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**CHILDREN AND YOUNG PEOPLE
LIVING OR WORKING ON THE STREETS:
THE MISSING FACE OF THE HIV EPIDEMIC
IN UKRAINE**

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Kyiv 2006

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This report is dedicated to all the children and young people who live, work and who have died - prematurely - on the streets of Ukraine.

They are the forgotten, the invisible, the excluded – the faces in the dark.

May this report contribute to raising the awareness and provide information about their lives, but more importantly may it motivate people in all sectors of society to reach out, advocate and take actions to protect and support these children and young people and to encourage and help them take up and lead a better, happier and healthier life.

Report by Anja Teltschik

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The picture on the cover page was taken by **David Gillanders**, Scottish photographer, who has worked closely with *AFEW* on a project on street children in Ukraine. This photo taken in Ukraine won first prize in the international UNICEF ‘Photo of the Year’ contest in 2005. Currently David undertakes social and humanitarian projects around the world. David Gillanders’ personal website: www.davidgillanders.com

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List of abbreviations and acronyms

AFEW	AIDS Foundation East-West
AIDS	Acquired Immune Deficiency Syndrome
CEE	Central and Eastern Europe
CIS	Commonwealth of Independent States
CSSFCY	Centre(s) of Social Services for Family, Children and Youth in Ukraine
GFATM	Global Fund to Fight AIDS, Tuberculosis, and Malaria
GO	Governmental Organization
HIV	Human Immunodeficiency Virus
ILO	International Labour Organization
INGO	International Non-Governmental Organization
MoES	Ministry of Education and Science of Ukraine
MoFYS	Ministry of Family, Youth and Sport of Ukraine
MoH	Ministry of Health of Ukraine
MoI	Ministry of Interior of Ukraine
NCC	National Coordination Council for the Prevention of HIV/AIDS
NGO	Non-Governmental Organization
SOS	Morse code distress signal
SOCIS	Centre for Social and Political Investigations (a research centre in Kyiv)
STI(s)	Sexually Transmitted Infection(s)
TB	Tuberculosis
UAH	Ukrainian currency (Hryvnia)
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session on HIV/AIDS (June 2001)
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
WHO	World Health Organization

1. INTRODUCTION AND BACKGROUND

“Street children are among the most physically visible of all children, living and working on the roads and public squares of cities all over the world. Yet, paradoxically, they are also among the most invisible and, therefore, hardest children to reach with vital services such as education and health care, and the most difficult to protect.”¹

Children and young people living or working on the streets are not a new phenomenon in Ukraine nor in the region of Central and Eastern Europe (CEE) and the Commonwealth of Independent States (CIS). In the Soviet Union, after the Bolshevik revolution and the Civil War in the 1920s, an estimated seven million children living on the streets, whose parents were either missing or dead, were institutionalised in children’s homes.² The Soviet regime was characterised by an extensive welfare system, including a huge network of state-funded, residential child-care institutions. The Soviet State took on many of the responsibilities of parents, thus increasing their dependence on state support and the state infrastructure. Many citizens even came to see state institutions as better places for child-care than the family.³ To some degree, similar beliefs can still be found in the Ukraine today. There are parents who leave their children on the steps of children’s homes or boarding schools in the hope that these state-run institutions will provide better care than that which they think they can provide themselves.⁴ But while the Soviet child-care institutions were able to keep children off the streets through a system of strict control and the punishment of runaways, worldwide evidence shows that long-term institutionalisation can have many negative consequences for children and young people, often leaving them unprepared for life outside the institution.⁵

The phenomenon of children and young people living or working on the streets of Ukraine re-emerged after the break-up of the Soviet system. The reforms introduced at that time focused primarily on the development of the economy, of an adequate political and legal framework, and on privatisation. The transition processes left the welfare system and the health and social sectors under-funded and neglected. As an example, the total budget for the social protection of children in 2005 amounted to only US\$ 660,000.⁶ Efforts to restructure the systems were introduced too slowly and without sufficient funding. There was a lack of strategy and the consequences of the fundamental changes that took place in the relationship between the Ukrainian State and its citizens since the early 1990s were not properly addressed. These changes meant that Ukrainian citizens received less state support and had an increased responsibility for their own welfare.

Today, many health and social services are not only in a poor state, but also often fail to provide even the minimum standard of care and support that the Ukrainian State guarantees

to its citizens. Social benefits are unequally distributed resulting in insufficient assistance being allocated to those families in greatest need. Many children's homes are destitute. Often, funds for these homes are not even sufficient to provide adequate food and clothing for the children nor competitive salaries for qualified staff.⁷

The transition processes also resulted in a country with a major gap between the rich and the poor.⁸ Over 20% of the Ukrainian population still lives in poverty and 3% in extreme poverty, which means on less than US\$ 1 per day.⁹ Unemployment is high and the number of crimes has increased from a recorded total of 393 per 100,000 population in 1980 to 1,162 per 100,000 in 1997.¹⁰ The number of dysfunctional families has also increased. A common cause of problems is severe financial difficulties in the family leading to other problems such as a break-down in communications between parents, or a parent starting to engage in unsafe or illegal activities. A general break-down of meaningful communications between parents and children is often linked to a lack of emotional support within the family and a failure on the part of social services to provide adequate assistance when disaster strikes, such as a serious illness or the death of one or more family members. Labour migration of one or both parents can mean that children are being left uncared for and unattended for long periods of time, or subject to domestic violence and abuse, or lead to the use of substances or drugs.¹¹ The life expectancy at birth continues to decline¹² and two major epidemics, HIV and tuberculosis (TB), are challenging Ukraine by adding to already high morbidity rates in the country.

The negative consequences of the former Soviet Union's welfare and child protection system, and the transition process, have had a severe impact on families in Ukraine. Children and young people are particularly vulnerable. According to the Head of the Department of Children in the Ministry of Family, Youth and Sport (MoFYS), a difficult situation at home or in a child-care institution is the main reason why thousands of children have taken to the streets in Ukraine. The phenomenon of children and young people living or working on the streets of Ukraine can in fact be explained by a combination of these situations. Neglect, violence, trauma and deprivation can cause serious damage to the developing personality of a child or young person resulting in physical, psychological and social problems. The current social policies on housing, employment and social security benefits¹³, as well as the criminalisation of drug users also add to the failure to create a protective environment for children and young people (see later chapters for more details).

The situation children and young people are facing on the streets of Ukraine is, however, no less dismal than at home or in the child-care institutions from which they have run away. On the streets they have to fight for their survival and have to integrate into a different kind of community, the 'street community'. Their socioeconomic situation might force them to become involved in anti-social, and sometimes criminal, activities. They are exposed to discrimination and to violence on the streets, to substance and drug use, and to sexual abuse as well as to other harmful factors. They may also find themselves excluded from health, education and social services and at alarmingly high risk of physical and psychological problems resulting not only from their previous circumstances, but as a direct consequence of their life on the streets.¹⁴

According to official statistics, Ukraine has a population of almost 47 million people of whom around 10 million are under the age of 18. Of these approximately 62,000 children are currently living in residential child-care institutions. There are no official statistics on the total number (the 'baseline') of children and young people living or working on the streets of Ukraine, but estimates provided by governmental and non-governmental organizations (hereafter subsumed under the term of 'service providers') or research institutes vary from 40,000 to 300,000. The most recent low estimate of the size of this population, used as a baseline to calculate how many children aged 10 to 18 are most likely to be exposed to HIV and might be in need of HIV services, amounted to 115,000 children.¹⁵ For the two cities, Kyiv and Odesa, that are the subject of the survey presented in this report, the estimates are about 12,000 children and young people living or working on the streets in Kyiv and around 4,000 in Odesa. The review of literature and research shows however that many of the estimates made in the past were overestimates, or were based on non-systematic estimates or counts.¹⁶ The estimates for Ukraine, Kyiv and Odesa, should therefore be regarded with caution, as there is no agreement currently among service providers and research institutes on the method of calculation nor on the definition of children and young people living or working on the streets. Consequently, this report is based on the fact that the actual baseline data is unknown. Because the real extent of the problem is unidentified, it has also been difficult to plan and implement adequate national and regional responses.

Children and young people living or working on the streets in Ukraine come from different places and countries. They are a highly mobile group, facing many risks and engaging in behaviours that expose them to a high risk of acquiring infectious diseases such as HIV, sexually transmitted infections (STIs), hepatitis B and C, and TB. The Ukrainian government has publicly acknowledged the challenge of providing adequate health, education and social services for this group, of protecting them from further harm and of supporting their reintegration into society. However, progress is very slow and hampered by the many obstacles inherent in the current child protection system. The issues that need to be addressed are many and complex. In addition, few of the Ukrainian State policies and national programmes targeting children and young people define special services for those living or working on the streets. Due to the lack of an adequate national monitoring and evaluation system, it is also almost impossible to assess the outcome and impact of programmes and projects implemented by service providers working with this group. The effectiveness of the national response over the past 16 years may be questioned though, given that the phenomenon has by now developed into a crisis.

A major step forward was taken this year with the development of four documents and programmes, which include the 2006 'Concept for a State Programme' ('2006 State Concept') and the 2006 'State Programme Aimed at Fighting the Homelessness and Neglect of Children 2006-2011' ('2006 State Programme on Homeless and Neglected Children'). The third document is the *Road Map to Universal Access to HIV Prevention, Treatment and Care in Ukraine by 2010* (*Road Map*) that was developed by a multi-stakeholder working group with the support of the United Nations Programme on HIV/AIDS (UNAIDS) in April 2006. The *Road Map* defines this group as one of the groups 'most-at-risk' of HIV infection, due both to the environment in

which they live and to their risk behaviours, and stresses the need to implement a basic package of HIV prevention and care services for them.¹⁷ The fourth document is the 2006 *Ukraine HIV/AIDS application to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) (2006 Ukraine GFATM proposal)* that includes ‘street children’, aged 10 to 18, as one of the key target groups for HIV prevention interventions for 2007-2011.¹⁸

Even though these are important documents and programmes, there are many challenges with regard to their implementation, harmonisation and evaluation. While the *2006 Ukraine GFATM proposal* for example still needs to be granted and will target children and young people solely in juvenile detention centres and state-run shelters, the *Road Map* is still lacking an implementation plan and has yet to be integrated into the ‘National Programme to Prevent HIV Infection, Support and Treat People Living with HIV/AIDS for the period 2004-2008’. Furthermore, the ‘2006 State Programme on Homeless and Neglected Children’ does not set a target nor describe interventions which could reduce the likelihood of exposure to HIV and other infectious diseases for children and young people facing risk situations or engaging in risk behaviours. For other limitations of the Programme, see chapter five.

2. A DEFINITION OF THE TARGET GROUP

In line with the Ukrainian legal definition of adulthood, children are human beings below the age of 18. Anyone above the age of 18 living or working on the streets is considered a ‘homeless adult’.

The Ukrainian legal terminology does not have a single fixed term for children and young people living or working on the streets (the ‘target group’). Instead, the following terms are used in different national laws and policies: ‘homeless children’, ‘children without care’ and ‘neglected children’. According to the 2001 Law of Ukraine ‘On the Protection of Childhood’:

1. ‘Homeless’ children are children who have been abandoned by their parents, or who have run away from home or from a child-care institution, and have no permanent dwelling; and
2. ‘Neglected’ children are children who are living in conditions unfavourable to their physical, emotional and intellectual development, through lack of financial security, caring support and a healthy atmosphere. Accordingly, neglect is understood as the weakening or total lack of parental or guardian oversight of a child’s behaviour, development and wellbeing.¹

The ‘2006 State Concept’ and the ‘2006 State Programme on Homeless and Neglected Children’ further speak about ‘children without care’, meaning children who are not cared for by a parent, a guardian nor by any type of child-care institution.

The difficulty with these definitions is that although all ‘homeless children’ may be considered neglected, not all ‘neglected children’ are necessarily homeless, as they may not choose life on the streets, despite unfavourable circumstances at home or in a child-care institution. In addition, some children who are living on the streets do have parents or a guardian, and are therefore legally ‘children under care’, despite the fact that those legally responsible might not fulfil their responsibility.

The United Nations Children’s Fund (UNICEF) uses the term ‘children living or working on the streets’.² For the purpose of this report, the UNICEF term was chosen and slightly adapted to ‘children and young people living or working on the streets’ to reflect adequately the Ukrainian situation, where young people³, particularly aged 19 or slightly older, are often members of the groups of children who are living or working on the streets and tend to have a strong influence on many younger group members.

UNICEF divides children living on the streets into three categories:

1. ‘Children 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;

2. Children who maintain contact with their families, however due to poverty or other reasons such as exposure to abuse, spend most of their days, and occasionally nights, on the street; and
3. Children who technically reside in state boarding schools or shelters, but for one reason or another have run away and now live on the streets.⁴

These categories have been criticised as not fully reflecting the many ways that children choose spend their lives on the street.⁵ However, given the difficulties with the Ukrainian legal definition and the inadequacy of other categories reviewed, the UNICEF categories were applied when recruiting interviewees for the survey in the cities of Kyiv and Odesa, which is described in the next chapter.

3. PURPOSE OF THE ASSESSMENT AND REPORT

In the last five years several small-scale surveys were conducted of the target group in Kyiv, Kharkiv and other cities of Ukraine, as well as an analysis of the policies relating to this target group, and in 2003 the MoFYS published a national report on ‘homeless and neglected children’. However, none of these documents focuses on this target group in the light of the growing HIV epidemic in Ukraine, despite the likelihood of this group’s exposure to HIV and to other infectious diseases. The aims of this report are to close this gap and:

- To assess and present the overall needs and demands of the target group, particularly in the cities of Kyiv and Odesa;
- To identify best practices and gaps in service provision, to highlight areas for improvement and to widen the scope of services, while taking into consideration existing capacities, finances and structures in Ukraine; and
- To provide recommendations and guidelines for the design, implementation and evaluation of a comprehensive, multisectoral national strategy for prevention, treatment, care and support for this target group, in the context of the country’s national response to children and young people who are ‘homeless’ and ‘neglected’, to the HIV epidemic, and in its efforts to promote healthy lifestyles.

The report presents the results of the first step in a joint project of UNICEF and *AFEW* that started in 2005 and targets children and young people living or working on the streets in Ukraine in the light of the HIV epidemic. It takes into account similar assessments performed in other countries.

The assessment for this report was conducted in two parts. The first consisted of a situation analysis conducted by UNICEF in cooperation with *AFEW*¹ that was executed between October 2005 and July 2006. It included structured in-depth interviews and meetings with representatives of selected international, national and local service providers (including faith-based organizations). The representatives were selected on the basis of their role and their responsibility in policy-making and law enforcement, in advocacy, in grant giving and management, in related research, and in direct service provision. All relevant sectors were represented, including health, social, education, law, and religion (see annex I for a list of interview partners).

Given that the majority of interviewees were either government employees or other, non-governmental ‘service providers’, the term ‘service providers’ will be used throughout the report to represent the range of informants from governmental, non-governmental and faith-based organizations.

Alongside the interviews, desk research and a secondary analysis were carried out that involved gathering, reviewing and analysing existing information (research results, literature, websites and available data and official statistics). This helped not only to assess the estimates and state-

ments of the service providers interviewed, but also to identify additional problems and to determine priority areas for national and regional responses. In addition relevant events such as conferences were attended and a consultation meeting was held in Kyiv with key stakeholders to discuss preliminary findings and recommendations (for a list of participants and minutes of the meeting, see annex II). There were several factors that restricted the situation analysis, including:

- Limited access to external and formal evaluations of national and local initiatives, providing valid and reliable information about their quality, and the lack of outcome- and impact-oriented indicators used in measuring progress and success;
- Few organizations and institutions exist in Ukraine that deal specifically with the target group;
- Lack of baseline data and shortage of disaggregated data for the target group, particularly at a national level where data on this group are currently included in general statistics about children and young people in ‘crisis situations’;
- The fact that there are no representative and reliable statistics for the target group regarding the incidence of HIV, STIs and other health problems, such as hepatitis or TB; and
- Some service providers refused to meet the interviewer or to share information.

The second part of the assessment comprised a quantitative and a qualitative survey conducted by *AFEW* in cooperation with UNICEF² during the period November 2005 – April 2006. The specific aim of the survey was to carry out a baseline study to assess the behaviour, attitudes, practices and knowledge, in addition to the needs and demands, of children and young people living or working on the streets of Kyiv and Odesa, the attitudes of service providers toward the target group, and the availability and adequacy of existing support services to meet current needs in relation to health in general, sexual health and HIV and AIDS in particular, education and leisure activities, stigma and discrimination, exploitation and substance and drug use. Another purpose of the survey was to complement the results of the situation analysis and to compare the view of the service providers with that of the target group.

The quantitative survey was conducted among children and young people living or working on the streets of Kyiv city (Kyiv) and Odesa city (Odesa), aged 10 to 19, through face-to-face interviews based on a standardised, pre-tested questionnaire (see annex III). In each of the two cities, 300 children and young people were recruited for interviews based on the UNICEF categories described in chapter two (600 altogether). The children and young people were recruited and partly interviewed with the assistance of local service providers. The team of interviewers underwent training beforehand and both cities were divided into separate zones to avoid overlaps. Before each interview, the consent of each child or young person was obtained and the principles of anonymity and confidentiality of the survey were explained to them. The majority of the children and young people were interviewed in places where they usually meet, including metro stations, pedestrian subways, supermarkets, bridges, railway stations, ruins of houses, houses under construction, markets and ‘hideouts’ or inside sewers. 10 per cent of the

children were interviewed at municipal reception and distribution centres, 6 per cent at boarding schools and 22 per cent at psychosocial rehabilitation centres.

The qualitative survey consisted of 25 in-depth interviews in each city (50 in total) with selected children and young people (see annex IV for the guidelines for the in-depth interviews). The interviews took place in a safe, quiet and relaxed environment. In Kyiv, children and young people were interviewed at the centres of the non-governmental service providers 'New Life' and 'Street children', while in Odesa they were interviewed in the premises of the non-governmental service provider 'The Way Home'. Care was taken to ensure that the participants were properly prepared for the interviews and supported by psychologists or social workers.

The survey data were disaggregated according to sex (male, female), age (the respondents were divided into two age groups: 10- to 14-year olds and 15- to 19-year olds) and the period of time spent on the street (up to one year, one to two years, and more than two years).

The main limitations of the survey are as follows:

- It was not possible to provide a representative sample in either city, as baseline data were not available;
- Wherever feasible, the data were tested for correlations between the level of HIV awareness and risk behaviours. However due to the small number of responses to several of the questions it was not always possible to correlate the data for length of time spent on the street, sex, age and risk behaviour;
- The survey did not include children and young people living or working on the streets who were held at juvenile detention or penitentiary facilities at the time of the survey;
- The survey took place in the winter, and therefore access to the children and young people was restricted;
- The data provided are self-reported and therefore are likely to include some untrue responses, for example when a child or young person gives an answer thinking that this particular response might be expected of them, or when they try to hide something. This is a bias that was impossible to eliminate from the analysis;
- Given that the per centage of respondents in Kyiv and in Odesa varied sometimes significantly in terms of sex, age, length of time spent on the street, sleeping at home or at a friends' apartment, having quit school and having one parent who is still alive, it was not possible to present the combined findings from both cities. The differences in per centages also explain some of the differing results in both cities, which will be pointed out in the relevant chapters; and
- It was not possible to analyse the number of children and young people reached by support programmes, given that the groupings by age and sex were too small to draw any reliable conclusions.

4. A PROFILE OF CHILDREN AND YOUNG PEOPLE LIVING OR WORKING ON THE STREETS IN UKRAINE

4.1 Sex and age distribution

The service providers interviewed estimated that the sex ratio is about 70 per cent males to 30 per cent females, and that the largest group of children and young people living on the streets in Ukraine is between 8 and 14 years old. The survey findings reflect these estimates. In both cities, males constituted the larger group of respondents (78 per cent in Kyiv and 65 per cent in Odesa).

For the purpose of statistical analysis by age, the children and young people were grouped into 'Juniors' aged 10 to 14, and 'Seniors' aged 15 to 19. Juniors constituted the larger group of respondents in both cities: 52 per cent, in Kyiv and 60 per cent in Odesa.

Table 1: Age distribution (Kyiv)

AGE	NUMBERS	PERCENTAGE
10	13	4.5
11	15	5
12	25	8.3
13	49	16.3
14	53	17.7
15	51	17
16	40	13.3
17	25	8.3
18	19	6.3
19	10	3.3
TOTAL	300	100

Table 2: Age distribution (Odesa)

AGE	NUMBERS	PERCENTAGE
10	23	7.7
11	21	7.0
12	34	11.3
13	49	16.3
14	53	17.7
15	52	17.3
16	28	9.3
17	21	7.0
18	15	5.0
19	4	1.3
TOTAL	300	100

These results are also similar to findings from quantitative and qualitative studies conducted in other countries.¹

4.2 Origin

Anecdotal evidence from the interviews of service providers suggests that many of the children and young people living or working on the streets of Ukraine come from small towns and villages, where opportunities for employment are limited and the economic situation is more difficult. Interviewees stressed that in some cases children and young people from even relatively stable families may leave home for the summer to earn some extra money in a bigger city, but can get caught in the cycle and never return home.

Target group members also come from various regions of Ukraine, from the Republic of Moldova (Moldova) and the Transdnistria region (particularly in Odesa), from the Russian Federation (Russia) and other former Soviet Union countries. The results of the in-depth interviews held in Kyiv and in Odesa supported this finding, as do data obtained from interviews with representatives of the Kyiv City Shelter for Minors that is run by the Kyiv City Department of Children, showing that in 2005 of 1,081 children who stayed at the shelter, 317 were from Kyiv, 758 had come from other regions of Ukraine, and six were from other former Soviet Union countries.

Most of the children and young people interviewed who came from far away reported that they had travelled by suburban electric trains.

4.3 Literacy and education

Overall, literacy levels in Ukraine are very high (99 per cent)², and so is the gross primary school enrolment ratio, which was 91.8 in 2005 according to official statistics. Administrative data gathered from Ukraine in 2004 show that 99 per cent of the primary school entrants reached grade five.² However anecdotal evidence from the interviews of service providers and the findings of the survey in Kyiv and in Odesa demonstrate that the target group belongs to the 1 per cent of the Ukrainian population whose literacy levels and education levels are very low.

Even though target group members have for the most part attended school at some stage in their lives, some of them have never attended regularly, and the average grade level completed tends to be about third grade for 16-year olds, and even less for those who are younger. Some interviewees estimate that only about 10 per cent of the children and young people living or working on the streets in Ukraine have basic reading, writing and math skills. They stressed that most of them have attended school for periods varying from a few months to a couple of years, and that there are rare cases of target group members who are excellent students and attended school regularly. These are usually children and young people who have not been on the streets for very long, or whose situation at home has been relatively stable. Some target group members receive school diplomas stating they have completed a certain level of study,

but this is usually misleading since the education system in Ukraine grades children and young people according to their age and not their education level.

According to the survey results, the greater number of the children and young people interviewed in Kyiv (72 per cent) and in Odesa (77.9 per cent) have some experience of going to school, but were out of school at the time of the interview. Less than one third said that they are still attending school (25.5 per cent in Kyiv and 13.4 per cent in Odesa) and only a few of the respondents (3.7 per cent in Kyiv and 8.7 per cent in Odesa) had never attended school.

The majority of children and young people interviewed had quit school at an early age. In Kyiv, 59 per cent quit school between the ages of 11 and 13 and in Odesa, 71 per cent quit school between the ages of 9 and 12, after completing second to fifth grades. A very small number of those interviewed in-depth that said that they had finished secondary school.

Table 3: Age at which the respondent stopped attending school (Kyiv)

AGE	NUMBERS	PERCENTAGE
7	1	0.7
8	10	6.7
9	7	4.7
10	16	10.7
11	23	15.3
12	34	22.7
13	32	21.3
14	17	11.3
15	10	6.7
TOTAL	150	100

Table 4: Age at which the respondent stopped attending school (Odesa)

AGE	NUMBERS	PERCENTAGE
6	1	0.5
7	6	3.2
8	12	6.3
9	27	14.2
10	38	20.0
11	39	20.5
12	31	16.3
13	20	10.5
14	14	7.4
15	1	0.5
18	1	0.5
TOTAL	190	100

A comparison with studies from other countries shows that the majority of children and young people living or working on the streets in these countries also have low levels of literacy and education, and at least half of them are no longer attending any school.⁴

4.4 Faith and religion

The experience of service providers interviewed is that the target group does not attend any church regularly. Their exposure to faith-based service providers is often limited to assistance provided by volunteers in the streets or in shelters run by these service providers, which may or may not involve religious indoctrination.

Some shelters run by governmental and non-governmental service providers also encourage children and young people to visit nearby churches, without necessarily favouring any one religion.

There were some concerns raised about certain 'sects' that exercised a hold over children and young people who had no parental care, but these seemed to be isolated cases rather than larger trends.

The faith of the target group was not a subject of the survey conducted in Kyiv and in Odesa. However, some of the children and young people interviewed in-depth said that they were believers, but did not enlarge on this further.

4.5 Relationships with families and guardians

According to the service providers interviewed, there are cases where one or both of the parents of those in the target group are dead or unaccounted for. However, most children and young people living or working on the streets of Ukraine are so-called 'social orphans', not biological orphans. That means that one or both parents are still alive, but may be at home, in prison, working elsewhere, sick and unable to take care of the child or young person, or missing. Findings of the survey support this. For example 60 per cent of the children and young people interviewed in Kyiv reported that their mother was still alive, as did 43 per cent of the respondents in Odesa.

In the opinion of most of the service providers interviewed, one of the principal underlying causes that lead children and young people to living on the streets is the difficulties that their parents face with regard to employment; either that parents are unemployed or that they have jobs that allow them little time with their family. The latter is especially true for many single-parent households. It might also include jobs in other parts of Ukraine or even abroad, meaning that children are left unattended, often for long periods of time. Besides the financial consequences, unemployment can also lead to serious depression, substance and drug use and domestic violence in the form of verbal, psychological and different forms of physical abuse. Service providers reported that children and young people are usually abused by one or both parents, an older sibling, or a stepparent who considers the child from the first marriage to be an 'intrusion'. Besides these, the interviewees gave the following reasons for children and young people taking to the streets:

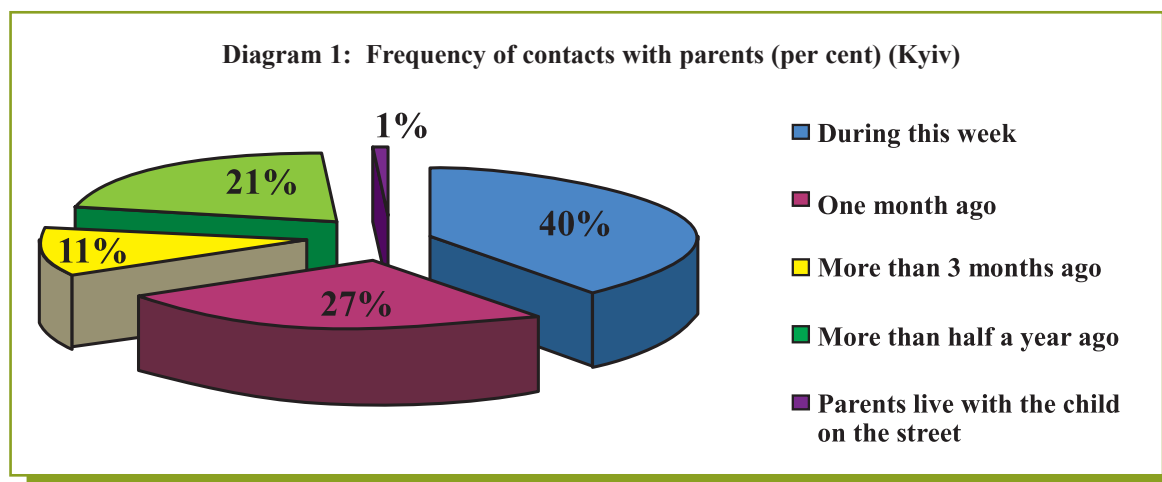
- Refusal to accept a new stepparent, even if they are well-meaning;
- Arrival of a new child in the family, either a natural sibling or one by marriage;
- Refusal to accept the authority of another family member or other guardian;
- Authoritarianism of parents;
- Deviant behaviour of the child or young person; and
- Misunderstandings that may get blown out of proportion within families with otherwise good relations.

According to the interviewees, in most cases children and young people maintain little or no contact with their families once they are on the streets, although some do remain in contact with siblings, extended family or friends. Despite this fact, they reported that many children and young people hope to be reconciled with their family someday and may even return home for short periods to attempt reconciliation. Experience shows however that without outside intervention and assistance, any hope of long-term reconciliation is not realistic because patterns tend to repeat themselves. Only about 10 per cent to 20 per cent of children and young people are sought out by their families, underlining the point that reconciliation depends not just on the will of children and young people to return home, but also on that of their parents to have them back. It was stressed that some children and young people still think of their own parents as role models during their first few months on the streets, despite any abuse they may have received from them, but that eventually they start looking up to group leaders in the street, and perhaps to social workers or other adults they have learned to trust.

In the survey, the frequency of meetings with parents was used as an indicator of the relationship of the target group with their parents, as well as whether or not the target group members are still in contact with their parents. The overall findings differ from city to city. Whereas in Kyiv 50 per cent of the respondents said that they either met or lived with (2 per cent) their parents, thus contradicting the statements of the service providers interviewed, in Odesa only 14 per cent of the respondents reported meeting or living (3 per cent) with their parents. It is not possible from the data analysis to explain this marked difference between the two cities and the contradiction with the experience of service providers. Additional research would be needed to understand these findings.

In both cities, there is a small group that claimed to have no parents (7 per cent in Kyiv and 8 per cent in Odesa).

The diagram below shows the frequency of the meetings with parents in Kyiv. It demonstrates that contacts with parents are relatively regular: 40 per cent of the children and young people had seen their parents at some point during the week of the interview, 27 per cent had met their parents about a month ago, 11 per cent had seen their parents more than three months before and 21 per cent had seen them more than half a year ago. A few (1 per cent of respondents) said that they were actually living together with their parents on the streets.



If a parent's rights have been legally terminated, other family members are usually appointed guardians by the court in Ukraine. Within the frame of the assessment for this report only one case could be identified in which someone who is working for a non-governmental service provider, in this case the Director of 'The Open Heart' in Kyiv, was granted legal guardianship of a child with HIV who lived on the streets before being accepted at 'The Open Heart Centre for Medical-Social Assistance'. Guardianship is a key tool of Ukraine's child protection system. Sometimes guardians are elderly family members which can cause problems, especially when they feel overwhelmed by the responsibility of caring for a young, demanding child or a difficult young person and do not receive adequate psychosocial support. In combination with other factors, this may cause the child or young person to decide to take to the streets.

Anecdotal evidence further suggests that there are some cases of children and young people who, orphaned by AIDS and living with HIV themselves, are taken care of by appointed guardians who are extended family members and who refuse to believe that the child or young person is sick and therefore refuse to have them treated with antiretroviral drugs. According to government employees, guardians are currently not being held accountable for such actions.

Service providers in Odesa mentioned cases of children and young people orphaned by AIDS who did not receive appropriate care and support in children's homes and took to the streets. Others, born to mothers living with HIV, had to stay a long time in hospital (sometimes several months) until a place could be found for them in a children's home. It is a major challenge in Ukraine to find an adoptive or foster family for these children, and efforts to do so are rarely successful.

