation concerning policy and legislation on medical and social services for children and adolescents most at risk of HIV infection,* analytical report, Kyiv, 2008.

that policy and decision makers and service providers undergo sensitivity training, in particular those who work directly with EVA and MARA[207]. There should be regular updates concerning amendments to legislation and an information campaign for service providers, many of whom might not know important things – for example, that the condom distribution and needle exchange services that NGOs provide to adolescents are actually legal.

- Adopt the international age category "adolescents aged 10 to 19" as a legal age category in Ukraine. Doing so will create a legislative and normative basis for national and subnational monitoring and for reporting about the response to adolescents in the country.
- Develop and enforce normative and legislative acts that support the development, implementation and monitoring of strategic action plans for EVA and MARA boys and girls at all levels (see Recommendation III for more information about strategic planning).
- Abolish the contradiction between Part 4 of Article 7 of the AIDS Law and the Civil Code in Ukraine concerning medical examinations (including HIV testing) for 14- to 18-year-old children without the mandatory consent and presence of a legal representative. According to Part 3 of Article 284 of the Civil Code, which the policy and legislation review says takes precedence over the AIDS Law, anyone older than 14 can receive medical assistance based on his or her informed consent alone.
- Develop and enforce legal and regulatory acts that regulate diagnostic and other health care services (including abortions) for orphans and children without parental care under 14. These services should include follow-up procedures, support and care for children who test HIV positive, in particular EVA and MARA. Furthermore, uncared-for children must have access to drug treatment and rehabilitation programmes and facilities and to SMT and antiretroviral therapy. Other countries' approaches in these areas deserve review. These prevention and treatment approaches are evidence-based and crucial to reducing harm and preventing HIV infection among MARA.
- Abolish mandatory HIV testing of children in shelters for minors. The MoFYS and the MoH approved such testing as of 28 September 2006 (№ 3297/645) and the Ministry of Justice of Ukraine registered it on 23 October 2006 (№ 1136/13010). It should be replaced by voluntary HIV testing and counselling that is consistent with current legislation (Part 3 of Article 7 of the AIDS Law). This will require regulating follow-up care, as mentioned previously, as well as adequate follow-up services, which may not yet exist for MARA who inhabit shelters for minors. When an HIV-positive MARA boy or girl runs away from a shelter, the authorities should cooperate closely with outreach workers, because running away reduces the child's chances of getting treatment.
- In line with the above, align Part 2 of Article 8 of the AIDS Law with the above-mentioned MoFYS and the MoH Order concerning "provision of information to pedagogical staffs (including social workers) of social protection facilities about the results of HIV tests among children who live at shelters for minors". This will require a legal and regulatory act that establishes a mechanism for provision of information on HIV infection. That act must define responsible individuals, the grounds for the provision of such information, procedures for monitoring compliance with legislation concerning confidentiality and so on.
- Review and improve the monitoring and enforcement mechanisms that ensure compliance with Part 5 of Article 7 of the AIDS Law and the Order on "Voluntary counselling and testing of HIV infection" (ratified by the Ministry of Health on 19 August 2005, № 415, and registered by the Ministry of Justice on 22 November 2005, № 1404/11684). That part of the AIDS Law and the Order concern free-of-charge and confidential HIV testing for children.
- Enforce existing rights-based anti-discriminatory policies, such as zero tolerance policies, in all organizations, institutions and agencies that provide direct services to EVA and MARA. They should especially be enforced in the health care, education and legal sectors. Provide EVA and MARA a mechanism

[207] Based on: Costigan, A., "Know Your Epidemic in Gender Terms: Most-At-Risk Adolescents (MARA) and HIV/AIDS in Ukraine", draft report, unpublished, 2007.

through which they can report abuse and other rights violations confidentially and without redress. Fear of redress is one of the reasons young people do not report incidents.[208]

- Adopt and enforce ethical guidelines at the national level for research and for programming for EVA and MARA. They should be based on the draft guidelines that UNICEF has developed.[209] Doing this will require running a national information and education campaign among researchers and direct service providers. The first steps towards introducing such guidelines have already been taken within the framework of the UNICEF MARA Project. A meeting of the Board of the Sociological Association of Ukraine on 6 November 2008 addressed the ethical principles that govern performing sociological studies among children. The Association adopted these principles, which are based on the draft UNICEF ethical guidelines, in December 2008.

In implementing these recommendations, the following additional points should be considered[210]:

- Implementing them will ensure that Ukrainian policies and legislation are consistent with international legislation and frameworks, such as the *CRC* and the *Optional Protocols of the CRC.* Ukraine is a signatory to both these documents[211].
- It is possible to implement some of the recommendations in the form of carefully monitored and evaluated pilot projects before rolling them out nationally.

c. Reforming the State care system for orphans and children deprived of parental care

More is required than legislative reforms. The State care system for orphans and children deprived of parental care also requires reform if the national HIV response for EVA and MARA is to be successful in the long run. A report that UNICEF Ukraine prepared in June 2008[212] sets out such a reform's essential elements. The first was as follows:

(i.) [Efforts should be strengthened] towards reintegrating children, where possible, into their own families, as the majority of families in trouble are experiencing crisis temporarily. The aim is to prevent placement [of children] in institutions.

That will require a functioning system of support for families in crisis. Such a system should include a range of community-based services beyond what is currently available in Ukraine. For instance, there must be short-term child-care options, such as short-term foster or respite care, to which families can turn during crisis. But current Ukrainian policy and legislation fail to support these options, despite evidence from abroad that they work[213].

It will also require allocating and managing funds and services in a way that is based on what children and families need; an agency that coordinates and manages assessments and services and service contracts; and a sound M&E system.[214]

The June 2008 UNICEF Ukraine report also listed the following as an essential element:

(ii.) When it is not possible to return a child to his/her family, [he or she should be placed] in alternative family-based care.

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[208] AIDS Foundation East-West and UNICEF, *Children and young people living or working on the streets: the missing face of the HIV epidemic in Ukraine,* Kyiv, 2006.

[209] Homans, H., "Guidance: Ethical issues in conducting quantitative research with adolescents engaging in HIV risk behaviour" (draft), UNICEF CEE/CIS, July 2007.

[210] UNICEF and UISR after Olexander Yaremenko, *The current situation concerning policy and legislation on medical and social services for children and adolescents most at risk of HIV infection,* analytical report, Kyiv, 2008.

[211] See at http://www.unicef.org/crc/ or http://www.crin.org.

[212] Bilson, A. and Carter, R., "Strategy development for the reform of the state care system for children deprived of parental care living in state institutions", a report for UNICEF Ukraine, unpublished, June 2008.

[213] Ibid.

[214] Bilson, A. and Harwin, J., "Changing minds, policies and lives: improving protection of children in Eastern Europe and Central Asia. Gatekeeping services for vulnerable children and families: A concept paper", Florence: UNICEF International Child Development Centre, 2003. Downloaded September 2004 from: http://www.unicef-icdc.org/publications/pdf/gatekeeping.pdf.

Family-based care includes long-term foster care, which is being developed in Ukraine. Foster parents taking in EVA or MARA boys and girls will require special training. An alternative method is to establish halfway homes and similar facilities that provide medium- to long-term care to MARA boys and girls who cannot be placed with foster families.

Again, successful work in this area will mean offering a range of alternative family-based care options. This will also require legislative changes, especially if civil society organizations are to provide these options.

Both of the elements that the UNICEF Ukraine report suggested mean steering resources away from institutional care and into community-based preventive and family-based services, based on the "money follows the child" principle[215]. They also mean establishing and enforcing standards of care.[216] Evidence from other post-Soviet countries demonstrates that it is possible to develop the sort of community-based prevention services that prevent institutional placement rather quickly.[217]

II. Formalize and strengthen multisectoral coordination

The "Sub-group on HIV prevention, treatment, care and support for at-risk children" was created under the auspices of the Interdepartmental Committee on Childhood Protection of the Cabinet of Ministers in May 2008. This sub-group could conceivably act as a national coordination mechanism for stakeholders in addressing the needs of EVA and MARA. It could strengthen cooperation between stakeholders and serve as a forum for the exchange of experience. As of now, however, the sub-group's membership structure has not been approved, and the sub-group has not met.

The Ukrainian Government should take the lead in coordinating the response to EVA and MARA and make the "Sub-group on HIV prevention, treatment, care and support for at-risk children" operational. Doing so will ensure that proper planning, programming, monitoring and evaluation characterise the response.[218]

At the subnational level, the local government should take the lead in coordination. It should ensure that the currently functioning Regional Advisory Boards on MARA are formalised (where this is still necessary) and continue to operate effectively.

At both levels, there must exist mechanisms to make sure that EVA and MARA representatives continue to take part in decision-making, planning, programming, monitoring and evaluation.

III. Develop, implement and manage strategic action plans

The established coordination mechanisms should be used as forums for developing, agreeing and overseeing the implementation and monitoring of multisectoral HIV/STI prevention strategic action plans for EVA and MARA at the national and subnational levels for the years 2009 to 2013. They must be based on the new national strategic HIV/AIDS frameworks.

[215] Note that a pilot project called "Money Follows the Child" took place in Kyiv oblast in 2006 and 2007 concerning the payment of state social benefits to orphans and children deprived of parental care. It was approved by the Cabinet of Ministers in 2006 (Decree No 106 of 6 February 2006 and Decree No. 81 of 31 January 2007).

[216] Bilson, A. and Carter, R., "Strategy development for the reform of the state care system for children deprived of parental care living in state institutions", a report for UNICEF Ukraine, unpublished, June 2008.

[217] Bilson, A. and Markova, G., "But you should see their families: Preventing child abandonment and promoting social inclusion in countries in transition", *Social Work and Social Science Review,* Volume 12, Number 3, 2007, pp. 57–78; and: EveryChild Consortium (2007), "Development of integrated social services for exposed families and children: Final Report", 29 March 2007– 28 September 2007.

[218] Note that this recommendation has also been included in the Resolution of the Fourth National Conference on "Changing the national system of monitoring and evaluation of measures to fight the HIV/AIDS epidemic in Ukraine", which took place from 24–27 September 2008 in Yalta, Ukraine, and the results of which were published by the MoH, UNAIDS and the International HIV/AIDS Alliance.

Planning and coordination groups will need to agree, develop, implement and monitor:

- Essential packages of prevention services for the various EVA and MARA sub-populations[219] as well as corresponding evidence-based service models[220].

  Later sections of this report will propose what an essential package should look like and a prevention intervention framework.

- National service standards, which set a quality and evaluation framework for service providers from all relevant sectors, independent of ownership.

- A human resource capacity-building plan. Building capacity may require a review of the pay and benefit systems that service providers working with EVA and MARA use. Such a review will ensure that providers recruit and retain high-quality staff. As a cost-effective measure, a pool of national trainers should be created and staffers at pre- and in-service education and training facilities should undergo training programmes, which should be institutionalised.

  Later sections of this report will highlight key areas in which human resource capacity must be built.

- A resource allocation and mobilisation plan. Earmarked funding must grow to ensure that evidence-based prevention services for EVA and MARA can be scaled up to the point where they affect the HIV epidemic. A plan should not only aim at obtaining donor funding and increasing the proportion of sub-national funding – it should also (and especially) increase the proportion of State funding earmarked for prevention programmes among EVA and MARA. This would ensure that local governments get from the State the support they need to address the situation and reduce the risk that the programmes will not receive the necessary funding.

  The financial resource plan for implementing the new National HIV/AIDS Programme 2009–2013 foresees small allocations of funds for training social services employees in how to work with risk groups and for running sensitisation programmes for various professional groups . (The latter are general anti-stigma and -discrimination programmes that do not address discrimination aimed at any one specific most-at-risk population group.) But the plan does not include a budget for the few evidence-based interventions that have been planned for EVA and MARA, such as outreach work on the streets. This is true even though some money has been set aside to make sure that an essential package of prevention services is implemented. This package, however, is not described in the new Programme, and in light of the huge gaps in services it will require more funding than what is currently envisaged.

A substantial increase in State funding is required. It should be earmarked for prevention programmes among EVA and MARA boys and girls and ensure that local governments receive the support they need to address the urgency of the situation and to reduce the risk that planned activities will not receive the funding they require to have an impact on the HIV epidemic and to reach the agreed national prevention coverage targets.

- An advocacy plan. The multisectoral coordination mechanisms for EVA and MARA that exist at the national and subnational levels can serve as a platform for coordinating, aligning and monitoring advocacy interventions. Good advocacy requires good data and other evidence, which means that it has to be linked to M&E systems. It also calls for a vocal constituency for HIV prevention among civil society organizations, which, in cooperation, with the media, must play a "watchdog" role. This may require advocacy training for civil society and media workers.

- A behaviour change intervention strategy that targets EVA and MARA and that cuts across all targeted HIV prevention projects, programmes and services. Such a strategy will require:

[219] See for instance: Homans, H., "Manual on Programming to Prevent HIV in Most-at-risk Adolescents" (draft), UNICEF Regional Office for Central and Eastern Europe and the Commonwealth of Independent States, Geneva, November 2007.

[220] See for example: Ibid., AIDS Foundation East-West and UNICEF, *Children and young people living or working on the streets: the missing face of the HIV epidemic in Ukraine,* Kyiv, 2006; WHO, *Preventing HIV/AIDS in young people: a systematic review of the evidence from developing countries,* UNAIDS Inter-Agency Task Team on Young People, WHO Technical Report Series No. 938, Geneva, 2006.

1. A well-coordinated national and/or subnational system for developing and disseminating informational and education material (such as material about prevention or that promotes HIV/STI testing and counselling). This system needs to use a common, multisectoral approach. It will work with, and build the capacity of, the mass media, and initiate community dialogues about adolescent health, development, sexuality and vulnerability and risk factors.

   Research shows that informational materials must take into account that EVA and MARA boys and girls, especially those living and working on the streets, are in general not highly educated. Members of the target populations should participate in creating these materials.

2. A similarly well-coordinated national and/or subnational system for the procurement, supply, dissemination and promotion of HIV prevention items (such as condoms). Such items should be free and easy to get in places where EVA and MARA congregate. They should also be available in more direct service facilities than is now the case.

3. A comprehensive approach to HIV/STI prevention, meaning a combination of intervention methods and models targeting EVA, MARA and their sexual and social networks. This approach will involve peer-based information and education work and integrate opinion leaders. Skills-building interventions (for example, about how to use condoms and negotiate condom use) and counselling (individual as well as for small groups and couples) will also play a role. They must be sensitive to age, gender and social status differences, as well as to peculiarities inherent in different population groups and settings. They should target places where risk behaviour occurs (that is, they should take an outreach approach). Furthermore, they must work in tandem with targeted interventions for reducing stigmatisation of and discrimination against EVA and MARA. Behaviour change interventions should promote consistent condom use with all types of sex partners (regular, casual, commercial) and pay particular attention to adolescent MARA who are at increased risk of HIV infection (such as adolescent IDUs, MSM-IDUs and FSWs who sell anal sex).

- An M&E and research plan that measures progress and makes sure results are being achieved. It will need to address the weaknesses of the current national and subnational M&E systems, and it must close gaps in research.

  What follow are specific recommendations on strengthening M&E systems in the context of work among EVA and MARA, and on building the evidence base for these populations:

Strengthen the M&E systems for EVA and MARA at the national and subnational levels by:

- Systematically disaggregating behavioural, biological and social data on HIV/AIDS and related issues (such as HIV vulnerability factors) by age. Also, revise the age breakdown used in national, sectoral and subnational monitoring and reporting systems so that the group of adolescents is adequately understood and there exists a basis for analysing differences among different age groups.[221] The following age breakdown is proposed: 10–14 years, 15–19 years and 20–24 years. It is noteworthy that the Resolution of the Fourth National M&E made the same recommendation.[222] A new guidance document on subnational M&E systems and HIV/AIDS indicators that Constella Futures will soon publish will contain this recommendation as well.
- Calculating and agreeing national and subnational population size estimates for adolescent IDUs, FSWs and MSM, and for adolescents who are living and working on the streets. These estimates will serve as denominators in calculating programme coverage and projecting the likely course of the HIV epidemic among these population groups. The estimates are also needed to estimate resource and capacity needs and as a basis for strategic planning and programming.[223] The Resolution

[221] WHO, *National AIDS Programmes. A guide to indicators for monitoring and evaluating national HIV/AIDS prevention programmes for young people,* Geneva, 2004.

[222] The Conference took place from 24–27 September 2008 in Yalta, Ukraine, and the Resolution was published by the MoH, UNAIDS and the International HIV/AIDS Alliance.

[223] UNAIDS, *A Framework for Monitoring and Evaluating HIV Prevention Programmes among Most-at-risk Populations,* Geneva, 2007.

also makes this recommendation.[224] The International HIV/AIDS Alliance, within the frame of the GFATM Project with respect to MARPs and MARA, is implementing it, as sub-chapter 1.3 of this report mentioned.