The analysis of the relationships of target group members with their families and guardians shows not only their many different backgrounds, but indicates also the differing psychological, medical and other needs that they may have. It also shows the additional vulnerabilities of target group members who have been orphaned by AIDS, who were born to HIV-positive mothers, who live with HIV or an AIDS-related disease themselves or who are cared for by guardians.

4.6 Health status and health risks

4.6.1 General health problems

Children and young people living on the streets all over the world not only face scarce resources, but also live in an environment that is often noisy, dirty, violent, unsafe and impersonal. They usually have restricted access to health care services, are often subject to violence, engage in harmful practices such as substance and drug use, face a huge number of risks to their overall wellbeing, and experience a wide range of health problems that are very similar in most countries, including respiratory and gastrointestinal problems and infectious diseases.⁵

There are no official statistics on the general health of the target group in Ukraine. According to the service providers interviewed, their main health problems include respiratory and gastrointestinal problems and infectious diseases such as hepatitis, TB, HIV and STIs, as well as fleas and lice, gynaecological problems, kidney problems from exposure to cold and dehydration, dental and eyesight problems, spinal and head injuries, and developmental delays. In Ukraine there is only one specialised medical centre for the target group; the 'Centre for Medical-Social Assistance' in Kyiv, founded by the non-governmental service provider 'The Open Heart', which is based in the Kyiv City Dermatological-Venereological Clinic. Out of 180 children and young people tested there during the first six months of 2006, 12 had been treated for syphilis, 38 for scabies, and 21 for lice. According to the medical statistics of the non-governmental service provider 'The Way Home' in Odesa, many children and young people suffer from more than one disease. Out of 480 children and young people tested and treated by the organization, 220 had gastritis problems, 130 bronchial problems, 70 pneumonia, 380 scabies, 40 dermatitis, 150 abscesses, 100 furuncles, 450 delays in their physical development, 280 spinal problems, 316 anaemia, 415 asthenia, 16 asthma, 26 sprains, 8 sinus problems, 62 herpes, 118 hepatitis, 204 laryngitis, 224 dental problems, and 32 girls had gynaecological problems. There is further anecdotal evidence from service providers in other cities of Ukraine that if abscesses and other serious infections remain untreated gangrene can develop, and some cases are reported of children who have had to have a limb amputated because the spread of the infection was putting their life at risk.

During the in-depth interviews (which were conducted in the winter), children and young people also reported having frostbitten feet and leg pains caused by the cold, memory disorders and a lack of coordination. Several mentioned that they had undergone treatment for syphilis and two revealed that they are living with HIV and had had co-infections such as TB. The number of respondents is small, because of the sensitivity of the subject and the fact that few of the children and young people had been tested for HIV or TB.

There are no official statistics on the number of children and young people living or working on the streets in Ukraine who have TB and who have undergone appropriate treatment. TB, like HIV, has reached epidemic proportions in Ukraine. The TB epidemic is categorised as a 'general epidemic', i.e. spread among and affecting the Ukrainian population as a whole. According to the World Health Organization's (WHO) *Report 2004 on Global tuberculosis control – surveil-*

lance, planning, financing,⁶ the estimated TB case rate is 95 cases per 100,000 people, and Ukraine had almost 47,000 TB cases in 2002. People living with HIV are highly susceptible to developing TB, and TB patients in Ukraine are ten times more likely to have multi-drug resistant TB⁷ than in Western European countries. Given these facts, the lack of data is worrying.

There are also no official statistics on the number of target group members who have a STI or have been treated for STIs and, according to the service providers, few of the target group members have yet been tested for HIV, primarily because of legal obstacles related to the consent of a parent or guardian (see chapter five for more details).

The service providers interviewed considered the many health problems of the target group to be mainly due to poor hygiene and nutrition, and the consequences of trauma, substance or drug use, unprotected sex, accidents or beatings. They reported that most children and young people accessing their services also have depression, and it can be very difficult to get them to express themselves. The depression often starts when they first leave their families, as they may have feelings of separation and even misplaced guilt at leaving, even though they may have been abused. The guilt can stem from worrying about parents who are sick, drinking too much alcohol or using drugs. Children and young people often feel either that they should have stayed to care for their parents, or that they were selfish in leaving. Depression can also be caused by feelings of having been abandoned by parents, especially if the child or the young person was adopted. Depression, as well as the use of substances and drugs, can lead to physical aggression towards others and even towards themselves, as evidenced by scarring on the arms of some children and young people observed by the interviewers conducting the survey in Kyiv and in Odesa. However, service providers also pointed out that most target group members do not intend to harm themselves, and suicides and overdoses are rare, as the survival instinct of the children and young people is what got them out on the streets to begin with. Not all agreed with this though and some highlighted the ambivalence between the survival instinct on the one hand and self-destructive and self-harming behaviour on the other, calling it 'a slow and unconscious suicide'. While these are subjective observations and must therefore be considered with caution, they underline the need for further research into this topic, especially as there are no official statistics on intentional self-harm, suicides or overdoses in the target group to validate either statement.

The children and young people who participated in the survey in Kyiv and in Odesa reported having a wide range of symptoms associated with many of the diseases mentioned above. During the past 12 months, they had primarily had respiratory problems (56 per cent of all respondents in Kyiv and 50 per cent in Odesa), and in Kyiv they also frequently reported bodily injuries and bruises (41 per cent in Kyiv, compared to 26 per cent in Odesa). They also mentioned abdominal pain (44 per cent in Kyiv and 37 per cent in Odesa), headaches (55 per cent in Kyiv and 40 per cent in Odesa), high temperature (46 per cent in Kyiv and 45 per cent in Odesa) followed by toothache (28 per cent in Kyiv and 22 per cent in Odesa), skin rash (16 per cent in Kyiv and 19 per cent in Odesa), and genital ulcers (4 per cent in Kyiv and 3 per cent in Odesa). A mere 8 per cent of the children and young people interviewed in Kyiv and 7 per cent of those in Odesa responded that they had no health problems during the past year.

Diagram 2: General health problems experienced in the past 12 months, reported by children and young people living or working on the streets of Kyiv (per cent)

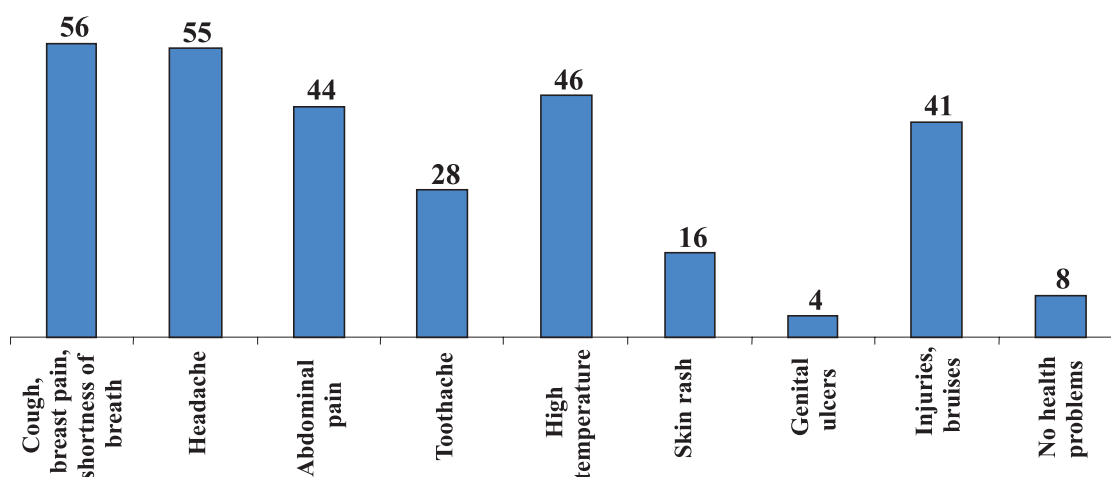
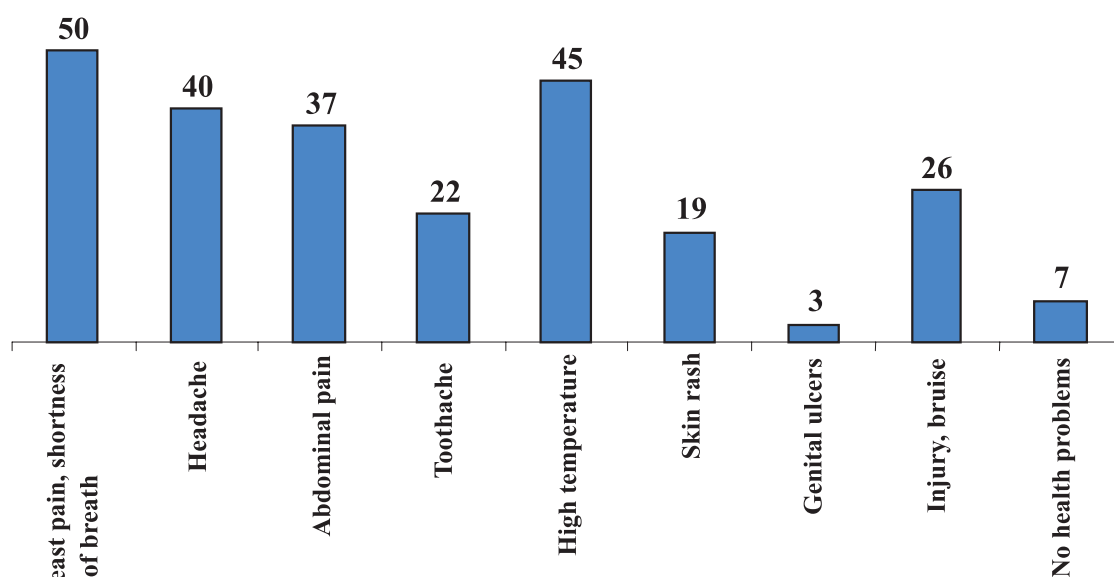


Diagram 3: General health problems experienced in the past 12 months. Reported by children living or working in the streets of Odesa (per cent)



The survey data were also analysed by sex, age group and length of time spent on the streets. Significant differences were observed between females and males concerning the incidence of respiratory diseases and of injuries and bruises. Of the male respondents in Kyiv, 59 per cent complained of a cough, shortness of breath and chest pain, compared to 45 per cent of the female respondents. While the data analysis does not provide any explanation for this difference, the fact that male respondents in Kyiv (46 per cent) and in Odesa (33 per cent) reported a

higher incidence of injuries and bruises compared to the female respondents (20 per cent in Kyiv and 12 per cent in Odesa) might be linked to data presented later on in this report, which show that male respondents are more frequently beaten and are using more substances and drugs, increasing the risk of accidental injuries whilst in a state of intoxication.

There is also a correlation between the number of self-reported health problems and the age group of the respondent. Seniors in both cities reported a far greater number of health problems than Juniors. This might be linked to the greater awareness levels of Seniors, as demonstrated for example by findings concerning the HIV awareness in sub-section 4.6.8 of this chapter.

When analysing the relationship between the self-reported health problems and the length of time spent on the streets, in Kyiv a significant difference was only found in terms of skin rash. Problems with skin rash were experienced by 12 per cent of the target group living on the streets for less than one year, while 23 per cent of those living on the streets for more than one year reported a skin rash. In Odesa, the differences were more evident. The occurrence of most of the health problems was higher among children and young people who had been living on the streets between one and two years than among those who had been there less than twelve months, particularly for respiratory problems, high temperature, abdominal pain and genital ulcers. Moreover, the number of children and young people interviewed who reported no health problems decreased from 10.9 per cent among those who had lived no more than a year on the streets to 5.8 per cent among those who had lived one to two years on the streets.

Table 5: Relationship between health problems experienced in the past 12 months and the length of time spent on the streets (per cent) (Odesa)

HEALTH PROBLEMS	LENGTH OF TIME SPENT ON THE STREETS	
	0 to 12 months N = 119	1 to 2 years N = 120
Cough, breast pain, shortness of breath	42	49.2
High temperature	37	48.3
Headache	46.2	30.8
Abdominal pain	26.9	42.5
Injury, bruises	30.3	18.3
Toothache	16.8	25.8
Skin rash	15.1	21.7
Genital ulcers	0.8	2.5
Reported no health problems	10.9	5.8

4.6.2 The risk of abuse and exploitation

Many children and young people leave their homes and take to the streets to escape abuse and exploitation. However, once living or working on the streets, they are usually exposed to abuse again. According to the service providers interviewed, abuse takes many forms in Ukraine, such as verbal, psychological and physical abuse as well as sexual and labour exploitation. Perpetrators can include parents, stepparents, siblings, other children and young people living or working on the streets, or in children's homes or shelters, employers, crime ring bosses, tenants of buildings the children and young people may inhabit, shop owners and people meeting the children and young people in the street. During the situation analysis, there were also some allegations of verbal, psychological, and in some cases, physical abuse by shelter staff and by law enforcement officers.

Abuse, in all its forms, has a negative impact on the physical and mental health of children and young people. Besides the anecdotal evidence given by service providers and the self-reported data of the children and young people interviewed in Kyiv and in Odesa, there are no reliable, official statistics on the abuse of this target group in Ukraine. Abuse is generally under-reported. According to service providers interviewed there are many reasons for this, including the lack of access to adequate services and to legal assistance, as well as the target group's mistrust of many governmental service providers. The anecdotal evidence shared by the service providers and the self-reported data of the children and young people interviewed raise major concerns about the abuse and exploitation of this target group and the protection of their rights.

The in-depth interviews showed for example that experience of sexual exploitation and violence seem to be relatively common among the target group. In Kyiv, 21 per cent of the children and young people interviewed, and 32.5 per cent of those interviewed in Odesa reported having experienced sexual violence or exploitation within the past six months, most of them being girls and young women. Further research would be needed to learn more about the sources of sexual violence and exploitation since these were rarely revealed.

19-year old woman in Odesa: "There was one incident, in the year of 2001, when (mother) made me sleep with him (some man). I told him I didn't want to sleep with him... Mother wanted him to give her a bottle of vodka. He did give her a bottle of vodka. She was sitting in the kitchen. I was sleeping. He woke me up, began molesting me. The situation was such that there was no money and she (the mother) needed a drink. She drank that bottle. The man was gone. I cried for a while... Then she slept herself sober. She didn't even tell me anything. She just didn't talk to me for three or four days. She got drunk... she came home drunk..."

Interviewer: "Was it the first time that you had such a contact?"

Woman: "Yes."

Interviewer: "Was it a contact involving a condom?"

Woman: "No. I don't remember whether or not a condom was used."

Interviewer: "And you haven't had any sexual contacts after that?"

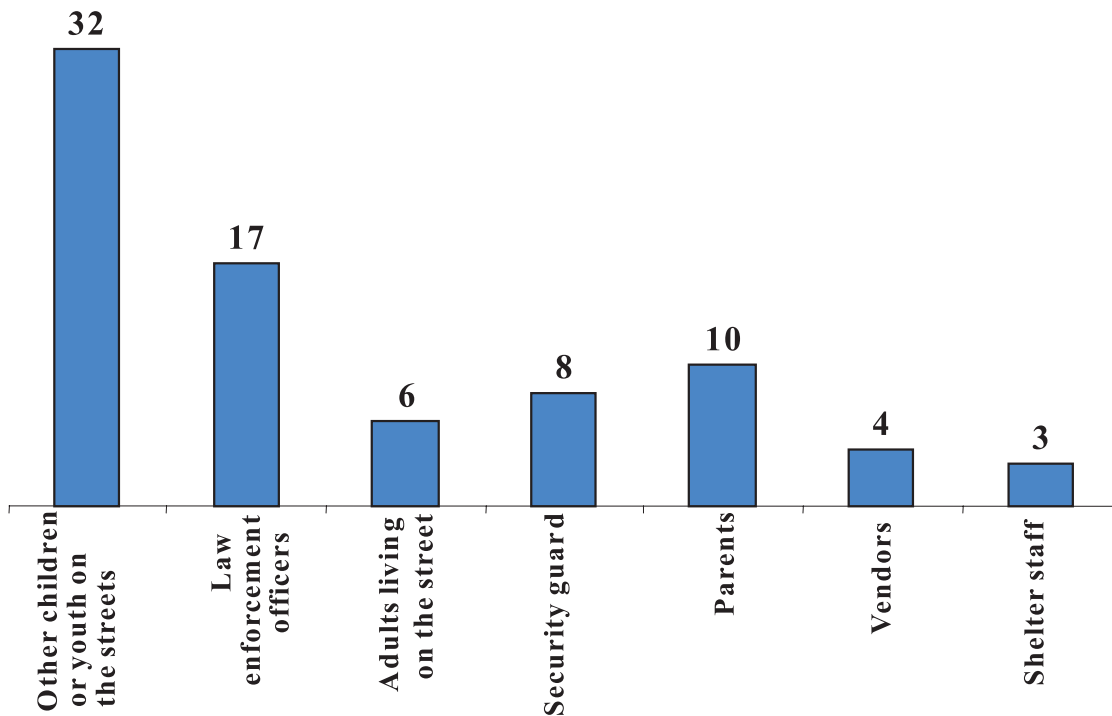
Woman: "No, I haven't."

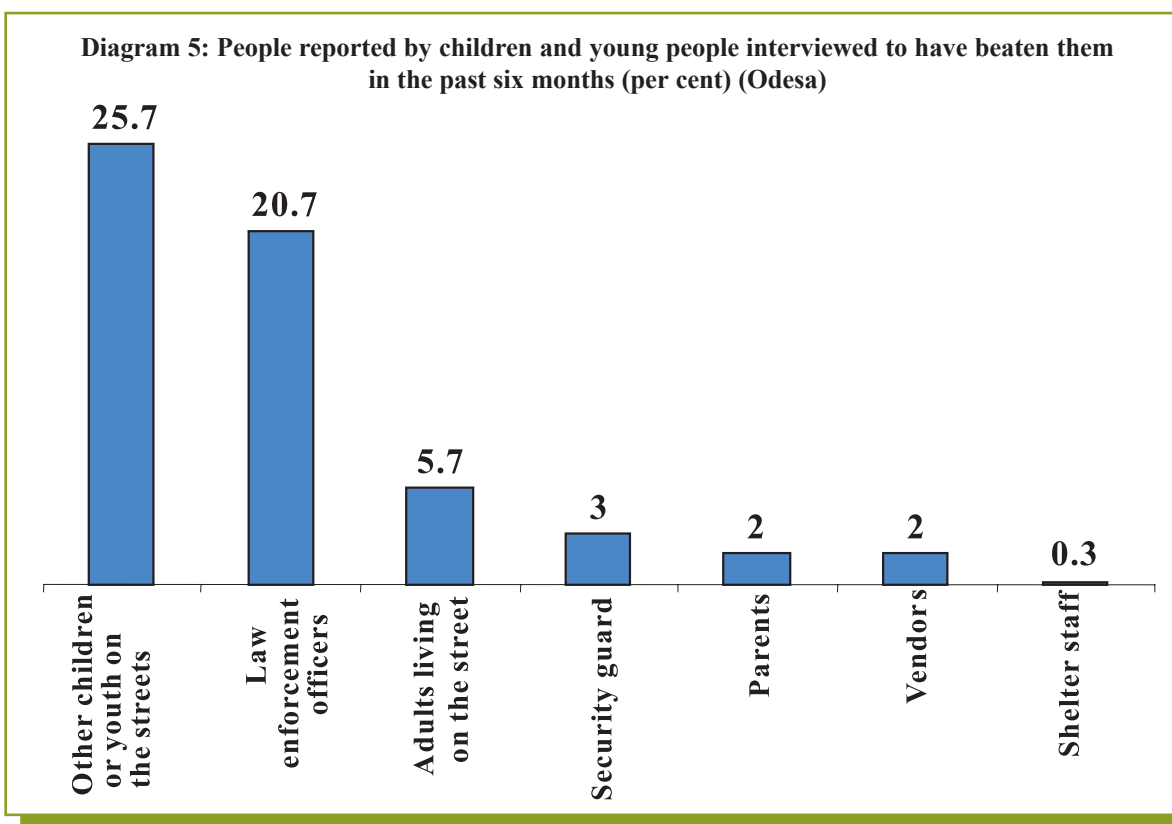
14-year old girl in Kyiv: “Someone tried to rape me once. It was a fat stranger. I was rescued by...(a boy’s name); he (the boy) is right here. I don’t want to recall it.”

13-year old girl in Odesa: “Attempts were made to rape me but I managed to slip away somehow. I don’t want and I don’t like it. I saw how my (female) friend was raped and I don’t want it.”

Concerning other forms of physical abuse, beatings were the most common. In Kyiv, 53 per cent and in Odesa, 47 per cent of the children and young people interviewed reported that they had been beaten in the past six months. As the main source of physical violence, they named other members of their target group (in Kyiv 32 per cent and in Odesa 26 per cent). Law enforcement officers took the second place with 17 per cent of respondents in Kyiv saying that representatives of the local police force had beaten them, and 21 per cent in Odesa. Furthermore, 10 per cent of the children and young people in Kyiv reported having been beaten by their parents during the past six months compared to 2 per cent in Odesa. This marked difference between the two cities might be linked to the fact that the respondents in Kyiv had more frequent contact with their parents than did the respondents in Odesa.

Diagram 4: People reported by children and young people interviewed to have beaten them in the past six months (per cent) (Kyiv)





There is a significant difference by age group of the respondents in replies to questions concerning beatings by law enforcement officers. Seniors reported more physical violence from law enforcement officers (26 per cent in Kyiv and 28 per cent in Odesa) than Juniors (10 per cent in Kyiv and 16 per cent in Odesa). Juniors (in Kyiv 34 per cent and in Odesa 31 per cent) reported more violence from other members of the target group than Seniors (in Kyiv 30 per cent and in Odesa 18 per cent).

Table 6: The relationship between the source of the beating and the age group of the children and young people (per cent) (Kyiv)

PERSONS REPORTED TO HAVE BEATEN THE CHILD (IN THE PAST 6 MONTHS)	AGE GROUP	
	JUNIORS 10 to 14 years	SENIORS 15 to 19 years
Other children and young people living or working on the streets	33.5	29.7
Law enforcement officers	9.7	25.5
Adults living on the streets	3.9	8.3
Parents	12.3	6.9
Vendors	4.5	3.4
Security guards	7.7	8.3
Shelter staff	1.9	4.1

Table 7: The relationship between the source of the beating and the age group of the children and young people (per cent) (Odesa)

PERSONS REPORTED TO HAVE BEATEN THE CHILD (IN THE PAST 6 MONTHS)	AGE GROUP	
	JUNIORS 10 to 14 years	SENIORS 15 to 19 years
Other children and young people living or working on the streets	30.6	18.3
Law enforcement officers	15.6	28.3
Adults living on the streets	4.4	7.5
Parents	2.2	1.7
Vendors	2.2	1.7
Security guards	1.7	5
Shelter staff	0.6	0

The length of time that the children and young people have spent on the streets also influences the experience of physical abuse. While lesser beatings are reported from parents more beatings are reported from law enforcement officers. Of those members of the target group who have lived less than a year on the streets, 12 per cent reported having been beaten by law enforcement officers in Kyiv and 19 per cent in Odesa, compared to 24 per cent in Kyiv and 30 per cent in Odesa of those who have lived more than a year on the streets. The reasons for that are, however, not clear from the data collected.

During the in-depth interviews in Odesa, the interviewers tried to explore the reasons for law enforcement officers beating the target group. The children and young people interviewed said that they were beaten for example for thefts and for being involved in fights. Some of them mentioned that it was their own fault and that they were beaten ‘not for nothing’. Others said they had been beaten in order to obtain information about other target group members who might be involved in thefts and the use of drugs, or for forcing a confession from a child or young person claiming to be innocent, particularly with regard to the use of substances and drugs. Being beaten ‘for fun’ and out of ‘sadism’, or for sitting in the wrong place or walking around in dirty clothes was also mentioned.

One respondent said that he had paid some money to the law enforcement officers, so that they would leave him alone and several girls reported that they sometimes succeed in being left alone when they ‘plead for mercy’. Besides speaking about beatings, detailed descriptions of how respondents had been tortured by law enforcement officers were also provided by a number of interviewees. More details on this issue are provided in chapters 5.2 and 6.3.

Besides the physical, verbal and psychological abuse the children and young people are experiencing at the hands of other children, young people and adults, the results of the situation

analysis indicate that they are also sometimes exploited for labour. They are particularly vulnerable to this form of exploitation as they are trying to earn a living and want to stay invisible. In some cases, the opposite may also be true, as children and young people trying to escape labour exploitation may take to the streets. This kind of exploitation is usually found in such fields as street trade, agricultural work, construction, sex work, and drug selling and trafficking.⁸ More children and young people from rural than from urban areas tend to want to work to support their families, and some are forced into work by their families, although a large number of them are interested in earning their own money. More than half of them are over the age of 15.⁹

The target group is also at risk of being trafficked within and outside of Ukraine. However, the trafficking of children is considered to be less widespread than that of adults in Ukraine (according to the International Labour Organization (ILO) in Ukraine¹⁰ 10 per cent of all trafficking victims known to return to the country are aged 12 to 18). Such cases are difficult to document¹¹ because it is often difficult for the border control to identify children being trafficked, and because children are rarely reported missing or come forward of their own accord. There are no official statistics on the number of children and young people living or working on the streets of Ukraine who have been trafficked, but the Ukrainian government has recognised trafficking in persons as a serious problem.¹² The majority of children trafficked are girls, though there are also some boys. Children are being trafficked for sex and the sex industry, cheap labour, as drug couriers, for begging and petty crimes.¹³ During the in-depth interviews in Odesa, one boy mentioned a case of trafficking. One of his acquaintances had been offered a paid job, had then been taken from the street and the city, and finally had been forced to collect scrap metal at a garbage dump, receiving neither payment nor food.

Trafficked children are often deceived, or have false promises made to them, or the poverty of their parents is used to put pressure on them. Two of the groups among children and young people considered most vulnerable to trafficking are those leaving children's homes¹⁴ and children whose parents are working abroad. There are reports that Roma families hire out their children for begging on the streets or pick-pocketing in other CIS countries.¹⁵ Trafficking in whatever form can traumatise children and young people and can have major impacts on their physical and mental health.

Given the sensitivity of the topic of organised crime, children and young people were only asked to report on their contacts with the world of crime in Kyiv and in Odesa during the in-depth interviews. Those interviewed in Kyiv stressed that the contacts with the world of crime are always directly related to 'money-making'. They reported for example collectively robbing drunken people to obtain mobile phones and money. Mobile phones are sold on and even though it was not said explicitly in the interviews, it was obvious that some of the children and young people represent one part of a chain of the theft and sale of mobile phones in Kyiv, which has become a well-established business.

Interviewer: "...where do you get money? How do you obtain it?"

11-year old boy in Kyiv: "I can beg... (Or) some man may be buying, for example, a hot dog. I'll steal his money. I'll take it for myself. I'll take it casually. Or perhaps I will take it from a drunken man walking by. I will bring him down and take his money."

Interviewer: "Can you bring him down when you are alone?"

Boy: "Alone, no. Well, I cannot do it alone. I do it only when there are two of us. If I take my flock (group), I tell one of them to bring him down."

Interviewer: "So do they obey you? You can give your boys orders?"

Boy: "I cannot give orders. They protect me. They are older than me."

Interviewer: "And how much money can you collect that way?"

Boy: "All that he had...Sometimes we left something. But we took away the mobile phone."

Interviewer: "And so what did you do with the mobile phone?"

Boy: "We shook it off."

Interviewer: "What does that mean?"

Boy: "We sold it."

Interviewer: "Did you already know who you should bring it to?"

Boy: "There are lots of such people."

An employee of the 'Detention Centre for Minors' in Kyiv run by the Ministry of Interior (MoI) said that the main reasons for members of the target group becoming involved in criminal activities are because they are forced by older members of their group, to make a living, and sometimes also for the thrill involved. In Odesa, a 13-year old girl told the interviewer how adults had tried to use her for criminal purposes, but that law enforcement officers had helped her and her friends.

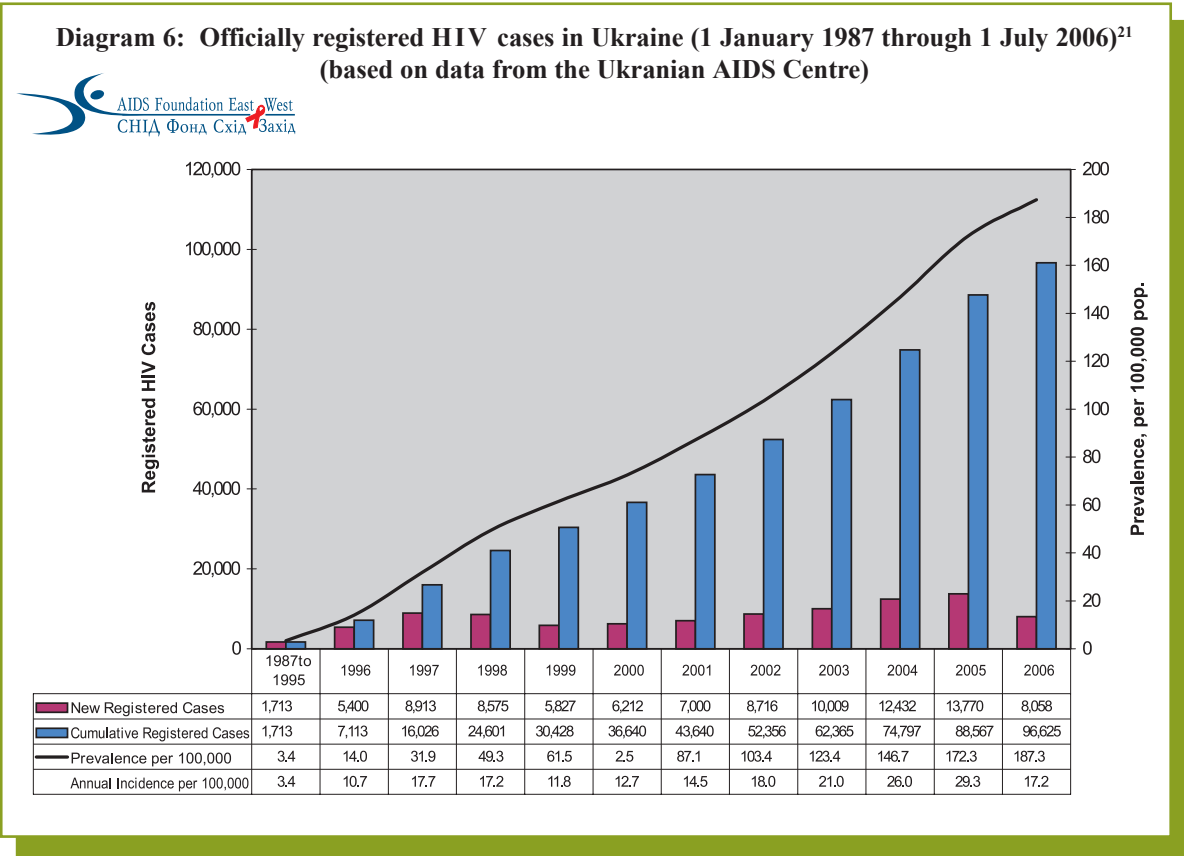
13-year old girl in Odesa: "We were abused and badly beaten. Two men – they wanted us to go about in their company harassing all those we meet – like snatching a handbag...they (the two men) would come and take (the stolen things) away and beat everyone. We went to the regional internal-affairs department and complained about it. (The law enforcement officers said), "We will look into it, we will". They (the two criminals) were summoned there and were told a few things; they did not bother us any more."

According to many of the children and young people interviewed in-depth, the risk of being exploited, molested or even abducted depends on the self-confidence of the child or young person in question. The greater their self-confidence, they said, the less the chance of it happening. Even though there is some truth in this, the statement still shows how much children and young people can underestimate the risks they are facing on the streets. Being involved in

criminal activities also puts them at risk of being harmed or harming others in the course of the activities and of being caught by law enforcement officers and detained, all of which can be harmful to their mental and physical health.

4.6.3 The HIV epidemic in Ukraine

Ukraine remains the worst affected by HIV/AIDS country in Europe. The estimated HIV adult prevalence in Ukraine is 1.46 per cent, or 344,000 people aged 15 to 49 who are living with HIV.¹⁶ As of 1 July 2006, there were 96,625 people diagnosed as living with HIV, compared to 36,640 in 2000.¹⁷ The estimated HIV prevalence for populations most likely to be exposed to HIV exceeds 5 per cent.¹⁸ Given these estimates, the HIV epidemic in Ukraine is still classified as a ‘concentrated¹⁹ epidemic’.²⁰



The population groups most likely to be exposed to HIV and most affected by the HIV epidemic to date are the most ‘marginalised’ groups, including injecting drug users, sex workers, men who have sex with men, and young people who are engaging in risk behaviours and living in situations of risk, such as the target group. While HIV infection-related research has been conducted on injecting drug users, sex workers and men who have sex with men over the past two years in Ukraine, the target group has not yet been included in sentinel epidemiological surveillance studies.²²

Women and children are also increasingly affected by the HIV epidemic. In 2001, 38.2 per cent of all newly reported cases of HIV in Ukraine were among women, while in 2005 the

proportion had increased to 41.6 per cent.²³ In 2006, 10,978 cases of HIV infection were registered among children, of which 98 per cent were born to HIV-positive mothers.²⁴ Available data are not disaggregated further nor are there estimates available for the category of 'children and young people living or working on the streets'. It is therefore not possible to know how many of them might be living with HIV or an AIDS-related disease. However, of 25 children living on the streets in Kyiv who were tested for HIV in 2005, five were found to be HIV-positive (20 per cent), and of 29 children tested in 2004 in Odesa, 20 tested HIV-positive (69 per cent). Combined with the many risk factors that will be discussed in later chapters, this might be an indication that the HIV prevalence among the target group could be relatively high, however appropriate research is needed to verify this assumption.

In addition to the children and young people already living with HIV, there are a growing number who are orphaned by AIDS. Some estimates have suggested there may be up to 47,000 children dually orphaned by AIDS by 2014.²⁵

The HIV epidemic in Ukraine continues to grow and to spread at an alarming rate, despite efforts by service providers and international donors. The regions most affected by the HIV epidemic are the South and East of Ukraine (as of now two thirds of all HIV cases were reported there),²⁶ but the epidemic is also spreading rapidly beyond these regions.

The HIV epidemic was and still is driven by the spread of HIV among injecting drug users (59 per cent of all cases).²⁷ The proportion of sexual HIV transmission is growing though, linked mostly to the spread of HIV from injecting drug users to their sexual partners, many of whom are not injecting drugs. The HIV prevalence among injecting drug users researched in thirteen different cities of Ukraine via sentinel epidemiological surveillance in 2005 ranged from 9.6 per cent in Sumy to 66.4 per cent in Mykolayiv. In Odesa city 41.3 per cent, and in Kyiv city 48.8 per cent, of injecting drug users tested HIV-positive.²⁸

Among female sex workers the HIV prevalence data available from sentinel epidemiological surveillance from 2004 varied from 8 per cent in the city of Kyiv to 32 per cent in the city of Mykolayiv.²⁹ In Odesa city, 27 per cent of the female sex workers tested for HIV tested HIV-positive. The data demonstrate that both of these groups engage in behaviours exposing them to a high risk of HIV infection.

Apart from these two groups and men who have sex with men, the HIV epidemic has affected youth the most. In Ukraine, 25 per cent of people living with HIV are currently under the age of 20 and of the newly registered HIV cases in 2005, 58.5 per cent were below the age of 30.³⁰ There are four major contributing factors. The first is the early age at which the first sexual encounter takes place and the number of sexual partners. Consistent with a behavioural surveillance study among young people conducted in 2004,³¹ the median age for the first sexual encounter in Ukraine is 17 years old. Of the urban youth surveyed 67 per cent, and of the rural youth 62 per cent, were sexually active at the age of 15 to 24. Those who reported having had sexual contacts with non-regular sexual partners in the past 12 months were 32 per cent of the urban respondents and 31 per cent of the rural respondents.

The second factor is the high levels of unprotected sex, indicated by a high level of abortion among girls and women aged 15 to 44³² and high rates of STIs. Ukraine still has the fourth highest rate of syphilis amongst children and young people aged 15 to 19 in the CEE and CIS region.³³ Syphilis rates among children have increased steadily³⁴ between 1990 and 2003. The rate for boys aged 0 to 14 was 0.14 per 100,000 population in 1990 and 2.72 per 100,000 population in 2003, while the rate for girls of the same age group increased from 0.25 per 100,000 population in 1990 to 3.6 per 100,000 population in 2003.

The other two contributing factors are injecting drug use and sex work. Of the estimated 560,000 drug users in Ukraine, 20 per cent are under the age of 19.³⁵ Half of all injecting drug users start injecting before the age of 24 and evidence suggests that the age at which users begin injecting drugs is dropping to between 13 and 15 in Ukraine.³⁶ Injecting drug users aged 15 to 19 currently present 32.3 per cent of the total number of people living with HIV in Ukraine.³⁷ Among female sex workers in Ukraine, 10 per cent to 20 per cent are minors (under the age of 18) involved in exploitative sex.³⁸

4.6.4 The links between substance and drug use, sex work and HIV in Ukraine

To understand better the extent to which the target group in Ukraine, who are involved in substance or drug use or in exploitative sex, are at risk of acquiring an infectious disease such as HIV, the following paragraphs summarise key results of an in-depth analysis of the situation of drug use, sex work and HIV in Ukraine conducted in 2005 by UNICEF and UNAIDS.³⁹

The majority of substance and drug users in Ukraine are male.⁴⁰ Both cities (Kyiv and Odesa) included in the survey for this report are among those with the highest prevalence of substance and drug use in the country.⁴¹ Data provided by health care facilities and the MoI indicate that substance and drug use continue to increase in Ukraine,⁴² also among young people aged 13 to 15.⁴³

The current 'drug scene' in Ukraine is said to 'exist in an optimum situation', as substances and drugs are easily available all over the country.⁴⁴ The majority of drugs are bought on the streets, at markets or at pharmacies.⁴⁵ Many drugs are relatively cheap; for example a single dose of 'shirka' (a commonly used, home-made opiate) costs between UAH 8 and UAH 12 (approximately US\$ 1.58 and US\$ 2.38). Most injecting drug users spend between UAH 40 and UAH 100 (approximately US\$ 7.92 and US\$ 19.80) per day on drugs.⁴⁶ The drug scene differs from scenes in other countries in that substances and drugs are mostly obtained in exchange for preparing, reselling or transporting them or for sexual services.⁴⁷ Most substance and drug users consume in groups⁴⁸ and, due to high levels of stigmatisation in Ukraine, the drug scene is hidden and difficult to reach.⁴⁹

The range of substances and drugs available for non-medical use has significantly expanded over the last years in Ukraine.⁵⁰ Homemade cannabinoids and opiates remain the most popular drugs. Homemade preparations of stimulants based on cheap and easily available medicines, such as 'Effect', 'Trifed', 'Coldact', 'Coldrex' and others, are particularly popular among

young injecting drug users.⁵¹ Studies from other countries further demonstrate that many children and young people living or working on the streets also use solvents⁵² that are inhaled or ‘sniffed’ through the nose or the mouth. They are particularly appealing to the target group, given that they work as a form of anaesthesia, decrease physical and emotional pain and appetite and can induce sleep.

The possible consequences of drug and substances use are well known and include the risk of dependency, mental and behavioural disorders, various health problems, and the risk of accidental death or injury due to a lack of coordination.

The main risk factors in relation to HIV infection among injecting drug users include:⁵³

- Widespread habit among groups of injecting drug users of using one syringe several times so risking the use of contaminated injecting equipment;
- Syringe cleaning sometimes takes place, but is usually limited to rinsing the syringe with boiled water or tap water, which is not sufficient to sterilise the syringe;
- Behavioural studies show that injecting drug users typically have active sex lives and that those who inject amphetamines practice unsafe sex more often than others;
- Someone else usually injects the drug when children or young people are using drugs for the first time. They therefore lack the control over the quality of the drug and the sterility of the equipment being used;
- Injecting drug users usually do not store syringes out of fear of being detained by law enforcement officers for ‘storage of drugs’, which is a criminal offence according to the Ukrainian law (see chapter five); and
- Young injecting drug users almost always fail to ensure the sterility of syringes sold pre-filled with drugs and usually have a lower level of awareness than older injecting drug users about the risks involved and available preventive measures.

In 2004, the Ukrainian AIDS Centre registered that half of the HIV-positive children aged 13 to 14 had a drug use history of one to two years, usually using ‘shirka’. About 5 per cent of the children registered said they were homeless⁵⁴ and 75 per cent of all the HIV-positive injecting drug users who were children and registered came from families in crisis.⁵⁵ According to the Ukrainian AIDS Centre the life expectancy of these children is extremely low and the main causes of death include AIDS-related diseases and drug overdose.⁵⁶

As highlighted above, there is a close link between sex work and injecting drug use in Ukraine. According to a 2004 survey, 20 per cent of female injecting drug users and 1.5 per cent of male injecting drug users provided sexual services in exchange for money or drugs. The level of HIV infection among female injecting drug users providing sexual services was almost five times higher than among those who are not injecting drugs (38.6 per cent, compared to 8.3 per cent).⁵⁷ Like many injecting drug users, sex workers often engage in behaviours exposing them to the risk of HIV infection and other infectious diseases, such as STIs, TB and hepatitis B and C. Their key risk factors include:⁵⁸

- Sexual relations with injecting drug users;
- Sex workers injecting drugs;

- Unprotected sex (willingly or by force), which is particularly widespread among sex workers providing the cheapest services or bartering sex for drugs; and
- Widespread practice of buying low quality, cheap condoms or products with an expired shelf life.

According to data from the MoI for 2003, there were at least 150,000 women involved in sex work and the sex business in Ukraine, and the number is increasing. While children and young people who are involved in exploitative sex are not subsumed under the wider group of ‘sex workers’ in this report, the risks they are facing when sexually exploited are often the same.

Children and young people living or working on the streets of Ukraine face all of the risk factors set out above. Their risk of exposure to HIV and other infectious diseases such as STIs, TB and hepatitis is even higher than that of other ‘marginalised’ groups. Living or working on the streets puts them in a situation of extreme vulnerability. They end up on the streets ‘as a survival response’ to the failure of the family and child protection forces.⁵⁹ On the streets they seek support and protection foremost from children and young people living in the same situation as them, which further increases the likelihood of becoming engaged in risk behaviours. Therefore they constitute a group of critical importance in terms of preventing HIV from entering the general population.

4.6.5 The risk of substance and drug use among the target group

The survey conducted in Kyiv and in Odesa partly confirms the findings of the in-depth analysis conducted in 2005 by UNICEF and UNAIDS set out in sub-section 4.6.4. Of the children in Kyiv 76 per cent, and of those interviewed in Odesa 94 per cent, responded in the affirmative when asked whether they had ever been in a state of intoxication, or ‘got a kick’ from the use of some kind of stimulant. Also, the frequency of consumption of substances and drugs in the past six months confirms a very high level of substance and drug use among this target group.

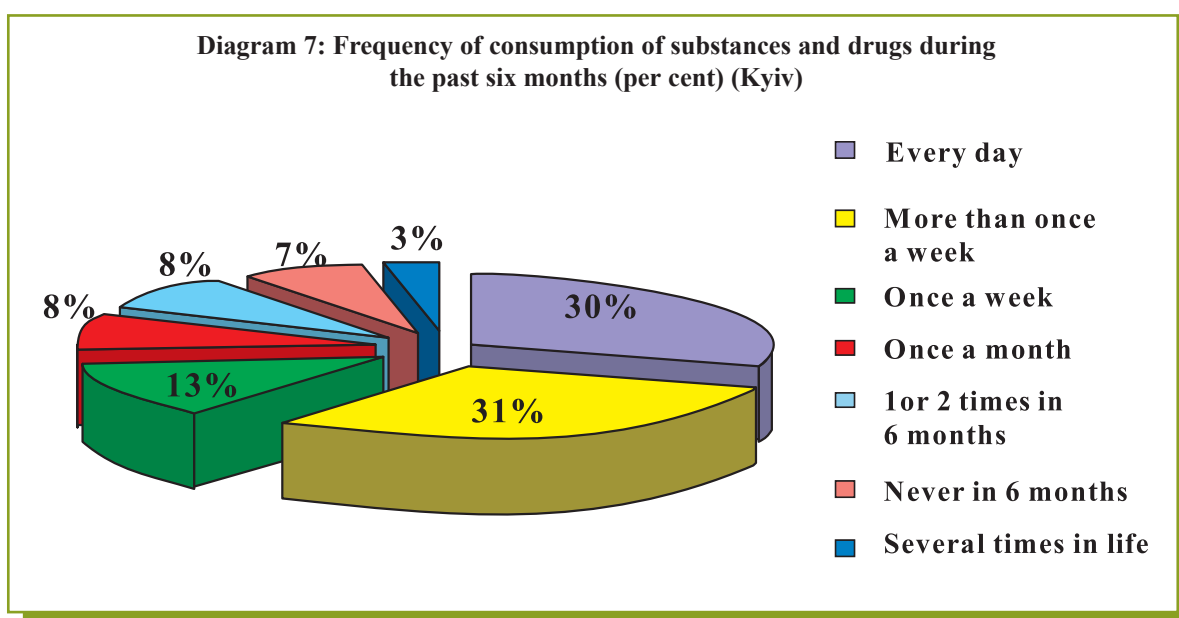
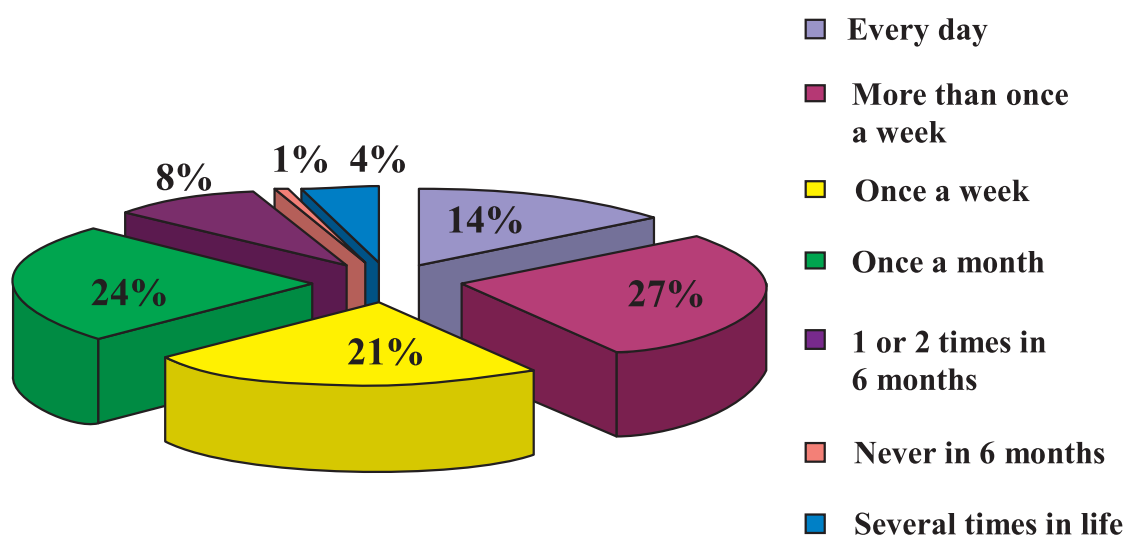


Diagram 8: Frequency of consumption of substances and drugs during the past six months (per cent) (Odesa)



Of the children interviewed 30 per cent in Kyiv and 14 per cent in Odesa reported using substances and drugs every day over the past six months. In Kyiv 31 per cent, and in Odesa 62 per cent, did so several times a week, and 13 per cent in Kyiv and 21 per cent in Odesa used substances and drugs once a week. A further 24 per cent in Odesa and 8 per cent in Kyiv replied that they use substances and drugs once a month, and 13 per cent in Odesa and 15 per cent in Kyiv either did not use substances or drugs at all during the past six months or used them only once or twice.

The children and young people interviewed use a wide range of substances and drugs in various forms and there are differences between Kyiv and Odesa, in the type and form of substances and drugs that children and young people reported using most frequently. In Kyiv, children and young people reported alcohol (49 per cent) as the most frequently used drug, followed by glue (39 per cent) and 'grass' (i.e. marijuana) (22 per cent) with only a mere 8 per cent claiming to inject drugs. Respondents in Odesa reported using glue most frequently (43 per cent), followed by alcohol (27 per cent), injecting of drugs (17 per cent) and pills (10 per cent). As this is not a representative study the differences might simply be incidental. Also, the survey did not reveal what other kind of solvents besides glue might be being used. As there is a wide range of solvents easily available and accessible in Ukraine, further research would be useful.

According to service providers interviewed, substance and drug use is rampant among the target group, as it not only helps them escape reality but serves as a means of recreation and also of initiation into some of the groups. Glue is considered most prevalent and accessible for children and young people of all ages (for example at any office supply store). This is also supported by a survey conducted in Kharkiv that was published in 2002,⁶⁰ in which 60.4 per cent of the children living on the streets who were interviewed admitted to using drugs, glue

being the most popular. The main reasons for using glue given by children in this survey included the influence of other people (58.4 per cent), curiosity (48.7 per cent), and the lack of something else to do (8.8 per cent).

The type and form of substances and drugs used differs according to length of time spent on the streets, to age group, and to gender. The survey data from Kyiv show that the longer the children and young people live on the streets, the higher their substance and drug consumption. Glue inhalation is 1.5 higher among those who have lived over one year on the streets, alcohol consumption 1.3 times higher, the consumption of pills four times higher and the injection of drugs 5.9 times higher. However, the data from Odesa show a less clear picture. As in Kyiv, the consumption of most substances and drugs increases after the children and young people have spent over one year on the streets, except for the consumption of glue, which decreases. After a street-life period of over two years, three forms of consumption prevail in Odesa: injecting drugs, taking pills and 'grass'. Given the small sample size and the lack of other surveys, it is not possible to provide any valid explanation for this difference. Further analysis might be useful to gain an understanding of how the length of time spent on the streets influences particularly injecting drug use among the target group.

The relationship between the consumption of different substances and drugs and the age group of the respondents reveals that in general the consumption increases as the consumers get older. There is only one difference, which is in the use of glue. While in Kyiv more Seniors (43 per cent) than Juniors (35 per cent) reported using glue, in Odesa the consumption of glue was reported by more Juniors (59 per cent) than Seniors (29 per cent). According to service providers interviewed, injecting drug use typically starts early on the streets, from the age of 15 or 16.

The in-depth interviews provide some additional insights into the use of substances and drugs among the target group in Kyiv and in Odesa. Glue inhalation is a very common practice, as it is accessible to children and young people both in terms of price and on account of its universal availability at a variety of retail outlets, as was pointed out by the service providers. Children and young people use different glue brands, such as 'Winter', 'Quintol', 'Naril', 'Butoprin', 'Monolith', 'Supermoment', and 'Moment-1'. Those interviewed in Kyiv said they mainly inhale glue, because it is used within the group that they belong to, because they want to have hallucinations (i.e. bright visions they can experience in the state of intoxication), and because the use of glue works as a substitute for food, as it can suppress appetite and help the child or young person to stop thinking about food. Some said that when faced with the dilemma of having to choose to buy either food or glue, they would rather opt for glue.

In Odesa, the children and young people interviewed presented the following reasons for quitting glue when they become older:

- Inhaling glue is a 'non-adult', low-status habit;
- The narcotic effect of glue gradually disappears;
- The respondent switched over to injecting drugs; and
- In view of increasing health problems, the respondent cannot use glue any longer.

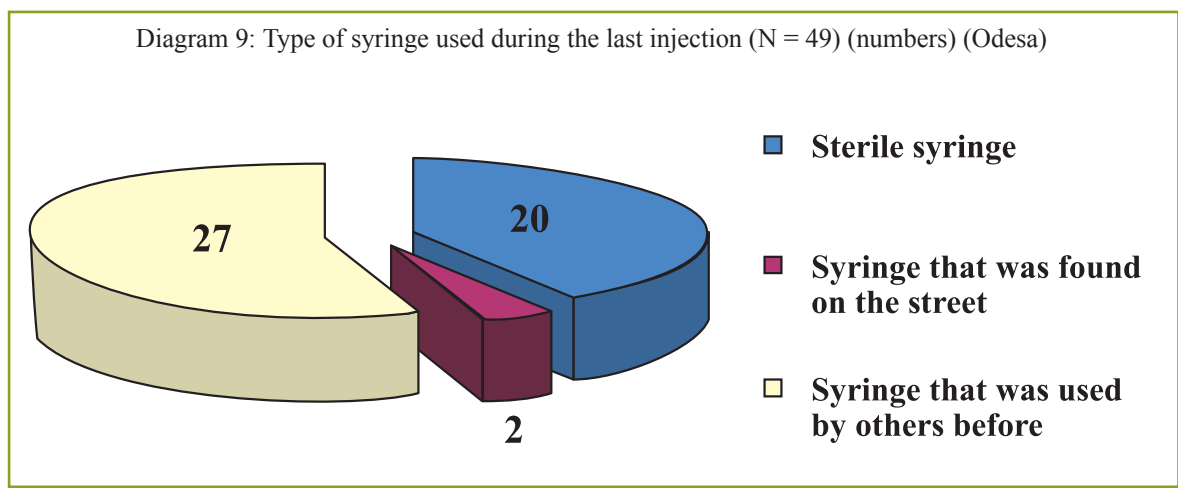
The relationship between the consumption of substances and drugs and the gender of the respondent indicates that there might be differences in the preference of females and males. In Kyiv 44 per cent and in Odesa 54 per cent of male respondents are more inclined to inhale glue, compared to female respondents (22 per cent in Kyiv and 35 per cent in Odesa). Furthermore in Odesa there is quite a distinct difference in the number of female and male respondents who are injecting drugs: 19.6 per cent male respondents compared to 10.4 per cent female respondents, and in the use of alcohol: 47 per cent female respondents compared to 25 per cent male respondents. In Kyiv, more male respondents (25 per cent) tend to smoke ‘grass’ than female respondents (12 per cent).

The correlation of the frequency of substance and drug consumption with the gender of the respondent in Odesa shows that female respondents (50 per cent) consume substances and drugs less frequently than male respondents (68 per cent).

The in-depth interviews revealed also that smoking cigarettes is widespread among the target group. All of the interviewees in Kyiv reported that they smoke, many of them from one to three packs per day.

In order to evaluate the level of risk when children and young people are injecting drugs, the survey assessed the sterility of the injecting equipment and the ways in which the drugs are injected, and discussed with them in in-depth interviews where and how easy it is to purchase substances and drugs, what type of substances and drugs they usually inject, why they started injecting drugs and whether they would like to stop. In both cities, the number of those reporting that they inject drugs are small and therefore the findings have to be considered with caution.

In Kyiv, 13 out of 44 respondents who inject drugs reported that they do so with non-sterile equipment, and 23 out of 44 said that they had rinsed the syringe before injecting, although it was not clear with what. In Odesa, 29 out of 49 respondents had used non-sterile equipment during their last injection.



According to one of the harm reduction specialists at the ‘Kyiv Centre of Social Services for Family, Children and Youth’ (Kyiv CSSFCY), due to the widespread use of contaminated syringes and needles and the use of non-sterile injecting equipment and solutions, target group members might become infected with HIV or hepatitis within months of starting to inject.

During the in-depth interviews in Odesa respondents mentioned as the main reasons for using non-sterile injecting equipment their ‘trust in the partner from whom they borrow a syringe’ and the ‘absence of sterile injecting equipment’.

16-year old girl in Odesa: “There were cases when we made injections with the same needle. It was precisely because some didn’t have any. We trust each other – that there was no infection. We have known one another for a long time.”

Interviewer: “But you remember, don’t you, that HIV can also be transmitted through a non-sterile needle?”

Girl: “I always shared the same needle with one person. I trusted him.”

The main drugs the children and young people participating in the in-depth interviews inject include homemade drugs from pharmaceuticals that can easily be obtained in a pharmacy, such as ‘Coldact’, ‘Coldrex’ or ‘Effect’. They also reported purchasing pills like ‘Ketanov’, ‘Tramadol’, ‘Tephedrine’ and ‘Tramadin’ at local pharmacies and stressed that they are never refused pharmaceuticals in pharmacies.

18-year old man Odesa: “I try to make as few injections as possible. It is about five times a day.”

Interviewer: “How much do you spend on that stuff in a week?”

Young man: “About UAH 100 (approximately US\$ 19.80).”

Interviewer: “And is it hard to obtain it?”

Young man: “No. At the pharmacy.”

Interviewer: “Did they ever refuse to give it to you?”

Young man: “On some occasions they didn’t have any. But if they had it they never refused.”

Interviewer: “But they surely know what you buy it for?”

Young man: “Yes, they do.”

Other places where drugs could be obtained were Service providers told also that children and youth obtain their drugs usually on the street, at open market bazaars, bars, discos and night-clubs or parks. They are often doubling their risk of acquiring an infection when bartering sex in exchange for the drug.

Another risk practice mentioned by the interviewees was ‘initiation’: the first injection being administered by another, usually older, child or young person, using a contaminated syringe.

When asked if they would stop using drugs, some children and young people interviewed in Odesa said that they had stopped when their health seriously deteriorated. Others are willing to quit but think that it is practically impossible, and yet others stressed that they have enough willpower to quit using drugs at any moment in time, or said that they are not addicted to drugs.

Service providers interviewed stressed that although most children and young people claim to know about the risks involved in injecting drugs, a lot of their knowledge is hearsay they may have picked up on the street, or erroneous information that has been passed on by word of mouth. Some believe that what they have been told is merely scare tactics, exaggerated facts that cannot possibly touch them. Others told interviewers that they are not concerned with the risks involved because they only live for the present and so long-term risks are irrelevant to them. Their only concern is where they can get their next ‘hit’ (drug dose).

All of the injecting drug users interviewed in-depth said that they had started smoking cigarettes, then moved on to consuming glue and pills and ended up by injecting drugs. They also emphasised that mixing alcohol with pills and injections is a fairly common practice. The key reasons they gave for starting to inject drugs were ‘out of curiosity’ and ‘to try everything’, ‘out of despair’ and ‘hoping to alleviate stress’, which is consistent with the statements of service providers, who said that the most common ‘push’ factors for substance and drug use among the target group are depression, peer pressure, looking for new thrills and adventure, and to escape from reality.

Many of the injecting children and young people interviewed said that they did not believe when they started that they could become addicted.

4.6.6 Sexual contacts and practices of the target group

The survey also assessed the sexual contacts and practices of the children and young people interviewed.

Table 8: Sexual contacts and the age group of the respondent (per cent) (Kyiv)

AGE GROUP	HAVE YOU EVER HAD SEXUAL CONTACTS?		
	Yes	No	No answer
10-14 years (Juniors)	18.1	75.5	6.5
15-19 years (Seniors)	69.7	28.3	2.1
TOTAL	43	52.7	4.3

Table 9: Sexual contacts and the age group of the respondent (per cent) (Odesa)

AGE GROUP	HAVE YOU EVER HAD SEXUAL CONTACTS?		
	Yes	No	No answer
10-14 years (Juniors)	21.7	77.2	1.1
15-19 years (Seniors)	89.2	8.3	2.5
TOTAL	48.7	49.7	1.7

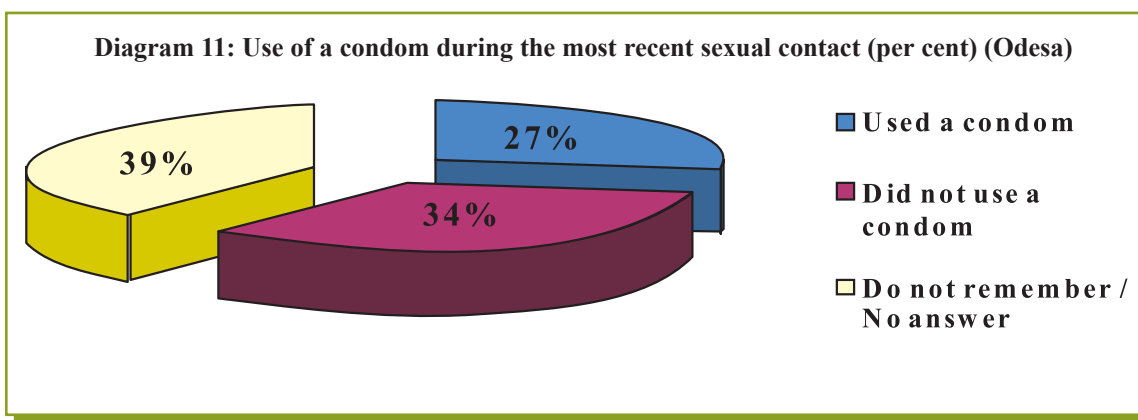
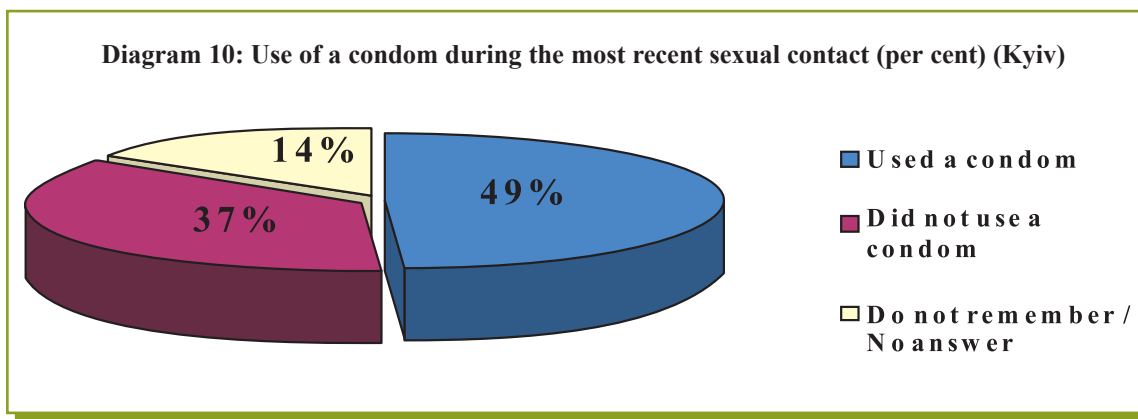
In total, slightly less than half of the children and young people in both cities report having had sexual contacts. As can be expected, Seniors report a much higher level of sexual contacts than Juniors. An analysis by gender only showed differences in Odesa, where female respondents (57.5 per cent) were more extensively involved in sexual activities than male respondents (43.8 per cent), which might be linked to the fact that a large number of the female respondents in Odesa reported being exploited for sex (see figures presented later on in this section, as well as sub-section 4.7.4).