- Agreeing a national set of indicators on EVA and MARA. They should be based on the MARA core indicator list that the UNICEF MARA Project developed (see Annex 2). Also, develop a standardised set of subnational indicators that will allow cross-regional analysis. Core indicators for EVA and MARA should be fully integrated into the national, sectoral and subnational M&E systems and indicator lists in Ukraine. The MoFYS has already integrated selected MARA indicators into its new sectoral management information system (DevInfo[225]). The core EVA and MARA indicators also need to be reported in national, sectoral and subnational HIV/AIDS reports. At the national level, this will require that the reporting framework on HIV/AIDS in Ukraine, which is currently set by UNGASS, is slightly changed.
- Standardising data collection among service providers working with EVA and MARA and agreeing a minimum set of data to be collected from service providers, independent of ownership. That minimum set should include data on age, sex, social status (a composite variable taking into account orphan and marital status, mobility, education level, employment status and living arrangements), risk behaviour, whether a person is a new/repeat client/patient, diagnoses, services and commodities provided and referrals to other services.[226] This will require standardised data collection instruments (including client feedback mechanisms). These instruments should be integrated, wherever possible, into existing organizational M&E systems (such as SYREX; see sub-chapter 1.3). This will also necessitate coordinating data flows from different sectors and creating a single common data base as part of an overall HIV/AIDS database. In some oblasts, M&E centres responsible for coordinating data flows and establishing a single HIV/AIDS database have already been created. This has been done with the support of a project that Constella Futures manages and that the United States Agency for International Development (USAID) funds.
- Ensuring that biological and behavioural HIV surveillance studies in Ukraine include sufficiently large samples (with the minimum sample being 300[227]) for adolescents (10 to 19 years old)[228] so that biological and behavioural trends can be monitored over time. This relates to existing surveillance studies among MARPs, STI patients, prisoners and the uniformed services, as well as to surveillance studies that might be conducted in the future on populations that are especially vulnerable to or at risk of HIV infection – for instance, among "bridge populations" or migrants.
- Ensuring that biological and behavioural HIV surveillance studies in Ukraine include sufficiently large regional samples (the minimum sample for adolescents aged 10 to 19 should be 300–400, depending on sampling methods and other factors) to enable a meaningful statistical analysis by region or city. As the results of a regional analysis of Baseline Study data show, some significant regional differences exist. It was not possible, however, to establish whether these findings were credible, an artefact of the Baseline Study or due to chance.
- Integrating behavioural surveillance on adolescents living and working on the streets into the national surveillance system on HIV/AIDS and conducting follow-up studies to the Baseline Study every three to five years. The Resolution also recommended this.[229]

[224] Ministry of Health of Ukraine, UNAIDS and International HIV/AIDS Alliance in Ukraine, Resolution of the Fourth National Conference on "Changing the national system of monitoring and evaluation of measures to fight the HIV/AIDS epidemic in Ukraine", Yalta, 24–27 September 2008.

[225] For more information on the DevInfo project, contact the MoFYS. For more information on the DevInfo software, see at www.devinfo.org.

[226] Homans, H., "Manual on Programming to Prevent HIV in Most-at-risk Adolescents" (draft), UNICEF Regional Office for Central and Eastern Europe and the Commonwealth of Independent States, Geneva, November 2007.

[227] Balakireva, O.M., et al., *Methodological recommendations on conducting research for monitoring the HIV epidemic in Ukraine,* International HIV/AIDS Alliance in Ukraine, Kyiv, 2008.

[228] Ibid.; and: Des Jarlais, D.C., et al., "HIV surveillance among injecting drug users", *AIDS* 2001, 15 (suppl 3): S13-S22.

[229] Ministry of Health of Ukraine, UNAIDS and International HIV/AIDS Alliance in Ukraine, Resolution of the Fourth National Conference on "Changing the national system of monitoring and evaluation of measures to fight the HIV/AIDS epidemic in

- Assuring that (bio-) behavioural surveillance study instruments assess the consistency of protective behaviour (condom use) for all MARA and focus on risk and protective behaviour in the last month, and not only on such behaviour the last time it occurred. This will help to produce a more realistic picture of the situation and reduce the existing social bias against questions about risk behaviour during last incidence of sex. In addition, (bio-) behavioural surveillance studies among adolescent MSM should explore sexual relations with females, as this is critical for programming. It is also suggested that the composite variable of "social status" be added to the variables used in (bio)-behavioural surveillance, so that the influence of sociodemographic characteristics and vulnerabilities can better be understood.
- Assessing and building M&E capacity concerning EVA and MARA boys and girls at all levels. This may require technical assistance. Training should focus on calculating population size estimates and indicators; on data analysis, interpretation and presentation; on creating and managing subnational M&E systems as a key element of strategic HIV/AIDS management; and on the use of standardised data collection systems.

Continue to develop the evidence base on EVA and MARA boys and girls as a basis for planning and programming by:

Developing research plans for EVA and MARA at the national and subnational levels. They should pay particular attention to behavioural surveillance, to the M&E of service provision, to the allocation and dispersal of funds and to operational research needs.

Closing research gaps in:

1. Intervention research that evaluates just how effective innovative prevention interventions and corresponding service models for EVA and MARA are.
2. Operational research on the stigma, discrimination, violence and rights abuses[230] that EVA and MARA face.
3. Qualitative and explorative research, particularly on:

- MARA who report MSM behaviour. More needs to be known about who they are, their sexual orientations, what influences their behaviour, their social and sexual networks and so on. Research has shown that MARA who report MSM behaviour do not necessarily identify themselves as homosexual, but rather have sex with other males as a transactional matter. This means that they do not belong to any homosexual scene that prevention interventions could target.[231]
- Risk and protective factors and behaviour among adolescents staying or living in shelters for minors, in psychosocial rehabilitation centres, in detention and distribution centres, in boarding or other special schools and in penitentiary facilities. There is little data available in Ukraine on these settings. But anecdotal evidence that governmental and non-governmental service providers and international surveys have provided suggests that adolescents face serious vulnerabilities in these settings and are at increased risk of HIV infection, particularly in penitentiary facilities[232].
- Risk factors that could lead to injecting drug use among adolescents living and working on the streets. Research into these factors would aid in developing anti-needle use interventions.[233]

Ukraine", Yalta, 24–27 September 2008.

[230] UNAIDS, *Assessing Gender Equality and Equity as Critical Elements in National Responses to HIV: Cambodia, Honduras and Ukraine, presentation of policy guidance to address gender issues,* 20th Meeting of the UNAIDS Programme Coordinating Board, Geneva, 25–27 June 2007.

[231] Ibid.

[232] See for instance: Homans, H., "Manual on Programming to Prevent HIV in Most-at-risk Adolescents" (draft), UNICEF Regional Office for Central and Eastern Europe and the Commonwealth of Independent States, Geneva, November 2007.

[233] LSHTM, "Investigating HIV risk behaviours amongst most-at-risk adolescents in Ukraine", submitted in partial fulfilment for the award of Master of Science, Demography & Health, University of London, by Clea Meynell, September 2008, unpublished.

- Overlapping risk behaviours among MARA boys and girls. This is critical towards deciding where interventions should be targeted.[234]
- Adolescents selling or engaged in transactional sex and their relationships with casual partners, particularly in terms of the way they use condoms. It would be helpful to understand who instigates condom use, and for what reasons. Research in this area may improve condom promotion and behaviour change interventions for EVA and MARA. It may even help in developing peer-based interventions among adolescents selling or engaged in transactional sex and other young people who are not.[235]

Once the research results are available, quantitative research should follow, thus ensuring a sound evidence base.[236]

Research capacity among EVA and MARA boys and girls should be assessed and built at the national and subnational levels.

Besides the new National HIV/AIDS Concept and National HIV/AIDS Programme for 2009–2013, the national strategic action plan for EVA and MARA will also need to take into account other national and international strategic frameworks, in particular:

1. The *Special Session of the UN General Assembly on Children "A World Fit for Children"*. [237]
2. The *CRC* and the *Optional Protocols of the CRC*, to both of which Ukraine is a signatory.[238]
3. The General Comment No.3 on *"HIV/AIDS and the Rights of the Child"*[239] of the CRC Committee.

IV. Agree a national prevention intervention framework for EVA and MARA boys and girls

The following proposed prevention intervention framework for EVA and MARA in Ukraine (Fig. 4.5.1) was developed for this report based on an intervention framework for MARA that the LSHTM proposed in 2007:

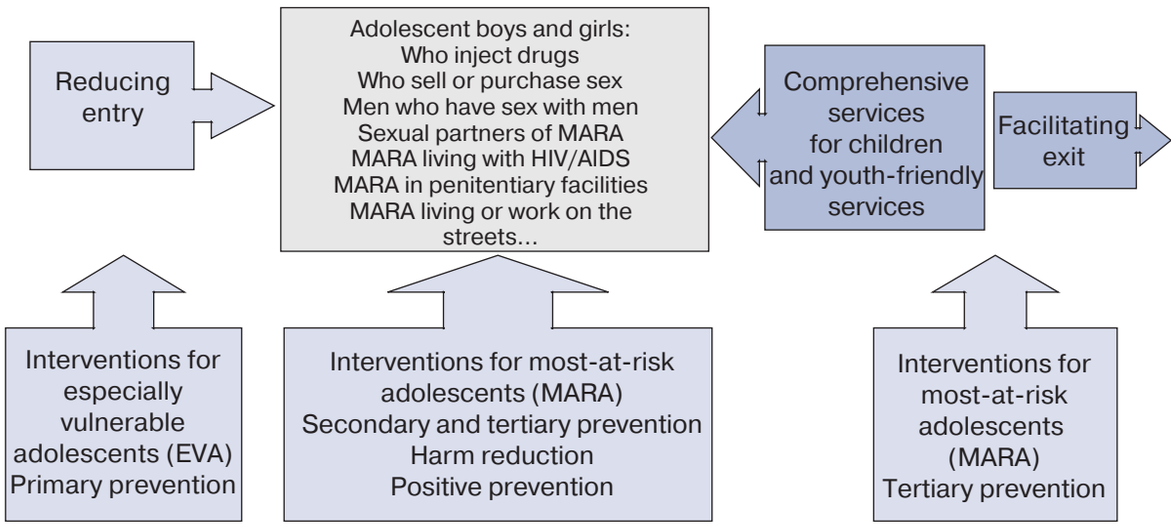

Fig. 4.5.1

[234] Ibid.

[235] Ibid.

[236] Ibid.

[237] State Institute for Family and Youth Development and Ministry of Family, Youth and Sports of Ukraine, "National Report on implementation of the decisions of the final outcome document of the Special Session of the UN General Assembly on Children (2002) and Action Plan "A World Fit for Children", Kyiv, 2007.

[238] See at http://www.unicef.org/crc/ or http://www.crin.org

[239] See at http://www.unhchr.ch/html/menu2/6/crc/doc/comment/hiv.pdf

The framework sets out a continuum of prevention services (from left to right) reflecting the different vulnerability and risk levels of EVA and MARA, as well as different intervention levels. It is noteworthy that this framework is similar to the general service approach of the CSSFCY in Ukraine.

a. Primary prevention

The continuum of prevention services starts on the left side of the graphic, with primary prevention interventions. Such interventions at this stage aim at reducing the number of adolescents starting to engage in ("enter") HIV risk behaviour. These are usually EVA boys and girls living in risky environments, such as on the street. They are one step away from initiating risk behaviour. Many of them are friends with MARA and use alcohol, inhalants or other substances and drugs, but do not yet inject. As the Baseline Survey demonstrates, non-injecting drug use is a major risk factor for starting to inject drugs, and the use of inhalants appears to be an important risk factor for unprotected sex.[240] It is therefore critical to use the window of opportunity still open at this stage to prevent initiation of risk behaviour, and to break the cycle[241] .

The research shows that non-injecting drug use is a major risk factor for progressing to injecting of drugs, and the use of inhalants appears to be an important risk factor for unprotected sex. It is therefore critical to use the window of opportunity that is still open for preventing the initiation of risk behaviour among EVA boys and girls.

Primary prevention interventions attempt to prevent harm before it happens. They focus mainly on psychosocial HIV prevention approaches. These include increasing HIV/AIDS-related knowledge; enhancing young people's perceptions of the HIV infection risk they face; building confidence and the skills required to cope with stress and psychological distress and protect a person from infection; and motivating adolescents to reduce their exposures to risk.

b. Secondary, tertiary and positive prevention

Once a boy or girl has started to engage in risk behaviour and has become most at risk of HIV infection (a MARA), is already infected with HIV, or is at increased risk of infection because of his/her sexual relations with a MARA boy or girl (depicted by the middle box), primary prevention approaches no longer suffice. Secondary and tertiary prevention measures are now required (see the middle column of the graphic).

Secondary prevention approaches focus on early detection, assessment and intervention. They target risk behaviour and risky situations. This is particularly crucial in light of the research findings that show that the younger the adolescent, the greater is his/her vulnerability to HIV infection. This is because he or she has less knowledge, a lower skill level, less access to services and so on.

Tertiary prevention, on the other hand, makes sure that a condition that is already bad does not get worse. It seeks to facilitate an "exit" from risk behaviour, if possible (see the right column of the graphic).

Secondary and tertiary approaches[242] focus first and foremost on promoting protective behaviours (condom use, reduction of sex partners and/or of risky injecting practices, promoting service-seeking behaviour) and on encouraging VCT and STI diagnostics and treatment. Once an EVA or MARA boy or girl is ready to stop risky behaviour, such as injecting drug use or selling sex, tertiary interventions try to help them exit. Tertiary HIV-related interventions include, for example, substitution maintenance therapy for MARA IDUs; halfway home programmes for MARA without parental care who are being released from detention centres or penitentiary facilities; psychosocial drug rehabilitation and re-socialization programmes; or livelihood

[240] LSHTM, "Investigating HIV risk behaviours amongst most-at-risk adolescents in Ukraine", submitted in partial fulfilment for the award of Master of Science, Demography & Health, University of London, by Clea Meynell, September 2008, unpublished.

[241] For more information, see at www.youthwg.org; or: Gray, R. (2007), "Curbing HIV in Drug-Driven Epidemics Worldwide", presentation by Rob Gray, Regional Representative, Population Services International (PSI) in Asia on 6 December 2007.

[242] Gudbransson, M., "Children in institutions: prevention and alternative care. Final report", Working Group on Children at Risk, approved by the European Committee for Social Cohesion at its 12th meeting in Strasbourg, 17–19 May 2004.

interventions that offer young people alternatives to the ways they are currently making their livings – by selling sex, for instance.[243]

Rehabilitation programmes for adolescents who use alcohol, solvents and drugs are of particular importance. The research shows that the majority of EVA and MARA use such things. This means that these programmes can be good places at which young people can exit as well as important entry points for HIV prevention. They should be linked up to psychosocial rehabilitation programmes in shelters, community centres and other support and care facilities. In Ukraine, a major scale-up of modern, free-of-charge psychosocial drug rehabilitation programmes for adolescents is urgently required to meet the existing needs.[244]

A major scale-up of modern, free-of-charge psychosocial drug rehabilitation programmes for adolescents is urgently required to meet existing needs.

The formal education and the business sector can also play an important role in secondary and tertiary prevention by helping EVA and MARA to re-integrate into the formal education sector or to find jobs.[245] This may require establishing new partnerships between the governmental, non-governmental and private sectors, as chapter 4.2.3.4 of this report stressed.

Positive prevention, a term rarely used in Ukraine, means providing prevention interventions and tools (condoms, sterile syringes, etc.) to HIV-positive adolescents so that they do not infect their current partners. The External Evaluation[246] shows that it remains largely underdeveloped in Ukraine .

It is critical to prioritise prevention interventions and empowerment programmes for adolescents who are living with HIV.

c. Providing comprehensive services

All these interventions require supportive environments if they are to be successfully completed. Vulnerability factors must be reduced. For example, those involved must improve youth access to a comprehensive set of support services (in the middle right box) that address the basic needs (hygiene, safety, food) and specific needs (health care and social and legal help) that EVA and MARA have. Qualitative research[247] among these population groups demonstrates that they do not value health highly and that their health-seeking behaviour is low. However, they consider meeting their basic needs to be important.

Evidence shows that delivering a comprehensive set of services requires one of two things. First, existing services must be MARA-friendly and a functioning referral system must exist to bridge Ukraine's highly specialised and vertical systems. Second, the services must be provided in one place, working through low threshold and drop-in centres to which outreach teams are attached. Doing this would minimise the need for referrals.[248] Both approaches are in their infancy in Ukraine and urgently require scaling-up .

Evidence shows that the delivery of a comprehensive set of services requires either that existing services be MARA-friendly and a functioning referral system exist, bridging the highly specialised and vertical systems in Ukraine, or that the services be provided in one place to minimise the need for referrals.

[243] Ibid.

[244] Burlaki, B.B., "Prevention of drug use among young people", methodological manual, Kyiv, 2008.

[245] See for instance: Barker, G., et al., *Review and Analysis of International Experience with Programs Targeted on At-Risk Youth,* The World Bank Group, LASHC Paper Series No. 5, Washington D.C., 1996; and: Harrell, A., *Evaluating Programs for Vulnerable Children and Youth,* The World Bank Group, LASHC Paper Series No. 3, Washington D.C., 1996.

[246] UNAIDS, "Comprehensive External Evaluation of the National AIDS Response in Ukraine: Consolidated Report (zero draft)", Kyiv, June 2008.

[247] See for instance: AIDS Foundation East-West and UNICEF, *Children and young people living or working on the streets: the missing face of the HIV epidemic in Ukraine,* Kyiv, 2006.

[248] Ibid.; and: Homans, H., "Manual on Programming to Prevent HIV in Most-at-risk Adolescents" (draft), UNICEF Regional Office for Central and Eastern Europe and the Commonwealth of Independent States, Geneva, November 2007.

Creating an enabling environment will require other initiatives that the proposed intervention framework does not include. They would be geared towards reducing stigma and discrimination[249], building social capital[250] and reforming legislation. Most of these are long-term initiatives, though, and require that all social sectors make major efforts. Tackling them should not mean ignoring the current needs of EVA and MARA.[251] However, anti-stigmatisation and -discrimination campaigns are critical to creating an environment conducive to targeted interventions for EVA and MARA. This report will address such issues separately (see Recommendation V).

The framework we propose here presupposes that an effective prevention approach needs to focus primarily on those adolescents who are most at risk of HIV infection, on those who are especially vulnerable to it and on those who already live with it. If these population groups are not reached and covered, HIV will continue to spread rapidly and could jump to the general population. Adolescents who live and work on the streets, who live in institutions and who practise overlapping risk behaviour (such as MSM-IDUs and their sex partners) therefore deserve special attention. The research this report describes has identified all of them as at increased risk of HIV infection.

A prevention approach for adolescents that will have an impact on the HIV epidemic in Ukraine needs to focus its efforts, capacities and resources foremost on those adolescent boys and girls who are most at risk of HIV infection, as well as on those who are especially vulnerable to HIV and who are already living with the virus. If these population groups are not reached and adequately covered with prevention and harm reduction services, HIV will continue to spread rapidly, and could jump to the general population.