The frequency of sexual contacts in Kyiv is relatively high with 28 per cent of those interviewed saying that they practice sex more than once a week, 17 per cent once a week, 19 per cent once a month, and 20 per cent less than once a month. A mere 16 per cent said they had had no sexual contacts during the past six months. An analysis by the length of time spent on the street and by age was not possible for the Kyiv data. The analysis of the Odesa data according to the frequency of sexual contacts, the age group and gender emphasises that Seniors practice sex more frequently than Juniors and female respondents more often than male respondents. In particular the number of Seniors who report having sex more than once a week is almost 10 times higher than the number of Juniors and the number of female respondents who practice sex nearly every day is 2.7 times higher than the number of male respondents.

The in-depth interviews revealed that the sexual life of the target group seems to start at an early age and involves frequent changes of partner. An 11-year old boy reported that one particular girl comes to their ‘hideout’ from time to time to have sex with some of the boys. More children and young people however reported sexual contacts among members of their own group.

According to service providers interviewed, sex is commonly used as a form of recreation and of forming bonds. The dominant type of sex tends to be heterosexual, especially among girls, although some boys reported homosexual contacts among friends or with ‘clients’, indicating that they are being involved in exploitative sex. As there are no official statistics on this issue further research would be useful.

The use of a condom during the most recent sexual contact varied greatly between the children and young people interviewed in both cities.



In both cities, more than one third of the respondents did not use a condom during their most recent sexual contact. However, in Kyiv the number of children and young people claiming to have used a condom is almost 50 per cent, while in Odesa city it is only 27 per cent.

Those survey respondents who said that they had sexual contacts were also asked if they had ever received money, food or other presents in return for sexual services, exploring how far they are being involved in exploitative sex. In Kyiv 18 per cent admitted having received recompense for providing sexual services and 39 per cent in Odesa. Due to the different overall number of responses to different questions, these figures differ from those in sub-section 4.7.4. Differences are also linked to the fact that children and young people do not always answer such sensitive questions truthfully.

An analysis of the data for Odesa showed that it is mainly female respondents who report having been involved in exploitative sex (77 per cent) compared to 11.4 per cent of the male respondents.

4.6.7 Other risk factors

Another factor that increases the risk of acquiring an infectious disease, which was mentioned by service providers, is intentional self-harm such as the cutting of some part of the body (usually the arm) and the exchange of blood with a friend ('blood fraternisation'). The in-depth interviews held in Kyiv and Odesa showed that this does occur, but somewhat rarely (for ex-

ample only six out of 25 of the children and young people interviewed in Odesa had ‘fraternised’ in this way in the past). Some of those interviewed (four in Odesa) had never even heard of this practice and many of the Seniors spoke about this as a ‘tradition’ among Juniors that is no longer practised once children become older.

During the in-depth interviews, children and young people were also questioned with regard to tattooing using non-sterile equipment. Some reported having tattooed themselves with non-sterile needles, while others seemed to be clearly aware of the risk involved.

13-year old girl in Odesa: “I was about to be tattooed and they wanted to make a very big pattern. Then a friend – my sister – came up, made a row and forbade it. She said, ‘Those are dirty needles and I don’t need that problem’”.

4.6.8 Risk awareness

Overall, the population in Ukraine has relatively low levels of awareness of HIV-related issues, and in particular has very little accurate knowledge of the ways in which HIV is transmitted. In 2004, only 14 per cent of young people aged 15 to 24 were able to correctly identify ways of preventing the sexual transmission of HIV and to reject major misconceptions about HIV transmission.⁶¹ While the majority knew that unprotected sex and injecting drugs with non-sterile equipment could lead to HIV infection, 52 per cent still believed that HIV could be transmitted via a mosquito bite, a common misconception. The awareness of HIV in a setting like a penitentiary facility differs from that in the general population and is highlighted here, as some members of the target group find themselves at some stage in their lives in a detention or penitentiary facility for minors. In a survey conducted in 2004,⁶² in which 86 per cent of the prisoners interviewed were younger than 40 and of reproductive age, 39 per cent of them correctly identified the methods of preventing HIV transmission. The number is relatively small because although the majority of the prisoners knew about the risks related to unprotected sex and the injecting of drugs with non-sterile equipment, 58 per cent still thought that HIV can be transmitted via a mosquito bite, and 70 per cent thought HIV can be transmitted from sharing a meal with someone who is living with HIV. Those aged 16 to 24 scored the lowest values.

According to information received from services providers, the target group’s understanding of safer sex practices indicates that this is a case where the perceived understanding of an issue might vary greatly from the reality. If the understanding of safer sex is minimal among the target group, then the practice of safer sex is miniscule in the view of the interviewees. Even those children and young people who claim to practice what they consider to be safer sex often miss the target. For example, one social worker working for the Kyiv City CSSFCY explained that some boys fully understood that it is necessary to use a condom to help prevent the transmission of STIs and HIV but did not know how to use one properly. Most children and young people can afford to buy condoms on the money they manage to collect, but contraception is not high on their list of priorities, said the interviewees. Even when they do purchase condoms, they may go for the cheapest brands that may not offer the necessary protection. Children and

young people also tend to believe that people they know could not possibly be carriers of a disease, so they will have unprotected sex with them.

Concerning contraception and unwanted pregnancies, the service providers interviewed said that the target group is usually aware of the need for contraception, but not necessarily familiar with the types of contraception available. They also stressed that the target group does not use contraception regularly. The reasons given were the limited availability of free contraception in Ukraine, the lack of concern about contraception among the target group, and their unwillingness to spend money on contraception. However, the interviewees also pointed out that instances of girls and young women living or working on the streets giving birth seem rare. They assume some pregnancies may end in spontaneous abortions (such as a miscarriage) because of their lifestyle, poor nutrition and infectious diseases. According to one service provider in Odesa, pregnancies that do go full-term usually result in the baby being put up for adoption, even when the young mothers may at first want to keep the child, but realise they have no realistic options for providing either for themselves or for their child.

The interviewees stressed that most information about STIs among the target group is based on myth. They are usually not familiar with symptoms and will only come for treatment in the most dire of circumstances. Even when they seek treatment, they might leave as soon as they begin to get better and so may never be properly cured. They often believe themselves to be 'invincible', which is a common notion among many young people. Some service providers reported that even when they took a child or young person to the funeral of a friend they would find a justification for the death of that person, but believed that the same would not happen to them.

Some interviewees estimated that seven out of ten children and young people do not know about HIV, and those that do know usually have acquired the knowledge via personal experience, for example by having a friend or a family member who is HIV-infected. This does not mean they are unaware that HIV exists. Rather it means they know little more than the name and cannot usually differentiate between HIV and AIDS, do not fully understand how HIV can be transmitted and do not understand the importance of getting tested for HIV and, if necessary, receiving treatment. According to the interviewees, a much larger number of the target group is aware of some STIs and their symptoms, because they usually know someone who has been infected or have themselves been treated.

In Kyiv and in Odesa, the majority of the children and young people interviewed were aware that HIV is a disease (79 per cent in Kyiv and 56 per cent in Odesa).

Diagram 12: Share of respondents who are aware that HIV is a disease (per cent) (Kyiv)

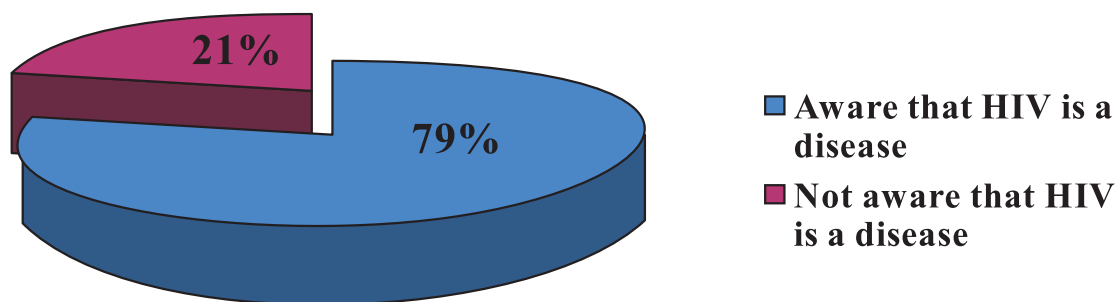
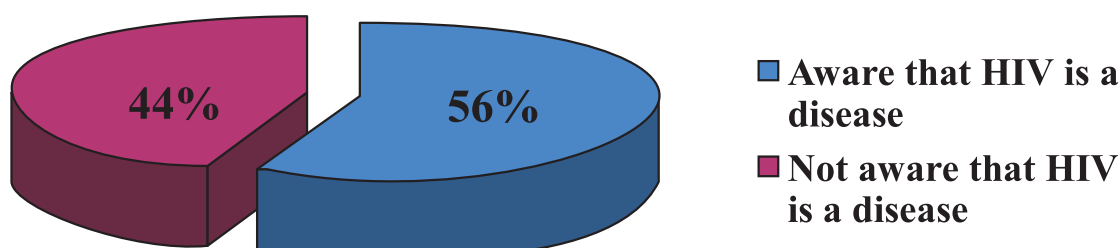


Diagram 13: Share of respondents who are aware that HIV is a disease (per cent) (Odesa)



The level of awareness of HIV was largely dependent on the respondent's age. Juniors were less informed (65 per cent in Kyiv and 49 per cent in Odesa) than Seniors (94 per cent in Kyiv and 66 per cent in Odesa).

Those children and young people who had responded correctly that HIV is a disease were asked about the main ways in which HIV is transmitted. Respondents in Odesa knew less about HIV transmission than did those in Kyiv. In Kyiv, 59 per cent of the respondents were aware of the risk of being infected through unprotected sex compared to 41 per cent in Odesa; 49 per cent were aware of the risk related to injecting drugs using non-sterile equipment in Kyiv, compared to 36 per cent in Odesa; and 15 per cent were aware of the risks involved in vertical transmission (mother-to-child-transmission of HIV) in Kyiv, compared to 9 per cent in Odesa. The overall proportion of the children and young people aware of two of the main HIV transmission modes (unprotected sex and use of non-sterile injecting equipment) amounted to 43 per cent of all respondents in Kyiv and to 33 per cent of all respondents in Odesa.

A link could be established between awareness of the main HIV transmission modes and the age group of the respondent in Kyiv. Among Juniors the awareness of the transmission of HIV through non-sterile injecting equipment or by having sex without a condom was much lower than among the Seniors. The difference is less distinct between the age groups concerning vertical transmission, which might be a result of the general lack of knowledge among them of this mode of HIV transmission.

The data were also analysed for a relationship between the level of awareness and the gender of the respondents, as well as the length of time spent on the streets, but no statistically significant

correlation was apparent which might be due to the small numbers of girls and young women responding to the questions.

To assess whether or not the level of awareness of HIV transmission modes made any significant difference in the use of condoms, the relationship between those two variables was established, but the analysis for Kyiv did not reveal any significant correlation. In Odesa, the differences between the groups of children and young people who were aware that HIV is a disease and of those who were not showed that 46 per cent of those being aware reported having used a condom during their last sexual contact, compared to 14 per cent of those who were not aware. That knowledge does not automatically lead to behavioural change can also be seen from the in-depth interviews, during which several respondents who were aware of the danger of acquiring HIV through unprotected sex said that they do not use condoms, as they trust that their partner is not living with HIV.

19-year old man in Odesa: “(One can become infected)...in a variety of ways – through blood, through a syringe, through some girl.”

Interviewer: “And do you protect yourself?”

Young man: “Why should I? Those are such girls that I think they don’t have anything of that sort and so...(I have sex) without condoms.”

Interviewer: “So you don’t protect yourself?”

Young man: “No. At that time, we didn’t protect ourselves. That girl was living with us permanently. Now we’ve expelled her, because we saw her going out with various blokes (boys or young men).”

The responses to the in-depth interviews held in Kyiv further demonstrate how many misconceptions may still exist in this population group about HIV.

Interviewer: “Through what is HIV transmitted?”

17-year old boy in Kyiv: “Of course I know. Through blood, through a cigarette filter, through sweaty hands. A condom should be used. Through kisses.”

18-year old woman in Kyiv: “One can contract the disease through the air.”

13-year old boy in Kyiv: “I will contract it if I smoke a lot, if I walk about wearing dirty clothes, if I pick up cigarette stubs from the floor.”

Interviewer: “Do you know what HIV and AIDS are?”

18-year old man in Kyiv: “Well, yes... well... it’s when... well, I don’t know... It’s syphilis... Yes? ... Through what is it transmitted? ... For example ... through the mouth ... maybe it’s through a kiss ... that it is transmitted? It’s transmitted through a syringe ... you shoot up and give it to someone else ...” (Laughs.) “It is transmitted through sex...”

However, there was a small proportion of respondents to the in-depth interviews who were quite knowledgeable about HIV and other infections. They said that they had previously received information in one form or another on this subject from social services.

A 17-year old boy responding to the question about HIV transmission modes in Kyiv: “I saw (video) cassettes in the shelter in... – about that AIDS, about drugs; I thought that glue was better after all – because if I shoot up once or twice and it happens to be a syringe or needle previously used by someone, then a disease can be contracted.”

The survey also assessed how many of the children and young people had been tested for HIV. Overall, only 18 per cent of those interviewed in Kyiv and 13 per cent of those interviewed in Odesa had ever been tested for HIV. In Kyiv 13 per cent of those who had been tested knew their test result, compared to 12 per cent in Odesa. Among the children and young people who are aware of HIV as a disease, 23 per cent had been tested in Kyiv and 24 per cent in Odesa.

Anecdotal evidence from service providers suggests that only a handful of the children and young people who were tested and are living with HIV are currently receiving antiretroviral therapy in Ukraine. There are no exact figures though, as the data collected by the AIDS centres are not disaggregated.

The age of the respondents also influenced whether or not they had been tested for HIV. While only 14 per cent of Juniors in Kyiv and 9 per cent of Juniors in Odesa had been tested for HIV, 41 per cent of the Seniors in Kyiv and in Odesa had undergone an HIV test.

Another factor influencing HIV testing in this survey was the length of time the children and young people had spent on the streets. More of those who had lived longer than a year on the streets had been tested for HIV (32 per cent in Kyiv and 27 per cent in Odesa) than of those who had lived less than a year on the streets (16 per cent in Kyiv and 18 per cent in Odesa). These findings might be explained by the fact that children and young people who live longer on the streets tend to have increased risk behaviours (for example they more often seem to inject drugs with non-sterile equipment; see sub-section 4.6.5), more health problems (see sub-section 4.6.1) and might have had more contacts already with medical and other support services that might have increased the chance that they were offered an HIV test.

The gender of the children and young people did not influence the findings of this survey.

The results of a sentinel surveillance study among young people conducted in 2004⁶² in a number of cities in Ukraine demonstrate that only 5 per cent of young people aged 15 to 24 in general had received voluntary HIV testing and counselling services in the last 12 months in Ukraine and knew the results of their test. In the same year another sentinel surveillance study of injecting drug users showed that a higher per centage of young people engaging in risk behaviours

than of young people in general seem to get tested for HIV (23 per cent of injecting drug users younger than 25 years old had been tested in the past 12 months for example, and 30 per cent of the injecting drug users over 25 years old).⁶⁴

4.7 Street life

4.7.1 Reasons for taking to the streets

There are a number of problems that contribute to children and young people leaving their home or child-care institution to go and live or work on the streets. According to the service providers interviewed, the number one reason for which children and young people run away from home are problems within their families, while escaping from child-care institutions is usually linked to maltreatment or the wish to flee from a confined environment.

As highlighted in sub-section 4.5, problems within a family can be further exacerbated by substance or drug use, by parents being in prison or involved in sex work or criminal activity, by children and young people being left in the care of other family members while the parents are working elsewhere, and finally by parents having been stripped of their parental rights. More often than not a family is facing a combination of problems such as alcohol use, beatings, disease, imprisonment or death of a parent, and loss of housing. Any of these problems might lead to another, forming a 'vicious circle' from which the child or young person tries to escape by running away.

The interviewees also said that sometimes a simple misunderstanding between a child or young person and the parents or carer can be blown up out of proportion and lead to the child or young person running away and ending up on the streets.

Interviewees also stressed that low salaries for teachers, social workers and others who work with families and children and young people have led to high turnover rates, and high burnout among those who stay. This in turn has led to breakdowns in communications between parents and teachers or social workers so that potential problems which the family or a particular child or young person may be facing are not addressed in time, with the result that they may grow to a point where the child or young person decides to run away. The respondents further cited the lack of after school leisure activities for children and young people, leaving them unoccupied and often without guidance, as a major problem.

Studies in other parts of the world emphasise that the main reasons for children and young people ending up on the streets are family problems, especially financial and social problems, substance or drug use, conflicts with the law, health problems of a parent or mistreatment of the child or young person.⁶⁵ In the survey among children living on the streets in Kharkiv⁶⁵ that was published in 2002, 30.8 per cent of the children said that they had run away after having been beaten by their parents, 28.3 per cent said that the main reason was that their parents drank too much alcohol, and 26.4 per cent reported having left home because of the influence of peers.

The survey conducted in Kyiv and in Odesa shows similar findings to those in Kharkiv. The number one reason given during in-depth interviews was problems within the families (so-called ‘push’ factor), followed by peer pressure or the wish to join ‘friends’ (so-called ‘pull’ factor).

13-year old girl in Odesa: “All the people I met – they would ask me, ‘...tell me, why do children go away from here onto the street?’ And I kept looking for an answer until now and I found it. It’s because they want to join friends (peers); that is the main thing...”

All of the children and young people interviewed in-depth came from difficult family backgrounds where one or both parents used drugs or alcohol, where violence, especially physical violence, was inflicted by a drunken parent, stepparent or other relative, where a parent was in prison, or where there were problems with a stepparent.

11-year old boy in Kyiv: “Daddy drinks. I left because of daddy. He was rude to me and all were rude. He swears. It’s not that he swears, he beats you as well. He used to hit me – with just about anything.”

13-year old girl in Odesa: “Mother and father are apart. Mother abandoned me when I was six years old. When I was six a stepmother appeared; and when I became ten years old I left home. Father started drinking; he used to chain me up... (And stepmother) (laughs); incited father against me. She kept saying that I should leave.”

None of the children or young people interviewed in-depth wanted to return to their homes. This finding is different to that of the survey conducted in Kharkiv, in which 72.5 per cent of the children interviewed said that they would like to live with their parents despite the problems at home, and it also differs from the views and experience of service providers, who stressed that the majority of children and young people would like to return home.

One of the many tragedies that the children and young people experience in their lives is the death of a parent. In Kyiv 27 per cent of the children had lost their mother and 31 per cent their father, while in Odesa almost 36 per cent had lost their mother and 33 per cent their father. Quite a few of those interviewed did not know whether or not their mother (13 per cent in Kyiv and 22 per cent in Odesa) or their father (21 per cent in Kyiv and 40 per cent in Odesa) are still alive or did not want to respond to this question. The experience of losing a parent can be deeply unsettling for the entire family.

17-year old girl in Kyiv: “When my mother had died, I did not want to study or do anything... My brother – he was the first one to start staying away from home. He told me it was fine on the street – no one shouts at you there... When mother had died, father sometimes shouted at me – because I could cry at times. He wouldn’t let me play... And he (brother) said, ‘No one shouts at you on the street...’ I began staying away with him... Now I don’t care what father says... Mother loved me more than anyone else did... I would never have gone out onto the street if mother had been alive.”

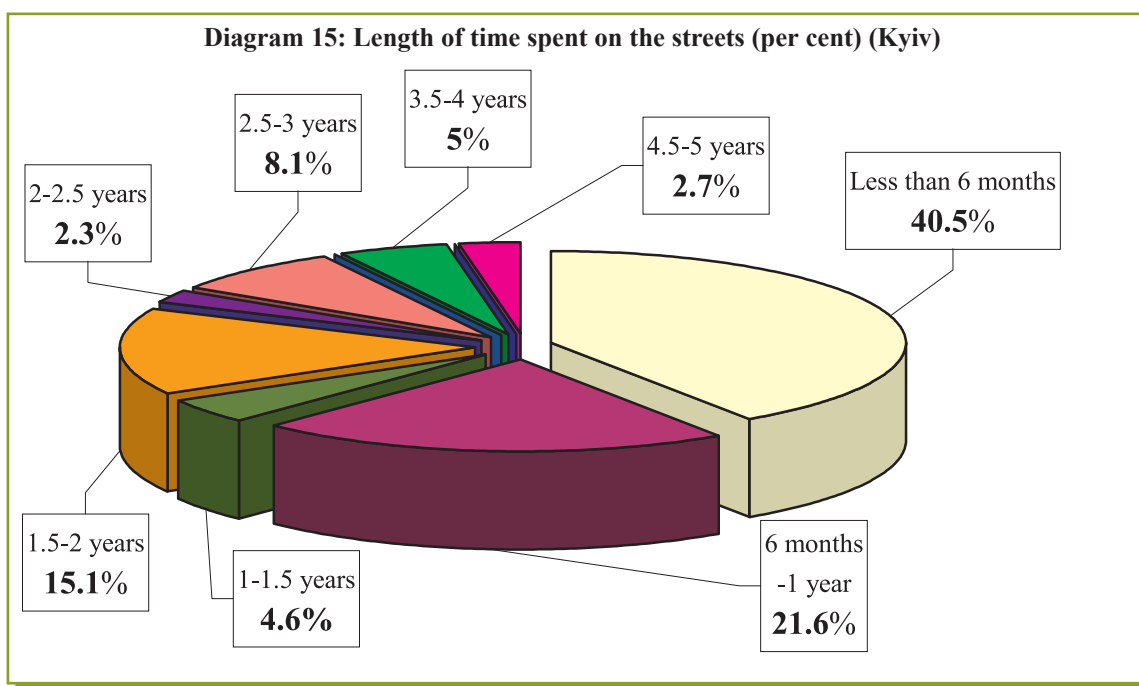
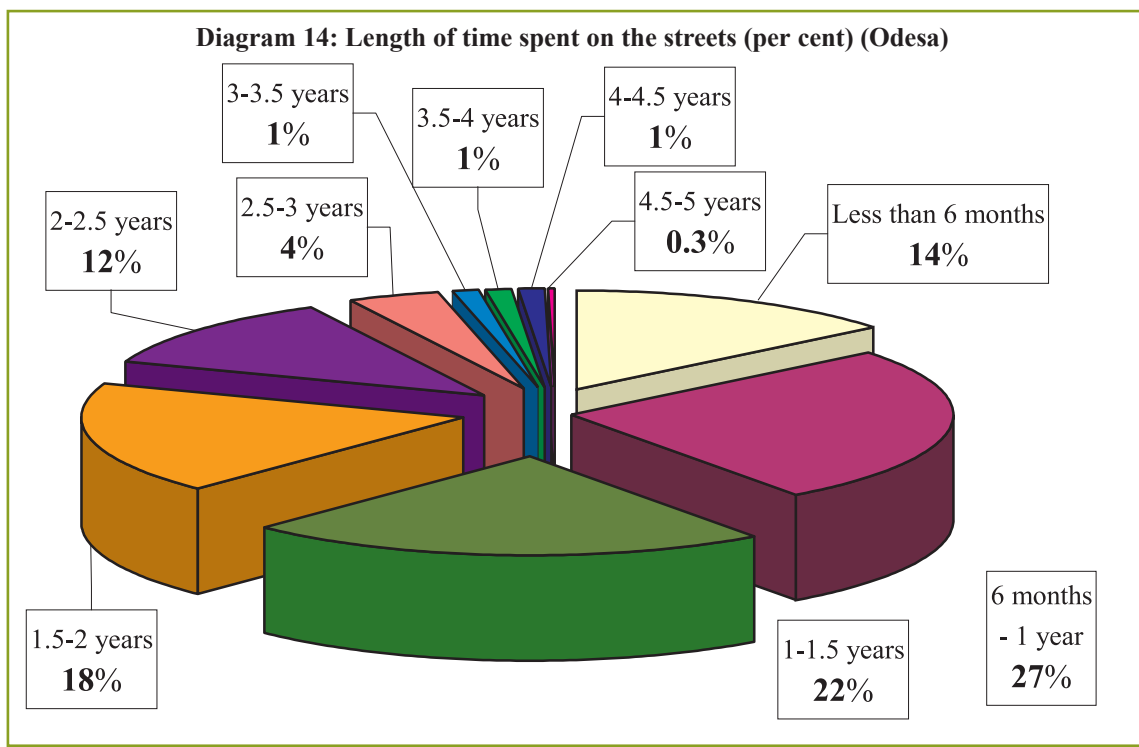
Another reason for taking to the streets is the poverty of the family or the loss of housing, in particular as a result of apartment-selling fraud in Ukraine, which was also mentioned on several occasions by service providers.

19-year old man in Kyiv: “Well, mother’s brother, in short – he wanted to sell the apartment – to exchange it for a single room... We exchanged it for one room through brokers and three months later the company said that there were people living there – when we had bought the new apartment...”

4.7.2 Length of time spent on the streets

The length of time children and young people live or work on the streets varies. Some spend most of their time on the streets but go home either daily or periodically to sleep and change clothes, according to service providers interviewed. Others return home or to a children’s institution after a week or two. There are those who survive two to six months, and are willing to enter a re-socialisation programme to get them off the street. Service providers pointed out that after six months this option becomes less probable, as children and young people get used to the taste of freedom and independence on the streets and have developed a new way of life and network of friends. Some children and young people never get off the streets, either because they continue life on the streets as an adult, or because their lifestyle has led them to an early death from disease or crime. There are, however, no statistics or other information on the number of children and young people remaining on the street into adulthood, nor on their lives as adults. There are no statistics either on the number of children and young people who die each year on the streets of Ukraine.

The survey results and the following diagrams (14 and 15) show that the majority of children and young people interviewed in Kyiv (62.1 per cent) had lived on the streets for less than a year at the time of the interviews, and most of those (40.5 per cent) for less than six months. In Odesa, the majority of children and young people interviewed had lived over a year on the streets at the time of the interviews (40 per cent between one and two years and 19.3 per cent up to five years); and 41 per cent had lived on the streets less than a year, of which only 14 per cent had lived on the streets for less than six months. It would be useful to conduct additional research the better to understand these marked differences between the two cities and to explore the reasons behind them.



4.7.3 Relationships and communication within the ‘street community’

According to the service providers interviewed, children and young people living in the streets usually live in groups of seven to 15 children. The results of a survey in Moldova, and in other countries, underline these findings.⁶⁶ However, the children and young people interviewed in-depth in Odesa stressed that their groups are usually smaller, consisting of three to five people, but can be as big as 10 to 20 people and that in most cases the size of the group is restricted by

that of the 'hideout'. There are also a few 'loners'. One respondent in Odesa emphasised that he is staying away from others, because he was not willing to be drawn into 'bad company'.

The interviewees further mentioned that groups have their own structures and hierarchies that provide the children and young people with a sense of belonging and protection, and those who are stronger are often seen as a role model despite the fact that older youths often exploit or abuse the younger children in return for ensuring their 'safety'. This was also the result of surveys conducted in other countries⁶⁷ and of the in-depth interviews held in Kyiv and in Odesa. The children and young people live in an environment in which 'the strong survive' and in a world in which the 'laws of force' and the 'right of the strong' prevail.

Interviewer: "And have you heard about someone forcing street children just like you to perform some kind of work? Or to do something?"

17-year old girl in Kyiv: "Of course; it's like that almost anywhere... They make us go begging and collect money for them ... or bring them food... Whatever they say has to be done. Sometimes ... some men come ... and live with them ... small ones and older ones there. They are together there, just like our company ... friends – walking about together... My brother is stronger than me; but he should be stronger than me – indeed, he is a guy ... I cannot hit back ... he hits me and I cry at once ... I cannot hit back ... He tells me, 'Go begging and collect money ... if you don't collect such-and-such amount ... if you don't bring such-and-such amount from there now ... that will be the end of you. And so I'll have to mooch (beg) for him...'"

Most children and young people also mentioned that a friend or a member of their group initiated them into the use of substances or drugs. One respondent said she had been given an injection forcibly. Another one noted that a lot depends on the leader of the group. She found herself in a group whose leader protected its members from substance and drug use. Transition from such a group to a different one had led another girl to the use of alcohol and tobacco.

In the experience of service providers, groups often form on the basis of whether substances or drugs are used or what types of substances and drugs are used. Sometimes the separation is on the basis of the sex of the group members, although many groups include females and males. It may take time for a group to allow a new face to become a member. Communication is thought to be pretty open among group members. Information on the streets is usually passed on via 'street post', by word of mouth, or from people who offer assistance in the streets, as well as in places where people gather.

The findings of the in-depth interviews in Kyiv and in Odesa underline that children and young people on the streets communicate primarily with other children and young people like themselves ('peers'). To the question as to whether they had any real friends, some replied that they regarded as their friends anyone living together with them in their 'hideout'. Others were more

particular about the notion of friendship, calling just one person a friend – or no one at all, saying that they have only ‘pals’, ‘acquaintances’, but no friends.

Interviewer: “Do you any have friends?”

13-year old girl in Odesa: “Just one person. It’s because that person will never leave me at a time of trouble. That’s the first thing... She – she will never leave me at a time of trouble – never will upset me. On the contrary, (she) will always support me. And it’s for that reason that I consider her to be a friend...She is also thirteen.”

The interviewees stressed that groups are not necessarily steadfast. Children and young people may switch between groups, either because of internal conflicts or because of seasonal mobility. The latter can also sever relationships, increasing feelings of loneliness and the consumption of substances and drugs, according to children and young people in Odesa. They also tend to trust each other more than anyone else, partially because they share similar backgrounds and problems, partially because they rely on each other for survival. Sometimes conflicts arise between groups regarding territory or places in which group members ‘operate’, but there were no reports on ‘street gangs’ and ‘street wars’ as known in other countries.

Loyalty in friendship and in the groups is highly valued. Usually, children and young people joining a new group will be ‘tested’ by the group members. It was stated that such ‘testing’ consists primarily in ‘framing’ the child or young person, as a result of which he or she may be punished by adults for something done by some other member of the group. If the child or young person does not ‘tell on’ the perpetrator(s), this means that the ‘applicant’ can be trusted and can be admitted to the group.

13-year old girl in Odesa: “Prestige must be gained. At first, yes, I was framed – duly tested to see what I was like. They played some dirty tricks on me and then accused none other than me. That was their way of testing me to see whether or not I was a flunkey (traitor). But on no occasion did I go to aunt..., or aunt..., or uncle..., or –. That’s how I gained prestige for myself. And so now, even street adults come – and they cannot bully me, because they know what sort of person I am...”

In the in-depth interviews, children and young people also referred to their ability to protect themselves by force, individually and collectively. They mentioned incidences when they jointly took revenge on someone who had hurt them. Respondents claimed that even adults were sometimes afraid of them.

15-year old boy in Kyiv: “I used to go to a toilet to drink water – and some friend of ours swore at his mother. She was working there, in the toilet, and he was a vendor renting a place on the market. He was a big fellow, a whale, and he always bullied us. Once we got together and hit him on the head. Some (of us) were also hit, but now he is afraid of us.”