V. Address and reduce stigma, discrimination and criminalisation of EVA and MARA boys and girls

As sub-chapter 4.3 showed, EVA and MARA suffer much from stigma, discrimination and rights violations. Professionals and direct service providers are often to blame here. This problem requires a comprehensive anti-stigma, -discrimination and -criminalisation campaign at all levels. In addition, the legal system requires reform, not least so that an effective juvenile justice system exists. The Government should expend its resources on keeping young people from committing offences in the first place. It should also strengthen community-based non-residential programmes that help children who are at risk of becoming offenders, as well as children who have been diverted from the justice system.

The new National HIV/AIDS Concept and National HIV/AIDS Programme 2009–2013 prioritise reducing stigma and discrimination and fomenting tolerance towards people living with HIV or an AIDS-related diseases. They also prioritise building tolerance towards such population groups as MARA. Interventions (such as primarily sensitisation training) should, the above documents suggest, target people who work in the health care sector and in the labour and social protection services. In addition, the new Programme stresses developing legal and advisory services for citizens, employers and trade union organizations to make sure that a system for reporting and monitoring discrimination exists. But after that, its recommendations stop. Furthermore the new Programme establishes no budget with which to pay for the initiatives it prescribes, beyond a small budget for "forming tolerant attitudes towards people living with HIV or an AIDS-related disease". This calls into question the Ukrainian Government's seriousness in tackling these discrimination issues – issues that constitute grave rights violations. Addressing these problems is critical to ensuring that interventions for EVA and MARA take place in a supportive, enabling environment.

[249] Homans, H., "Manual on Programming to Prevent HIV in Most-at-risk Adolescents" (draft), UNICEF Regional Office for Central and Eastern Europe and the Commonwealth of Independent States, Geneva, November 2007.

[250] "Social capital" in this context refers to the development and strengthening of local communities and social networks. According to Putnam (see: Putnam, R. D., *Bowling Alone. The collapse and revival of American community,* New York, 2000): "Child development is powerfully shaped by social capital. Trust, networks, and norms of reciprocity within a child's family, school, peer group, and larger community have far-reaching effects on their opportunities and choices, educational achievement, and hence on their behaviour and development," displayed on: Smith, M. K. (2007) 'Social capital', The encyclopaedia of informal education, www.infed.org/biblio/social_capital.htm, Last update: 01 October 2008.

[251] Busza, J., "Intervention design. Moving from data to implementation", presentation given at a data analysis workshop in Kyiv, March 10–13, 2007, London School of Hygiene and Tropical Medicine, (2008).

We therefore recommended the following:

Prioritise the development and implementation of a comprehensive campaign aimed at reducing stigma and discrimination against, as well as criminalisation of, EVA and MARA. Do this in partnership with the affected communities and civil society. Key elements of such a campaign would include:

(a) Sustained evidence-informed advocacy and social mobilisation involving Ukraine's religious, cultural and political leaders.

(b) Mainstreaming targeted HIV prevention into direct service providers' programmes.

(c) Empowerment programmes that target the most affected communities and population groups.

(d) Redressing violations of the law and of EVA and MARA boys and girls' human rights.[252]

Review the juvenile arrest, detention, public defence and probation system in order to:

- Strengthen enforcement of anti-discriminatory and zero tolerance policies. Also, increase funding to the Public Defender Offices to ensure that the system protects child victims of violence, especially police violence, and punishes persecutors. The system must also ensure that EVA and MARA accused of offences receive proper legal defence and that the Public Defender Offices and other legal support services do their jobs in identifying, monitoring and reporting abuse of EVA and MARA.[253]
- Make detention centres and police departments more youth-friendly. The "green room" projects can expand to offer HIV prevention services, thus widening the range of services that the Criminal Police for Minors provide.
- Mainstream HIV prevention work into probation services. This will require strengthening the latter.

We recommend incorporating HIV prevention, children's rights, juvenile justice and other issues related to EVA and MARA into the curricula of the relevant professional education and training institutions. This will help make these efforts sustainable.

VI. Adapt prevention, treatment, care and support services to the needs of EVA and MARA boys and girls

As the evidence presented in this report stresses, HIV prevention and harm reduction, as well as PMTCT, VCT and STI services, are rarely adapted to the specific needs of MARA boys and girls in Ukraine. The same holds true for general health care services, as well as for many of the social, legal, vocational and other services that Ukrainian young people receive. Even the country's youth-friendly clinics are not EVA- and MARA-friendly. Making them so will require a comprehensive training and sensitisation programme as part of the strategic capacity-building plan mentioned in Recommendation II.

Research suggests focusing on:

1) Training direct service providers to provide adequate services to EVA and MARA. Especially important are services pertaining to adolescent health, development and sexuality, counselling services and communications initiatives. Other services that require especial attention are those that touch on legal, ethical and child protection issues and on HIV, STIs and risk behaviours. Evidence-based prevention approaches for working with especially vulnerable families and EVA and MARA are also crucial.[254]

2) Strengthening social service and NGO capacity to help EVA and MARA who are still living with their families or with other primary caregivers (such as grandparents). This requires a client-centred and client management approach. Community-based psychosocial counselling services and day-care centres

[252] Homans, H., "Manual on Programming to Prevent HIV in Most-at-risk Adolescents" (draft), UNICEF Regional Office for Central and Eastern Europe and the Commonwealth of Independent States, Geneva, November 2007.

[253] O'Donnel, D., et al., Juvenile Justice Assessment: Ukraine (revised draft), draft report based on an assessment mission conducted from 11 to 23 May 2008 in Ukraine (Kyiv, Kharkiv), unpublished, 2008.

[254] Homans, H., Questions for the development of a National Action Plan on MARA, group work material developed for a strategic planning workshop on MARA in Moldova from 12–13 September 2007, unpublished, 2007.

for EVA and MARA and their caregivers can complement these efforts, as can a wider range of short-term child-care services (see also Recommendation I).

3) Building the capacities of the child protection services (such as departments for children, the Criminal Police for Minors and the neighbourhood police) to intervene as early as possible in cases of abuse and domestic violence or other serious crises in a family. These services must become sensitive to HIV-related vulnerabilities and risks and to available HIV prevention and support services. They must also participate in community-based prevention referral networks and programmes.

Developing MARA-friendly services will, furthermore, require the following: that direct service providers' facilities be subject to quality standards; intervention materials (such as waiting room posters, informational flyers and provider pocket guides); making HIV prevention an essential component of client/patient service; and a functioning referral system for needs that require more extensive counselling or other services.[255] All MARA-friendly services will need to have outreach capabilities. The latter can be integral to the services, or else the services can work in cooperation with an outreach provider. The latter model could be useful, because EVA and MARA are reluctant to seek out services on their own.

Overcoming barriers to service provision for migrating adolescents deserves special attention. These adolescents may be best served by low threshold centres that provide a comprehensive set of services that do not require documentation at the service access point, but that rather provide help in obtaining documentation.

The following principles are proposed for EVA- and MARA-friendly services[256]:

- They must be socially inclusive with regard to differences in age, sex, population group, risk behaviour and social status.
- They must be non-discriminatory.
- They must be equal in terms of offering access to free-of-charge services and prevention commodities and methods for EVA and MARA.
- They must be needs-based and participatory.
- Service provision must be based on the informed consent of the adolescent.
- Service must be integrated with other services and sectors, ensuring continuity of care and adequate referrals.
- Services must reduce risk factors and harm, particularly in cases of overlapping risk behaviour, and they must increase the protective factor.
- Services must reach out to EVA and MARA and motivate service-seeking behaviour.
- Service providers must have been trained in EVA- and MARA-friendly approaches, in adolescent health and development and in counselling and communication in accordance with, for example, the World Health Organization's (WHO) "Orientation programme on adolescent health"[257].
- There must be quality assurance, which requires observing national norms and standards, obtaining client feedback and providing evidence-based services.
- Services must be sustainable.

[255] See at www.effectiveinterventions.org

[256] Slightly revised from a list set out in: Homans, H., "Manual on Programming to Prevent HIV in Most-at-risk Adolescents" (draft), UNICEF Regional Office for Central and Eastern Europe and the Commonwealth of Independent States, Geneva, November 2007.

[257] WHO et al., *Orientation programme on adolescent health for health-care providers,* Core and Optional Modules, Geneva, 2006, see at: www.who.int/child_adolescent_health/documents/9241591269/en/. Note that a module for MARA is in development.

VII. Implement an essential evidence-based package of prevention services for EVA and MARA boys and girls

In 2007 UNICEF developed an essential prevention intervention package for MARA boys and girls[258]. It was based on the essential WHO package for HIV prevention, treatment, care and support interventions in concentrated and generalised HIV epidemics[259]. It included:

1. Information, education, skills-building and counselling work, as parts of a comprehensive behaviour change intervention strategy.
2. Promoting condoms for males and females.
3. Harm reduction services.
4. Outreach services.
5. Referral to HIV and other treatment, care and support services.
6. Voluntary counselling and testing for HIV, including "positive" prevention.
7. Early diagnosis and treatment of STIs.

This model is similar to the basic package that the *Road Map* for adolescents and at-risk children aged 10 to 18"[260] years proposed. However, it also incorporates STI services and counselling on a wider range of issues than simply legal ones. For example, it also offers services pertaining to and information about the risks of trafficking and exploitation. In addition, it promotes a behaviour change intervention approach.[261]

Prior to the implementation of an essential package of prevention services in a given locality, providers must do certain things. They must estimate the size of the target population, map out where EVA and MARA congregate and review response capacities and the target populations' specific needs, risks and vulnerabilities. As these differ, they must also examine why they differ, taking into account age, social status, differences between population groups and in risk behaviour, gender norms and assumptions, power relations, the extent to which EVA and MARA have access to prevention services and what barriers to access exist. These assessments will help planners identify priority population groups in their oblasts, cities or rayons. That is, they will help them decide who is at increased risk of HIV infection and to programme accordingly .

> Prior to implementing an essential package of prevention services in a given locality, the size of the target population will need to be estimated; places where EVA and MARA boys and girls congregate will have to be mapped; and response capacities and the specific needs, risks and vulnerabilities of EVA and MARA in the locality will have to be reviewed. This data will help planners to prioritise and programme accordingly.

Given the low HIV/STI prevention service coverage for EVA and MARA in Ukraine, prevention services must scale-up rapidly, particularly in the most affected localities .

> Given the huge gaps in and low coverage with HIV/STI prevention services in Ukraine for EVA and MARA boys and girls, major efforts will have to be undertaken to scale-up prevention services rapidly, particularly in localities most affected by the HIV epidemic.

[258] Slightly revised from: Homans, H., "Manual on Programming to Prevent HIV in Most-at-risk Adolescents" (draft), UNICEF Regional Office for Central and Eastern Europe and the Commonwealth of Independent States, Geneva, November 2007.

[259] WHO, *Towards Universal Access by 2010: How WHO is working with countries to scale-up HIV prevention, treatment*, care and support, HIV/AIDS Programme, Geneva, 2006.

[260] The Road Map proposed a minimum package of prevention services, including: information, education on HIV/AIDS in primary and secondary schools, counselling on legal issues, harm reduction programmes (taking into account the specific features of underage children) and means to prevent sexual and non-sexual HIV transmission and VCT. See: UNAIDS, et al., *Road Map on Scaling-up Towards Universal Access to HIV/AIDS Prevention, Treatment, Care and Support in Ukraine by 2010.* Report prepared by a Multi-Stakeholder Working Group on Universal Access, based on the results of three national consultations, with technical assistance from the Joint United Nations Programme on HIV/AIDS (UNAIDS), Kyiv, 2006.

[261] Homans, H., "Manual on Programming to Prevent HIV in Most-at-risk Adolescents" (draft), UNICEF Regional Office for Central and Eastern Europe and the Commonwealth of Independent States, Geneva, November 2007.

In addition, all available entry points for HIV/STI prevention for EVA and MARA should be used. This requires continuing to mainstream prevention programmes into child-care institutions, detention centres and juvenile penitentiary facilities, especially into pre-release programmes. Also, non-traditional entry points for HIV/STI prevention, such as pharmacies, should be used, as recent pilot schemes implemented within the frame of the USAID-funded SUNRISE project in Ukraine suggest.[262] The Baseline Survey has shown that pharmacies play an important role in the provision of prevention commodities and means.

Prevention services for EVA and MARA must be evidence-based. As Ukraine has to date seen little research on HIV interventions for EVA and MARA, we recommend reviewing evidence from other, and especially neighbouring, countries[263] before programming begins.

VIII. Sustain the prevention response

Continuing to build the CSSFCY capacity is one way of sustaining the response.

However, CSSFCY capacities are limited and the population groups in question tend to distrust governmental services. NGOs usually provide outreach and other low threshold and comprehensive services. In light of this, we recommend the following:

Develop mechanisms and supportive legislation to strengthen and regulate cooperation between the governmental and non-governmental sectors. An example of this sort of mechanism would be an NGO contracting mechanism for local government that would select and register services that civil society provides[264]. Funding for civil society organizations' evidence-based services must continue. These organizations currently rely heavily on international donor funding, which threatens their sustainability.

More flexibility is needed to broaden the spectrum of the social services that civil society organizations can provide and the range of mechanisms with which they provide them.[265]

The new National HIV/AIDS Concept and National HIV/AIDS Programme 2009-2013 foresee creating mechanisms that would let NGOs to provide social services to people living with HIV or AIDS-related diseases and to groups at risk of HIV infection. These services have yet to be defined, and the new Programme envisages no budget for them. It is unclear if one of these mechanisms will be financial, helping fund civil society organizations' work.

[262] Contact the Kyiv offices of PATH or the International HIV/AIDS Alliance in Ukraine for more information.

[263] See for example: WHO, *Preventing HIV/AIDS in young people: a systematic review of the evidence from developing countries,* UNAIDS Inter-Agency Task Team on Young People, WHO Technical Report Series No. 938, Geneva, 2006; Homans, H., "Manual on Programming to Prevent HIV in Most-at-risk Adolescents" (draft), UNICEF Regional Office for Central and Eastern Europe and the Commonwealth of Independent States, Geneva, November 2007; AIDS Foundation East-West and UNICEF, *Children and young people living or working on the streets: the missing face of the HIV epidemic in Ukraine,* Kyiv, 2006; Kissing, D.M., et al., "HIV seroprevalence in street youth in St. Petersburg, Russia", in: *AIDS 2007*, Vol 21 No 17, pp. 2333–2340; Stephenson S., "Street children in Moscow: using and creating social capital", The Editorial Board of The Sociological Review, Malden, MA, 2001; or the following website: www.crin.org.

[264] Bilson, A. and Carter, R., "Strategy development for the reform of the state care system for children deprived of parental care living in state institutions", report for UNICEF Ukraine, June 2008.

[265] Ibid.

5. FURTHER USE OF THE RESULTS OF THE RESEARCH

Research is only justified if its results are widely disseminated and used for a specific purpose. The UNICEF MARA Project's main purpose was to collect data on EVA and MARA, in order to strengthen the evidence base about them and deepen understanding of their behaviours and behaviour determinants and how they use services. The project was to serve as a foundation for planning, programming and monitoring Ukraine's HIV prevention response for these population groups. This project achieved its goal. A comprehensive evidence base on EVA and MARA in Ukraine now exists. It includes baseline data that provide additional information about their vulnerabilities and HIV infection risk. The findings have spread widely in Ukraine and generated much discussion, mainly during national and subnational multisectoral stakeholder meetings, but also during international conferences. The project developed a list of core indicators, some of which, as mentioned above, have already been integrated into the MoFYS' sectoral M&E system on children (DevInfo data base). This has strengthened national monitoring. Core indicators for MARA were also presented to the National HIV/AIDS M&E Working Group in August 2008. Because MARA are so important to the HIV epidemic, these indicators may find inclusion in the national list of HIV/AIDS indicators. This report's results and the core indicators were, additionally, presented at the 4th National HIV/AIDS M&E Conference in September 2008. The conference's Resolution mirrors in certain respects some of this report's key recommendations.

Most critically, UNICEF is supporting the development of strategic action plans for HIV/STI prevention for EVA and MARA at the national and subnational levels, in cooperation with Project partners. It is thus following up on one of this report's key recommendations. The strategic planning process will generate the strategic framework for operational planning at the service-provider level, building capacity, mobilising resources and implementing innovative, evidence-based service models. The State social services play a critical role in this MoFYS-supported work. This process will hopefully catalyse Government efforts to meet the prevention needs of one of its most vulnerable and at-risk population groups, one that the HIV/AIDS response has to date largely ignored. The Government will also hopefully use what limited resources exist to fund effective prevention models. This work is even more urgent in light of the unprecedented 2008 global economic and financial crisis, which has hit countries in transition, such as Ukraine, particularly hard. The crisis will exacerbate the pressure on adolescents, young families and young job-seekers, as well as on the country's health care and social systems.