4.7.4 Earning a living on the streets

Children and young people living on the streets need to find a way to earn a living. According to service providers interviewed they can make between UAH 100 and UAH 150 (approximately US\$ 19.80 and US\$ 29.70) a day doing odd jobs like helping out with deliveries at the market, cleaning cars, distributing flyers or selling newspapers. A number of children and young people are also involved in begging, stealing, or providing sexual services in exchange for food, money, substances or drugs. The income generated in these ways is sometimes larger than that which average working adults make in legitimate jobs in Ukraine. Coupled with the fact that a legitimate job curtails the freedom gained on the streets, the motivation for the target group to become involved in vocational training or to look for legitimate work can be non-existent.

As highlighted in sub-section 4.6.2, target group members do not always work willingly in a particular ‘job’, but are often exploited for labour.⁶⁹

The survey conducted in Kyiv and in Odesa also assessed the target group’s sources of income. Those interviewed in-depth mentioned a variety of ways in which they obtain money while living on the streets; by collecting scrap metal, in particular copper which can often be found at waste disposal sites, through odd jobs at construction sites, including plastering and house painting (amounting to about UAH 20 (approximately US\$ 4) or more a day), by working as loaders or porters at the railway station from time to time, earning on the average between UAH 30 and UAH 40 per day (approximately US\$ 6 and US\$ 8), by selling newspapers, and in rare cases street cleaning or digging and chopping wood, earning around UAH 20 (approximately US\$ 4) or more a day, as well as collecting bottles for recycling, selling nuts, having a seasonal job in the countryside etc.

However, many respondents said that they did not work on a regular basis. For a variety of reasons they either quit the job or were dismissed. In some cases, salary was not paid to them.

14-year old boy in Kyiv: “Sometimes I get money from people whom I ask for it. Sometimes – I remember finding UAH 100 (approximately US\$ 20); sometimes I nab (take) a small amount from my mother. Sometimes she gives me an amount – she receives money for us and gives me some. But at present she doesn’t give me anything. Her last but one pension – I am so embarrassed – even... knows – mother gave just UAH 10 (approximately US\$ 2) to me while to my brother, UAH 100 plus something. Sometimes people ask me to fetch them wa-

ter. I have an acquaintance at a kiosk. I bring her buckets of water and she says to me, ‘What should I give you – money or a patty?’ If I say, ‘Money,’ then she says, ‘How much?’ I tell her and she gives that much to me. At...(a restaurant) it’s the same thing. Or I may carry out litter somewhere – crumbs of biscuits, pomegranates, pastry... I have a lot of acquaintances.”

Some of the ways of earning a living include illegal activities. According to a hypothesis embedded in the survey, earning a living is a big problem for the target group and it can force them to commit offences now and again. The in-depth interviews provide an insight into diverse illegal ways of obtaining money, such as burgling of kiosks, robbing pedestrians of their money by force and threats, stealing of property by breaking into apartments or cars through windows, picking pockets, stealing food and other things from stands at marketplaces, group attacks at computer clubs, and robbing drunken people of their mobile phones or money, as mentioned previously.

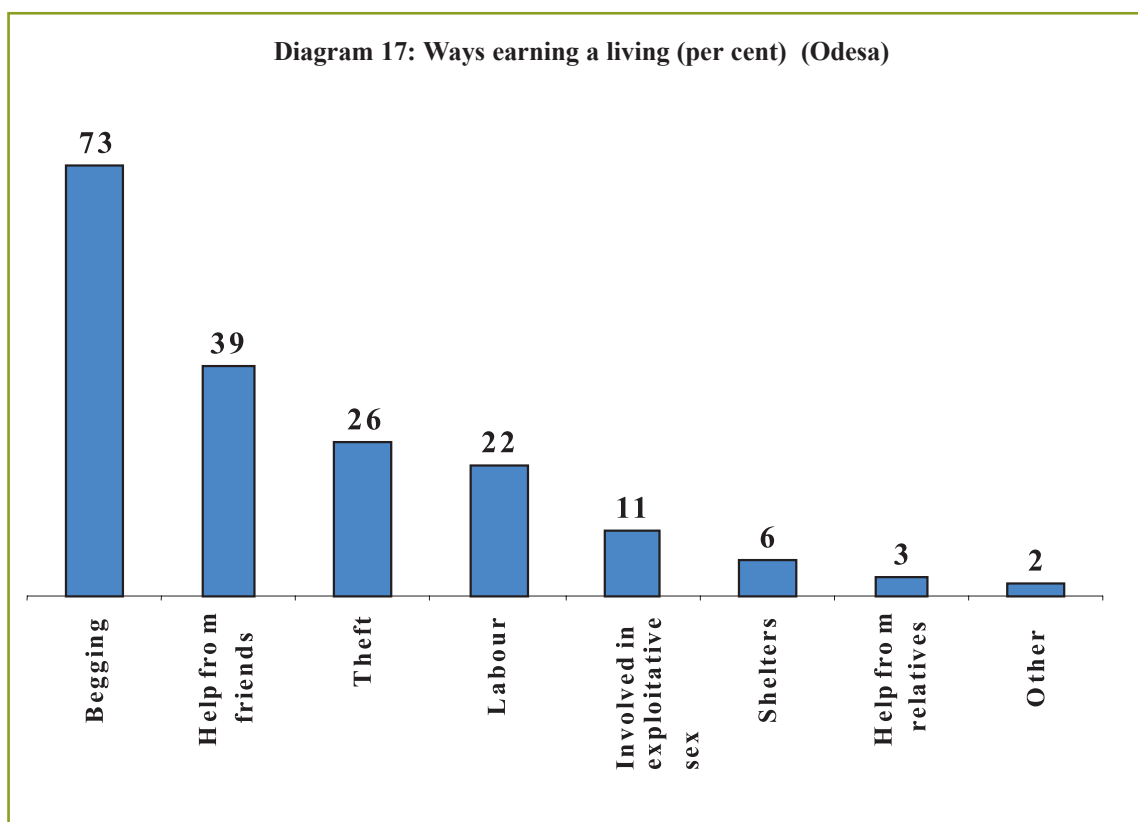
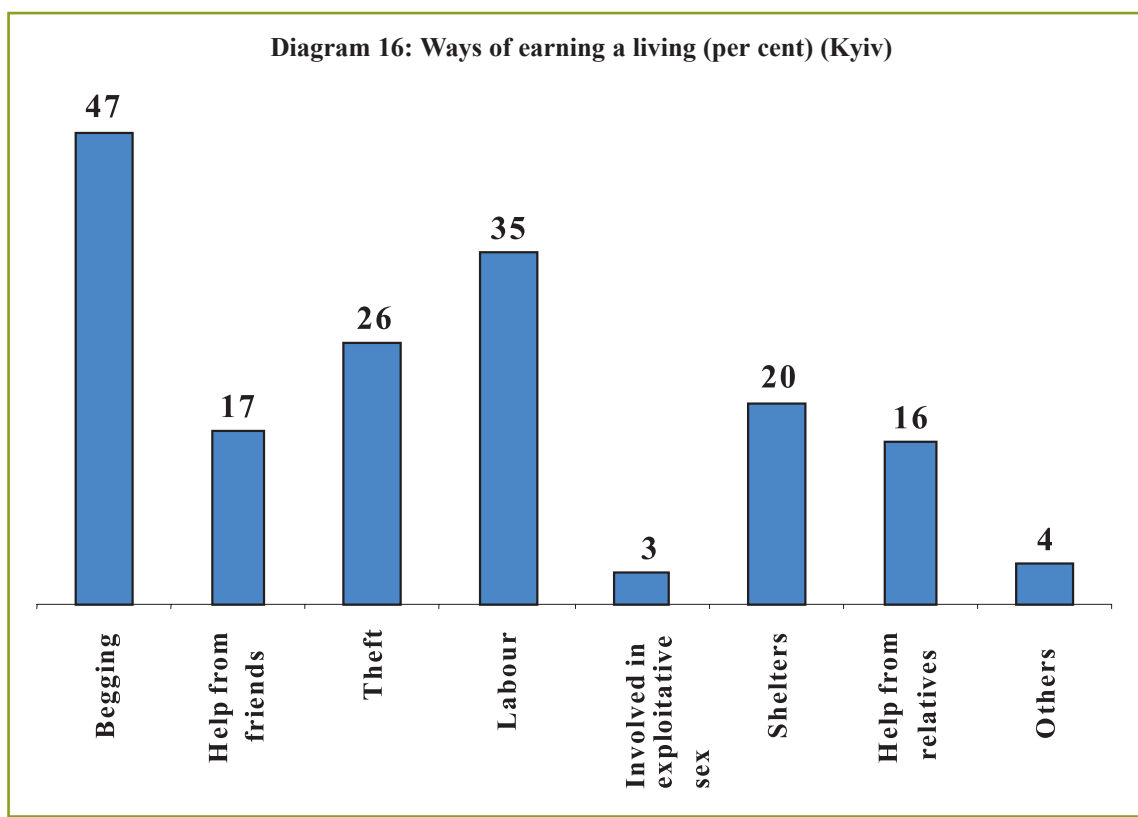
By picking pockets children and young people can make between UAH 5 and UAH 200 (approximately US\$ 0.99 and US\$ 39.60) a day. Some of those respondents who were still in touch with their parents said that they steal also things from home sometimes, and others stressed that the people who are robbed are quite frequently foreigners exchanging currency or giving something to the children and young people. Two respondents described situations when they had promised to provide sexual services and then ran away at night, after robbing the ‘client’.

The in-depth interviews pointed out that girls and young women might be less extensively involved in physically hard or risk-related work than boys and young men. A number of respondents said that the male members of a group usually provide food and money, while it is up to the female members to ‘keep the house in order’. Such statements reflect common stereotypes.

Respondents also emphasised that girls and young women are more often involved in exploitative sex than boys and young men.

Interviewer: “Did any adult make an offer on the street? For money perhaps?”
13-year old girl in Odesa: “Yes. Many times. Men of all sorts... Once, a woman made such an offer.”

According to the survey, the most widespread way to earn a living is by begging (47 per cent of the children and young people in Kyiv and 73 per cent in Odesa). In other respects the situation appears to be slightly different in the two cities. In Kyiv, 35 per cent of the children and young people report having a job, 26 per cent admitted stealing, and most of the others said that they get help either from shelters (20 per cent), friends (17 per cent) or relatives (16 per cent). In Odesa, besides begging, the main ways of earning a living are help from friends (39 per cent), theft (26 per cent) and labour (22 per cent), while support from shelters or family plays a rather small role (6 per cent and 3 per cent respectively). The greater number of children and young people receiving support from relatives in Kyiv might be linked to the higher proportion of children and young people still in contact with their parents.



In both cities, children and young people also acknowledged being involved in exploitative sex and, as seen from previous figures, the number was significantly higher again in Odesa (11 per cent) than in Kyiv (3 per cent).

The ways in which the target group earns a living in Ukraine correspond with the findings of a study conducted in 1999 in Moldova,⁷⁰ but differ from other countries, in which odd jobs such as cleaning cars or searching through garbage prevail.⁷¹

An analysis of the survey data by sex indicates that there might be a relationship between ways of earning a living and the sex of the respondents. Male respondents (51 per cent in Kyiv and 75 per cent in Odesa) beg more frequently than female respondents (34 per cent in Kyiv and 68 per cent in Odesa). Female respondents in Kyiv, however, more frequently receive help from relatives (31 per cent of female respondents, compared to 12 per cent of male respondents), shelters (29 per cent of female respondents, compared to 8 per cent of male respondents), and in Odesa also from friends (50 per cent of female respondents, compared to 33 per cent of male respondents). The analysis of the data does not provide an explanation of these findings, which might be linked to differences in support-seeking behaviour or in attitudes towards girls and boys. Further research would be needed to explain these differences.

More female respondents (9.8 per cent of female respondents, compared to 1.3 per cent of male respondents in Kyiv, and 29.2 per cent of female respondents in Odesa, compared to 1.5 per cent of male respondents) reported being involved in exploitative sex, while labour and theft appear to be more frequently used to earn a living by male respondents in both cities (labour: 41 per cent of male respondents versus 15 per cent of female respondents in Kyiv, and 26 per cent of male respondents versus 16 per cent of females respondents in Odesa; theft: 28.5 per cent of male respondents versus 18.5 per cent of female respondents in Kyiv, and 31 per cent of male respondents versus 16 per cent of female respondents in Odesa).

The age group also seems to be a factor in the way a child or young person is earning a living. Again, differences between the two cities are apparent.

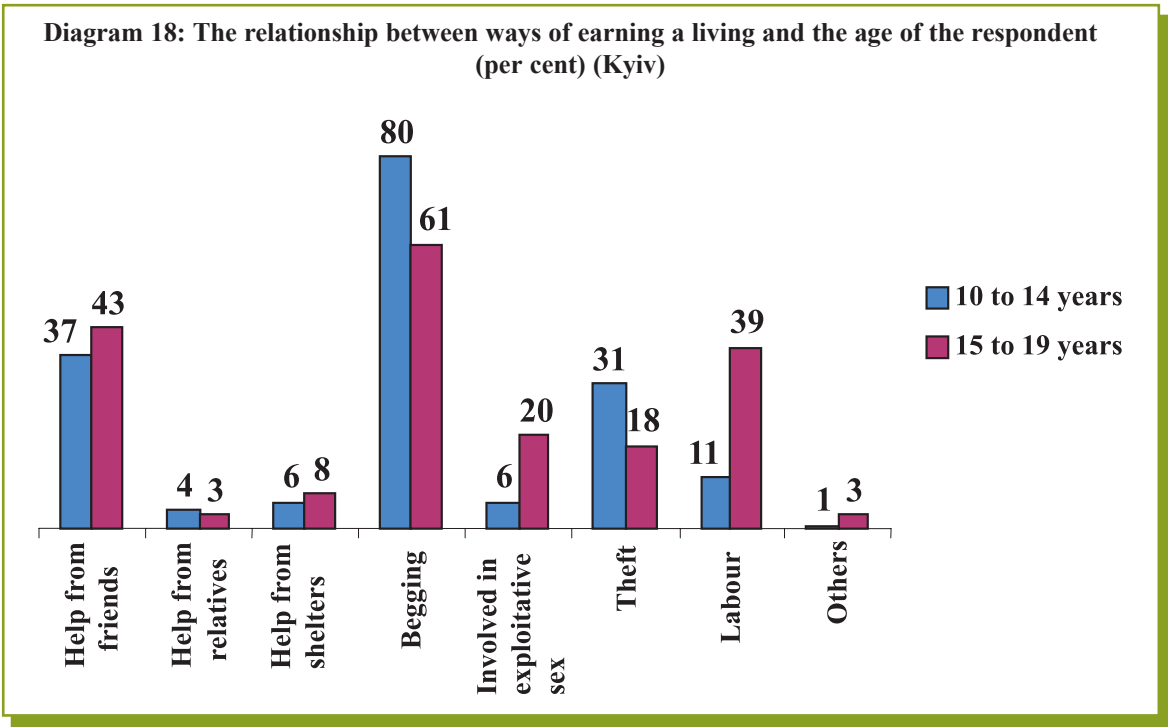
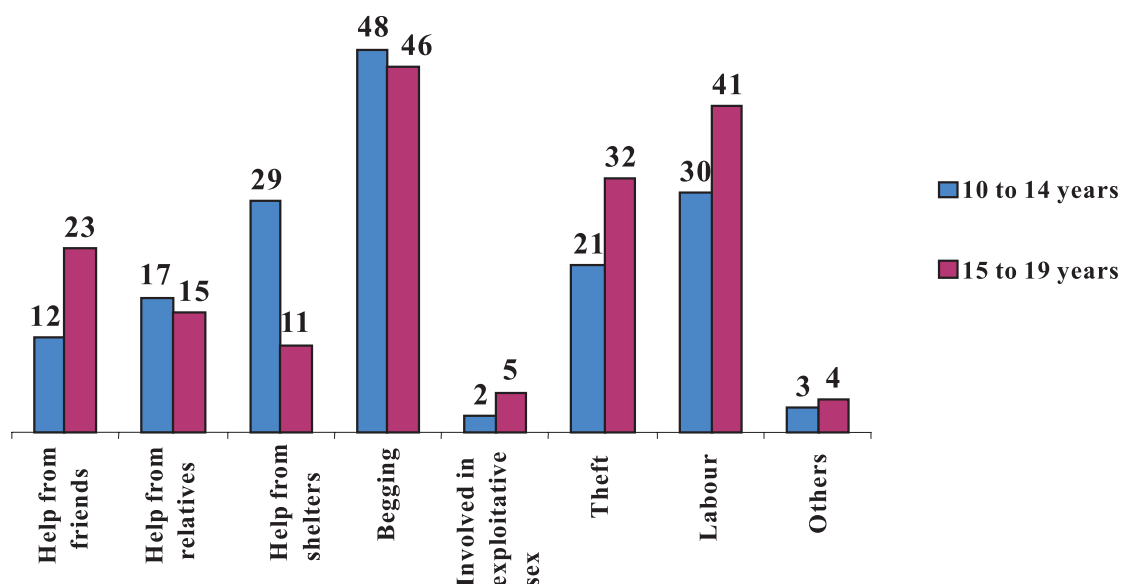


Diagram 19: The relationship between ways of earning a living and the age of the respondent (per cent) (Odesa)



In Kyiv 29 per cent of the Juniors, compared to 11 per cent of the Seniors, receive help from shelters. Seniors (32 per cent) practice more theft than Juniors (21 per cent) and receive more help from friends (23 per cent) than Juniors (12 per cent). In Odesa, Juniors are more involved in begging than Seniors (80 per cent compared to 61 per cent) and theft was also reported more frequently by Juniors than by Seniors (31 per cent versus 18 per cent) in Odesa. Similarly in both cities, Seniors more often claim to have a job than Juniors (41 per cent versus 30 per cent in Kyiv, and 39 per cent versus 11 per cent in Odesa).

The in-depth interviews in Odesa and in Kyiv indicated that some Seniors think that begging is more advantageous for Juniors, as adults feel ‘more sorry for them’ and they are able to collect greater amounts. Also, a number of Seniors said that they were ashamed of begging.

Interviewer: “Are you too shy to beg?”

17-year old boy in Kyiv: “I cannot even imagine it... I was afraid that some relative or neighbor of mine might see and tell (others about it), when I was still living at home.”

19-year old woman in Kyiv: “In the past, I used to beg; but now I am adult and no one will give me anything. Now no one gives (me anything), saying, ‘Go and work.’”

A correlation of the ways of earning a living with the gender-based age groups for both cities primarily showed that with increasing age, there seems to be a considerable increase in the share of female respondents reporting being involved in exploitative sex: for example from

13 per cent among the Juniors to 52 per cent among the Seniors in Odesa. However, the small sample size for the female group allows for no definite conclusions.

Male respondents in the Junior group primarily beg (82 per cent), while 31 per cent receive help from friends and 33 per cent steal. Male respondents in the Senior group tend to earn their living by labour (45 per cent of the Senior males, compared to 14 per cent of the Junior males) in Odesa.

The length of time spent on the streets might also influence the ways of earning a living. However, the data were inconclusive and are therefore not presented here. The only valid conclusion that could be drawn was that the number of children and young people working and being involved in illegal activities seems to increase with the length of time spent on the streets.

According to the results of the in-depth interviews, the children and young people reported that they spend the money they earn primarily on buying food, substances and drugs, or on visiting a computer club. Some of the Seniors stressed that they were trying to rent an apartment with the money, to live with someone's family and pay rent, or to occupy a vacant furnished room.

4.7.5 Leisure and recreation

Service providers interviewed said that, besides using recreational substances and drugs and having sex, children and young people living on the streets in Ukraine enjoy using slot machines, visiting computer and other clubs, and attending outdoor concert events. By some estimates children and young people spend up to 70 per cent of what they earn on slot machines, because 'the money is relatively easily earned and easily spent'.

The in-depth interviews held in Kyiv and in Odesa confirmed that one of the favorite pastimes for the target group is playing slot machines or computer games at computer clubs. The respondents admitted to spending a large proportion of the money they earn on this. As the tariffs at computer clubs are much lower at night, children and young people said that they frequent them in the evening more often than during the day. They also visit day-care centres and other places offering different activities for them, such as computer classes, videos and television, and craft workshops (sewing, woodworking, drawing or other arts and crafts). In the in-depth interviews, children and young people mentioned these leisure activities several times as 'a more interesting way' to spend their time than on the streets. Some of the interviewees who are in touch with day care and psychosocial rehabilitation centres had a relatively organised daily schedule, including studying at a school or being taught at the centre. Many of the in-depth interviewees had also attended a recreational and educational summer camp and the vast majority said that they would like to go to such camps again.

Judging by the descriptions of a 'typical day' provided by children and young people in Kyiv and in Odesa, during daylight hours they usually look for money, 'hang around', communicate with one another, walk the streets, and from time to time visit a place of support. Leisure

consists primarily of ‘walking about’, ‘smoking’, ‘inhaling glue’ and playing games: football, slot machines, or computer and play station games. Places where the children and young people ‘walk about’ are for example railway and bus stations, pedestrian subways, and markets. In Odesa, the children and young people also seek out places frequented by holidaymakers, in particular foreigners. One of the reasons for this might be that these places may offer more opportunities to earn a living by doing odd jobs linked to the holiday season, by begging, by being involved in exploitative sex or by pick-pocketing.

14-year old boy in Kyiv: “Sometimes I walk without a purpose; sometimes, when there is nothing to do, I collect bottles. I wake up at twelve. I go and beg for a while. I go to... for an hour. I go there to have a meal. I come here. I go to the Left Bank. Then late in the evening I get back from the Left Bank. I walk about – walk about. They have a social service there for all people in Kyiv. There, you can have your hair cut, have a meal and wash yourself for free. I go there. At any rate, there is nothing to do here. There, I can communicate with someone, have a free meal. There, I can watch television. Services are held there.”

By night, the interviewees reported sleeping in various places, wherever they find warmth or are ‘at home’. Some of the children and young people are also very active by night, either because there is nowhere to sleep at night and it is too cold to sleep, or because they earn a living at night. In the summer especially they can spend the nights in company out in the open air. Most of them said that at night they are ‘afraid at first’ and often reported drinking alcohol and smoking cigarettes, so as to stop being numb with cold or to get rid of their fears. They ‘warm themselves up’ and ‘become merry’.

13-year old girl in Odesa: “We were together because it was safer that way and we didn’t feel so afraid. When we slept by the sea we were very afraid – of someone killing us, or something else.”

As mentioned earlier in sub-section 4.2, many of the children and young people living on the streets of Ukraine are very mobile. According to service providers interviewed they move about out of fear of police raids that would place them in institutional care, or because the dwellings they have been using have been shut down or destroyed. They also share a sense of adventure that spurs them to explore new places, or move where there may be more resources. Seasonal mobility is also prevalent, with children and young people moving to warmer climates when the temperatures make street life difficult, or going to tourist locations where they might be able to earn more. The Kyiv City CSSFCY estimates that around 79 per cent of children and young people living on the streets of Kyiv are from other parts of the country, and gather in the capital where they feel their chances of making it on their own are enhanced by a higher standard of living, especially during winter months.

4.7.6 Needs and demands

There have been few surveys among the target group in Ukraine aimed at assessing their needs and demands. According to the service provider 'Caritas Ukraine', the children and young people they serve rank their needs as follows:

1. Food;
2. Clothing;
3. Substances and drugs; and
4. Hygiene.

However an analysis of the situation shows that needs that are less immediate, such as education and work, also rank high.

The service providers interviewed reported that children and young people living on the streets usually get their food by begging or stealing at markets, in exchange for odd jobs, or through local soup kitchens or humanitarian programmes that bring food to them in the streets. The interviewees stressed that in most cases the food they do get is cold, or not necessarily good quality resulting in subsequent gastrointestinal problems.

Adequate accommodation is also rare according to the interviewees. Only a few of the children and young people who spend most of their time in the streets actually sleep at home. Most sleep in often cold, dirty and dangerous places. Some sleep occasionally in shelters, especially if the weather is bad. There are cases of children and young people who do not even remember sleeping in a bed. For example, the Director of the non-governmental service provider 'ASPERN' that used to run a shelter in Kyiv spoke of an eight-year old girl who came in to spend the night and did not get up all day. When asked why she would not leave her bed and if she felt sick, the girl admitted that she had never slept in a bed before, and was afraid that if she got up, her bed would be given away to someone else.

Clothing is mostly received from humanitarian organizations, donations from people in the street, now and then from home, every so often from stealing and sometimes bought by money obtained from begging or stealing. At other times, interviewees said that they simply find clothing in the trash. The clothes are often the wrong size, torn and inadequate for the season.

Hygiene is low on the list of priorities for the target group, not only because of lack of access to adequate facilities, but also because many of them were never taught the basics and importance of hygiene. This leads to many health problems, particularly with regard to the spread of infectious diseases. In many of the places where the children and young people live, there is not only no hot water, but no water at all. Toilet facilities are non-existent and children and young people may use the area surrounding their 'hideouts' freely.

The results of the survey in Kyiv and in Odesa confirm that the living conditions of the target group do not even conform to basic standards and that their basic needs for food, housing, clothing, health care and education etc. are not met.

Table 10: Places where the children and young people living on the streets stay overnight (per cent) (Kyiv)

	At home	At a psychosocial rehabilitation center	At a reception and distribution center	At a 'hideout' on the street	On the street	Other
Most frequent sleeping place	14.8	18	8.1	40.4	3.7	15
Last sleeping place	10.4	17.8	11.7	39.9	4.7	15.4

Table 11: Places where the children and young people living in the streets stay overnight (per cent) (Odesa)

	At home	At a psychosocial rehabilitation center	At a reception and distribution center	At a 'hideout' on the street	On the street	Other
Most frequent sleeping place	2.7	10.7	4	78	2.7	2
Last sleeping place	1.3	7.3	2.7	83.3	3	2.3

The majority of respondents said that they sleep in 'hideouts' on the street (40 per cent in Kyiv and 78 per cent in Odesa sleep there frequently, and 40 per cent in Kyiv and 83 per cent in Odesa slept there last night). The second place that children and young people most frequently sleep in were psychosocial rehabilitation centres, at home (in Kyiv) or at reception and distribution centres. Other nighttime shelters primarily included apartments of friends, computer clubs, boarding schools, pedestrian subways and trade centres.

The situation is very similar in other countries, such as Russia, where 47 per cent of children and young people attending a local drop-in centre sleep in 'hideouts'.⁷²

The in-depth interviews also showed that, as a rule, children and young people try to make their 'hideouts' as comfortable as possible, furnishing them with things like old mattresses (usually found in the trash), blankets and cardboard boxes. However, they said that quite often employees of municipal services or law enforcement officers destroy their 'hideouts'.

14-year old boy in Kyiv: "I had the misfortune to lose my things. Previously, I lived on a ventilation grating; I kept some things there. Repairmen came and all things were gone somehow. There was a sleeping bag and a blanket there."

The in-depth interviews confirmed that clothing is another important aspect of the everyday life of the target group. Children and young people tend to wash their clothes on their own, in basements and sewers or at support centres. New clothing is either given to them at support centres, or by strangers, or stolen. In the winter season, the biggest problem mentioned was shoes. Many of the children and young people interviewed complained about their feet being

numb with cold and requested warm clothes from the interviewers (73 per cent of the children and young people asked the interviewers for warm shoes). Within the frame of the quantitative survey, the interviewers were also asked to observe how many of the children and young people they interviewed were wearing adequate winter clothes. According to the interviewers in Odesa, only around 35 per cent were properly dressed, i.e. wearing a warm overcoat, winter shoes and a warm cap. The majority of those properly dressed belonged to the Senior group (15- to 19-year olds).

Food is a major and very urgent issue for the target group. However, it seems to be fairly accessible, as in both cities the majority of children and young people interviewed had eaten at least one main course hot meal the day before the interview (63 per cent in Kyiv and 60 per cent in Odesa), although the results of the interviews indicated such meals were irregular. Some of them go to charitable organizations and church-run ‘soup kitchens’ to get a meal. Also, adults at marketplaces or begging sites provide them from time to time with food and drink.

11-year old boy in Kyiv: “In...(name of city), they feed me. Familiar vendors. So they give me bread, lard with garlic.”

Interviewer: “And do they give you a main-course meal – some sort of soup?”

Boy: “Yes, they do. It happens all of the time. So if I want to eat they give me. They just offer every day on their own: ‘Do you want to eat – do you want?’”

11-year old boy in Odesa: “Yes, I used to pay (for food) before; but then I met uncle... – he said that he would pay the money and I would eat for free. I was just wandering about asking for small coins and he asked, ‘Do you want to eat?’ He took me to the canteen and fed me. And besides,...(name of another child) was already familiar with that uncle...”

Younger children frequently cited support from adults in getting food, while older children and young people did not mention this type of help, but usually had to seek food actively themselves. Still, children and young people of the Senior group were usually better fed than children of the Junior group (70 per cent, compared to 51 per cent).

Malnutrition weakens the children and young people physically and can impair their mental abilities, including their ability to learn. According to *The State Of The World’s Children 2006* report of UNICEF,⁷² “...Those who do not complete primary school are less likely to have the literacy, numeracy and cognitive skills that improve their prospects of earning a decent income in adulthood...”.

The interviewers also asked the children and young people what sort of help they would currently need. In Kyiv, 26 respondents asked for food, 18 for clothes; 15 for assistance in completing their education or in finding a job, 11 for glue or cigarettes, 9 for money, 9 for housing, 5 for medical assistance, and 4 for toys or sweets. In Odesa, 73 per cent of the adolescents

asked for (warm) clothes, 50 per cent for food, 13 per cent for housing, 10 per cent for medical help, another 10 per cent for individual means of protection such as condoms and sterile needles, 5 per cent for hygiene products and 3 per cent for help in finding their parents. A very small number of children and young people in Odesa also asked for candles, money, help with finding a job, a blanket, a mattress, child security benefits, or help in getting official documents. Many children and young people aged 16 to 19 requested help in obtaining legal documents as well, particularly a passport. The problem was especially pressing for those who came from Russia or Moldova. In most cases, birth and education certificates had been lost, which prevents the children and young people from accessing many health and education services, as well as from getting a regular job.

The survey data show that the needs as identified by the children and young people interviewed are almost all very practical and linked to ensuring their survival and relative safety on the streets.

There was no consensus among the service providers interviewed as to how the target group perceives its own future. Some said that most of the children and young people live only in the present day with little concern for their future. Others however (particularly shelter staff) mentioned that children and young people often projected themselves into a future where they had jobs, family and stable prospects. One of the main results of focus groups conducted by the non-governmental service provider 'The Way Home' among children and young people living in the streets of Odesa was that the majority of them expect to die in the streets.

In the in-depth interviews in Kyiv and in Odesa, the children and young people were also questioned with regard to their plans for their future. In Kyiv, those in the Senior group hoped especially to find a job, to obtain the relevant education and to acquire a profession.

Interviewer: "So what sort of job would you like to have?"

14-year old boy in Kyiv: "I don't know; whatever I can find."

Interviewer: "And what do you like – what can you do?"