ANNEX 1:

PLANNED AND ACTUAL REPRESENTATION OF THE REGIONAL ADVISORY BOARDS

Kyiv – Regional Advisory Board

№	Name of organization	Planned participation	Actual participation
1	Kyiv city youth-friendly clinic	+	
2	"Service for Children's Rescue" ICF	+	+
3	"Steps of Life" (Kroki Jittya) NGO	+	+
4	"Time to Live Plus" (Chas Jittya Plus) UCF	+	+
5	"Step by Step" (Krok za Krokom) NGO	+	+
6	Kyiv city Services for Children	+	+
7	Kyiv city Centre for Social Services for Families, Children and Youth	+	+
8	"Child's Hope" (Dityacha Nadiya) CF	+	+
9	"Light in Life" (Svitlo v Jitti) CO	+	+
10	Kyiv city Clinical Hospital №5	+	+
11	"Childhood Without AIDS" NGO	+	+

Donetsk – Regional Advisory Board

№	Name of organization	Planned participation	Actual participation
1.	Project "Bereginja" (Makeevka city)	+	+
2.	"Caritas-Donetsk" charity fund	+	+
3.	"MARTIN Club" youth NGO (Makeevka city)	+	+
4.	"Asol" centre for social rehabilitation of children with disabilities and orphans (Ugledar city)	+	+
5.	"Source of Revival" (Torez city) youth NGO	+	+
6.	"Asol" youth NGO for children with disabilities and orphans (Vugledar city)	+	+
7.	"Pilgrim" charity fund (Mariupol city)	+	
8.	Republic "Pilgrim" centre for children's rehabilitation (Mariupol city)	+	
9.	Drug rehabilitation centre for adults "Transformation" by Azov	+	
10.	"Give Bread to the Poor" Christian Charity Mission (Makeevka city)	+	
11.	Department of Education and Science of the Donetsk Oblast Administration	+	+
12.	Donetsk Oblast Health Centre	+	+
13.	"Mariupol City Youth Alliance" NGO	+	+
14.	Centre for Social Services for Families, Children and Youth (Drujkovka city)	+	+
15.	"New Day" (Noviy Den) NGO (Kramatorsk city)	+	+
16.	Donetsk Oblast Maternity and Childhood Centre	+	+
17.	"Youth's Health" (Zdorovya Molodi) NGO (Donetsk city)	+	+
18.	"Alliance of Enthusiasts" (Soyuz Zahoplennih) NGO for children (Donetsk city, Jasinovatskij district)	+	+
19.	Local representatives of the International HIV/AIDS Alliance in Ukraine	+	+

20.	Local representatives of the Health Policy Initiative project in Ukraine	+	+
21.	Services for Children of the Donetsk Oblast Administration	+	+
22.	Donetsk Oblast Criminal Police for Minors	+	+
23.	Department for Social Security of the Ministry of Interior – Donetsk Oblast Administration	+	+
24.	"Gorlitsa" NGO	+	+
25.	Social Council of the State Penitentiary Department of Ukraine in Donetsk Oblast	+	+
26.	Deputies of local councils of the cities of Drujkovka and Mariupol	+	+
27.	"Your Victory" (Tvoya Peremoga) centre for drug users (Donetsk oblast)	+	+
28.	"Your Victory" (Tvoya Peremoga) NGO (Donetsk city)	+	+
29.	"Status+" NGO (Donetsk oblast)	+	+
30.	"Church of Christ" religious NGO	+	+
31.	Regional office "Well-being of Children" (Blagopoluchiya Ditey) CF	+	+
32.	Donetsk city Centre for Social Services for Families, Children and Youth	+	+
33.	Donetsk Institution of Market and Social Policy	+	+
34.	Donetsk oblast society of the Red Cross	+	+
35.	Donetsk oblast Centre for Social Services for Families, Children and Youth	+	+
36.	Donetsk National University	+	+
37.	Donetsk Oblast Centre for AIDS Prevention	+	+
38.	"Alliance of Ukrainian Women" NGO (Donetsk city, Jasinovatskij district)	+	+
39.	Secondary school №67 (Donetsk city, Kuybishev district)	+	+
40.	Donetsk Oblast Centre for Psychosocial Support	+	+
41.	Department of Family and Youth of the Donetsk Oblast Administration	+	+
42.	Shahtar district Centre for Social Services for Families, Children and Youth	+	+
43.	"Health of the Nation" (Zdorovya Natsii) CF, Donetsk oblast	+	+
44.	Amvrosiy district Centre for Social Services for Families, Children and Youth	+	+
45.	Donetsk city Health Centre	+	+
46.	Donetsk city "Society of Assistance to People Living with HIV"	+	+
47.	"Foundation Youth of Donbass" NGO	+	+
48.	NGO "Women NGO of Starobishev district"	+	+
49.	Makeevka city Centre for Social Services for Families, Children and Youth	+	+
50.	"Goodwill Pastor" (Dobriy Pastor) CF	+	+
51.	"Word of Life" (Slovo Jittya) religious NGO	+	
52.	"Alliance of Young Ukrainian State Employees" NGO (Jdanovka city)	+	+
53.	Institution of Legal Expertise of Donetsk Oblast Central Clinical Hospital	+	+
54.	"Care" (Pikluvannya) CF of Donetsk Oblast Skin and Venerological Dispensary	+	+
55.	Slavyansk district Centre for Social Services for Families, Children and Youth	+	+

Dnipropetrovsk – Regional Advisory Board

№	Name of organization	Planned participation	Actual participation
1	Criminal Police of the Ministry of Interior of Ukraine in Dnipropetrovsk oblast	+	+
2	Dnipropetrovsk city drop-in centre for children and youth living with HIV	+	+
3	"Rock of Rescue" (Skala Spasinnya) church	-	-
4	Dnipropetrovsk city Psychosocial Rehabilitation Centre	+	+
5	Barvinok shelter for minors	+	+
6	Dnipropetrovsk oblast Centre for Social Services for Families, Children and Youth	+	+
7	Dnipropetrovsk Oblast Health Centre (governmental institution)	-	-
8	Services for Children of the Dnipropetrovsk Oblast Administration	+	+
9	"Dniper Humanitarian Initiatives" NGO	-	+
10	"Children of the Future" (Diti Maybutnjogo) CF	-	-
11	Dnipropetrovsk City Centre for AIDS Prevention	+	-
12	Dnipropetrovsk oblast department UCO Ukrainian Network of People Living with HIV	+	+
13	"Your Perspective" (Tvoya Perspectiva) NGO (Krivoy Rig city)	+	+
14	Department of Health in Dnipropetrovsk oblast	+	+
15	Dnipropetrovsk Oblast Narcological Dispensary	+	+
16	Dnipropetrovsk City Distribution Centre	+	+
17	DEF Group Informational Marketing Company	+	-
18	Dnipropetrovsk oblast society of the Red Cross	+	-
19	Methodological association of psychologists and social pedagogues of professional education in Dnipropetrovsk oblast	-	+
20	Local representative of the International HIV/AIDS Alliance in Ukraine	+	+
21	State Penitentiary Department of Ukraine in Dnipropetrovsk oblast	+	-
22	Dnipropetrovsk Oblast Skin and Venerological Dispensary	+	+
23	Institution of Post-graduate Professional Education, Chair of Culture and Health	+	-
24	"Help" NGO (Dnipropetrovsk city)	+	+
25	"Alex" NGO (Dnipropetrovsk city)	-	+
26	Dnipropetrovsk Oblast Methodological Centre of Professional Education	-	+

Mykolaiv – Regional Advisory Board

№	Name of organization	Planned participation	Actual participation
1	Mykolaiv oblast department UCO Ukrainian Network of People Living with HIV	+	
2	"Time to Live" (Chas Jittya) Association of People Living with HIV (Mykolaiv)	+	–
3	Centre for the Prevention and Treatment of People with AIDS (Mykolaiv oblast)	+	–
4	Centre for Social Services for Families, Children and Youth (Mykolaiv oblast)	+	+
5	Mykolaiv oblast Health Centre	+	+
6	"New Century" (Noviy Vek) CF (Mykolaiv oblast)	+	+
7	"Orkhideja" CF (Mykolaiv oblast)	+	_

8	“Penitentiary Initiative” social youth movement (Mykolaiv oblast)	+	+
9	Criminal Police for Minors of the Ministry of Interior of Ukraine in Mykolaiv oblast	+	–
10	Mykolaiv Oblast Narcological Dispensary	+	_
11	Mykolaiv local “Christian Mission Emmanuel” CF	+	_
12	Mykolaiv Secondary School for Social Rehabilitation	+	_
13	Mykolaiv local “Yunitus” CF	+	+
14	Mykolaiv city Centre for Social Services for Families, Children and Youth	+	+
15	Mykolaiv city shelter for minors	+	+
16	Mykolaiv Regional Resource Centre	+	+
17	Services for Children of the Mykolaiv Executive Committee	+	+
18	Department of Education and Science of Mykolaiv Oblast Administration	+	+

ANNEX 2:

CORE MARA INDICATORS FOR UKRAINE

УКРАЇНСЬКИЙ ІНСТИТУТ СОЦІАЛЬНИХ ДОСЛІДЖЕНЬ імені Олександра Яременка

unicef

UNICEF programme: "HIV prevention in most-at-risk adolescents (MARA) in Ukraine and South Eastern Europe"

Calculation of core MARA indicators based on:

1. A secondary analysis of data on MARA boys and girls (under the age of 20) from the 2007 behavioural surveillance studies among MARPs in Ukraine (IDUs, FSWs, MSM)
2. Baseline research among adolescent boys and girls aged 10 to 19 years who are living and working on the streets in Ukraine

Description of survey samples	Adolescents living and working on the streets		Most-at-risk adolescents			
			IDUs		FSWs	MSM
Total sample	805		4,143 IDUs, including 259 adolescent IDUs aged 13-19 years		1,602 FSWs, including 281 adolescent FSWs aged 13-19 years	1,764 MSM, including 212 adolescent MSM aged 15-19 years
Sex distribution	boys	70% (565)	boys	66% (170)		
	girls	30% (240)	girls	34% (89)		
Age distribution						
under 15 years	38		1		1	
15-17 years	44		34		33	28
18+ years	18		65		66	72

CORE MARA INDICATORS							
I. ADOLESCENTS LIVING AND WORKING ON THE STREETS							
Indicator		**Total**		**Boys**		**Girls**	
		%	**N**	**%**	**N**	**%**	**N**
BEHAVIOUR							
INJECTING DRUG USE							
% who report ever injecting drugs *Denominator: all survey respondents.*		15.5	805	16	565	14	240
% who report injecting drug use before age 15 / before age 18							
Denominator: number answering "yes" to the question "Have you ever injected a drug?" who also answered the question "How old were you when you first injected a drug?" excluding "don't know," "no answer" and "no response."	*before age 15*	45	125	41	92	56	33
	before age 18	98		98		97	
% who report sharing needles in the past month (receptive) *Denominator: number answering "yes" to the question "Have you ever injected a drug?" who also answered the questions "How many times during the last month did you inject using a needle/syringe that had been previously used by someone else?" and "In the last 30 days, how many times did you inject using a pre-filled syringe?" excluding "don't know," "no answer" and "no response."*		61	92	62	69	57	23
% who report the use of sterile injecting equipment the last time they injected *Denominator: number answering "yes" to the question "Have you ever injected a drug?" who also answered the questions "On the last occasion you injected, did you use a new, clean needle/syringe?" excluding "don't know," "no answer" and "no response."*		76	86	77	62	71	24
frequency of injecting drug use in the last month							
Denominator: number answering "yes" to the question "Have you ever injected a drug?" who also answered the question "In the last 30 days, how often did you inject?" excluding "don't know," "no answer" and "no response."	*every day*	11	56				
	2–6 times during a week	55					
	weekly or less	34					
number of sharing partners in the last month							
Denominator: number answering "yes" to the question "Have you ever injected a drug?" who also reported sharing partners and who answered the question "How many times during the last month did you inject using a needle/syringe that had been previously used by someone else?" excluding "don't know," "no answer" and "no response."	*1*	17	24				
	2	37					
	3–5	34					
	6–10	8					
	more than 10	4					

MSM BEHAVIOUR							
% who report having had anal intercourse with a male *Denominator: all those who answered this question.*				10	551		
% who report MSM behaviour before age 15 / before age 18							
Denominator: number of boys answering "yes" to the question "Have you ever had anal intercourse with a boy/men?" who also answered the question "How old were you when you had anal intercourse with a boy/men for the first time?"	*before age 15*			74	54		
	before age 18			96			
number of male sex partners in the last month / in the last year							
Denominator: number of boys answering "yes" to the question "Have you ever had anal intercourse with a boy/men?" who had male sex partners and who also answered the question "How many male sex partners have you had during the last month/year?" excluding "don't know," "no answer" and "no response."	*...last month*						
	1			52	27		
	2			37			
	more than 3			11			
	...last year						
	1			44	41		
	2			19			
	3-5			20			
	6-10			12			
	more than 10			5			
% MSM who report ever receiving money for sex from a male partner *Denominator: number of boys answering "yes" to the question "Have you ever had anal intercourse with a boy/men?" who also answered the question "How many men have given you money, drugs, food or clothes for sex in the last 12 months?" excluding "don't know," "no answer" and "no response."*				52	47		
% MSM who used a condom during last incidence of anal sex with a paying male partner *Denominator: number of boys reporting anal sex with a male paying partner who also answered the question "The last time you had sex with a commercial male partner, did you use a condom?" excluding "don't know," "no answer" and "no response."*				39	26		
% who used a condom during last incidence of anal sex with a non-paying male partner *Denominator: number of boys answering "yes" to the question "Have you ever had anal intercourse with a boy/men?" and who reported condom use during last incidence of anal sex with a non-paying partner.*				36	44		
% who report using condoms consistently with a male partner *Denominator: number of boys answering "yes" to the question "Have you ever had anal intercourse with a boy/men?" who also answered the question "In the last 12 months how often did you use condoms with your male partners (regular, casual, commercial)?" excluding "don't know," "no answer" and "no response."*				4	54		

SELLING SEX							
% who report ever receiving money/gifts/drugs for sex (vaginal/anal) *Denominator: all survey respondents.*		28	805	17	565	57	240
% who report selling sex before age 15/before age 18 (among girls)							
Denominator: number of girls answering "yes" to the question "Have you ever received money, goods, drugs or another reward in exchange for sex?" who also answered the question about the age of initiation of selling/transactional sex excluding "don't know," "no answer" and "no response."	*before age 15*					57	127
	before age 18					95	
number of commercial sex partners in the last year (among girls)							
Denominator: number of girls answering "yes" to the question "Have you ever received money, goods, drugs or another reward in exchange for sex?" who had commercial sex partners in the last year and who also answered the question "In the past year, how many commercial sex partners have you had?" excluding "don't know," "no answer" and "no response."	*1*					5	95
	2					23	
	3–5					18	
	6–10					16	
	more than 10					38	
% using condoms the last time they sold sex (among girls) *Denominator: number of girls answering "yes" to the question "Have you ever received money, goods, drugs or another reward in exchange for sex?" who had commercial sex partners in the last year and who also answered the question "The last time you had sex with a commercial partner, did you use a condom?" excluding "don't know," "no answer" and "no response."*						64	92
% who used condoms consistently with clients in the last year (among girls) *Denominator: number of girls answering "yes" to the question "Have you ever received money, goods, drugs or another reward in exchange for sex?" who had commercial sex partners in the last year and who also answered the question "In the last year, how often did you use condoms with commercial sex partners?" excluding "don't know," "no answer" and "no response."*						8	116
SEXUAL EXPERIENCE (for all survey respondents, regardless of other risk behaviours)							
% who report ever having had sex (vaginal/anal/oral) *Denominator: all respondents answering this question without "no response".*		74	796	70	558	82	238
% who report sex before age 15/before age 18							
Denominator: number answering "yes" to the question "Have you ever had (vaginal/anal/oral) sexual intercourse?" who also answered the question about the age at which they first had sexual intercourse, excluding "no response" and "don't know."	*before age 15*	76	574	76	386	76	188
	before age 18	99		99		99	

number of sex partners in the last year							
Denominator: number answering "yes" to the question " Have you ever had sex?" who had sex partners in the last year and who also answered the question "How many sex partners did you have during the last year?" excluding "don't know" and "no response."	*1*	20	525	20	364	21	161
	2	20		21		18	
	3–5	31		33		27	
	6–10	18		17		20	
	more than 10	11		9		14	
% who report a regular/casual/commercial partner in the last year							
Denominator: number answering "yes" to the question "Have you ever had sex?" who also answered the question "In the past 12 months, have you had sex with a regular/casual/commercial partner?"	*regular partner*	37	525	34	364	44	161
	casual partner	75		80		65	
	commercial partner	25		11		56	
% who used condoms during last incidence of sex							
Denominator: number reporting regular/casual/commercial sex partners in the last year and who also answered the question "The last time you had sex with a regular/casual/commercial partner, did you use a condom?" excluding "don't know," "no answer" and "no response."	*regular partner (only girls)*					43	74
	casual partner	47	342	46	247	50	95
	commercial partner	65	128	64	36	65	92
% using condoms consistently in the last year							
Denominator: number reporting regular/casual/commercial sex partners in the last year and who also answered the question "In the last year, how often did you use a condom with a regular/casual/commercial partner?" excluding "don't know," "no answer" and "no response."	regular partner (in the last month)	12	204	9	126	18	78
	casual partner	15	431	16	305	11	126
	commercial partner	10	155	15	39	8	116
OVERLAPPING RISKS							
% MARA reporting more than one MARA behaviour (IDU, sex work (SW), MSM)							
IDU+SW (among girls)						10	240
IDU+MSM (among boys)				3	565		
MSM+SW (among boys)				5			
IDU+MSM+SW (among boys)				1			
BEHAVIOURAL DETERMINANTS and VULNERABILITIES							
% with correct knowledge about HIV sexual transmission *Denominator: all those answering both the questions "Can you prevent HIV transmission by having sex with one faithful, uninfected partner?" and "Can the correct and consistent (regular) use of condoms reduce the risk of HIV transmission?"*		46	805	44	565	50	240

% with correct knowledge about HIV transmission through IDU *Denominator: all those answering the question "Can you reduce HIV transmission by using a clean, unused needle for injecting drugs?"*	61	805	61	565	61	240
% who can identify one formal source of condoms *Denominator: all respondents who answered the questions on condom supply.*	46	805	45	565	47	240
% of IDU who can identify places where sterile injecting equipment is available *Denominator: number answering "yes" to the question "Have you ever injected a drug?" who also answered the question on sterile injecting equipment supply.*	58	125	59	92	54,5	33
% who report forced sex *Denominator: all those answering the question "Have you ever been forced to have sex?" excluding "no response."*	23	743	11	538	52	205
% who report forced sex in the last year *Denominator: all those answering the question "Have you ever been forced to have sex in the last year?" excluding "no response."*	15	732	7	534	37	198
% who report harassment from the police *Denominator: all those answering this question.*	76	805	83	565	58	240
% who report having been detained or incarcerated *Denominator: all those answering the questions on detention/incarceration excluding "no response."*	50	805	58	565	31	240
% who report having been institutionalised in the child protection system *Denominator: all those answering the question "Have you been in a shelter for minors?" excluding "no response."*	57	805	63	565	44	240
COVERAGE						
% who can identify sites where VCT is available *Denominator: number answering the questions on VCT supply.*	51	805	49	565	56	240
% who have tested for HIV in the past 12 months and know their result *Denominator: all those answering both the question "Have you had an HIV test in the past 12 month and do you know your result?" excluding "no response."*	12	805	10	565	16	240

II. INJECTION DRUG USERS								
Indicator		**Total**		**Boys**		**Girls**		
		%	**N**	**%**	**N**	**%**	**N**
BEHAVIOUR								
INJECTING DRUG USE								
% who report ever injecting drugs *Denominator: all survey respondents. N =259 (170 boys and 89 girls).*		100	259	100	170	100	89
% who report injecting drug use before age 15/before age 18							
Denominator: all survey respondents. N = 259 (170 boys and 89 girls).	*before age 15*	15.5	259	21	170	4	89
	before age 18	86		86		83	
% who report sharing needles in the past month (receptive) *Denominator: number answering the question "How many times during the last month did you inject using a needle/syringe that had been previously used by someone else?" excluding "don't know," "no answer" and "no response."*		30	253	29	165	31	88
% IDU who report the use of sterile injecting equipment the last time they injected *Denominator: number answering the question "On the last occasion you injected, did you use a new (sterile) needle/syringe?" excluding "don't know," "no answer" and "no response."*		81	254	80	166	82	88
frequency of injecting drug use in the last month							
Denominator: number answering the question "In the last 30 days, how often did you inject?" excluding "don't know," "no answer" and "no response."	*every day*	33	253	33	165	30	88
	2–6 times during a week	33		34		32	
	weekly or less	34		33		38	
number of sharing partners in the last month							
Denominator: number answering "yes" to the question "On the last occasion you injected, did you share your needle/syringe?" and who also answered the question "How many sharing partners did you have in the last month?" excluding "don't know," "no answer" and "no response."	*1*	21	67				
	2	13					
	3–5	43					
	6–10	18					
	more than 10	5					
MSM BEHAVIOUR								
% who report having had anal intercourse with a male (BSS 2004) *Denominator: all male respondents who answered this question.*				2	308		

SELLING SEX							
% who report ever receiving money/gifts/drugs for sex (vaginal/anal) *Denominator: all those who answered this question. N = 195 (120 boys and 75 girls).*		12	195	3	120	25	75
% using condoms the last time they sold sex (among girls) *Denominator: number of girls answering "yes" to the question "Have you ever received money, goods, drugs or another reward in exchange for sex?" who also answered the question "The last time you had sex with a commercial partner, did you use a condom?" excluding "don't know," "no answer" and "no response."*						86	21
% who used condoms consistently with clients in the last month (among girls) *Denominator: number of girls answering "yes" to the question "Have you ever received money, goods, drugs or another reward in exchange for sex?" who also answered the question "When you had sex with a commercial partner in the last month, did you use a condom?" excluding "don't know," "no answer" and "no response."*						33	21
SEXUAL EXPERIENCE (for all survey respondents, regardless of other risk behaviours)							
% who report having had sex (vaginal/anal/oral) *Denominator: all respondents who answered this question.*		83	259	80	170	90	89
% who report sex before age 15/before age 18							
Denominator: number answering "yes" to the question "Have you ever had sex?" who also answered the question "How old were you when you had sexual intercourse for the first time?" excluding "don't know," "no answer" and "no response."	*before age 15*	33	204	25	126	46	78
	before age 18	99		99		100	
number of sex partners in the last 3 months							
Denominator: number answering "yes" to the question " Have you ever had sex in the last 12 months?" who also answered the question "With how many partners did you have sex in the last 3 months?" and who had sex partners in the last three months excluding "don't know," "no answer" and "no response."	*1*	34	196	34	119	35	77
	2	18		16		21	
	3–5	23		29		13	
	6–10	14		15		12	
	more than 10	11		6		19	
% who report a regular/casual/commercial partner in the last 3 months							
Denominator: number answering "yes" to the question "Have you ever had sex in the last 12 months?" who also answered the question "Did you have sex with a regular/casual/commercial partner in the last 3 months?" excluding "don't know," "no answer" and "no response."	*regular partner*	50	194	42	118	61	76
	casual partner	67	193	74	118	57	75
	commercial partner (buying sex)	5	194	6	118	3	76
	commercial partner (selling sex)	12	195	3	118	25	77

% who used condom during last incidence of sex							
Denominator: number answering "yes" to the question "Have you ever had sex in the last 12 months?" who reported regular/casual/commercial sex partners in the last 3 months and who also answered the question "The last time you had sex with a regular/casual/commercial partner, did you use a condom?" excluding "don't know," "no answer" and "no response."	*with a regular partner*	54	94	57	49	51	45
	with a casual partner	67	112	64	75	73	37
	with a commercial partner (buying or selling sex)	83	30	78	9	86	21
% using condoms consistently in the last year							
Denominator: number answering "yes" to the question "Have you ever had sex in the last 12 months?" who reported regular/casual/commercial sex partners in the last 3 months and who also answered the question "When you had sex with a regular/casual/commercial partner in the last year, how often did you use a condom?" excluding "don't know," "no answer" and "no response."	*with a regular partner*	28	95	35	49	22	46
	with a casual partner	38	131	44	86	27	45
	with a commercial partner (buying or selling sex)	41	29	63	8	33	21
OVERLAPPING RISKS							
% MARA reporting more than one MARA behaviour (IDU, SW, MSM)							
Denominator: all survey respondents.	*IDU+SW*	12	195	3	120	25	75
BEHAVIOURAL DETERMINANTS and VULNERABILITIES							
% with correct knowledge about HIV sexual transmission *Denominator: all those answering both the questions "Can you prevent HIV transmission by having sex with one faithful, uninfected partner?" and "Can the correct and consistent (regular) use of condoms reduce the risk of HIV transmission?"*		58	259	58	170	60	89
% with correct knowledge about HIV transmission through IDU *Denominator: all those answering the question "Can you reduce HIV transmission by using a clean, unused needle for injecting drugs?"*		91	259	90	170	91	89
% who can identify one formal source of condoms *Denominator: all respondents who reported sex in the last 12 months and who answered the question on condom supply excluding "no response."*		81	200	80	123	82	77
% IDU who can identify places where sterile injecting equipment is available *Denominator: number answering the question on sterile injecting equipment supply excluding "no response."*		93	259	94	170	92	89
% who report forced sex *Comment: The 2007 IDU BSS did not include any separate question on experience of forced sex. However, "forced sex" was one reason that could be named by the respondents for not being able to use a condom during sexual intercourse. This has been reported here, to provide at least an indication of forced sex among this population group.*		2	200	2	123	4	77

COVERAGE						
% who have purchased/obtained condoms from outreach, local projects, etc. in the past 12 months *Denominator: all those who had ever had sex in the last 12 months and who answered this question excluding "don't know," "no answer" and "no response."*	47	197	47	121	46	76
% of IDU who have obtained sterile injecting equipment from a needle exchange and/or outreach project in the past 12 months *Denominator: all those answering this question excluding "don't know," "no answer" and "no response."*	53	257	57	168	45	89
% who have been reached by an HIV prevention programme in the past 12 months *Denominator: all those answering this question.*	31	259	30	170	32	89
% who can identify sites where VCT are available *Denominator: number answering the questions on VCT supply excluding "no answer" and "no response."*	77	259	75	170	80	89
% who have tested for HIV in the past 12 months and know their result *Denominator: all those answering the question "Have you had an HIV test in the past 12 months and do you know your results?" excluding "no response."*	14	259	13	170	15	89

III. FEMALE SEX WORKERS			
Indicator		**%**	**N**
BEHAVIOUR			
INJECTING DRUG USE			
% who report ever injecting drugs *Denominator: all survey respondents.*		19	281
frequency of injecting drug use in the last month			
Denominator: number answering "yes" to the question "Have you ever injected a drug?" who also answered the question "How often did you inject in the last 30 days?" excluding "don't know," "no answer" and "no response."	*every day*	45	54
	2–6 times during a week	31	
	weekly or less	24	
SELLING SEX			
% who report ever receiving money/gifts/drugs for sex (vaginal/anal) *Denominator: all survey respondents.*		100	281
% who report selling sex before age 15/before age 18			
Denominator: all survey respondents.	*before age 15*	15	281
	before age 18	85	

number of commercial sex partners in the last week			
Denominator: number of girls answering the question "In the last week, how many commercial sex partners have you had?" excluding "don't know," "no answer" and "no response."	*1–5*	23	263
	6–10	29	
	11–20	23	
	more than 20	25	
% using condoms the last time they sold sex *Denominator: number answering the question "The last time you had sex with a commercial partner, did you use a condom?" excluding "don't know," "no answer" and "no response."*		76	276
% who used condoms consistently with clients in the last month *Denominator: number of girls answering "In the last month, did you use condoms (consistently) with your commercial sex partners?" excluding "don't know," "no answer" and "no response."*		52	267
SEXUAL EXPERIENCE (for all survey respondents, regardless of other risk behaviours)			
% who report ever having had sex (vaginal/anal/oral) *Denominator: all survey respondents.*		100	281
% who report sex before age 15/before age 18			
Denominator: all survey respondents.	*before age 15*	50	281
	before age 18	100	
% who report having sex with a non-paying partner in the last week *Denominator: number answering the question "How many non-paying partners did you have in the last week?" excluding "don't know," "no answer" and "no response."*		57	221
number of non-paying sex partners in the last week			
Denominator: number answering the question "How many non-paying sex partners did you have in the last week?" who had such partners excluding "don't know," "no answer" and "no response."	*1*	56	126
	2	23	
	3–5	18	
	more than 5	3	
number of sex partners in the last week			
Denominator: number answering the question "With how many people have you had sex in the last week?" excluding "don't know," "no answer" and "no response."	*1–5*	20	262
	6–10	27	
	11–20	26	
	more than 20	27	
% using condom the last time they had sex			
Denominator: number who reported regular/casual/commercial sex partners and who also answered the question "The last time you had sex with a regular/casual/commercial partner, did you use a condom?" excluding "don't know," "no answer" and "no response."	*with a regular partner*	25	119
	with a casual partner	51	171
	with a commercial partner	76	267

% using condoms consistently in the last year			
Denominator: number reporting oral/vaginal/anal sex at some point in their lifetimes and who also answered the question "When you had oral/vaginal/anal sex in the last year, did you use a condom?" excluding "don't know," "no answer" and "no response."	*oral sex*	37	264
	vaginal sex	61	280
	anal sex	50	175
OVERLAPPING RISKS			
% MARA reporting more than one MARA behaviour (IDU+SW) *Denominator: all survey respondents.*		19	281
BEHAVIOURAL DETERMINANTS and VULNERABILITIES			
% with correct knowledge about HIV sexual transmission *Denominator: all those answering both the questions "Can you prevent HIV transmission by having sex with one faithful, uninfected partner?" and "Can the correct and consistent (regular) use of condoms reduce the risk of HIV transmission?"*		83	281
% with correct knowledge about HIV transmission through IDU *Denominator: all those answering the question "Can you reduce HIV transmission by using a clean, unused needle/syringes for injecting drugs?"*		96	281
% who can identify one formal source of condoms *Denominator: all respondents who answered the questions about condom supply.*		99	281
% who report forced sex *Comment: The 2007 FSW BSS did not include any separate question on experience of forced sex. However, "forced sex" was one reason that could be named by the respondents for not being able to use a condom during sexual intercourse. Therefore this has been reported here, to provide at least an indication of forced sex among this population group.*		1	281
COVERAGE			
% who have purchased/obtained condoms from outreach, local projects, etc. in the past 12 months *Denominator: all those answering this question excluding "don't know," "no answer" and "no response."*		66	267
% who have been reached by an HIV prevention programme in the past 12 months *Denominator: all those answering this question.*		61	281
% who can identify sites where VCT is available *Denominator: number answering the questions on VCT supply excluding "no response."*		82	281
% who have tested for HIV in the past 12 months and know their result *Denominator: all those answering both the question "Have you had an HIV test in the past 12 months and do you know your result?" excluding "no response."*		41	281

IV. MEN HAVING SEX WITH MEN			
Indicator		**%**	**N**
BEHAVIOUR			
INJECTING DRUG USE			
% who report ever injecting drugs *Denominator: all survey respondents.*		1.4	212
frequency of injecting drug use in the last month			
Denominator: number answering "yes" to the question "Have you ever injected a drug?" who also answered the question "In the last 30 days, how often did you inject?" excluding "don't know," "no answer" and "no response."	*every day*	-	3
	2–6 times during a week	33	
	weekly or less	67	
MSM BEHAVIOUR			
% who report having had anal intercourse with a male *Denominator: all survey respondents.*		100	212
number of male partners in the last 6 months, disaggregated by type of sexual intercourse (oral, anal insertive, anal receptive)			
Denominator: number of respondents who had oral sex/receptive anal intercourse/insertive anal intercourse in the last three months and also answered the question "With how many boys/men did you have oral sex/receptive anal intercourse/insertive anal intercourse in the last 6 months?" excluding "don't know," "no answer" and "no response."	*oral sex*		
	1	16	190
	2	21	
	3–5	32	
	6–10	15	
	more than 10	16	
	insertive anal intercourse		
	1	24	136
	2	24	
	3–5	29	
	6–10	13	
	more than 10	10	
	receptive anal intercourse		
	1	36	134
	2	19	
	3–5	23	
	6–10	13	
	more than 10	9	

% who report having had regular/casual/commercial sex partner in the last 6 months			
Denominator: number answering the question "How many regular/casual/commercial sex partners did you have in the last 6 months?" excluding "don't know," "no answer" and "no response."	*regular partner*	66	174
	casual partner	77	175
	commercial partner	14	176
% MSM using a condom during last incidence of sex with a paying male partner *Denominator: number of boys reporting sex with a paying partner who also answered the question "Did you use a condom the last time you had sex with a paying male partner?" excluding "don't know," "no answer" and "no response."*		75	20
% using a condom during last incidence of sex with a non-paying male partner			
Denominator: number of boys reporting non-paying sex partners (regular and/or casual partners) who also answered the question "Did you use a condom the last time you had sex with your regular/ casual partner?" excluding "don't know," "no answer" and "no response."	*with regular partner*	72	92
	with casual partner	82	88
SELLING SEX			
% who report ever receiving money/gifts/drugs for sex (vaginal/anal) *Comment: The 2007 MSM BSS did not include any separate question on experience of selling sex. Instead, the BSS reports on the % of MSM among all survey respondents who were involved in commercial sex in the last 6 months, either by selling or buying.*		14	212
SEXUAL EXPERIENCE (for all survey respondents, regardless of other risk behaviours)			
% who report having had sex (vaginal/anal/oral) *Denominator: all survey respondents.*		100	212
% who report having had heterosexual intercourse *Denominator: all survey respondents.*		71	212
% who report having had heterosexual intercourse in the last 6 months *Denominator: number answering "yes" to the question "Have you ever had heterosexual intercourse?" who also answered the question "How many heterosexual sex partners did you have in the last 6 months?" excluding "don't know," "no answer" and "no response."*		53	58
number of heterosexual sex partners in the last 6 months			
Denominator: number answering "yes" to the question "Have you ever had heterosexual intercourse?" who also answered the question "How many heterosexual sex partners did you have in the last 6 months?" and who also had such partners in the last 6 months excluding "don't know," "no answer" and "no response."	*1*	61	31
	2	16	
	3–5	13	
	more than 5	10	
% who used condoms during last incidence of sex with a female sex partner *Denominator: number answering "yes" to the question "Have you ever had heterosexual intercourse?" who also answered the question "The last time you had sex with a female sex partner, did you use a condom?"*		73	33

% who used condoms during last incidence of sex with a male partner			
Denominator: number who reported regular/casual/commercial sex partners and who also answered the question "The last time you had sex with a regular/casual/commercial sex partner, did you use a condom?" excluding "don't know," "no answer" and "no response."	*with a regular partner*	72	92
	with a casual partner	82	88
	with a commercial partner	75	20
OVERLAPPING RISKS			
% MARA reporting more than one MARA behaviour (IDU, SW, MSM)			
Denominator: all survey respondents.	*IDU+MSM*	1	212
	MSM+SW	10	
	IDU+MSM+SW	-	
BEHAVIOURAL DETERMINANTS and VULNERABILITIES			
% with correct knowledge about HIV sexual transmission *Denominator: all those answering both the questions "Can you prevent HIV transmission by having sex with one faithful, uninfected partner?" and "Can the correct and consistent (regular) use of condoms reduce the risk of HIV transmission?"*		74	212
% with correct knowledge about HIV transmission through IDU *Denominator: all those answering the question "Can you reduce HIV transmission by using a clean, unused needle for injecting drugs?"*		92	212
% who can identify one formal source of condoms *Denominator: all respondents who answered the questions about condom supply*		83	212
% who report forced sex *Comment: The 2007 MSM BSS did not include any separate question on experience of forced sex. However, "forced sex" was one reason that could be named by the respondents for not being able to use a condom during sexual intercourse. Therefore this has been reported here, to provide at least an indication of forced sex among this population group.*		1	212
COVERAGE			
% who have purchased/obtained condoms from outreach, local projects, etc. in the past 12 months *Denominator: all those answering this question excluding "don't know," "no answer" and "no response."*		54	208
% who have been reached by an HIV prevention programme in the past 12 months *Denominator: all those answering this question.*		45	212
% who can identify sites where VCT is available *Denominator: number answering questions on VCT supply excluding "no answer" and "no response." N=212*		71	212
% who have tested for HIV in the past 12 months and who know their result *Denominator: all those answering both the question "Have you had an HIV test in the past 12 months and do you know your result?" excluding "no response." N=62*		24	212

ANNEX 3:

Study protocol for the UNICEF MARA baseline study 2007–2008

Study Protocol – Ukraine
Baseline study (2007–2008)
UNICEF programme: "HIV prevention in most-at-risk adolescents (MARA) in Ukraine and South Eastern Europe"

Title of study

"Surveillance of HIV risk behaviour, behavioural determinants and vulnerabilities and service use of adolescent boys and girls most at risk aged 10 to 19 years in Ukraine"

Definition of Most-At-Risk Adolescents (MARA):

- "Most-at-risk adolescents are boys and girls who are most at risk of HIV infection as a result of their behaviour, in particular:
  1. Male and female injecting drug users (IDUs) who use non-sterile injecting equipment.
  2. Males who have unprotected anal sex with males.
  3. Females and males who sell unprotected sex, including those who are trafficked for the purpose of sexual exploitation and have unprotected (often exploitative) transactional sex.
  4. Males who have unprotected sex with female sex workers". [266]

Background

Ukraine is experiencing one of the fastest-growing HIV epidemics in the world. Injecting drug use with non-sterile injecting equipment is still driving the epidemic, and young people, especially those who are most at risk of HIV, are bearing the brunt of new infections.[267] Social research and behavioural surveillance studies in Ukraine indicate that the average age at which young people start engaging in HIV risk behaviour continues to decrease[268], particularly among especially vulnerable adolescents[269]. In addition, vulnerability to HIV risk behaviour among adolescents remains high[270], unsafe injecting and sexual practices are still

[266] Homans, H., "Guidance on Programming to Prevent HIV in Most-at-risk Adolescents", second draft, UNICEF Regional Office for Central and Eastern Europe and the Commonwealth of Independent States, Geneva, May 2006.