Boy: "When I was on my way to Kyiv, I was not going to work. I was going to rob some drunken man – break into some small shop – anything except working. I thought, 'You are fools, so you will work; but I am clever: I will steal from someone and I will have money.' There is a song I heard: 'When you have three grand in your pocket, your sadness is gone at once'. Nowadays you cannot make a fortune by stealing. I saw that it was really impossible to earn a lot. It is high time I did something. I will seek employment."

18-year old man in Kyiv: "I want to go to work, even if (I have to start) from a small job. I know people who start from a small job and then they succeed. They work...– and then he can install tiles although he has never been taught to do it; he simply copes with it. And the boss sees this and considers him to be, not a... (worker without qualification) anymore but a (qualified) worker instead – and



pays him more... I didn't know how to do it; this should be learnt. I simply know a man. If I were alone, there would be serious problems. The man tells me, 'Don't do that; it should be done in such-and-such way' – and I understand it. Now I can also do a few things on the computer. I used to love the computer in the past because of the games in it. But now I like serious programmes, not only games."

Male respondents in both cities mainly dreamed of becoming an electrician, a metalworker, a long-distance driver, a loader, a sportsman, a welder, a house painter, fireman or bricklayer, and female respondents mentioned primarily wanting to be a hairdresser or a vendor. Only very few respondents dreamt of becoming a lawyer, a journalist, or a designer.

16-year old girl in Odesa: "I want to be a public prosecutor. That's what I like – I don't know why. To complete education. I will complete my education. I will take my documents from school. I was told that, with a passport, I already have a right to study here..."

One girl said she wanted to be a singer and many girls also spoke of their wish to 'look nice' in the in-depth interviews. A number of the children and young people said they had no plans for the future. They primarily 'live for today'. Respondents in the Junior group particularly found it hard to answer the question about their future plans, but this is no different from many children who are still living at home.

Some children and young people mentioned that they would like to have what they lacked in their childhoods: a large rich house, safety, a car, a good family and a respectable job. Others would like to go abroad, to some place where they believe their life will take a different turn, where they would be wanted and will achieve success.

13-year old boy in Odesa: "I want to live normally, to work. First, I want to be 19 now and have a passport in my hands. Second, I want to have two apartments, two cars, a wife – no, I will have a wife later on – and a bodyguard. The third wish: let my life go on effortlessly, smoothly. Well, so that I will work, believe in God, pay a part of my salary for pension, study, acquire a profession – businessman or manager or something like that, and so on."

5. The rights of children and young people living or working on the streets of Ukraine and the national framework for response

5.1 An overview of the legal framework and state programmes

The Ukrainian government has ratified a number of international and United Nations (UN) conventions, protocols, declarations and resolutions protecting the rights of children and young people, including those living with HIV. Table 13 in annex V provides an overview of the ratification and adoption status in 2006 of some of the most relevant documents. According to these documents, the Ukrainian government has committed itself to protecting a wide range of rights of Ukrainian children and young people. These rights include for example:

- ‘Non-discrimination of any kind;
- All actions concerning children shall primarily consider the ‘best interests’ of the child;
- The right to protection and care that is necessary for the children’s wellbeing, taking into account the rights and duties of parents and legal guardians. This includes protection from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation (particularly sexual and economic exploitation), trafficking, sale and abduction of children etc. For this, adequate social programmes (prevention, support, care etc.) shall be established;
- Child-care institutions and services shall conform to standards (particularly concerning safety, health, number and suitability of staff, supervision etc.); and
- Children temporarily or permanently deprived of their family environment shall be specially protected, which includes the provision of suitable alternative care for the children’.

Many of these international documents form the basis of today’s legislation in Ukraine pertaining to children and young people, including those living with HIV. Table 14 in annex VI gives an overview of some of the key Ukrainian laws, decrees and resolutions relevant to the protection and care of children and young people, especially for those most likely to be exposed to HIV and to other infectious diseases.

Although many laws and other legal documents exist in Ukraine relating to children and young people who are ‘neglected’ or ‘homeless’ or who come from ‘families in crisis’, including those living or working on the streets, some are more relevant to this assessment, and will be emphasised as they deal specifically with issues addressed in this report.

There is the ‘Constitution of Ukraine’ that outlines the rights of all Ukrainian citizens, and guarantees the right of equality regardless of race, skin colour, national, ethnic or social background, economic status, state of health, place of residence, language or any other circumstance, as well as the right to education, labour and medical care.

The law 'On the Protection of Childhood' underlines the high priority placed on the protection of children's rights to life, health care, education, social security and comprehensive development. Specifically, the State guarantees all children access to qualified medical assistance in state and community health care institutions, safe and sanitary living conditions, sufficient nutrition and the formation of skills for healthy living. This legislation also defines the concept of 'homeless children' as described in chapter two. It places the responsibility for providing support to these children on state agencies at the national and local level, as well as on anyone 'with knowledge of children who are not under the care of any guardians'. According to the statutes of the Law, these children are to be placed temporarily in shelters until the proper authorities can determine whether they should be returned to their homes, or placed in children's homes, state boarding schools, family type homes or foster homes while awaiting further actions, or possible adoption. During this period, they should be provided with medical, legal and psychological assistance, educational opportunities and social assistance services. This legislation is in accordance with many international norms, however it focuses more on addressing the symptoms of 'homelessness' and on taking children and young people off the street and less on the causes of 'homelessness', especially on primary prevention and support to caregivers (parents, guardians, among others). Furthermore it is of a strategic and declaratory nature and therefore a number of additional normative acts were developed to provide guidelines for putting the Law into practical use.

The law 'On the Safeguarding of Organizational-Legal Conditions for the Social Protection of Orphans and Children without Parental Care' subsumes all 'homeless children' into the group of 'children without parental care'. There are no provisions made in the Law to reflect the fact that 'homeless children' are usually living or working on the streets and highly mobile. As a result, even though article 17 clearly outlines that the Ministry of Health (MoH) and services providing support to children are jointly to determine a 'complex of individualised psychological, rehabilitation and correctional assistance', also for children 'in extreme situations', as well as 'overall medical care, semi-annual medical checkups and any medical procedures including hospitalisation, as outlined in article 34', there are no mechanisms described for how this support is to reach children and young people living or working on the streets.

The law 'On the Basis of Social Protection of Homeless Citizens and Children' also defines the concept of 'homeless children' in article 2 as 'children who were forced into leaving their family or child care facility where they were placed, or left of their own accord, and have no specified place of residence' and separates them from the more general category of children without parental care. Article 5 reaffirms the rights of homeless citizens and children to health care, as well as to legal and social assistance. Section II outlines the process for registration of 'homeless children' by the 'Services for Children', and specifies that such registration must be of their own free will. Section IV, article 15 specifies the types of shelters available for 'homeless children' such as shelters for minors and centres for psychosocial rehabilitation, run by the 'Services for Children'. This Law outlines some of the key mechanisms for supporting these children, however, it is still based on the belief that these children need to be taken off the streets, registered (voluntarily), provided with the necessary documentation and then referred to ap-

appropriate care. It does not take sufficient account of the fact that many children and young people run away from child-care institutions, the difficulties related to getting the necessary documentation, the lack of adequate facilities, and the time it may take to convince a child or a young person to leave his or her life on the streets.

The law ‘On Social Work with Children and Youth’ defines some of the key approaches and services that should be offered to children and young people living on the streets, including outreach alongside social rehabilitation, to be carried out by juvenile services and CSSFCY, systematic tracking and supervision of children and young people who are in difficult life situations, a systematic and full range of interventions addressing life problems and maintaining and improving their social status and living conditions. The social follow-up and rehabilitation shall include social, medical, psychological, legal, informational, financial, and other services, and assistance shall also be provided to children and young people who have experienced violence and abuse or other extreme situations (such as trafficking).

In a decree issued by the Ministers of the MoFYS and the MoH ‘On the Approval of Cooperation between the Centres of Social Services for Youth and the Health Institutions in the Provision of Medical Assistance and Social Services for Children and Youth’, it is further specified that the CSSFCY shall provide social services aimed toward the promotion of a healthy lifestyle, prevention of STIs and HIV, safeguarding of reproductive health and preparation for informed parenthood, development of responsible behaviour in sexual and interpersonal relations, provision of psychological help and referrals to medical assistance. ‘Youth friendly clinics’ are mentioned, where children and young people can receive diagnosis and treatment, preventive care for STIs and HIV, and reproductive health care. According to the Law and the Decree, services provided by ‘Youth friendly clinics’ should be available to all children and young people. However, according to UNICEF, most of these services do not reach children and young people living on the streets, as they attract primarily those with active health-seeking behaviour. The same holds true for many of the other services listed in the Law and in the Decree. Another limitation of the Law is that it refers primarily to services provided via the CSSFCY or other services run by governmental service providers. Specialised services to be provided by the CSSFCY are specifically outlined in the Order No. 14 of the MoFYS issued on 4 February 2002 approving services, such as psychological assistance via a ‘Telephone Trust Hotline’, centres for social rehabilitation of children and young people with ‘functional deficits’, services for youth secondary employment, mobile counselling services for social work in rural and mountain localities, counselling units for injecting drug users (so-called ‘Dovira’, i.e. ‘Trust’ points), and social services for youth in detention and penitentiary facilities.

In the law ‘On Social Services’ the term ‘social worker’ is defined alongside terms such as ‘social services’, ‘social support’, ‘social centres’ and ‘temporary shelter for minors and adults’. The Law is important, as it mentions social services provided by ‘whatever form of ownership, as well as by individuals’, for example non-governmental and faith-based service providers. Orphans and ‘impoverished youth’ are listed among the beneficiaries of a wide range of social services described, which are similar to those set out in the law ‘On Social Work with Children and Youth’.

This Law also provides the legal basis for the licensing of social services and creates the possibility of financial support from the State on a competitive basis to non-governmental service providers. It fails however to define ‘financial support’ clearly and even though it stresses the importance of cooperation among all entities, it does not discuss mechanisms for cooperation.¹

Standards and norms applying to all ‘subjects of social work’ are defined in the law ‘On Government Standards and Guarantees’. Guidelines are given for the provision of social services for children and young people including the methods to be used, but some of the standards and norms would need to be reviewed taking into consideration evidence-based approaches and best practice examples from Ukraine and abroad. The Law further fails to set clear standards for services provided by non-governmental and faith-based service providers, and the enforcement of the Law is hampered by the lack of a comprehensive national service monitoring and evaluation system based on quantitative and qualitative indicators.

The law ‘On Charity and Charity Organizations’ guarantees support for a defined set of charity activities, but it leaves the cooperation between state and non-governmental service providers within the frame of joint initiatives unclear.²

There is a range of laws, decrees and other legal documents now in Ukraine pertaining to the rights of people living with HIV and the rights of their families, and to the protection of the population in regards to HIV infection. The first law was adopted in 1991, and in 1998 a new law was passed. In none of these Laws is there any mention of children and young people living or working on the streets as the group most likely to be exposed to HIV. The 1991 law ‘On the Prevention of AIDS and the Social Protection of the Population’ is in principal in line with most of the international norms and recommendations of WHO relating to HIV and AIDS, but it has had limited impact so far on the course of the HIV epidemic, as there are many obstacles to its implementation and enforcement.

One of the main impediments currently restricting the access of the target group to HIV services concerns parental consent. Article 12 of the decision ‘On the Common Regulation for Centres for HIV-Positive Children and Youth’ approved by the Cabinet of Ministers of Ukraine on 15 February 2006 states that admittance to an AIDS centre must be approved by the director of the centre, based on the request of one of the parents, or of the guardian of the child or young person, or of the individual himself, if he or she is no longer considered a minor. The child must have an identity document and a medical referral. As such, children and young people living on the streets, who usually have no documentation and are not necessarily still in contact with a living parent or a guardian, are automatically excluded from the services provided by AIDS centres and other, similar institutions. This Decision contradicts the ‘Law of Ukraine on the Protection of Childhood’, mentioned earlier, which guarantees free medical care in all state facilities to all children. In practice, some facilities do accept children and young people without documentation, but they remain the exception. In another decree ‘On the Protocol of Voluntary HIV Counselling and Testing’ of the MoH, the full testing procedures are charted out, as well as issues relating to parental consent when seeking an HIV test. In addition, there is information about provisions in the ‘Civil Code of Ukraine’ regarding the age at which a young person can be tested without parental consent. Usu-

ally individuals are considered minors until they reach the age of 18, but there are circumstances under which exceptions are made. For example, in section II, article 32, it is stated that an individual aged 14 to 18 is still considered a minor, but has some rights. Article 284 states this includes the right to choose a physician and methods of treatment, according to the physician's recommendations. Medical care for a person who has reached the age of 14 can then be provided with the consent of this person alone. Article 34, section II also states that a minor who is legally married automatically gains full rights, and maintains those rights even if the marriage ends. Article 35 states that full rights may be granted to an individual of 16 years of age or older, who works legally, who is listed as the mother or father of a child, or who is involved in business as an entrepreneur. Article 285 does state though that parents (foster parents), legal guardians or tutors have a right to receive information about the state of health of a child or a person under care. While this does not contradict any of the above, in real life this Article is often interpreted as another obligatory requirement to involve a parent or a guardian in the provision of the service. All of the above exceptions are further contradicted by article 7 of the law 'On the Prevention of AIDS and the Social Protection of the Population' that states that anyone under the age of 18 must have the approval of a parent or a guardian in order to be tested for HIV. These issues are critical in determining the accessibility of HIV voluntary testing, counselling, prevention and treatment services for children and young people living on the streets, and the fact that they are complicated for the average citizen only makes it more insurmountable for them.

The new 'Criminal Code' of Ukraine adopted in 2001 regulates trafficking of minors, the use of substances and drugs, as well as sex work and sexual exploitation of minors. Article 149 defines 'trafficking in persons or other illegal agreement regarding the transfer of an individual' as a crime against the will, honour and dignity of a person, including children. The regulations pertaining to trafficking closely reflect international norms. Key problems include the coordination of activities among various service providers, sufficient funding for the implementation of measures to enforce the law, and clear timelines and accountability among the institutions responsible.³

The provision of sex is now no longer punishable as a 'crime', as it used to be in Ukraine, but should simply be punished by administrative means such as a fine. Exploiting a minor for sex or engaging an adult in sex work remains a crime though, and should be punished accordingly. While decriminalising those being sexually exploited was a vital step, it will still take time to change the attitude of society and of law enforcement officers toward sex workers and sexually exploited minors. Further, it will also take time to inform children and young people living on the streets about this change to the Law and to encourage them to come forward and seek legal assistance if they have been sexually exploited.

Articles 314 to 316 of the 'Criminal Code' refer to the prevention of illicit drug circulation. The Code does not establish a criminal liability for the use of drugs, but for 'purchasing, producing, transporting or storing' drugs, even without intent to sell the drug, which means that every drug user (including children and young people living on the streets who are using drugs) violates the law, as it is not possible to use drugs without producing, buying, transporting and storing them at least for a short while.⁴ Once registered as a drug user, access to several profes-

sions and to a driver's license is prohibited. In addition, the drug user is required to attend a drug rehabilitation facility. In case of children and young people using drugs, the latter is hardly significant given that there are, to date, very few drug rehabilitation facilities in Ukraine accepting children and young people for treatment.

Apart from various laws, decrees and other legal documents, there are a number of relevant governmental concept papers and state and national programmes addressing issues concerning children and young people engaging in risk behaviours and living in risk situations. Table 15 in annex VII provides an overview of key state and national programmes and concept papers pertaining to the issues raised in this report.

From 2003 until 2005, the 'State Programme to Prevent the Homelessness of Children' governed activities relating to children and young people living on the streets of Ukraine. It was not possible to establish whether or not a formal evaluation of its outcomes and impact was ever conducted. However, service providers interviewed stressed that the implementation of the Programme was hampered, as it clashed with other national programmes addressing issues of children in crisis, and either divided or duplicated the responsibilities of the work. It also left room for various interpretations of how certain issues should be approached and by whom, which led to a situation, according to the interviewees, where 'everyone expected someone else to be responsible for the implementation of certain points, and in the end no one ended up taking responsibility'. Funding needs and sources of funding were not clearly spelt out and therefore lack of finances prevented implementation in many cases. The Programme also did not take into consideration the importance of responding to the individual needs of each child and of improving the situation; rather it focused on the elimination of the problem as a whole, which was the approach in the former Soviet Union. Interviewees also stated that the Programme had failed to clarify the division of responsibilities between the governmental and the non-governmental players.

On 7 December 2005, the Cabinet of Ministers of Ukraine approved the 'Concept for a State Programme' and 'The State Programme Aimed at Fighting the Homelessness and Neglect of Children 2006-2011'. The main objectives of the Programme include:

- a. Decreasing the number of homeless children without care by 50 per cent;
- b. Developing the necessary legal and financial basis to overcome child homelessness;
- c. Developing effective forms of work to prevent child homelessness, identifying families in which children are being abused and protecting these children;
- d. Introducing new forms of social support for children in different risk settings;
- e. Developing a database with information about orphans and homeless children;
- f. Protecting the rights of orphans, the rights of homeless children and of people who want to adopt children;
- g. Organising a network of social care facilities for children and improving the quality of work in these facilities;
- h. Providing training and retraining for the employees of social care facilities for children; and
- i. Improving the normative and legal basis of social protection of children.

The Ministry responsible for the overall implementation and coordination of the Programme is the MoFYS. Besides the reduction of the number of ‘homeless’ and ‘neglected’ children, the Programme particularly seeks to reduce as much as possible the period of time that children are spending on the streets and being ‘neglected’. The main principles and values underlying the Programme are in line with the international conventions cited earlier in this chapter. It is hoped to move the restructuring of the current residential child-care system forward by developing a range of family type forms of child-care (particularly for children under the age of 10), by dismantling the huge system of children’s homes and boarding schools and by reorganising the current shelters into centres of psychosocial rehabilitation. It is also the intention to provide more support to families in crises to prevent the children and young people taking to the streets. Foremost behind this reasoning is the belief that children need to grow up in a family environment in order to receive proper guidance and support, and that they require role models on how to build their own family life when they become adults. Otherwise, children from dysfunctional homes who grow up in the streets or in institutions will generally have tremendous difficulty in establishing successful families of their own.

Although this Programme obviously includes the target group, it seems to focus primarily on children who are already in the child-care system. The Programme also does not address adequately the issue of HIV and underlying risk behaviours and risk factors in the environment of the child and young person. Despite focusing strongly on the rights of the child, the Concept and Programme fail to address what services should be provided to children and young people in need of immediate care, as well as the question of how the transition and restructuring process will be funded and managed and how the underlying social and economic causes of the situation will be addressed.

According to the Deputy Director of the State CSSFCY, discussions on the further restructuring of the child-care system and the development of additional services, such as ‘Children’s Villages’,⁵ are already under way. As the Concept and the Programme came into force recently, it is too early yet to evaluate what influence and impact they will have on the current situation, particularly for the target group. It is however clear that the Concept and Programme will need to be harmonised with other state and national programmes in order to avoid duplication of activities, the development of parallel structures. It is further necessary to close existing gaps in the Programme (see chapter eight) to ensure a comprehensive national response.

Another new approach that the government of Ukraine is now taking for the care of children who are under guardianship is set out in a statement made by the Cabinet of Ministers of Ukraine on an ‘Experiment in the Allocation and Payment of State Social Assistance to Orphans and Children without Parental Care’, based on the principle that ‘the money follows the child’. The idea behind this initiative is to make sure that the children are getting the most of the government subsidies allocated to them, by having those funds follow them no matter where they are placed in the system, instead of the funds going through the institutions. This approach has been successful in many countries in Western Europe. But even though this Statement addresses a vital issue, it will have to be implemented in circumstances which are already difficult and where obtaining decent and affordable housing is a problem even for the

ordinary citizen in Ukraine. That means that options for members of the target group in terms of housing and long-term accommodation are still very restricted.

The Chief Specialist of the Kyiv City CSSFCY stressed that until 2006 there was also no overall strategy at any level to address the issue of the prevention of HIV and STIs in the target group. In 2002 the Multisectoral Comprehensive programme 'The Nation's Health for 2002-2011' established that the 'growing morbidity of socially dangerous diseases, in particular TB, HIV and AIDS and STIs, is an important problem' and that healthy lifestyles should be promoted. With regard to the HIV protection of children and young people in general, Ukraine has committed itself to reaching the following United Nations General Assembly Special Session on HIV/AIDS (UNGASS) targets by 2010:⁶ 95 per cent of young people will be aware of HIV, the prevalence of HIV among young people will be reduced by 25 per cent; and the transmission of HIV from mother to child will be reduced by 50 per cent. The 2005 and 2006 UNGASS reports published for Ukraine demonstrate that there is still a long way to go. For example in 2004, only 14 per cent of young people could both correctly identify the ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission; this means that Ukraine missed the target of 90 per cent that had been set for 2005 by UNGASS.⁷

An overall HIV strategy, the 'Concept of the Strategy of Government Action targeted at the prevention of the spread of HIV/AIDS', was adopted by the Cabinet of Ministers on 4 March 2004. The strategic approach is specified via the 'National Programme to Prevent HIV Infection, Support and Treat People Living with HIV/AIDS for the period 2004-2008'. The focus of both documents is the prevention of HIV, the development of safer behaviour and the expansion of access to treatment, support and care. The Programme promotes a multisectoral approach, but although it covers most of the important areas that need to be addressed, it lacks coherence, and does not identify the specific steps that need to be taken, nor by whom they are to be taken. In most cases there is no identifiable source of funding for activities and, without specific budgets, service providers have no clear directive and are less accountable for taking on the responsibilities. An additional problem hampering the implementation of this Programme is the inconsistency between actual needs and the availability and distribution of funds. According to a representative of the Ukrainian AIDS Centre, the Programme further fails to answer the question of how programmes, currently funded by international donors, will be funded in the future, once international funding has run out. This applies especially to antiretroviral therapy programmes, given that the numbers of people in need of antiretroviral therapy will increase in the coming years. For example, 447 children in Ukraine are receiving antiretroviral therapy as of August 2006 according to the Ukrainian AIDS Centre, of which less than 10 per cent are supported through the state budget. In the interviews with service providers it was stressed that of the children presently receiving antiretroviral therapy, only two or three are children who formerly lived on the streets.

The Programme barely addresses the issues of children and young people, and HIV and AIDS. None of the specifics are highlighted nor sufficiently regulated relating for example to services

for children orphaned by AIDS, to specific actions needed to address children and young people engaging in high risk behaviours, to antiretroviral and substitution therapy for children and young people, to increasing access to education, quality medical assistance and social services (common problems among children and young people living with HIV in Ukraine according to representatives of the 'All-Ukrainian Network of People Living With HIV/AIDS'), nor to the need to collect disaggregated data for different groups of children and young people.

A sectoral programme on HIV prevention, treatment and care for people living with HIV in the criminal justice system for 2004 to 2008 was developed in April 2004. The agency responsible for its implementation is the State Penitentiary Department. As with most programmes, this one also lacks adequate funding and regulations pertaining for example to the cooperation with non-governmental service providers, particularly in the follow-up of patients on antiretroviral therapy accessing or leaving the criminal justice system.

Only with the development of the *Road map*⁸ and the *2006 Ukraine GFATM proposal*⁹ mentioned in chapter one, were children and young people living on the streets recognised as a group engaging in behaviours leading to a high degree of exposure to HIV and therefore needing a response at a national level. The *Road Map* for example talks about 'Adolescents and children at-risk (including orphaned children, street children, juvenile detainees, youth in special care institutions, children and adolescents who live in problem families etc.)' as a key target group for HIV-related activities. By 2010, 60 per cent of this group is to be covered by a 'specific minimum package of prevention services' and a 'minimum package of multifaceted care and support services'. The coverage of antiretroviral therapy of all patient categories by 2010 is to reach 50,000 people. It is unclear though if any members of the target group will be included in the treatment programme, especially in light of their living conditions and problems in terms of adherence. There is also no mention of access to substitution therapy for the target group. While this document is groundbreaking in recognising this group of children and young people as a target for the national response, it lacks an action plan, definitions of mechanisms for its implementation, clear responsibilities and monitoring indicators and has yet to be officially adopted.

5.2 Rights awareness and violations of rights

While the range of rights of children and young people in Ukraine are wide and in most areas in accordance with international norms, a review of how these rights are enforced with regard to the target group shows that in every aspect these children and young people have their rights severely violated. For example, their physical and mental wellbeing is not protected and many of them face forms of physical and mental violence, neglect and maltreatment, injury, abuse and even torture (see chapter four, sub-section 4.6.2). In addition to the evidence on torture provided by the children and young people interviewed in-depth in Kyiv and in Odesa, there is evidence reported by the European Commission in Ukraine, which referred in its *Country Report 2004*¹⁰ to the annual report of the 'National Human Rights Ombudsperson' in Ukraine of 2002 on the situation of human rights in the country. The

Ombudsperson had registered allegations by 12,000 individuals in 2001 concerning torture and maltreatment, most commonly in the context of interrogations for the purpose of eliciting a forced ‘confession’ or in penitentiary facilities. The ‘European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment’ was cited as sharing these concerns, particularly with regard to detention in Ukraine. The Committee visited Ukraine in 1998, 1999, 2000 and 2002 and published its reports in October 2002 and in December 2004. The 2002 report referred to methods of maltreatment amounting to torture such as burns on the skins (see also chapter 6.3 for the same allegation made by a 13-year old girl from Odesa) and asphyxiation by placing a plastic bag over a detained person’s head, and beatings.¹¹

Many of the children and young people living or working on the streets are also being exploited (sexually or economically), and there are reports of them having been trafficked, sold and abducted (see chapter four, sub-section 4.6.2). As other chapters will show, they also experience discrimination, have very limited access to adequate education, health and social care services. Many child-care institutions and services do not conform to standards, for example in terms of the number and qualification of staff. There are few high-quality programmes addressing the needs of the target group in Ukraine and, due to the lack of support, some of these children and young people die on the streets.

Other rights commonly violated include human rights such as the right to a place to live, the right to work and the right to study. As mentioned in the previous chapter (sub-section 4.7.1), children and young people often have their rightful claim to inherit housing abused by those speculating on making a profit by selling apartments from under them. Service providers interviewed stressed that this is especially true for children or young people whose parents have died or who have spent a considerable amount of time in children’s homes and upon release learn that their parents or extended families have sold their homes. In Odesa for example, 1,863 petitions and requests regarding the violation of children’s right to housing had been reviewed in 2004. Of these, 77 cases were accepted and 68 brought to court. In 127 cases, the illegal sale of a child’s dwelling could be prevented.¹²

Target group members who are injecting drugs may be exposed to rights violations common among injecting drug users in general in Ukraine, such as:

- Searches and examinations without sufficient legal grounds by law enforcement officers, including widespread practice of torture;
- Violations of rights when attempting to access medical care, causing great distrust of medical staff, include refusals to provide services, failures to respond to ambulance calls and disclosure of confidential information, often caused by the fear of infection among medical staff;
- Refusal by social workers to designate child-care assistance or other types of social assistance to unwed mothers who are injecting drug users;
- Public stigmatisation and discrimination; and
- Discrimination at the workplace, including dismissal, refusals to hire etc.¹³

In the view of the service providers interviewed, the target group's awareness of their rights is relatively low among the target group, and what they know is usually spread by word of mouth or learned at presentations in support centres or shelters. Rights awareness was not a subject of the survey conducted in Kyiv and in Odesa.

A problem is that even those children and young people who are aware of their rights to some extent, either do not know where to turn to for legal assistance or have little faith that their rights will be granted and defended, given particularly high levels of corruption in Ukraine.¹⁴ Service providers interviewed also pointed out that children and young people are sometimes afraid of the consequences they might face in trying to bring a violation of their rights to the attention of authorities, especially if criminal elements or law enforcement officers are responsible for the violation. Children and young people with low literacy levels are also often unable to complete the most basic application forms for assistance. Although legal assistance is technically available, it would require the client, in this case the child or young person living on the street to diligently pursue the case, or to have a committed legal counsel, either scenario being more the exception than the rule in Ukraine, according to the interviewees.

Not all interviewees agreed with the need to increase the awareness of rights among the target group. Some, mostly in governmental structures, stressed that 'children and young people are too young to exercise their rights', and that 'they do not always understand what is best for them'. They feel that the government needs to take responsibility for these children and young people when their parents have failed to do so, and that this responsibility should not be 'muddled' with the issue of children's rights. Particularly, they argued that given the epidemic proportions of HIV and TB in Ukraine, these children have to be taken off the streets, forcibly if necessary, so they do not infect even larger numbers of people. However, there were many others, particularly among non-governmental and faith-based service providers, who disagreed strongly with this approach, as their experience shows that children and young people who have been forced into care usually run away at the earliest opportunity and take to the streets again. Also, if coerced, they are rarely willing to comply with the restrictions enforced in child-care institutions, and might refuse to participate in rehabilitation programmes.

6. Services and activities targeting children and young people living or working on the streets

6.1 The range and uptake of services

In accordance with the legislation of Ukraine, the target group should have access to a wide range of prevention, treatment, care and support services, including medical, social, educational, vocational, legal, psychological services (see the previous chapter). A full mapping of services provided to the target group has however never been conducted, and to date no comprehensive database exists on available services in Ukraine. CSSFCY have internal referral systems but, according to some of their representatives, they contain incomplete records, particularly when it comes to services provided by non-governmental and faith-based service providers.

Table 16 in annex VIII provides a list of key service providers and agencies showing those involved in policy-making and law enforcement, and those involved in service development, funding and delivery, including those aiming to build the capacity of service providers in the country. The organizations were divided into international and national service providers, as well as into governmental and non-governmental agencies. As a mapping of services was not in the scope of the assessment, the list may not be exhaustive. However, it does illustrate the range of agencies and service providers dealing with the topic and the range of services in place.

Overall, there are four ministries, one state department and one state centre responsible for policy-making, law enforcement, service provision and overseeing affairs related to the target group. The overall responsibility is carried by the MoFYS, which coordinates the activities of all other ministries in this area. As of August 2006, the MoFYS was overseeing a national network of 96 shelters, 22 psychosocial rehabilitation and crisis centres (sometimes based in shelters), 267 children's homes, 256 foster families and 181 family type homes, most of which are managed by local authorities. The majority of child-care services have now been integrated under the auspices of the MoFYS, which was a positive step in terms of improving national coordination and clarifying roles and responsibilities among the different agencies.

The role of the Ministry of Education and Science (MoES) is focused on the education of children and young people, including thematic education on important issues relating to healthy lifestyles and the prevention of HIV, substance and drug use in schools and other educational institutions. The Ministry oversees the countrywide network of schools, including special schools and boarding schools.

The State CSSFCY oversees the activities of a wide network of regional and local CSSFCY throughout Ukraine. These centres primarily deal with the implementation of social services set out in laws and state and national programmes (see the previous chapter). They support children while they are in child-care facilities, in adoptive families and in family type homes, as well help those children who are leaving institutional care to reintegrate into society. They support young mothers, families in crisis, and people who are released from prison and work

on the prevention of homelessness, of violence and of crime. They also provide social support to people living with HIV and to young drug users through a network of harm reduction services. They are also involved in the training and education of volunteers and social work students, as well as social advertising.

The MoH carries the responsibility for all health care facilities for the Ukrainian population, and there is now a network of HIV services in place provided by local AIDS centres and other facilities across Ukraine, while the MoI is mainly responsible for delinquent minors and detention centres for minors, as well as for raids during which children and young people are taken off the streets and returned either back home, to distribution and reception centres or to shelters. The State Penitentiary Department is responsible for penitentiary facilities for minors and all services provided to them within these facilities.