[267] UNAIDS and WHO, *AIDS Epidemic Update*, Geneva, December 2005.

[268] See e.g.: UNICEF and UNAIDS, *Risk and protective factors in the initiation of injecting drug use,* Kyiv, 2006; Ministry of Health of Ukraine, *National Report on the Follow-up to the UNGASS Declaration of Commitment on HIV/AIDS, Reporting Period: January 2003–December 2005,* Report prepared by the Ministry of Health of Ukraine in collaboration with the National Coordination Council on HIV/AIDS and with technical assistance from the International HIV/AIDS Alliance in Ukraine and the Joint United Nations Programme on HIV/AIDS (UNAIDS) in Ukraine, Kyiv, 2006; UNICEF and UNAIDS, *A Review of Work With Injecting Drug Users in Ukraine in the Context of the HIV/AIDS Epidemic*, Kyiv, 2005; and: AIDS Foundation East-West and UNICEF, *Children and young people living or working on the streets: the missing face of the HIV epidemic in Ukraine,* Kyiv, 2006.

[269] "In the context of HIV, vulnerability refers to those factors/determinants that contribute to adolescents' engaging in risk behaviours. It is therefore different from risk where the adolescent girl or boy has already engaged in the risk behaviour. An especially vulnerable adolescent could therefore be defined as one who is susceptible to, or unable to protect him- or herself from, significant harm or exploitation linked with HIV infection…certain settings, such as being in juvenile detention or living on the street, are environments where coercive risk behaviour often takes place, so particular attention needs to be paid to them.""Vulnerability to HIV is influenced by three sets of variables, and the interactions between them: (1) factors such as group or subculture membership, (2) the quality and coverage of information, services and programmes and (3) broader societal and environmental influences." Adapted from: WHO and DFID, (2004) in: Homans, H., "Guidance on Programming to Prevent HIV in Most-at-risk Adolescents", second draft, UNICEF Regional Office for Central and Eastern Europe and the Commonwealth of Independent States, Geneva, May 2006.

[270] UNICEF and UNAIDS, *Risk and protective factors in the initiation of injecting drug use,* Kyiv, 2006; Ministry of Health of Ukraine, *National Report on the Follow-up to the UNGASS Declaration of Commitment on HIV/AIDS, Reporting Period: January 2003–December 2005,* Report prepared by the Ministry of Health of Ukraine in collaboration with the National Coordination Council on HIV/AIDS and with technical assistance from the International HIV/AIDS Alliance in Ukraine and the Joint United Nations

widespread and existing HIV services reach mainly those members of most-at-risk populations (MARPs) who are older than 25[271].

While there is data available in Ukraine on HIV prevalence, risk behaviour and service coverage of MARA aged 15 to 19[272], the evidence base on MARA aged 10 to 14 has so far been very weak. Data is not routinely collected on age, sex and especially diversity[273].

Most MARA in Ukraine are not yet covered by HIV prevention, treatment, care and support services[274]. But given that the epidemic is still young, there is a real opportunity to intervene with MARA and provide proven effective and evidence-based interventions for HIV prevention and care. This will help contain the epidemic and reduce its impact.

After consulting with key stakeholders in Ukraine[275], UNICEF decided to combine two research strategies:

(1) To conduct desk research on what evidence about MARA in Ukraine is available. The research will include a secondary analysis of HIV risk behavioural data, behavioural determinants and vulnerabilities and service coverage of MARA aged 10 to 19. The data on MARA will be derived from an overall sample of MARPs (IDUs, female sex workers (FSWs) and men who have sex with men (MSM)) aged 10 to 49+ years. The latter were surveyed within the frame of behavioural surveillance studies conducted among IDUs, FSWs and MSM in 2007 in Ukraine.

(2) To conduct a baseline study examining HIV risk behaviour, behavioural determinants and vulnerabilities and service use of adolescent boys and girls who are most at risk, aged 10 to 19 and living and working on the streets of Ukraine. This particular group was chosen for the baseline study because:

- While there are no official statistics on the number of adolescents living and working on the streets in Ukraine or a national consensus estimate of the size of this population group, their number is certainly significant and has been growing over the past 17 years. Figures published by ministries, research institutes and non-governmental organizations differ greatly. They indicate that there are from 30,000 to 50,000 and even up to 300,000 "street children".[276] The most recent low population estimate, which an

Programme on HIV/AIDS (UNAIDS) in Ukraine, Kyiv, 2006; UNICEF and UNAIDS, *A Review of Work With Injecting Drug Users in Ukraine in the Context of the HIV/AIDS Epidemic*, Kyiv, 2005; and: UISR, *Analytical report: Level and trends of tobacco use, the use of alcohol and narcotic substances among young school students in Ukraine,* ESPAD: The European School Survey Project on Alcohol and Other Drugs, Kyiv, 2008.

[271] Ministry of Health of Ukraine, *National Report on the Follow-up to the UNGASS Declaration of Commitment on HIV/AIDS, Reporting Period: January 2003–December 2005*, Report prepared by the Ministry of Health of Ukraine in collaboration with the National Coordination Council on HIV/AIDS and with technical assistance from the International HIV/AIDS Alliance in Ukraine and the Joint United Nations Programme on HIV/AIDS (UNAIDS) in Ukraine, Kyiv, 2006.

[272] Data of the 2004 to 2007 behavioural and sentinel surveillance studies conducted by the Ukrainian AIDS Prevention Centre and the International HIV/AIDS Alliance. For reports on the 2007 bio-behavioural surveillance studies, see at www.aidsalliance.org.ua.

[273] "Diversity" in terms of MARA refers to the different socioeconomic background and characteristics of MARA, e.g. MARA who have been displaced, who live on the streets, who are children of migrants or who belong to an ethnic minority group such as the Roma (see: Homans, H., "Guidance on Programming to Prevent HIV in Most-at-risk Adolescents", second draft, UNICEF Regional Office for Central and Eastern Europe and the Commonwealth of Independent States, Geneva, May 2006.

[274] See: AIDS Foundation East-West and UNICEF, *Children and young people living or working on the streets: the missing face of the HIV epidemic in Ukraine,* Kyiv, 2006; and: Ukrainian Government, "Ukraine 6th Round Proposal to the Global Fund to Fight AIDS, Tuberculosis and Malaria", Kyiv, 2006. Coverage with HIV/AIDS services for this population group is estimated to be less than one per cent.

[275] The Ministry for Family, Youth and Sports is officially supporting the UNICEF research and has reviewed the study protocol via its focal point for the UNICEF MARA project. Furthermore, within the frame of the project, UNICEF has established a National Research Advisory Board, which is a sub-group of the Working Group for HIV Prevention, Treatment, Care and Support for At-risk Children in Ukraine that was created in spring 2007. Both groups have yet to be officially approved by the Ministry of Family, Youth and Sports. They are currently acting as informal advisory groups on issues related to policy, legislation, services and research on HIV/AIDS and children and young people at risk of HIV infection

[276] State Institute for Family and Youth Development and Ministry of Family, Youth and Sports of Ukraine, "National Report on implementation of the decisions of the final outcome document of the Special Session of the UN General Assembly on Children (2002) and Action Plan "A World Fit for Children", Kyiv, 2007; AIDS Foundation East-West and UNICEF, *Children and young people living or working on the streets: the missing face of the HIV epidemic in Ukraine,* Kyiv, 2006; and All-Ukrainian Coalition of non-government organizations Unite for Children, "Alternative report on the implementation of the Optional Protocol to the UN Convention on the Rights of the Child, on the Sale of Children, Child Prostitution and Child Pornography", Kyiv, 2006.

HIV/AIDS multi-stakeholder group in Ukraine used as a baseline to calculate how many "street children" aged 10 to 18 are most at risk of HIV and in need of HIV services, claimed that 115,000 children were living on the streets[277].

- Most adolescents who are living and working on the streets of Ukraine have not been tested for HIV and therefore do not know if they are living with the virus. Qualitative research shows that there are many reasons for this. One of them is that adequate HIV and outreach services for this population group are lacking. Another is that legal barriers exist to testing them. Yet another is that they do not regularly practise health-seeking behaviour. On the other hand, the research also demonstrates that this group is not only especially vulnerable to HIV, but that a significant number of girls and boys belonging to it engage in HIV risk behaviour, making them most at risk of HIV.[278] Data from HIV behavioural surveillance studies conducted in 2004 and 2006 support this claim, indicating that approximately 10 per cent to 20 per cent of FSWs who are working on the streets are between 12 and 17 years old[279]. Data from a representative study among young IDUs indicate that more young IDUs than adult IDUs are living on the streets[280].
- There are no data or estimates available, however, on HIV prevalence and incidence for this population group. The Ukrainian AIDS Prevention Centre's HIV case register includes cases in which it was clear that certain adolescents who had registered as HIV-positive were also homeless, but such information is not being collected in a systematic manner. Officially published data on HIV infection among adolescents who are living and working on the streets are not representative and are primarily products of HIV tests conducted among two small groups of such adolescents, one from Kyiv and one from Odessa. The results showed that of 25 Kyiv children living on the streets who were tested for HIV in 2005, five were HIV-positive (20 per cent); and that of 29 Odessa children tested in 2004, 20 tested HIV-positive (69 per cent).
- In addition, data from the HIV sentinel surveillance studies[281] conducted in the last three years among adolescent IDUs, FSWs and MSM aged 10 to 19 in Ukraine indicate that the overall number of adolescents living with HIV is increasing and that the HIV prevalence rate among MARA most likely exceeds 5 per cent.

The results of the 2007 HIV sentinel surveillance studies and the 2007 HIV behavioural surveillance studies (BSS) will give the Ukrainian research team a chance to analyse HIV prevalence, HIV risk behaviour, levels of HIV knowledge and coverage with HIV services among 10- to 19-year-old MARA. The sizes of the 2007 samples are as follows[282]:

- IDUs aged 13 to 19 years = 280 males and females.
- FSWs aged 13 to 19 years = 280 males and females.
- MSM aged 15 to 19 years = 200 males.

to the UN Convention on the Rights of the Child, on the Sale of Children, Child Prostitution and Child Pornography", Kyiv, 2006.

[277] Ukrainian Government, "Ukraine 6th Round Proposal to the Global Fund to Fight AIDS, Tuberculosis and Malaria", Kyiv, 2006.

[278] AIDS Foundation East-West and UNICEF, *Children and young people living or working on the streets: the missing face of the HIV epidemic in Ukraine,* Kyiv, 2006.

[279] Data presented in: Ministry of Health of Ukraine, *National Report on the Follow-up to the UNGASS Declaration of Commitment on HIV/AIDS, Reporting Period: January 2003–December 2005,* Report prepared by the Ministry of Health of Ukraine in collaboration with the National Coordination Council on HIV/AIDS and with technical assistance from the International HIV/AIDS Alliance in Ukraine and the Joint United Nations Programme on HIV/AIDS (UNAIDS) in Ukraine, Kyiv, 2006.

[280] UNICEF and UNAIDS, *Risk and protective factors in the initiation of injecting drug use,* Kyiv, 2006.

[281] Ukrainian AIDS Prevention Centre (2004 to 2007 data).

[282] Please note that 2007 was the first year in which adolescents aged 10 to 14 were included in the overall surveillance sample. In previous years only adolescents aged 15 to 19 were included, even though some adolescents aged 12 to 14 were also tested (their numbers were too small to draw any conclusions from). The engendered results of the survey and re-analysis are not ready yet, but will be presented in the final research report.

While the majority of people living with HIV in Ukraine continue to be male, the surveillance studies and the Ukrainian AIDS Prevention Centre's case register indicate that the epidemic is becoming more and more feminine.

A basis for strengthening existing and developing new interventions for MARA is currently taking shape in Ukraine. Efforts have been made in the past two years:

- To scale-up HIV/AIDS services for MARPs, as well as social and health services for youth in general and for especially vulnerable adolescents in particular[283].
- To implement pilot interventions for children and adolescents living and working on the streets based on client-centred and harm reduction approaches[284].
- To officially recognise "adolescents and children at risk" as a key target group for HIV/AIDS prevention and care services[285]

Social research[286] indicates that the general profile of adolescents living and working on the streets in Ukraine is as follows:

1. The majority are male and younger than 18. They ended up on the streets due to a combination of factors (for example poverty, serious family dysfunction and insufficient informal and formal social support).
2. They are highly mobile, making it difficult to keep track of them. Most can be found, though, in urban areas. Most are natives of the cities in which they live, but others come from neighbouring countries and other Ukrainian cities (seasonal mobility).
3. Most appear to be "social orphans"[287]. They have low education levels, many health problems and very limited access to health, education and legal and social services. Even their basic needs (accommodation, food, clothing and hygiene) are not met adequately.
4. Key HIV vulnerability factors for them include, particularly, their need to earn a living. This makes them especially vulnerable to being exploited for sex or labour and to becoming involved in crime.
5. Many have experienced serious psychological distress in their lives, including violence, abuse and/or exploitation. An explorative study in 2006 in Kyiv and Odessa observed differences linked to the genders of the respondents, particularly concerning incidence of injuries and physical violence. Significantly more boys than girls reported injuries and bruises. Boys also reported being more frequently beaten than girls and that they used more substances and drugs (including injecting drugs), thereby increasing their risk of accidental injuries in states of intoxication. The same study revealed:
    a. That almost one-third of the adolescents (most of them girls) interviewed had experience with sexual exploitation and violence.
    b. Girls reported exchanging sex for food, money, drugs or other goods more frequently than boys did.
    c. The dominant type of sex seems to be heterosexual among this population group, although some boys reported sex with male friends or with male "clients".

[283] E.g. a network of youth-friendly clinics has been created within the primary health care system in Ukraine. So has a network of counselling points for young injecting drug users. These are integrated into the Centres of Social Services for Families, Children and Youth; however, MARA rarely frequent these services and do not yet reach out to them.

[284] E.g. two new drop-in centres providing a whole range of health, social, education and legal services to this population group have been established in Ukraine; see at http://www.doctorsoftheworld.org/projects/ukraine.cfm..

[285] UNAIDS, et al., *Road Map on Scaling-up Towards Universal Access to HIV/AIDS Prevention, Treatment, Care and Support in Ukraine by 2010.* Report prepared by a Multi-Stakeholder Working Group on Universal Access, based on the results of three national consultations, with technical assistance from the Joint United Nations Programme on HIV/AIDS (UNAIDS), Kyiv, 2006.

[286] See at www.aidsalliance.org for the 2004 behavioural surveillance reports on different MARPs; AIDS Foundation East-West and UNICEF, *Children and young people living or working on the streets: the missing face of the HIV epidemic in Ukraine*, Kyiv, 2006; Reports of the Ukrainian AIDS Prevention Centre (2004–2007) on sentinel surveillance studies conducted among MARPs in Ukraine; and: All-Ukrainian Coalition of non-government organizations Unite for Children, "Alternative report on the implementation of the Optional Protocol to the UN Convention on the Rights of the Child, on the Sale of Children, Child Prostitution and Child Pornography", Kyiv, 2006.

[287] "Social orphans" are here defined as children and adolescents who are not biological orphans, which means that one or both parents are still alive.

d. The majority of the respondents reported using either solvents or substances and drugs, including alcohol. Approximately one third reported injecting drugs. Approximately half of those injecting admitted to doing so using non-sterile equipment.

e. Most of the respondents aged 15 to 19 reported having sex regularly with changing partners. Condom use during these sexual encounters is too rare.

6. MARA aged 14 to 22 who are living on the street are at particular risk of being detained by the police and eventually incarcerated, especially for theft or drug "storage and transportation" (which implies criminal responsibility). Detention and other penitentiary facilities remain high-risk environments for adolescents, especially in terms of starting or continuing HIV risk behaviours, and with regard to forced sex.

This group has complex needs and suffers frequent rights violations. They have trouble getting the services they need, including HIV services, and they face a variety of vulnerability and risk factors on the street. Given all this, the research team decided that the baseline study (research strategy 2) would focus on MARA boys and girls living and working on the streets, but also address the key HIV vulnerability factors of other adolescent boys and girls on the streets – that is, those who do not practise most-at-risk behaviour.

The baseline study and the data from the secondary analysis (research strategy 1) will together serve:

(1) As a tool for advocacy with regard to scaling up HIV services for MARA and strengthening child protection for them.

(2) As a basis for developing and scaling up the coverage, quality and equity of prevention and harm reduction services that are both MARA-friendly and targeted at MARA living and working on the streets.

(3) As an instrument for mobilising communities to create a more supportive environment for MARA, one in which their access to services will increase and in which service standards will be a certainty.

The National *Road Map on Scaling-up Towards Universal Access to HIV/AIDS Prevention, Treatment, Care and Support in Ukraine by 2010 (Road Map)*, which a multi-stakeholder working group led by UNAIDS and the Ministry of Health of Ukraine developed in April 2006, sets out the key national access goals and targets and interventions that need to be scaled up for this particular population group in Ukraine. The *Road Map* defines this population group as: "Adolescents and at-risk children (including orphaned children, street children, juvenile detainees, youth in special care institutions, children and adolescents who live in problem families, etc.)". The definition includes MARA as well as adolescents especially vulnerable to HIV infection.

The *Road Map* established the prevention target for this group for 2010 as "60 per cent coverage of adolescents and at-risk children aged 10 to 18 with a specific minimum package of prevention services, including:

- Information
- Education on HIV/AIDS in primary and secondary school
- Counselling on legal issues
- Harm reduction programmes that take into account the specific features of underage children
- Means to prevent sexual and non-sexual HIV transmission
- Voluntary HIV counselling and testing."

The package will meet national standards and approved guidelines and the services it provides will be without interruptions and "…based on client-centred and individual approaches responsive to clients' changing needs." The package will integrate prevention, treatment, care and support services, and interventions will ensure equity of access and avoid discrimination. The *Road Map* also stipulates that "…ethical standards/codes of ethics should be adopted at the national level for all medical and non-medical specialists involved in prevention programmes in all regions."

HIV/AIDS care and support services will consider the special needs of children and at-risk adolescents and take into account age and gender. The *Road Map* sets the overall target for all population groups in need of care and support at 30 per cent.

The service package that the *Road Map* defines does not cover diagnosis of and treatment and care for sexually transmitted infections and HIV, even though these services are included in the minimum service package that the Draft UNICEF MARA Guidance (May 2006) describes. The Guidance also describes vulnerability-reduction programmes that the *Road Map* list does not include. UNICEF in Ukraine has already initiated some of the programmes and approaches that the *Road Map* mentions. These include the following: a review of MARA-related policy and legislation with a view to eliminating the barriers to access that MARA face; getting MARA (including those living and working on the streets) involved in national strategic planning consultations (for example, on developing a framework for action for the MARA HIV-prevention response); developing a network of youth-friendly services; and supporting the Ukrainian National Plan of Action for implementing the *UN Convention of the Rights of the Child (CRC)* and the *CRC Optional Protocols*.

The UNICEF response and study

With the Irish Government's support, the UNICEF Regional Office for Central Europe and the Commonwealth of Independent States has been doing forward work on HIV prevention for MARA within the frame of their programme on "HIV prevention in most-at-risk adolescents in Ukraine and South Eastern Europe". Ukraine was identified as one of the priority countries for this work. Considerable emphasis is being placed on building evidence and capacity of local research institutions and developing national norms and standards and evidence-based programming (including monitoring and evaluation), so that sustainable systems are in place at programme's end. It is expected that models for delivering targeted HIV prevention interventions for MARA boys and girls are operational and have been costed, and that research will have been conducted according to innovative models of vulnerability reduction and service delivery.

For this year, UNICEF is planning a secondary analysis and a baseline survey of HIV risk behaviour, behavioural determinants and vulnerabilities and service use of MARA aged 10 to 19 years in Ukraine, including adolescents who are living and working on the streets. This study protocol presents the baseline study design. The results of the secondary analysis and baseline survey will be officially presented at the regional, national and international levels. They will serve to:

- Build an engendered evidence base on MARA boys and girls in Ukraine.
- Improve monitoring and evaluation of the national HIV response to MARA boys and girls.
- Prepare qualitative and intervention research among MARA.
- Plan interventions as described in the "Background" based on sound evidence (including the monitoring and evaluation of the interventions).

As the "Background" also mentions, UNICEF in Ukraine has already made various efforts to create a protective and supportive environment for MARA boys and girls. It has, for example, reviewed policy and legal frameworks.

Population group(s):

Adolescent boys and girls aged 10 to 19 years[288] who are living and working on the streets.

Eligibility criteria for the baseline study:

1. Adolescent boys and girls aged 10 to 19 who have lived at least three months on the street, do not attend school regularly and spend at least 50 per cent of their time on the streets.
2. Adolescent boys and girls aged 10 to 19 who have lived at least three months on the street, have no regular work, attend no vocational or any higher education facility and spend at least 50 per cent of their time on the streets.

[288] The age range for adolescents used is consistent with the definition WHO provides, as mentioned earlier in this report. It reflects a Ukrainian situation in which adolescents and young people, particularly aged 19 or slightly older, are often members of groups of adolescents who are living and working on the streets and tend to have a strong influence on younger group members, especially in terms of HIV risk behaviour. For supportive evidence, see: AIDS Foundation East-West and UNICEF, *Children and young people living or working on the streets: the missing face of the HIV epidemic in Ukraine,* Kyiv, 2006. This definition varies slightly from the definition UNICEF uses for the purposes of MARA programming. That definition includes adolescents aged 10 to 18, in line with the *UN Convention on the Rights of the Child*.

"Living on the streets" is defined here as:

- Adolescent boys and girls aged 10 to 19 who have no contact with their families, live in temporary dwellings (such as abandoned buildings) or have no permanent dwelling and sleep in a different place every night.
- Adolescent boys and girls aged 10 to 19 who maintain contact with their families and/or caregivers, but, due to poverty or other reasons, such as exposure to abuse or neglect, spend at least 50 per cent of their days, and occasionally nights, on the street.
- Adolescent boys and girls aged 10 to 19 who reside in temporary shelters and who have lived on the streets prior to entering the shelter (criteria (a) or (b))[289].
- Adolescent boys and girls aged 10 to 19 who technically reside in state boarding schools, psychosocial rehabilitation centres or other child-care facilities, but for one reason or another have run away and now live on the streets (criteria (a)).

As the baseline study includes MARA who are living and working on the street, as well as adolescent boys and girls who are especially vulnerable to HIV and living and working on the street, "risk behaviour" has not been included as a separate eligibility criteria in the above list.

The eligibility criteria set out above will also be applied to any member of the social network of an adolescent who is eligible for the baseline study. He/she will be asked to refer members of his/her social network.

Site(s):

The following five research sites were chosen for the baseline study:

1. Kyiv city.
2. Donetsk city.
3. Dnipropetrovsk city.
4. Mykolaiv city (eventually Mykolaiv oblast as well).
5. Rivne city and oblast (pilot site).

The four key research sites (1.-4.) were selected based on the following criteria:

- Sufficient numbers of adolescents aged 10 to 19 years who are living and working on the streets to derive a proper sample size.
- Consideration of HIV prevalence data (medium to high) and trends (increasing) in the possible research site.
- Presence of governmental and non-governmental organizations providing services (health, social, education, legal, others) to the population group and that can serve as "gatekeepers"[290] for accessing the group.
- Cost-effectiveness considerations.
- Interest demonstrated by local authorities in using the research findings to strengthen the local HIV response for MARA girls and boys.

[289] There are two ways that adolescents enter temporary shelters: either they access them voluntarily or they are taken to them by the authorities. According to the Law of Ukraine (20/95-BP) on *Services and Institutions for Minors,* when the police pick up children, i.e. persons under the age of 18 years, on the street, they have to report them to the child protection services (departments for children). The police may transfer a child to a temporary shelter if a child has no other place to go to, cannot be taken back to his or her family or needs medical attention – if he or she has overdosed, for example. After a child has been reported, the departments for children, usually in cooperation with the State social services, start working with the family and the child. If necessary, child protection services involve social services, for example,. in case the family needs social support (that is, for "families in crisis"). It should, however, be noted that quite a few of the children transferred to temporary shelters escape and return to the streets. For supporting evidence, see: AIDS Foundation East-West and UNICEF, *Children and young people living or working on the streets: the missing face of the HIV epidemic in Ukraine,* Kyiv, 2006.

[290] A "gatekeeper" means in this context an organization with direct contact with the research target population. The organization is in a position to help in accessing and recruiting target population members.

The project team also sought advice from national stakeholders on possible research sites during a meeting of the Working Group on HIV Prevention, Treatment, Care and Support for At-risk Children that currently acts as an informal stakeholder advisory group to the Ministry of Family, Youth and Sports. It was established in spring 2007.

The project team selected the fifth site, Rivne, as an additional research site based on discussions with key stakeholders that had asked UNICEF to include a western region to ensure a better representation of the situation across Ukraine (west, central, south, east). However, given the small numbers of adolescents living and working on the streets in that region, it functioned only as a pilot site for the research.

Objective:

The baseline study's objective is to collect sex and age disaggregated empirical data that will allow for calculating indicators describing HIV risk behaviour, behavioural determinants and vulnerabilities and use of HIV services for adolescent boys and girls living and working on the street in Ukraine.

For a list of core and country-specific indicators, please see Annex I[291].

While the core indicators are the same as for the MARA studies that the project team will conduct in other UNICEF MARA programme regions, the Ukraine baseline study will not provide benchmarks for MARA in general. Instead, it will provide a baseline for adolescents and MARA who are living and working on the streets.

Benchmarks for MARA in general will instead be derived from the secondary analysis of sentinel and behavioural surveillance studies on HIV prevalence, risk behaviour, behavioural determinants and vulnerabilities and service coverage conducted in 2007 among IDUs, FSWs and MSM aged 10 to 24 years in Ukraine (see also point "Background").

Sampling:

The sampling for the baseline study will be conducted via location-based and network sampling. Snowball sampling will be used for referral of entire networks.

Prior to the sampling, a "community advisory board" (CAB) will be created through a research introductory round table. The CAB will then hold a working meeting in each research site. It will consist of key stakeholders and representatives of the research population group and will include, but is not limited to:

- Non-governmental and faith-based service providers.
- Governmental service providers, particularly the Centres for Social Services for Families, Children and Youth (CSSFCY), representatives of local shelters and psychosocial rehabilitation centres and representatives of Child Protection Services and the Criminal Police for Minors.
- Departments and/or committees of the oblast administrations working with children.
- Representatives of the Regional HIV/AIDS and Tuberculosis Councils.
- Representatives of the research population group.
- Any other relevant stakeholders.
- Representatives of the research team, including a gender expert.

The main role of the CAB will be to:

1. Guide the research team during fieldwork.
2. Get community representatives actively involved in discussing, planning, monitoring, undertaking and evaluating fieldwork and data collection and preliminary findings; and to determine the need for possible interventions and define them.

[291] Note: the annexes to the study protocol are not included in this report. For a list of core MARA indicators for Ukraine, see Annex 2 to this report.

3. Act as a valuable resource to the research team, helping the latter improve their understanding of local situations.

4. Positively influence the way in which the community acknowledges and responds to the results of the research.

After the CAB has been created, each research site will be mapped to identify locations in which the research target group is congregating and/or living and to estimate how many of them there are. Selected members of the CAB, primarily direct service providers (including the CSSFCYs) and members of the research population group, will help identify key groups of adolescents, including MARA, who live and work on the streets, and where they congregate. The mapping process will also help identify priority locations for the provision and scaling up of targeted interventions. A situation needs assessment of existing HIV, STI, social and harm reduction services will complement the mapping process. The project team will perform that assessment in tandem with the CAB. It will also perform a risk assessment that considers the safety of both adolescent/MARA girls and boys and fieldworkers/interviewers.

The project team developed target numbers for the baseline survey using 2005 and 2006 statistics from the Ministry of Family, Youth and Sports on children accessing the nationwide system of shelters for minors:

Region	2005	2006
Dnipropetrovsk	1,907 children (including 1,663 who were living on the streets)	1,739
Donetsk	3,940 children (including 2,170 who were living on the streets)	3,484
City of Kyiv	1,288 children (including 927 who were living on the streets)	976
Mykolaiv	748 children (including 624 who were living on the streets)	758
Rivne	390 children (including 196 who were living on the streets)	376

The breakdown according to age and sex was as follows in 2005:

Region	Boys				Girls			
	Age groups			Total	Age groups			Total
	3–6	7–14	15–18		3–6	7–14	15–18	
Dnipropetrovsk	167	793	275	1235	146	404	122	672
Donetsk	292	1623	706	2621	209	745	365	1319
Mykolaiv	64	334	81	479	61	177	31	269
City of Kyiv	43	548	366	957	30	206	95	331
Rivne	42	179	68	289	15	51	35	101

These numbers do not provide the total number of adolescents living and working on the streets in each region/city and there are no agreed population size estimates for each region/city due to various legal, structural, capacity and other issues (see "Background"). However, they are the only officially available data and therefore had to be used to calculate target numbers. The target numbers were also compared with sample sizes used in selected qualitative and quantitative studies on this population group in Ukraine[292].

City/Region	Target number
Kyiv city	200 in total: 140 boys + 60 girls
Donetsk city	200 in total: 140 boys + 60 girls
Dnipropetrovsk city	200 in total: 140 boys + 60 girls
Mykolaiv city/region	200 in total: 140 boys + 60 girls
Rivne city/region	100 in total: 70 boys + 30 girls
TOTAL	900 in total: 630 boys + 270 girls

Girls have been included in the sample using a quota system based on available data on sex distribution among adolescents living and working on the streets. The resulting sex distribution of the sample may there-

[292] E.g. AIDS Foundation East-West and UNICEF, *Children and young people living or working on the streets: the missing face of the HIV epidemic in Ukraine,* Kyiv, 2006.

fore not actually reflect the target population's composition in each research site, nor among the social networks recruited.

Interviewees will receive an incentive to participate in the study. It will consist of some food and a sweet. The research team will discuss with the CAB whether or not coupons for certain services might also be handed out to the research population group.

Fieldworkers:

In each research site, the project team will identify a group of five interviewers. One fieldwork manager will supervise them. The interviewers and fieldwork managers for the baseline study come from the national network of the Ukrainian Institute of Social Research after Olexander Yaremenko. The network comprehends all possible research sites discussed.

In cooperation with the CAB, the project team will also recruit fieldworkers to support the research team in mapping possible research locations and recruiting research population group members. Selected fieldworkers from NGOs or CSSFCY might also train to become interviewers. Careful consideration will, however, be given to the latter due to the risk of "desirability bias" and the fact that the target group has limited access to most social services.

The fieldwork team (including fieldwork managers, interviewers and fieldworkers) will undergo briefing and training prior to starting data collection. Its members will receive interview and fieldwork guidelines (please see Annex II[293]) that will focus in particular on:

- Understanding MARA, gender and HIV risk behaviour, behavioural determinants, vulnerabilities and service use.
- The sampling approaches the study uses and how to recruit the samples, including corresponding ethical and gender guidelines.
- Where to conduct the interviews. The project team will discuss the where' with the CAB as well, and of course the mapping process will largely dictate choice of locations.
- How to conduct interviews, including ethical and gender guidelines (concerning, for example, the ages, genders and roles of the interviewers and fieldworkers, and child protection issues).
- Cooperation within the research team and with the CABs.
- Interviewer and fieldworker safety.
- Supervision and debriefings by fieldwork managers.
- Provision of information about local support services to (potential) interviewees[294].
- Guidelines for referring (potential) interviewees to local support services.

The eligibility criteria that the project team will use in including organizations in that list of stakeholders from which individuals will be recruited for fieldwork include:

- Coverage of the population group.
- Characteristics of the clients served: these should match the eligibility criteria for the research population group.
- Provision of direct services to the research population group, including outreach, drop-in centres and similar services.
- Experience in participating in research studies (this is not mandatory, though).

[293] Note: the annexes to the study protocol are not included in this report. A copy can be obtained from the UNICEF office in Kyiv.

[294] The list of services for referral will also be discussed and agreed with the CAB.

Data instrument:

Girls and boys will receive separate questionnaires. Please see Annex III[295].

Piloting of the instrument:

Plans are to pilot the instrument (the standard questionnaire) in Kyiv city.

The purposes of piloting the instrument:

- To test questions by various criteria: adequateness, adolescent-friendly formulation, whether they prompt answers, conforming with memorisation of events, etc.
- To test the sample-recruiting procedure
- To test the interview approach (the locations in which the research is carried out, the requirements for interviewers, the incentives for participating in the interviews and so on).

Piloting the instrument will involve interviewing 10 male adolescents and five female adolescents. The eligibility criteria for piloting the instrument are:

1. See list of eligibility criteria under point "Population group(s)". These eligibility criteria will be tested during the instrument piloting phase.
2. The adolescents most have sexual and injecting drug use experience.
3. The adolescents must live in appropriate places (on the street, in shelters).
4. They must be in these age ranges: 10 to 14 years, 15 to 17 years and 18 to 19 years.

Training for fieldworkers:

The Ukrainian Institute of Social Research after Olexander Yaremenko will plan, organise and conduct interviewer training. It will take place in Kyiv in early October 2007 (two days, 25 to 30 participants). The agenda/curriculum of the training will be available in September 2007. Fieldworkers will learn about research sites and fieldwork managers will participate in interviewer training sessions.

As mentioned under the point "Fieldworkers", the interviewers, fieldworkers and fieldwork managers will also receive interview instructions, ethical and gender guidelines for fieldwork and interviewing and an information package for (potential) interviewees prior to data collection.

Ethical Issues:

UNICEF has developed overall ethical and gender guidelines for conducting research among MARA that will serve as a framework for this study: see Annexes IV and V.

The Ukrainian research team developed ethical and gender guidelines for interviewers, fieldworkers and fieldwork supervisors based on this framework: see Annex II.

The ethical guidelines make reference to key ethical issues within the Ukrainian context, especially with regard to child protection issues. According to Ukrainian legislation, any person encountering a child without parental care is obliged to inform the authorities. Child abuse and exploitation should also be reported to relevant authorities. The research team will ensure that all this is done by working closely with the (1) key focal point for the UNICEF MARA Programme within the Ministry of Family, Youth and Sports, (2) the National Research Advisory Board, (3) the CABs in each research site (including representatives of child protection services) and (4) local focal points within each CSSFCY. The procedures the guidelines describe are in line with existing laws.

In addition, as mentioned previously, each interviewer and fieldworker will have an information package for (potential) interviewees. It will include a list of relevant local services. Each research team member will

[295] Note: the annexes to the study protocol are not included in this report. A copy can be obtained from the UNICEF office in Kyiv.

know how to use it and how to refer a child to the appropriate services. Key focal points within the CABs and the CSSFCY will help to ensure that children and adolescents have access to adequate services.

Data analysis:

The Ukrainian Institute of Social Research after Olexander Yaremenko will analyse the data. The Research Team Leader and the London School of Hygiene and Tropical Medicine (LSHTM) will help it do so.

SPSS.PC will be used for data entry and data analysis. Data will be disaggregated by:

- Age
- Sex
- Location
- Risk behaviour
- Social setting
- Vulnerability factors/determinants.

Resources required:

All resources needed for the baseline research are covered by UNICEF Ukraine.