Given the decentralised governance system in Ukraine, there are also various departments at the oblast and city administration level responsible for implementing services for children and young people, including the Department of Children (Services for Minors) and the Department of Youth. The target group is mainly dealt with by the Department of Children that works with families in crisis situations, responds to appeals of citizens and is responsible for protecting children's rights to housing, property etc.

In the non-governmental and faith-based sector, there are a number of Ukrainian organizations providing a wide range of services to children and young people, but most of them reach only a small percentage of their target audience. Table 16 in annex VIII also lists some services that are not yet reaching the target group at large, but that have the potential to do so and were therefore included into the list. Non-governmental and faith-based service providers primarily supply services complementary to those offered by the Ukrainian State and local administrations, filling gaps in governmental service provision. The range of services provided by non-governmental and faith-based service providers includes:

- Support to families in crisis situations;
- Hotlines;
- Outreach services (often including food services) and peer-to-peer programmes;
- Drop-in and day-care centres;
- Shelters;
- Psychosocial rehabilitation centres;
- Drug rehabilitation and drug use prevention services;
- Medical assistance;
- Legal assistance;
- HIV prevention and harm reduction programmes, as well as support for children and young people living with HIV and AIDS-related diseases;
- Camps and other recreational activities;
- After-school programmes and activities;
- Schooling and vocational programmes;
- Reintegration and semi-independent living programmes;

- Support to children and young people in detention or penitentiary facility for minors;
- Training programmes for professionals from different sectors;
- Advocacy programmes particularly on children's rights;
- Awareness raising; and
- Community mobilisation programmes.

There are also various new services in the planning in Ukraine. In Kyiv and in Odesa for example, non-governmental service providers plan to set up a centre for emergency assistance providing support to children and young people who have experienced domestic violence or other abuse, and a halfway house offering temporary housing and social support including legal advice and job search assistance for young people in crisis situations and who have already gone through initial psychosocial rehabilitation.

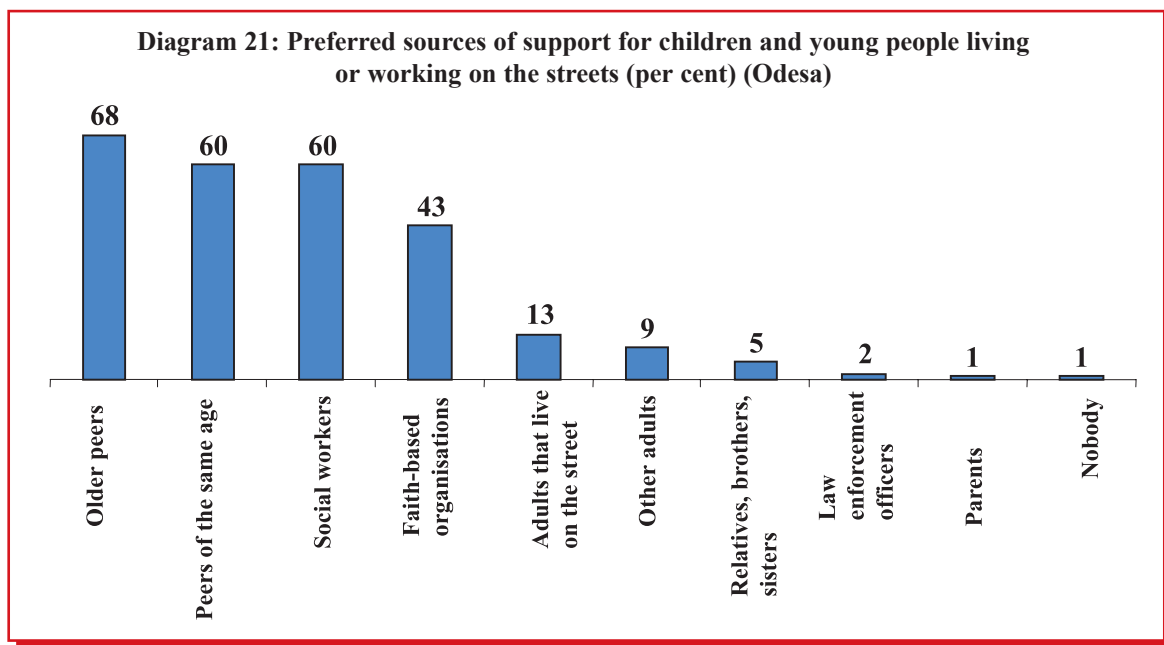
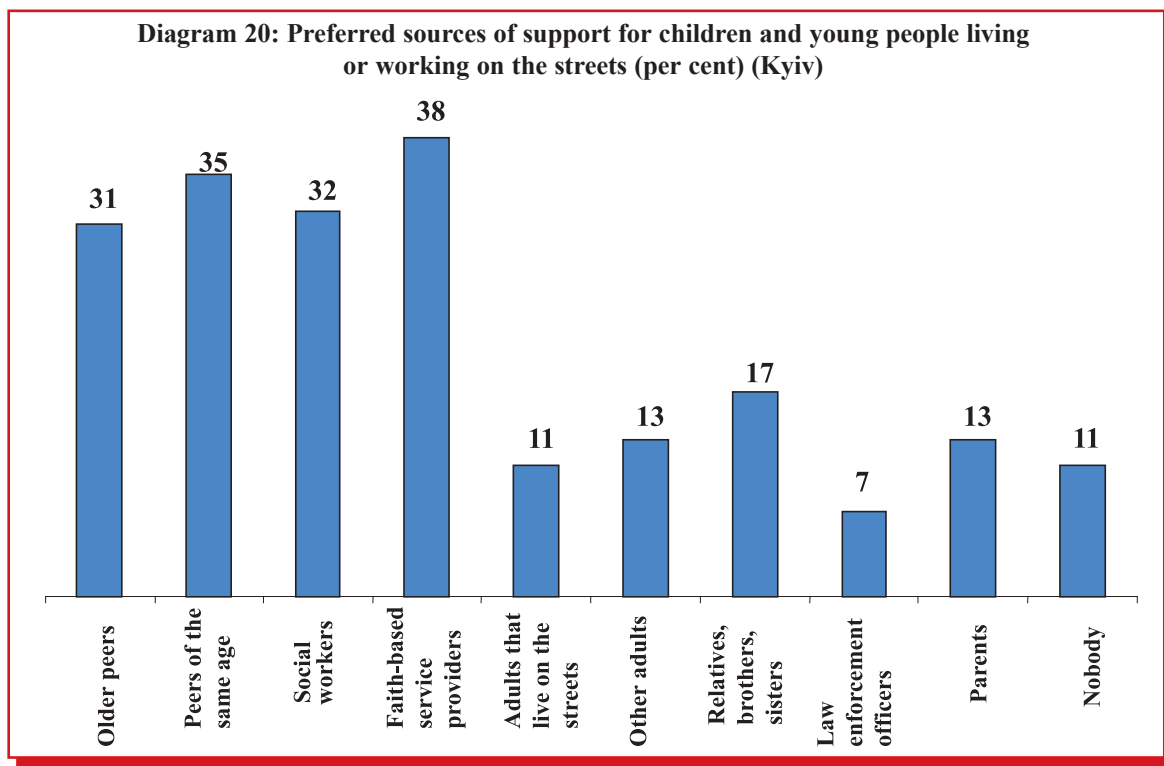
In addition, there are various international non-governmental and faith-based service providers giving funding, managing grants or implementing support programmes for the target group, usually in cooperation with Ukrainian partner organizations. The programmes they implement in Ukraine focus especially on:

- Advocacy and policy development;
- Qualification of professionals working in the area;
- Development of training and information material;
- Behavioural and epidemiological research;
- Development of family type and foster care;
- Awareness raising among the public and working with the media;
- Programmes on prevention, health promotion, care, support and treatment in areas such as HIV, TB, reproductive health etc.;
- Development of networks of services and integrated services;
- Support to national and local coordination mechanisms; and
- Some direct services, particularly in the area of humanitarian assistance such as food, housing and clothes.

According to the service providers interviewed, the preferences of the target group in terms of taking up services depend primarily on whether the services are provided by a governmental or a non-governmental service provider and how appealing or restrictive they are. In line with the interviewees, the target group is more likely to go to a shelter or medical assistance point run by a non-governmental service provider, because they tend to be wary of any state-run institutions and are afraid of being referred to a children's home or boarding school. Reasons for going into any of the organizations include need of shelter, clothing, food, medical assistance, a haircut, a shower, laundry and recreation. The more recreational activities are available and the more attractive the facilities, the more likely children and young people are to come back regularly or even agree to stay. Children and young people who have lived on the streets for some time prefer day-care centres and shelters that do not limit their freedom. In the views of the interviewees, children's homes tend to be more regimented, and therefore

might be more appealing to younger children who might still feel more of a need to be taken care of and guided.

The survey results from Kyiv and Odesa illustrate the perception of the target group of the various services provided to them.



According to the data, respondents in Kyiv receive support primarily from faith-based service providers (38 per cent), followed by other members of their group, who may be older than

themselves (31 per cent) or of the same age (35 per cent), and by social workers from governmental and non-governmental service providers (32 per cent). A much smaller proportion received help from relatives, parents, adults living on the streets and other adults. Law enforcement officers were also mentioned (7 per cent). A mere 11 per cent of the respondents said that they did not receive support from anybody. The picture differs slightly in Odesa, where a larger number of respondents reported getting help from other children and young people living on the streets, either older than themselves (68 per cent) or of the same age (60 per cent), followed by social workers (60 per cent) and faith-based service providers (43 per cent). The overall high percentages in the Odesa diagram are due to the fact that respondents could name more than one group of people from whom they had received support and did so more frequently. It is noteworthy that adults living on the streets were also named (13 per cent) as helping the target group in Odesa, while help from most of the other groups was insignificant. Compared to Kyiv, almost all children and young people interviewed in Odesa receive some form of help. Only 1 per cent said that no one helped them.

Almost one third of the children and young people interviewed in Kyiv (33 per cent) and in Odesa (38 per cent) had previously received assistance in the form of care in a children's home. According to the results of the in-depth interviews, most of the children and young people who had previously lived in a state-run child-care facility had repeatedly escaped from there. The main reasons given for running away were being beaten by older children and young people, boredom and 'longing for friends' in the streets, lack of freedom (they had been 'locked in'), and psychological pressure and physical humiliation by staff.

13-year old boy in Kyiv: "I would have remained at the boarding school if there had been normal respect for children there."

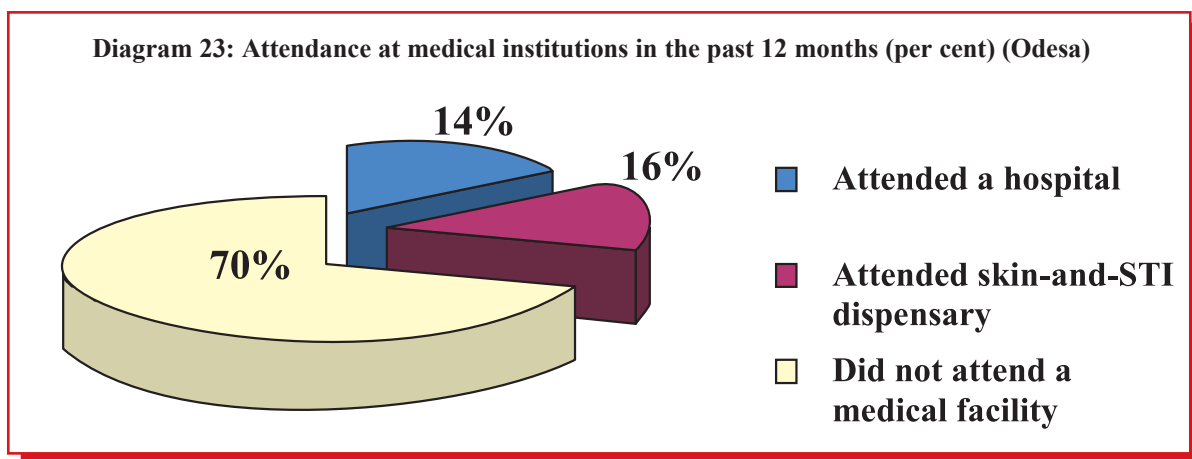
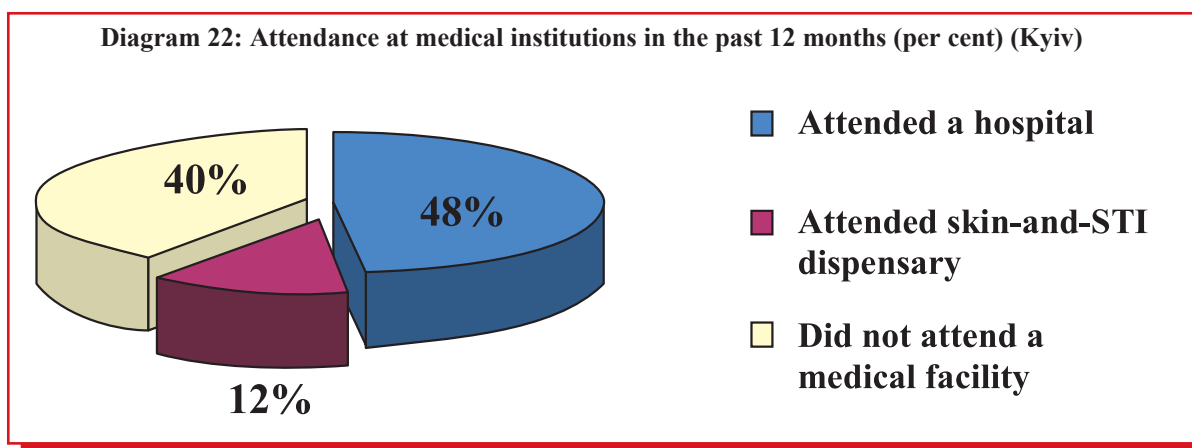
Interviewer: "The teachers didn't respect you?"

Boy: "Oh no, senior children."

19-year old man in Odesa: "For example in...(name of a boarding school). There, the director resorts to such things that, although...(the director) has no right to beat children – small ones –...(the director) simply kicks them and so on; so how can you abstain from saying something to...(the director) in response if...(the director) simply comes up to you and hits you hard and swears at you as well – says a lot of things about you and starts insulting your parents? Many children are deeply hurt by that; it's family business; what right does...(the director) have to insult their parents? It's because many say that you will be the same (as your parents)... It's just that at many boarding schools – on the contrary – instead of that – in the main they ought to give the child a hope that 'you will grow up, you will be normal,' this and that; but they – on the contrary, they suppress you. Most likely, that was my reason (for running away)."

As stated by service providers interviewed, the probability of a child or young person running away from a state institution varies. In the first two weeks, they may run away because they realise they have problems they need to deal with, and past experience has taught them to run under such pressure. They may also run away when they realise that they need to make a serious commitment to changing their lives. Otherwise, they can usually last about three to four months observing all the rules, said the interviewees.

In order to assess the care children and young people receive from medical institutions, those who had reported health problems in the past twelve months were asked in the survey whether or not they had seen a physician during that period¹.



In spite of the high number of self-reported health problems among the target group in Kyiv and in Odesa, not all of them had attended a medical facility when they were sick in the past twelve months. The figures vary for the two cities. While in Kyiv only about 40 per cent of the children and young people interviewed reported not having attended a medical facility when sick in the past twelve months, in Odessa the figure was 70 per cent. The data do not allow for a further analysis of this marked difference, however it would be useful to conduct more research into why children and young people in Odesa seem less likely to seek out medical care than those in Kyiv.

Of those who had received medical assistance at a facility, 48 per cent were in a hospital in Kyiv and 14 per cent in one in Odesa, while 12 per cent in Kyiv and 16 per cent in Odesa went to the

skin-and-STI dispensaries. When asked about the effectiveness of the treatment received, 68 per cent of the respondents in Kyiv and two thirds of those in Odesa thought that it had helped. However, it should be noted that the in-depth interviews revealed that most of the children and young people when taking medications for therapeutic purposes mix them with alcohol and continue to use other substances and drugs, which casts doubt on their ability to adhere to a prescribed drug regimen and on the effectiveness of the treatment.

While the analysis of the Kyiv data did not show any correlations with the age group of the respondents, the sex and the length of time they spent on the street, the data for Odesa could be analysed according to age groups. The main finding is that the proportion of respondents who had been treated at the skin and STI dispensary was larger among the Seniors (26 per cent) than among the Juniors (only 9 per cent). This might be explained by the fact that Seniors have sex more frequently than Juniors (chapter four, sub-section 4.6.6), which, given the high level of unprotected sex among this group of the population, may expose them to a higher risk of acquiring an infectious disease such as STIs or HIV.

During the in-depth interviews respondents reported that they rarely seek medical assistance by themselves. Very often they choose self-treatment or simply pay no attention at all to their health problems. Cases in which children and young people interviewed mentioned self-treatment included poisoning, skin rash and bronchitis. Children and young people said that they usually attended a medical facility:

- When a passing stranger recognised that the child or young person needed help and called an ambulance or brought the child or young person by taxi to a clinic;
- When the police or other patrolling officers realised that the child needed help and referred the child or young person to a medical facility;
- When the children or young people themselves recognised a need for medical assistance among one of them and called an ambulance; or
- When the children or young people were visited by social workers or volunteers, or visited one of the support services and were then referred to medical facilities for diagnosis and treatment or were diagnosed and treated at the service point itself.

Interviewer: “And did you come to the hospital on your own, or were you brought there?”

13-year old boy in Odesa: “Not on my own. I was simply flat down, rolling up my eyes, feeling pain and unable to do anything. A man came up, asked what the matter was. I hardly whispered to him. He took out his mobile phone and made a call. They came and took me away. He paid money for me and drove off. They told him that the amount was sufficient.”

The children and young people also reported that they are usually only referred to medical facilities in emergencies and extreme situations, such as when they have broken bones, ab-

scesses, have overdosed or have attempted suicide. In some cases, severe injuries go undetected and may cause the death of a child or young person.

19-year old man in Odesa: “The very first one who died was... He had been shooting up three to five times every day. It happened like this: at first he went to fetch ‘Effect’; he wanted to come back and stir it up as soon as possible, so as to shoot up. He was in a hurry and he did not notice there was two-way traffic there; it was near... – we were living in a dugout there. A car hit him in the pelvis and he kept on walking; everything was all right and then he could no longer make water. Then a swelling began. Then he could no longer defecate. Then we saw that his belly was like that of a (pregnant) woman in her seventh month. He no longer shot up; no one gave him (any drugs); so in three days’ time, because he was unfit for the toilet, he died.”

The majority of the children and young people interviewed in-depth were well aware of places to which they can turn when they are in need of medical assistance.

When interviewed, the service providers mentioned another source of medical assistance which was not revealed by the survey, the ‘neighbourhood pharmacy’, where children and young people can easily obtain advice and medicines.

6.2 The quality of services provided and activities conducted

There are many ‘... children who are currently beyond the reach of laws, budgets, programmes, research and, often, the governments, organizations and individuals seeking to fulfill their rights. Not only do these children face exclusion from essential health-care services, education, safe drinking water and decent sanitation in the present, they are also likely to face exclusion from full participation in society as adults. Many of them suffer from protection violations that heighten the risk of their exclusion and make them, in effect, invisible’,² ‘The exclusion of these children, or any children, from the services, protection and opportunities that are theirs by right is unacceptable’³

Children and young people living or working on the streets provide the greatest challenge for service providers, as they receive very little protection and are extremely difficult to reach and to follow-up with.⁴ The *UN Convention on the Rights of the Child* that Ukraine ratified in 1991 provides a strategic framework for states to ensure the quality of services to protect and support children. In article 3, it stresses that services provided ‘shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision’ and it acknowledges that ‘the

ability of states to actually provide the requisite level of protection⁵ is related to the economic condition of that state', hence article 4 states that 'State parties shall undertake such measures to the maximum extent of their available resources, where needed within the framework of international cooperation'.

In order for the Ukrainian government, in particular the MoFYS, to be in a position to fully oversee, regulate, monitor and evaluate the implementation of rights and of high-quality services for vulnerable children and young people, including those living or working on the country's streets, it would need to have adequate funding set aside for this purpose and a range of supportive mechanisms and tools in place, including a guiding policy, a multisectoral strategy and action plan, a set of national service standards and a standardised reporting system for all service providers, as well as a comprehensive monitoring and evaluation system.

Even though various State policies addressing different categories of children and young people exist, there is no single State policy or multisectoral strategy and action plan in place in Ukraine to guide, to monitor and to evaluate the activities that are currently being implemented.

There are national standards for the delivery of social services set out in the Ukrainian legislation and policies, but the standards could be higher and take into account more new evidence and best practices within and outside of Ukraine, particularly with regard to services provided to 'families in crisis' and to the target group. Existing standards are also not sufficiently enforced among service providers, and given that no packages of services have been defined for children and young people at different levels of risk, the existing standards do not succeed in ensuring adequate high-quality services for them.

While it is difficult and rarely cost-effective to measure the impact of activities provided by one organization, the impact of the national response should be measured. This should be done at regular intervals, and the measurements should be based on an agreed set of national indicators for vulnerable children and young people, which has yet to be developed in Ukraine. A reporting system for governmental service providers exists, but the indicators used for monitoring, evaluating and reporting on services and other activities related to the target group are not sufficient either to ensure nor to assess the quality of the services and activities conducted, particularly in terms of their outcomes. A review of the websites of various service providers in Ukraine shows for example that service providers mostly gather and present input and output data, such as how many and what forms of services were provided in a given year. Some do report on a few outcome indicators, such as the number of children and young people who have been returned to their families, but in the review only two non-governmental service providers could be identified that gave specific information on outcomes, including the improvement in the overall development of the children they serve.

International donors supporting projects in this area usually have clear guidelines requiring the implementing partner to monitor and evaluate project activities. Sometimes donors employ external evaluators to assess the effectiveness of an activity. However, given that very few

of the donor evaluation reports are widely published and disseminated, it was not possible to evaluate, within the frame of this report, how many of the donor-funded activities are currently successful or have been so in the past.

Official reports and reviews on the situation of the target group published during the past five years in Ukraine provide no in-depth evaluation of the quality of services provided and activities conducted. Usually they only point out general problems related to the implementation of state, national or local programmes. The lack of implementation plans and mechanisms for turning state and national programmes into action may be one of the key reasons for this.

As of today, no overview of the overall funding (national, local and international) available for services for the target group exists. No comprehensive analyses of donors and costs have been conducted and, combined with the lack of baseline and disaggregated data, a proper estimation of the needs of this target group in terms of coverage and funding is consequently hampered.

Still, the government openly acknowledges that Ukraine is facing a crisis situation when it comes to children and young people living or working on the streets and to families in crisis, even if they might not know the full extent of the problem nor how well all current services work. There has been enough evidence presented and discussions held on the gaps in services and their low coverage, on the violation of children's rights, and on the need to reform the current child-care system, for the Ukrainian President Yushchenko to announce that the welfare of children in the country is a national priority, and to declare 2006 the 'Year of Children's Rights' in Ukraine. In November of 2005, the President personally met with representatives of all spheres of children's services at a forum dedicated to an open discussion of the issues. This discussion resulted in further consultations between the MoFYS and selected service providers, the identification of some of the key problem areas, the redefinition of approaches, a plan for the gradual overhaul of the system of child-care in Ukraine, and in the development of the new '2006 State Concept' and '2006 State Programme on Homeless and Neglected Children'. Some of the main strengths and weaknesses of these two documents were discussed in chapter five.

Tables 17 and 18 in annex IX provide an overview of key social and other services, programmes, facilities and activities in Ukraine for the target group (table 17), as well as for service providers (table 18) from the point of view of their quality. 'Quality' in this report includes first and foremost: the level of accessibility of services, service effectiveness, service coverage and existing gaps in services. The tables also demonstrate selected good practice examples from Ukraine. They are based on the results of the interviews with service providers, and the desk research conducted. An in-depth analysis of the quality of services was not within the scope of the assessment for this report. However, anecdotal evidence provided by the target group, the abuse, violence and maltreatment described by them, their many unmet needs, their low level of education and of HIV awareness, the high levels of risk factors and their overall poor health reported in chapter four, and the violation of their rights pointed out in chapter five, clearly indicate that the services and activities provided are, overall, insufficient and in some cases even ineffective in addressing their many needs.

The following quote from a 19-year old youth in Odesa shows, though, that help offered is often appreciated and that the creation of a supportive environment can greatly enhance the chance of a child or young person deciding to change his or her behaviour.

“Most of the time I was living with a guy in a sewer; so he came and said, ‘... there is a place where one can eat, sit for a while for free, warm oneself’ – because it was winter already. It was cold. He said, ‘You will hear there about God and so on, but,’ he said, ‘you can have a meal and there is a place to wash yourself and change clothes.’ And so I went there, and then we went here, in...(name of a street), to some other...(people). I started going...there... At first I went there just to have a meal. I was already 17, 18, and I decided to stop mugging (stealing), because many boys had been detained and many were under supervision, many had been locked up – and so I simply said to myself, no, I will try not to do such things. So I went to those believers; we communicated and we found a common language very easily...and they even gave me some work...”

That those members of the target group who were subjected to HIV prevention activities in social service centres (see chapter four) were able to give correct answers to the question on the modes of HIV transmission demonstrates that targeted prevention programmes can have tangible results.

The following provides a summary and main conclusion of the findings presented in the two tables in annex IX.

Despite the lack of baseline data for the target group in Ukraine, a review of available, accessible and effective services based on anecdotal evidence reveals that the coverage of the majority of services provided is too low to adequately meet their needs. There might be some exceptions, when looking at the number of shelters available and humanitarian assistance programmes providing food and other basic necessities, but overall, services need to be scaled up, particularly services aiming to reduce risk behaviour and to create a protective and enabling environment. This is further supported by coverage data set out in the *2006 Ukraine GFATM proposal* that show that current HIV prevention, treatment, care and support services cover only 26% of injecting drug users, 9.4% of female sex workers, 7.9% of the prison population, 1.3% of men who have sex with men, 18.5% of people living with HIV in need of care and support, and 0% of ‘street children’.⁶ The coverage data for ‘street children’ is not complete, as there are various service providers in Ukraine who work with this target group (see tables 17 and 18 in annex IX) and provide HIV prevention and some care and support services. In light of the overall need, it is true however that the coverage is insignificant.

Currently, there is still an imbalance between the focus of policy-makers and service providers on reducing and eliminating the ‘symptoms’ (such as the daily needs of the children and young people) of the problem, and the relatively little attention paid to the underlying ‘causes’ (especially social, economical and legal issues, pertaining particularly to the support of families and

guardians), mostly because they feel that they have neither the capacity nor the experience in advocacy nor the power to address these causes.

Furthermore there seems to be a disparity between those services focusing on supporting children and young people already living or working on the streets, and those services providing extensive prevention and support programmes to ‘families in crisis’, caretakers (parents, guardians, among others) and to children and young people in risk situations (including those orphaned by AIDS, those living with a parent who is HIV positive or has an AIDS-related illness, and those who are themselves HIV positive).

Clear gaps in services could be identified in the area of primary prevention such as parent education and after-school activities, and violence prevention programmes, as well as in secondary and tertiary prevention such as in harm reduction and HIV and STIs prevention programmes. Another, particularly big, gap was identified in mental health services and psychosocial counselling and support offered to children and young people living or working on the streets, in shelters or in detention and penitentiary facilities, as well as to the staff working with them. This is particularly worrying considering the high level of mental health and psychological problems that children and young people living or working on the streets have, and the many traumas they have experienced (see chapter four), and given the high turnover rates among staff due to burn-out.

Staff interviewed, particularly staff of governmental organizations, also mentioned frequently the need for higher health and safety standards at their workplace and for access to means of protection, as well as the need for a competitive salary package and other work incentives.

During the interviews, representatives of various governmental service providers like the CSSFCY admitted that they are not properly equipped to cope with the problems faced by the target group, including such issues as HIV. This was echoed by other service providers, who said that official statistics on how well the situation is being handled could be misleading. For example, referrals should not be considered the provision of a service because, without close monitoring and guidance, those referrals are worthless to children and young people, who disappear into the streets. Statistics showing how many children and young people were returned home may give the impression that their situation has been changed for the better, when in fact many of them are further traumatised each time they are sent back to a bad situation after going through psychosocial rehabilitation. Among the agencies who deal with these children and young people, many complained that they have neither the facilities, personnel, nor time to dedicate to each individual for proper evaluation and care. Quite a few service providers further mentioned the lack of adequate pre-service (initial) and in-service training and the necessary qualification to work with the target group. Others feel that existing resources are spread too thinly, with insufficient coordination and follow through, and are therefore ineffective.

Children and young people who have lived in children’s homes and boarding schools for a long time are usually unprepared for an independent life once they are ready to leave the institutions. There are currently insufficient alternative care places available in Ukraine such as fos-

ter homes or family type homes, as well as a lack of adequate reintegration programmes. According to the Head of the Department of Children of the MoFYS, official statistics show that one in seven of those leaving children's homes attempt suicide out of complete hopelessness. The '2006 State Programme on Homelessness and Neglect of Children' envisages increasing the number of alternative services and either restructuring or dismantling some of the existing child-care institutions such as boarding schools. However, one of the biggest challenges that Ukraine will face in this respect is how to manage the process, how to take care of the children and young people in these institutions during the restructuring while there are not yet enough alternative services in place, and how to mobilise a sufficient amount of resources to expand alternative services. The Programme does not provide any answers to these questions.

The need to reform the juvenile justice system in order better to reflect the specifics of cases relating to the target group, and to help speed their cases through the system so they are not stuck in clinics, temporary shelters or detention centres longer than absolutely necessary, was identified as a key area for improvement.

Children and young people who are detained or imprisoned may also face additional risks in detention and penitentiary facilities, in particular due to the high incidence of infectious diseases in the facilities, among other issues (see the following chapter for more details).

Stigmatisation and discrimination against the target group remain major obstacles in accessing adequate health care and education services. Other obstacles are issues relating to parental consent, the need for official documents, unofficial payments for services, and the lack of health-seeking behaviour among the group (see also chapters four and five). Access is further restricted because some service providers and professionals, mostly those working in the primary health care system, in pharmacies and in the ambulance service, are not yet adequately included in the national response, even though they can be considered potential 'gatekeepers' of the access to this target group. Such 'gatekeepers' also include owners and staff of computer clubs. However as long as computer clubs allow the target group to use their clubs as overnight shelters, and do not restrict access of minors to violent and pornographic Internet sites and computer games, and as long as pharmacies sell freely to members of the target group, and to minors in general, legal substances that are easily convertible into drugs, often in the full knowledge of the intended use of these substances, and make few efforts to promote healthy lifestyles among their customers and to help prevent infectious diseases such as HIV, STIs and TB, it is expected that it will be a relatively long time before these 'gatekeepers' are willing to support the national response. This is also another area where legislation is not properly enforced and sanctions for breaking the law (such as fines) are not effective enough to change common practice.