Quality Assurance/Management:

The following structures are in place and the following instruments will be used for quality assurance:

The UNICEF Regional Office contracted the LSHTM as an International Consultant. Its task was to strengthen the evidence base and national capacity to programme effectively for HIV prevention for MARA girls and boys in Ukraine and other selected countries.

The Ukrainian research team tasked to coordinate, design, implement and prepare the publication of the study was selected via an open UNICEF tender. It consists of:

- An international Research Team Leader (Anja Teltschik) who is responsible for facilitating all national-level research activity and coordination with other research teams at the regional level, including liaising with the LSHTM regarding technical assistance. She is also responsible for delivering research outputs and serves as the central contact person during planning, implementing and analysing data collection. She coordinates with other research programmes and projects in Ukraine, particularly with:
  - The UN PAF project on "Strategic data collection and services indicator development on HIV and related issues for young people (10–24 years)". The projects complement each other and will run in parallel; and
  - The UNAIDS coordinated project on "Comprehensive Evaluation of the National AIDS Response" in Ukraine, which will also look at most-at-risk populations and HIV services for children and young people.
- A national Research Team from the Ukrainian Institute of Social Research after Olexander Yaremenko, comprising:
  - The Baseline Survey Manager, Olga Balakireva.
  - The Qualitative Study Manager and gender expert, Yuliya Galustian.
  - A team of Researchers from the Institute.
  - A group of fieldworkers and a team of five interviewers plus one fieldwork manager in each research site.
  - One legal advisor.
  - One translator.

The research team is working together with the Research Team Leader, the LSHTM, UNICEF and others in developing an appropriate study design for the MARA research and is implementing all research components and activities.

UNICEF in Ukraine is the overall supervisor of the Research Team, including the Team Leader.

The Team Leader reports monthly to UNICEF on research progress. In addition, regular meetings between UNICEF, the Team Leader and the Research Team take place, as do regular working and progress meetings between the Team Leader and the Research Team.

UNICEF Ukraine has agreed the research with the Ministry of Family, Youth and Sports. A focal point for the research has been appointed and has provided a support letter.

As part of quality control, the research instrument will be piloted (see "Piloting of the instrument").

Fieldwork managers will regularly debrief fieldworkers and interviewers. The fieldwork managers will report regularly about fieldwork progress to the Research Team and Team Leader. Members of the Research Team will conduct site visits to oversee the work of the fieldwork managers and the research.

UNICEF initiated a Research Coordination Group as part of the Working Group on HIV Prevention, Treatment, Care and Support for At-risk Children that key stakeholders (governmental, non-governmental and faith-based) who work with children in Ukraine at both the national and local levels established in spring 2007. The Group acts as a National Research Advisory Board for all research that is being conducted or planned on HIV/AIDS, children and young people in Ukraine, including MARA. Both groups still await approval from the Ministry of Family, Youth and Sports. In the meantime, they act as informal advisory groups. The Group's first meeting took place in July 2007. During it, the first draft of the protocol for this study was presented and discussed.

At the local level, the Research Team, together with the Team Leader, will commence fieldwork with round tables for key stakeholders at which they will present and discuss the planned research. Working meetings will follow. As mentioned under the point "Sampling", CABs will be set up in each city/region. They will enhance cooperation, coordination and collaboration among local stakeholders. Also, selected local organizations (see "Fieldworkers") will help recruit interviewees. Members of the research population group will also take part in the research, primarily through the work of the CABs.

Agreements and consultations with authorities and community

Please see above and under "Sampling".

The Ministry of Family, Youth and Sports of Ukraine has committed itself to this research and to subsequent action. Existing policy and legislation discusses the need for more research, particularly among the research population group, and to scale up the coverage, quality and equity of services for MARA and adolescents living and working on the streets. See, for example:

- International treaties[296], particularly:
  - The *United Nations Convention on the Rights of the Child (CRC)*, ratified in Ukraine on 28 August 1991.
  - The General Comment No.3 on "HIV/AIDS and the Rights of the Child", adopted by the *CRC Committee* in November 2003.
  - The *Optional Protocol to the United Nations Convention on the Rights of the Child on sale of children, child prostitution and child pornography,* ratified in Ukraine on 3 July 2003.
  - The final outcome document of the *Special Session of the UN General Assembly on Children "A World Fit for Children",* signed by Ukraine on 10 May 2002.

[296] Please note that international treaties that have been ratified and approved by the Supreme Council of Ukraine become an integral part of national legislation according to article 9, paragraph 1 of the Constitution of Ukraine. If an international treaty conflicts with national legislation, article 19, paragraph 2 of the "International Treaties Act of Ukraine" stipulates that the former takes precedence.

- The *UNGASS Declaration of Commitment on HIV/AIDS (UNGASS Declaration)*, adopted by Ukraine in 2001.

- National policy and legislation, especially:
  - The Law *On the Basis of Social Protection of Homeless Citizens and Children and on Organizational and Legal Conditions for the Social Protection of Orphans and Children Deprived of Parental Care.*
  - The Concept for a State Programme Aimed at Fighting the Homelessness and Neglect of Children for 2006–2010 and the State Programme Aimed at Fighting the Homelessness and Neglect of Children for 2006–2011.
  - The *National Report on implementation of the decisions of the final outcome document of the Special Session of the UN General Assembly on Children (2002) and Action Plan "A World Fit for Children"* prepared by the State Institute for Family and Youth Development and the Ministry of Family, Youth and Sports of Ukraine (Kyiv, 2007).

ANNEX 4:

List of variables used in the UNICEF MARA baseline study[297]

Variables
Sociodemographic profile
City
Sex
Age
Where did you live during the last 3 months?
Do you spend most of your time on the street?
How long have you been living on the street?
School attendance during this study year
Place of birth? (Type of settlement)
Place of birth? (Oblast)
Place of birth? (Country)
How long have you been living in this city?
Where did you live before? (Type of settlement)
Where did you live before? (Oblast)
Where did you live before? (Country)
Educational level
Is your mother alive?
Is your farther alive?
*Orphan status
Do you live with your mother/foster mother?
Do you live with your father/foster father?
Do you live with your brother/sister?
Do you live with your grandmother/grandfather?
Do you live with other relatives (uncle, aunt, etc.)?
Do you live with your wife/husband (official marriage)?
Do you live with a partner (de facto marriage)?
Do you live with your guardian?
Do you live with friends?
Do you live alone?
Do you live with other people?
*Living with friends
*Living with parents
*Living with adult relatives
Which of the following documents do you presently have? (Birth certificate)
Which of the following documents do you presently have? (Identification code)
Which of the following documents do you presently have? (Medical card)
Which of the following documents do you presently have? (Passport, certificate about the loss of the passport, certificate about release from detention centre, other)
Which of the following documents do you presently have? (Education certificates such as school leaving certificate, diploma, etc.)
Which of the following documents do you presently have? (Single ticket free transportation ticket for orphans under the age of 18)
Which of the following documents do you presently have? (Other)
Nationality

[297] Composite variables used in the analysis are marked with the symbol "*"

Alcohol/drug use
Have you ever used alcohol?
Have you ever inhaled glue or any other toxic solution or substance?
Have you ever smoked weed/marijuana?
Have you ever used non-injecting drugs?
Have you ever injected a drug?
Have you ever used other substances or drugs? (What kind?)
How old were you when you first injected a drug?
* Length of time of injecting drug use
When was the last time you injected?
How often have you injected drugs in the last 30 days?
On the last occasion you injected, did you use a new, clean needle/syringe?
In the last 30 days, how often did you use a syringe after someone else had squirted drugs into it from their syringe?
In the last 30 days, how often did you inject drugs using a syringe that had been filled from a working syringe?
In the last 30 days, how often did you inject drugs using a pre-filled syringe?
In the last 30 days, how often did you use a filter or cotton that someone else had previously used to draw up drugs with your needle/syringe?
In the last 30 days, how often did you draw up your drug solution into your syringe from a mixing container?
How many times during the last month did you inject using a needle/syringe that had been previously used by someone else?
In the last month, how many times did you inject using a non-sterile (unclean) needle/syringe?
*Needle/syringe sharing
From where do you obtain syringes? (Pharmacy)
From where do you obtain syringes ? (Needle exchange point)
From where do you obtain syringes? (Outreach worker)
From where do you obtain syringes? (Stealing)
From where do you obtain syringes? (Hospital)
From where do you obtain syringes? (At the place where I inject drugs)
From where do you obtain syringes? (Picking up a used syringe from the street or other places)
From where do you obtain syringes? (From IDU-friends)
From where do you obtain syringes? (From non-IDU friends)
From where do you obtain syringes? (From sex partners)
From where do you obtain syringes? (From my family)
From where do you obtain syringes? (Other)
* Knowledge of formal places where sterile injecting equipment is available

Sexual practices
Have you ever had vaginal intercourse?
How old were you when you had vaginal intercourse for the first time?
How many sex partners did you have during the last year?
When was the last time you had vaginal intercourse?
Have you ever had anal intercourse? (With a heterosexual partner)?
Boys: Have you ever had anal intercourse with a boy/man?
Boys: How old were you when you had anal intercourse with a boy/man for the first time?
Boys: When was the last time you had anal intercourse with a boy/man?
Boys: How many male sex partners have you had during the last month?
Boys: How many male sex partners have you had during the last year?

Boys: Have you ever been forced by a male partner to have sex or forced him yourself in the last year?
Boys: The last time you had sex with a male partner, did you use a condom?
Boys: How many commercial male sex partners have you had in the last month?
Boys: The last time you had sex with a commercial male partner, did you use a condom?
Boys: How often did you use condoms with a male sex partner (regular, casual, commercial) in the last 12 months?
Do you have a regular sex partner?
How long have you been with this partner?
How often did you use condoms in the last month with your regular sex partner?
Girls: The last time you had sex with your regular sex partner, did you use a condom?
Is your regular sex partner an injecting drug user?
Boys: How many regular female sex partners did you have in the last year?
In the past 12 months, have you had sex with a casual partner?
In the past 12 months, how many casual partners did you have sex with?
The last time you had sex with a casual partner, did you use a condom?
How often did you use condoms in the last year with casual sex partners?
Have you received a reward for sex (money, goods, drugs, etc.) in the last 12 months?
Girls: How old were you when you first received a reward for sex?
* Length of time selling sex (Girls)
When was the last time that you had sex with a commercial sex partner?
Girls: How many commercial partners did you have sex with in the last year?
The last time you had sex with a commercial partner, did you use a condom?
In the last year, how often did you use condoms with commercial sex partners?
Have you ever received a reward for sex? (Money)
Have you ever received a reward for sex? (Food)
Have you ever received a reward for sex? (Clothes)
Have you ever received a reward for sex? (Drugs)
Have you ever received a reward for sex? (Goods)
Have you ever received a reward for sex? (Other)
*Have ever received a reward for sex
Have you ever been forced to have sex?
Have you been forced to have sex in the last year?
Where do you get condoms? (At a pharmacy, shop, petrol station)
Where do you get condoms? (At a newsstand)
Where do you get condoms? (From an outreach worker)
Where do you get condoms? (Stealing)
Where do you get condoms? (Hospital)
Where do you get condoms? (From friends)
Where do you get condoms? (From sex partners)
Where do you get condoms? (From my family)
Where do you get condoms? (Other)
* Knowledge about a formal source of condoms
Have you ever had genital sores, ulcers or unusual genital discharges?
What did you do? (Went to private health care facility for diagnostics and treatment)
What did you do? (Went to a pharmacy to buy drugs for self-treatment)
What did you do? (Went to a traditional healer for diagnostics and treatment)
What did you do? (Cured myself at home)
What did you do? (Stopped having sex)
What did you do? (Asked outreach workers for advice)
What did you do? (Called a helpline)

What did you do? (Went to an anonymous counselling/testing site (“Dovira”) site for help)
What did you do? (Other)
What did you do? (Did nothing)
Girls: Have you ever been pregnant?
Girls: How many times have you been pregnant in your life?
Girls: Do you have children?
Girls: How many children do you have?
Girls: Have you ever had an abortion?
Girls: How many times have you had an abortion?
Girls: Have you ever had a miscarriage?
Girls: How many times have you had a miscarriage?
Overlapping risks
* Overlapping MARA behaviour (Girls)
* Overlapping MARA behaviour (Boys)
* Selling sex (last 12 months) + IDU
* Selling sex (last 12 months) + IDU + MSM
Behavioural determinants and use of services
Can having sex with one faithful, uninfected partner reduce the risk of HIV transmission?
Can the correct and consistent (regular) use of condoms reduce the risk of HIV transmission?
Can a healthy-looking person have HIV?
Can a person get HIV from mosquito bites?
Can a person get HIV from drinking from the same glass with somebody who is infected?
Can a person get HIV by sharing the toilet, swimming pool or sauna with somebody who is infected?
Does using a clean, unused needle/syringe for injecting drugs reduce the risk of HIV transmission?
*HIV knowledge
Where is it possible to take a voluntary HIV test?
Anonymous counselling/testing site – “Dovira”
Hospital
AIDS Prevention Centre
Polyclinic
Antenatal clinic
Private doctor
Drug treatment clinic
Blood transfusion station
Other
Have you ever had an HIV test?
Have you had an HIV test in the past 12 months and do you know your result?
Where did you last get tested for HIV? (Anonymous counselling/testing site “Dovira”)
Where did you last get tested for HIV? (Hospital)
Where did you last get tested for HIV? (AIDS Prevention Centre)
Where did you last get tested for HIV? (Outpatient department)
Where did you last get tested for HIV? (Polyclinic)
Where did you last get tested for HIV? (Private hospital)
Where did you last get tested for HIV? (Drug treatment clinic)
Where did you last get tested for HIV? (Blood transfusion station)
Where did you last get tested for HIV? (Other)
* Who have tested for HIV in the past 12 months and who know their result
Have you ever been stopped or harassed by the police?

In the last year, how many times have you been stopped or harassed by the police?
What was the reason? (Drug use)
What was the reason? (Drug storage)
What was the reason? (Preparation of drugs)
What was the reason? (Drug sale)
What was the reason? (Prostitution)
What was the reason? (Pilferage)
What was the reason? (Vagrancy)
What was the reason? (Suspicious behaviour)
What was the reason? (Theft/larceny)
What was the reason? (Causing bodily harm)
What was the reason? (Hooliganism/robbery)
What was the reason? (Drinking alcohol in public)
What was the reason? (Detained during a police raid)
What was the reason? (Other)
Have you ever been in a pre-trial detention centre?
Have you ever been in a remand penitentiary facility?
Have you ever been in a distribution centre for minors?
Have you ever been in a shelter for minors?
Have you ever been in a juvenile colony?
Have you ever been in any other juvenile penitentiary facility?
Have you ever been in a special room for children in a police department?
Have you ever been in a special distribution centre for homeless people?
Have you ever been in a regional police department?
Pre-trial detention centre (Physical violence, assault)
Distribution centre for minors (Physical violence, assault)
Shelter for minors (Physical violence, assault)
Juvenile colony (Physical violence, assault)
Other juvenile penitentiary facility (Physical violence, assault)
Special room for children in a police department (Physical violence, assault)
Special centre for homeless people (Physical violence, assault)
Regional police department (Physical violence, assault)
Pre-trial detention centre (Injecting drug use)
Remand centre (Injecting drug use)
Distribution centre for minors (Injecting drug use)
Shelter for minors (Injecting drug use)
Juvenile colony (Injecting drug use)
Other juvenile penitentiary facility (Injecting drug use)
Special room for children in a police department (Injecting drug use)
Special centre for homeless people (Injecting drug use)
Regional police department (Injecting drug use)
Pre-trial detention centre (Forced sex)
Remand centre (Forced sex)
Distribution centre for minors (Forced sex)
Shelter for minors (Forced sex)
Juvenile colony (Forced sex)
Other juvenile penitentiary facility (Forced sex)
Special room for children in a police department (Forced sex)
Special centre for homeless people (Forced sex)

Regional police department (Forced sex)
Have you ever applied for help to medical services?
Have you ever applied for help to medical services in the last year?
Have you ever applied for help to social services?
Have you ever applied for help to social services in the last year?
Have you ever applied for help to…? (Centre for Social Services for Families, Children and Youth)
Have you ever applied for help to…? (Youth-friendly clinic)
Have you ever applied for help to…? (Non-governmental organization)
Have you ever applied for help to…? (Service for Children)
Have you ever applied for help to…? (Faith-based organization)
Have you ever applied for help to…? (Needle exchange point)
Have you ever applied for help to…? (Drug rehabilitation centre)
Have you ever applied for help to…? (Dispensary (narcological, STI, tuberculosis)
Have you ever applied for help to…? (Anonymous counselling/testing site – “Dovira”)
Have you ever applied for help to…? (Polyclinic)
Have you ever applied for help to…? (AIDS Prevention Centre)
Have you ever applied for help to…? (Psychosocial rehabilitation centre)
Have you ever applied for help to…? (Shelter for minors)
Did you receive the help that you needed? (Centre for Social Services for Families, Children and Youth)
Did you receive the help that you needed? (Youth-friendly clinic)
Did you receive the help that you needed? (Non-governmental organization)
Did you receive the help that you needed? (Service for Children)
Did you receive the help that you needed? (Faith-based organization)
Did you receive the help that you needed? (Needle exchange point)
Did you receive the help that you needed? (Drug rehabilitation centre)
Did you receive the help that you needed? (Dispensary (narcological, STIs, tuberculosis)
Did you receive the help that you needed? (Anonymous counselling/testing site “Dovira”)
Did you receive the help that you needed? (Polyclinic)
Did you receive the help that you needed? (AIDS Prevention Centre)
Did you receive the help that you needed? (Psychosocial rehabilitation centre)
Did you receive the help that you needed? (Shelter for minors)

ANNEX 5:

Additional references

The following list of references was compiled by Clea Meynell, who conducted an additional analysis of the data of the Baseline Survey among adolescents living and working on the streets in Ukraine: LSHTM (2008), Investigating HIV risk behaviours amongst most-at-risk adolescents in Ukraine, submitted in partial fulfilment for the award of Master of Science, Demography & Health, University of London, by Clea Meynell, September 2008, unpublished.

Her reference list is included in this report as an annex, as many of the conclusions Meynell drew that were cited in this report refer to other research that the reader might find useful.

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