As yet the mass media in Ukraine is only marginally involved in promoting healthy lifestyles and the impact so far of social mass media campaigns has been limited. One of the main reasons is that social advertising campaigns are still dependent on the willingness of TV, radio and other media to place their ads free of charge or at heavily discounted rates. Given that media is a business, social ads are rarely shown at prime time on television or placed in the most effective places across urban and rural areas. In addition, healthy lifestyle campaigns are launched alongside massive advertising of products such as tobacco and alcohol that can be harmful to

the health. Such advertising is often coupled with a message that these products can increase sexual potency, showing sometimes several potential sexual partners, while ignoring related risks. Despite the fact that advertising and mass media have shown that they can influence and form public opinions, there is no ban yet of such potentially harmful advertising in Ukraine.

Risk behaviors, particularly the use of substances and drugs, are a major problem in the target group, as this habit prevents them from accessing a large number of available support services. Detoxification is not sufficient to prepare them either for reintegration into society or for living in a child-care facility or family type home, and access to drug rehabilitation programmes for the target group, and for children and young people in general, is almost non-existent in Ukraine. Even access to detoxification services can be restricted, particularly for minors, and the access to substitution therapy, currently only available within the frame of a few pilot programmes for people living with HIV in Ukraine, is still non-existent for target group members living with HIV. This means they are denied access to a highly important tool for increasing their adherence to antiretroviral therapy.

Data on the number of target group members living in rural areas are not available, but anecdotal evidence presented by service providers suggests that the number is smaller than in urban areas, but can grow significantly during summer months due to the availability of seasonal work. Services in rural areas are even more restricted than in urban areas, as there are fewer service providers, and city services usually lack transportation means to reach out to the target group members living or working in rural areas of Ukraine.

The lack of access to sufficient information and disaggregated data on which to base decisions is another major obstacle to the planning and provision of adequate services. In addition, the fact that the current legislation does not allow for data to be shared between different service providers, especially between those from the governmental and non-governmental sectors, is another obstacle to keeping track of target group members and to adequately meet their needs.

Most of the existing services lack appropriate funding or their sustainability is at stake, especially when they depend mainly on international donors, which is the case for most non-governmental and some faith-based service providers. There is also tough competition for the limited resources between many of the non-governmental service providers, increasing the difficulty of making a joint response (see section 6.4 for more details).

Besides funding, most services lack sufficient human resources to reach out to all those in need, and quite a few service providers mentioned the lack of adequate training and re-training and of the necessary qualifications for working with this target group.

There are also gaps in the integration of services, particularly between the primary and secondary care level, as well as between paediatric and adult medicine⁷ resulting in cases of children and young people getting ‘lost’ in the system, or no one being willing to take responsibility for them.

A comparison with in-depth reviews, conducted for the ‘World Bank Group’, of services provided to 10- to 19-year old children and young people living or working on the streets in other

countries during the mid to late 1990s,⁸ demonstrates that, at some point in time, all of these countries faced very similar problems to those that Ukraine is currently experiencing, such as a relatively low coverage rate of services, the fact that there are few evaluations on the outcomes and impact of the work and even fewer on the cost-effectiveness and cost-benefits of the projects, the lack of financial and human resource capacity, limited involvement of the community and the private sector, and restricted accessibility and availability of adequate health, education and employment services for the target group. It is vital, therefore, to review international experience and responses when addressing quality issues and gaps in services.

6.3 Attitudes and behaviour of professionals toward the target group

Non-discrimination is a right of each Ukrainian citizen according to the Ukrainian Constitution. Article 2 of the *UN Convention on the Rights of the Child* also stresses this as a responsibility of the state. In addition, article 19 emphasises that ‘state parties shall take all appropriate measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child’. As highlighted in chapter five, these rights are often violated when it comes to the target group, revealing that the attitudes and the behaviour of many people in Ukrainian society toward these children and young people can be extremely negative.

However, attitudes and behaviour vary greatly from person to person and from organization to organization, as revealed by the assessment for this report. Besides instances of stigmatisation, discrimination, exploitation and severe maltreatment, there are also many examples of compassion, selfless support and high commitment, even outside of normal office hours. The results of the interviews with service providers showed that sometimes within one person, it is possible to find positive as well as negative attitudes toward the target group.

Before a negative attitude can result in harmful behaviour, there must be additional factors at work, usually related to personality, to personal history, as well as to environment. However, no such explanation can excuse any of the violations of rights which were reported by the majority of the children and young people interviewed for the survey in Kyiv and in Odesa (see chapters four and five). Perpetrators must be prosecuted and punished, especially so since most cases are never brought to the attention of authorities for the reasons already mentioned in chapters four and five, including the highly restricted access of children and young people to legal support, their very limited ‘voice’ in the Ukrainian society, and their fear of creating even more problems for themselves if they report the incident.

The following table summarises the key positive and negative characteristics of children and young people living on the streets of Ukraine according to service providers interviewed.

Table 12: Key positive and negative characteristics of the target group as seen by services providers interviewed

Positive characteristics	Negative characteristics
<ul style="list-style-type: none"> • Their understanding of the need to help one another; • Their independence and self-sustainability; • Their adaptability; • Their creativity; • Their extrovertness; and • Their ability to earn and budget money. 	<ul style="list-style-type: none"> • That they tend to know more about their rights than responsibilities and feel they are entitled to support from the government; • That the majority of them are involved in illegal and criminal activities; and • That there are children and young people who have learned ‘to use’ the organisations providing help in order to sustain their lives on the streets.

Interviewees expressed a range of attitudes. There were many who have compassionate feelings for this target group. They see the children and young people as individuals with the same rights as any Ukrainian citizen, and who need to be individually supported within the context of what is best, meaning least harmful, for them. There were, however, critics of this approach, who expressed concern that providing support to children and young people on the streets instead of taking them off the streets is insufficient to protect them from harm, as it leaves them in the same risk situation.

Others expressed their concern about the children and young people posing a threat to society and to themselves because of their many health problems and risk behaviour. Some interviewees pointed out that quite a few children and young people living on the streets refuse the medical treatment offered to them. Their concerns were often emphasised by the conviction that it is best to get the child or young person off the street as quickly as possible and either back home, into institutional or medical care, if necessary by force, and to keep them in care or treatment as long as it takes to treat or rehabilitate them. Often the belief underlying this approach was that these children and young people cannot make informed decisions, especially when they are using substances or drugs and that it is therefore legitimate to restrict their rights temporarily. However, the need to respect these children and young people, so that they learn to respect themselves, was sometimes mentioned in the same breath. This approach was questioned by others, who stressed that additional force only traumatises the children and young people further and will sabotage preventative and harm reduction measures.

The concern raised about the threat to the society posed by children and young people was further underscored by requests to introduce mandatory HIV testing for the target group in order to prevent a spread of the disease to the general population and to ensure that the children and young people receive the treatment and care they need. Some interviewees even went so far as to request that those testing HIV-positive should not be admitted to (specialised) schools, reflecting the fears of many parents in Ukraine.

In the in-depth interviews in Kyiv and in Odesa, children living with HIV reported that after one child in their group had apparently died from an AIDS-related disease, the rest of their group had been ordered by law enforcement officers to undergo an HIV test. That is how the child learned that he was living with HIV. Another child stated that he was offered money to undergo HIV testing and learned about his status that way. These are clear violations of the

rights of the children and illustrate that there seem to be quite a few professionals supporting mandatory HIV testing for this target group.

Some interviewees also mentioned their concerns for their own security and health given the lack of adequate health and safety measures at work and the limited access to appropriate means of protection, such as gloves to use when dressing wounds.

Other interviewees see these children and young people not as individuals with rights, but rather as ‘hopeless cases’, a group of people whose ‘fate’ is already determined and unchangeable, given their ‘genetic’ predisposition to a life of crime and substance and drug use because of their parents’ problems. Taking them off the street, shutting them up and rehabilitating them seemed the best approach in the view of people with this attitude.

While attitudes in general differed, there were government employees in particular whose attitudes were more that of a ‘prosecutor’ than of an ‘advocate’ for this target group. This ambivalence and the differences in attitudes are also reflected in the laws and state and national programmes on child protection (see chapter five).

Yet it must be stressed that with the President of Ukraine making children and young people a national priority in 2006 and the MoFYS taking action and starting to develop a new framework for a national response, which fully acknowledges the problem and which has led to an open discussion, a major first step has been taken towards improving not only services, but also the inherent attitude of professionals working with the target group.

When asked who the people are who discriminate against children and young people living or working on the streets in Ukraine, the service providers interviewed pointed to Ukrainian society and local communities as having a major responsibility for a widespread stigmatisation of and discrimination against ‘marginalised’ groups in Ukraine. Many see injecting drug users especially as ‘public disturbers’ and ‘dangerous criminals’.⁹ The interviewees gave examples, such as tenants treating with disdain the children or young people living in their buildings and who wanted the basements or hallways cleared. Others referred to communities resenting having child-care institutions nearby and complaining to the management or to local authorities.

Interviewees thought that on the whole people in Ukraine keep their distance because of the way in which the children and young people dress or behave. The Head of the Department of Children at the MoFYS in particular stressed that the community at large tends to play the role of ‘prosecutor’ rather than of ‘advocate’, an attitude still found among some colleagues of hers, as highlighted earlier on in this chapter.

Stigmatisation in schools and resentment by shop and restaurant owners who do not want them begging in front of their stores or restaurants were also mentioned.

In the survey in Kyiv and in Odesa, children and young people were also asked about the attitudes towards them of teachers, physicians, the police, vendors, and security guards among others. There were practically no complaints about teachers and only a few complaints about classmates, primarily from girls, who felt they were resented due to their clothes and back-

grounds and reported that they had been called ‘bomzhara’ (a derogatory word referring to a homeless individual in the Russian language). The girls felt deeply humiliated and insulted by this epithet. One respondent mentioned that he and his friends were attacked in a basement by ‘domashniaks’, i.e. children in parental care who are living at home and who beat them ‘just to show off’, because they ‘do not understand homelessness’.

Complaints about security guards and vendors were rare too. One respondent had experienced resentment from employers who had been opposed to recruiting him, however he stressed that when they got to know him better, they had apologised for their initial reaction.

There are some examples of good practice in Ukraine where service providers are trying to improve the attitude of the public toward the target group. For example some are actively involving local communities in their social events or offering integrated services (in particular vocational training) for children and young people in general, including those living or working on the streets.

In terms of the attitude of school directors and teachers toward the target group, the interviewees said that the children and young people rarely attend school, and that when they do, they are not always treated well by other children and teachers because of the level of their education relative to their age, and their way of dressing. Although some service providers have agreements with local schools and some children attend these schools, in many cases teachers or volunteers come to work with the students at the premises of the service providers. This is mainly because of the problem that the age of the student rarely corresponds with his or her educational level, an issue which schools are usually not prepared to take into account when accepting a student. There have also been quite a number of cases, according to the ‘All-Ukrainian Network of People Living With HIV/AIDS’, in which a child or young person living with HIV was refused schooling, and had caused major protests among parents who feared that their children would be at risk of infection by sharing a classroom with an HIV-infected child. It can therefore be assumed that a child or young person living on the streets and with HIV would experience similar discrimination.

Stigmatisation and discrimination against people living with HIV in Ukraine is still very widespread. According to data from two national surveys conducted in 2004 among young people aged 15 to 24 and adults aged 25 to 49 that were based on a representative sampling for key social and demographic characteristics, the tolerance level among young people toward people living with HIV is near to 0 per cent and that of adults around 2 per cent. These highly negative findings were due to the fact that hardly anybody gave a positive answer to any of the questions relating to stigma and discrimination. Only when the question concerned caring for a member of the family living with HIV were the answers mostly positive.¹⁰

As stressed by the interviewees, some of the children face a double, in some cases even multiple stigma, since they are living on the streets, might be injecting drugs, perhaps involved in exploitative sex and might have in addition a serious infectious disease like HIV or TB.

Concerning the attitudes of the target group to service providers, the latter when interviewed said that the target group fears most health care facilities, because they expect to be maltreated, refused appropriate treatment (particularly when they lack official documents) or because they

do not want to get passed onto child-care institutions. Discrimination in the health care system can be the root of discrimination at all other levels said representatives of the Ukrainian AIDS Centre and of the 'All-Ukrainian Network of People Living With HIV/AIDS', particularly in the case of a child or young person living with HIV, because once the confidentiality of a patient is breached in the hospital or clinic where they are being treated, the news of their status travels quickly, especially in rural areas, and can cause unwarranted waves of hysteria in the patient's school, workplace, and community.

The data from the quantitative survey discovered that while in Kyiv 63 per cent of the respondents would visit the same physician again, only 35 per cent of those interviewed in Odesa would go back to theirs. During the in-depth interviews, various cases were cited in which the children and young people felt they had been badly treated by medical personnel in the facilities they had attended. However that was not the rule. Respondents mentioned lack of money to pay for the treatment as well as lack of official documents as a reasons for being refused treatment or for being neglected by medical personnel. For example two respondents whose legs had been fractured said that physicians were unwilling to apply plaster casts because they were unable to pay and had no documents. These kinds of experiences, coupled with the fact that the target group usually seeks medical care only in emergencies, and in general expressed rather a strong unwillingness to go and see a physician, might explain the findings. Nevertheless, the data and information do not explain the marked difference between the two cities and further investigation would be useful.

Other reports and assessments underline that young people and especially substance and drug users tend to express a general wariness of medical services¹¹ because: they do not trust in treatment or test results given the overall low quality of medical services in Ukraine; they fear negative attitudes of some physicians towards youth in general; they believe that physicians are more interested in earning money than in providing quality medical services; or they fear facing a bad test result. Children and young people living or working on the streets who are injecting drugs, living with HIV or who are involved in exploitative sex seem to run a particularly high risk of being refused help and treatment by health care services. The international non-governmental organization 'Human Rights Watch' stated, in a report published in March 2006,¹² that health care providers discriminate widely against these groups. While some were refused access, others were discharged once their HIV status became known, or received inadequate care. Ambulances in Ukraine in particular refuse to transport people living with HIV and drug users according to the Report. Another obstacle is the official registration of drug users by health care and drug treatment services such as narcology centres which share their data with the police. It is one of the reasons why drug users often do not seek health care or drug treatment.

The children and young people interviewed in-depth in Odesa and in Kyiv said that the most common reason for stigmatising and insulting them is their appearance and most of them consider it to be quite natural and even try to look tidy, in spite of the circumstances in which they live.

19-year old man in Odesa: “I always walk about clean and tidy... it stands to reason. I look after myself. And if someone says rude things to me, I will hit him. Or at first I will swear at him for a while...and if I see that I must hit him, I will. Otherwise... At first, when we went into shops, even if I was dirty after work...well, this can only happen at night, when I go to a basement or some other place...at first they looked so (disapprovingly), but afterwards... apparently...I don't know...because of pity or something else...(they would be helpful). So in the daytime I am tidy when I come there. It depends... And afterwards, they even lent me money and everything was all right.”

Children and young people living or working on the streets also report stigma within their groups and the struggle to avoid becoming an ‘underdog’.

19-year old man in Odesa: “Well, there are some specific nuances on the street. For example, someone there may say a dishonorable word, which you don't deserve, like ‘homo’ or ‘asshole’ or something else, right? In such a case you must give him a smack right away – hit him, defend your dignity, or something else. If you don't stand up for it, everyone will push you around. That's what street-life is!”

Most of the complaints from the children and young people interviewed in-depth were about the attitudes and behaviour of law enforcement officers, even though some children and young people pointed out that they have good relations with them, that the officers showed real concern for them and that they were even helped by them. However, quite a few children and young people reported maltreatment, even torture, a practice also known to many drug users¹³ and still prevalent in Ukraine as a whole.¹⁴ When asked about the reasons for the torture, the respondents said that the main purpose is to either obtain information on crimes or on other people or to ‘hang’ an unsolved case on the child or young person in custody. Respondents also claimed that their appearance alone could sometimes make law enforcement officers aggressive.

Interviewer: “What is the militia's attitude to you?”

13-year old girl in Odesa: “It is good.”

Interviewer: “But have you ever been beaten at a militia station?”

Girl: “Once... Yes, I was beaten so as to make me inform on a friend. And yet I kept silent... They stubbed out a cigarette on my hand. They took a sticky tape, glued it on and tore it off. They hit me with a baton. They made me squat a hundred times. If you don't squat they kick you.”

Interviewer: “And what relations do you have with the militia?”

18-year old woman in Kyiv: “Everything is all right. They know that I don’t steal. They check fingerprints. They detain you and make a check; if you don’t steal anything – if you are clean – then they let you go. Some militiamen are bad. They can write in their paper that you have stolen this and that and they can lock you up. But some are normal, understanding.”

18-year old man in Kyiv: “Sometimes you have to climb onto a stool and they tell you to screw in a bulb – and you do so, because if you don’t, things will be even worse for you. Then he hits you and you fall. They kick you and beat you. Once two of my ribs – it was a very serious bruise. I stayed at the hospital for a long time. I don’t have those (medical) certificates though. I would like to have those certificates. I am afraid to file a suit, because I am living in the street, so if I file a suit – many people can help me prove it – but if I file a suit – after all, I live in the street – after that they will meet me somewhere and things may become even worse.”

A 13-year old boy in Kyiv reported that he and his peers are sometimes used by law enforcement officers for their own purposes, that means for example to clear a pedestrian subway of a drunken man. In exchange the boy and his friends were allowed to keep some of the money they had taken from the man. Another respondent noted that many children and young people living and working on the streets in Odesa are rounded up during raids preceding the visit of high officials to the city.

The ‘Human Rights Watch’ report published in March 2006¹⁵ also mentions the negative attitudes among law enforcement officers in Ukraine, particularly toward injecting drug users and sex workers. The report highlights that while the police have a legitimate interest in controlling illicit drug possession and sex work, there are cases in which drug users and sex workers accessing or leaving harm reduction and HIV prevention programme sites or being approached by outreach workers were particularly targeted and detained, thereby undermining government efforts to ensure that these groups, who are most likely to be exposed to HIV, have access to prevention information and protection means. It resulted in some people avoiding services such as needle-exchange points. Another reported practice is for law enforcement officers to target pharmacies which are used by many children and young people living or working on the streets to buy syringes or medication. Many of the harm reduction and HIV prevention programmes have now entered into cooperation agreements with the local police, based on these experiences.

The report also looked into maltreatment and torture. The main reasons for law enforcement officers to target drug users, sex workers and apparently children and young people living or working on the streets too, seem to be so-called ‘pervert incentives’ such as the need to fulfil

periodic 'work plans' and 'arrest quotas'. The success of police work seems still primarily to be measured by the number of arrests made and cases solved, thus creating an incentive to force 'confessions' and to arrest those who are an easy target due to their involvement in illegal activities such as drug 'use' (storage, transportation), and their lack of official documentation (a particular problem for the target group).

There are no studies or reports on the situation of the target group in detention and penitentiary facilities in Ukraine and the attitudes of law enforcement officers in these facilities toward them. Only general statistics are available. However reports on the overall situation might provide some insight of what risks children and youth may face upon detention and imprisonment.

As of 1 October 2006 there were 2,292 male and 132 female prisoners in prison colonies for children and young people aged 14 to 22 according to the State Penitentiary Department. The majority of them were aged 16 to 18 (72 per cent) and 53 per cent of them were imprisoned for theft, 28 per cent for robbery or assault, 6 per cent for imposing heavy physical injuries on others and 4 per cent for premeditated murder. The larger part of the children (69 per cent) had been convicted before, but had not been imprisoned previously. Over one third of the imprisoned children and youth (37 per cent) had never been to school, 52 per cent came from single parent families, 21 per cent were orphans and 8 per cent were educated in special schools. The State Penitentiary Department further stressed that every year, around 30 children and young people are imprisoned who can neither read nor write.

Disaggregated data on the number of HIV-infected children and young people in the colonies or on the number of target group members were not available. It is known though that the HIV prevalence is high in penitentiary facilities in Ukraine. According to the *2006 Ukraine GFATM proposal*,¹⁶ over 4,400 HIV infections and 132 people with an AIDS-related disease were registered in 2006. Given that the prison population amounts to approximately 160,000 people in Ukraine, the HIV prevalence is 2.7 per cent of prisoners, but because HIV testing is voluntary, it is estimated that the actual number is much higher. So far, access to antiretroviral therapy in detention and penitentiary facilities in Ukraine has been non-existent and even though progress has been made, access is still extremely low, especially for minors. Apart from HIV, TB is also widespread in the facilities.

There are few psychologists in the facilities who could provide sufficient support to the prisoners or detainees living with HIV. Chapter six and table 17 in annex IX highlighted the lack of adequate social work support for minors. There are no official figures published on the number of detainees and prisoners who are injecting drugs within the facilities and according to service providers interviewed, evidence of rapes and beatings among prisoners, particularly of younger prisoners, is also anecdotal and not researched adequately. The 'Human Rights Watch' report of 2005 stresses that torture and maltreatment continue to be a significant challenge in prisons in Ukraine.¹⁷ According to the report, the 'Human Rights Ombudsman of Ukraine' estimates that law enforcement officers may torture or maltreat around 30 per cent of all detainees, resulting in some cases in permanent physical damage or even death. In most cases however, the perpetrators are neither investigated nor prosecuted for their crimes.

The Report also highlights that the conditions in prisons continue to be poor, as they are overcrowded (Ukraine has one of the highest imprisonment rates in the whole of Europe), and prisoners have insufficient access to food, adequate sanitary facilities and health care services. However, colonies for children and young people have seen vast improvements over the last few years in Ukraine according to several service providers interviewed. The ‘European Committee on the Prevention of Torture and Inhuman or Degrading Treatment or Punishment’ even found exemplary conditions on its visit to the ‘Centre for the reception and allocation of minors’ in Zhytomyr. Living conditions and educational and recreational areas were meeting standards and a structured programme of educational, recreational and social activities was provided, including psychological support.¹⁸ The State Penitentiary Department recognises the importance of comprehensive rehabilitation and reintegration programmes for minors and of cooperating closely with other service providers. Increasingly, non-governmental organizations are providing recreational and social services in penal colonies for minors. The Department is in the process of developing a strategy to reform the detention and penitentiary facilities for minors with the aim of turning them more into educational-pedagogical rehabilitation and reintegration centres.

Besides the risks which children and young people may face within the detention and penitentiary facilities, there are risks consequent on one of their parents being imprisoned, as mentioned in chapter four. Children are also born to mothers who are in prison. During the desk research and interviews, no studies were found and only anecdotal evidence provided by interviewees on the life of these children that suggests that some of them run the risk of ending up at some stage in their lives either on the streets or even in prisons. The stress and trauma that these children are exposed to is enormous, even in the few existing prisons in which mothers can keep their children up to the age of three, where they are usually only allowed to see and play with them for a few hours each day.

Besides the ‘marginalised’ groups mentioned, there is one other group or rather community in Ukraine that is highly stigmatised and discriminated against, excluded socially, politically, economically and even geographically, but which on the other hand constitutes one of Europe’s largest and most vulnerable minorities,¹⁹ the Roma community. In line with Givel²⁰, the overall number of Roma is more than 48,000 people (2001 Ukraine Census), but leaders of the community estimate that there are more than 80,000 Roma in Ukraine, living all over the country, but particularly in Donetsk, Dnipropetrovsk, the Carpathians, Mykolaiv and Odesa regions. The results of a round table held in Kyiv on 5 November 2003 on ‘Development communities and improved social conditions for Roma of Ukraine’ show that Roma are generally poor and experience discrimination and racism. They are excluded from participation in state governmental bodies and are subject to a wide range of health problems, including TB, reproductive health issues etc. Studies on this community in Eastern and Central Europe demonstrate further that quite a number of the Roma children and young people are working on the streets due to the overall impoverished state of that community. They may be forced by their own parents to beg on the streets or may even have been ‘sold’ to neighbouring countries and to criminals forcing them to beg and steal etc.²¹

While there have been in-depth studies in neighbouring countries, the community in Ukraine has so far hardly been subject to an assessment or in-depth research. However, reviewing the evidence from the neighbouring countries, one can assume that the situation of Roma in Ukraine is

similar and characterised also by seasonal employment often hindering a regular education for the children and young people,²² a strong dependency on social assistance,²³ lack of access to basic health care, as well as lack of information about health issues²⁴ and low health awareness,²⁵ which particularly places children and young people at risk. The number of children born is usually higher in this group than in the general population,²⁶ while at the same time they face a higher infant mortality rate and a shorter life expectancy than the general population creating a young population group in which contraceptive practices are almost completely absent and men rarely use condoms. According to a UNDP report on Roma in the CEE that was published in 2002, this, combined with poverty and discrimination which has led some Roma to become involved in drug trafficking, drug use and sex work, places this community, including their children and young people, at a disproportionate risk of HIV, hepatitis C and B and STIs.²⁷

6.4 Cooperation and coordination

There are coordination bodies at the national, as well as at regional, local and district levels, addressing a wide range of topics, including issues concerning children and young people, HIV and AIDS. The most relevant coordination bodies for the problems addressed in this report are described below.

The ‘Inter-departmental Commission on the Protection of Childhood’ was established by the Cabinet of Ministers of Ukraine on 3 August 2000. It is responsible for facilitating and coordinating state policies on child protection among state departments and prepares proposals for the implementation of international conventions and declarations ratified by Ukraine, such as the *UN Convention on the Rights of the Child*. The Commission’s other functions include the protection of children’s rights and freedoms, the preparation of draft laws, other normative acts and state programmes on the protection of childhood in cooperation with service providers, scientific institutions, local authorities and communities. It is also responsible for the organization of and participation in national and international conferences, and consultations on the social and economic state of children. The Commission prepares the annual government reports on the state of children in Ukraine including a list of proposals concerning measures for improvement. The Commission includes representatives of the MoFYS (Chair of the Commission), the MoH (Deputy Chair), the MoES and of Parliament, the Head of the ‘National Council of Children’s Organizations Federation of Ukraine’, the ‘Ukrainian Parliament Commissioner for Human Rights’, the Presidential Secretariat, the UNICEF Representative in Ukraine, and others. The Commission meets at least quarterly.

Another important national coordination body is the ‘National Coordination Council for the Prevention of HIV/AIDS’ (NCC) including its secretariat and six committees, as well as coordination councils in each region of Ukraine, which was established in May 2005. As of August 2006 the NCC had 17 members, each representing a key constituency involved in the national response to HIV and AIDS in Ukraine. Government representatives have a majority of 50 per cent plus one in the NCC. Its main aim is to coordinate the national response to HIV and

AIDS in Ukraine and the implementation of a unified HIV policy.²⁸ The NCC committees include (1) 'Treatment and care', (2) 'Work with vulnerable groups, including prevention', (3) 'Healthy lifestyles (health promotion)', (4) 'Strategic planning, budget, and monitoring and evaluation', (5) 'Human rights', and (6) 'Regional policy'. The 'Committee for the Fight Against HIV/AIDS and other Socially Dangerous Diseases' that was established as a governmental body within the MoH in May 2006 works in partnership with the NCC to coordinate the activities of governmental bodies in the area of HIV and AIDS and other 'dangerous social diseases'. The NCC is also cooperating with other national councils, such as the 'National Council on TB' and the 'National Coordination Board for Combating Drug Abuse'²⁹. Byelaws of the NCC had specified that implementation by central and local executive authorities of the Government of Ukraine of decisions made by the NCC should be mandatory, however the Ministry of Justice has decreed that the article in the byelaws will have to be revised, as it contradicts other laws and regulations.³⁰ In addition, the Government of Ukraine decided in 2006 to re-establish a governmental, multisectoral HIV/AIDS committee and to reform the NCC to broaden its scope to include TB and issues related to drug use. However, a head for this committee has not been appointed and therefore it is not yet functioning.

There is also a 'UN Theme Group on HIV/AIDS' that further serves to coordinate activities in this area and which is often used by UN and non-governmental organizations as a forum for advocacy.

Other relevant national coordination bodies comprise the 'Inter-Agency Coordinating Council for the Prevention of Trafficking in Persons' that is a permanent advisory body under the Cabinet of Ministers of Ukraine and the 'Drug Control Committee' at the MoH that implements international cooperation activities in the areas of drugs.

There are so far only two national coordination bodies in place that have the potential for addressing the issues of the target group; the 'Inter-departmental Commission on the Protection of Childhood' and the NCC with its Committee on 'Work with vulnerable groups, including prevention' that deals particularly with issues relating to groups most likely to be exposed to HIV. But while the 'Inter-departmental Commission on the Protection of Childhood' is primarily a multisectoral governmental commission and the input from non-governmental and faith-based service providers and the target group itself is therefore limited, the NCC Committee on 'Work with vulnerable groups, including prevention' has so far not dealt with the target group.

This fact, coupled with the lack of disaggregated data on this group and the fact that legislation often subsumes this group under wider categories of children and young people, creates a situation in which one can readily assume that the coordination of agencies and service providers that are, or should be, targeting this group is far from optimal.

According to the observations of some service providers interviewed who are personally involved in coordination councils or committees at the regional or city level, cooperation and coordination at these levels seemed in some cases more effective and targeted than at the national level. Many of the respondents in Odesa for example commented that their 'Regional Coordination Council on HIV/AIDS' was effective, because it had reworked the 'National

HIV/AIDS Programme' to be more concrete in its goals and in the assignment of roles within their 'Oblast HIV/AIDS Programme'. On the other hand, the 'City Coordination Council on HIV/AIDS' in Odesa did not function at all, according to local service providers, and when the city government changed in 2006 the Council was even temporarily cancelled.

In addition to the legally established bodies, a number of non-governmental service providers have formed more or less formal alliances to coordinate their activities, such as that established in 2005 in Kyiv by service providers working with children and young people in crisis situations, including those living on the streets. Another, 'The Coalition of HIV-service NGOs', was established in 2004, and is an alliance that supports the consolidation of over 50 non-governmental HIV-service providers from 20 regions of Ukraine working in HIV prevention, harm reduction, and providing care and support to people living with HIV.³¹

Cooperation between non-governmental service providers often seems more coherent and straightforward than among governmental agencies. However, there is usually a lack of coordination and cooperation mechanisms at the local level and there is also much competition between non-governmental service providers for the limited international and national funding for activities, and this hampers their ability to make a joint and agreed response.

Donor strategies are not always compliant with state and national programmes, sometimes due to the lack of coherent national social and health policies. In the same way as some state and national programmes, some donor programmes do not adequately take into account the actual needs of the population, either because of the lack of official data or because the target group(s) and corresponding service providers were left out of the strategy and programme development process. Donor-funded programmes and projects do not therefore always have the desired outcome of tackling an existing problem. The duration of funding from donors is limited, as is the amount given and the categories of expense which are being funded. There is no guarantee that once a project or programme is completed and has had tangible results, future funding will be available to expand, replicate or continue the project or programme, and this is a threat to the sustainability of services. This also increases the risk of non-governmental service providers focusing on project- and programme-related planning cycles rather than on strategic planning.

Most of the local non-governmental service providers are, in addition, caught in the dilemma between 'wanting to help and do good', while at the same time having to secure funding to ensure that they can sustain their capacity, functionality and relations with their clients. Sustainability remains a major issue for non-governmental service providers. Most are heavily dependent on international funding, and when programme money runs out there are no guarantees that the state will continue to fund even effective programmes. Despite the legal option for the state to fund services provided by non-governmental providers, there are only few to date that receive state funding. In addition, the funding is very limited and does not usually cover the full costs of overheads and staff related to those activities being funded. Many non-governmental service providers interviewed stressed that they are mostly left out of decision-making processes and that these processes are not transparent.

In general, interviewees reported varying levels of cooperation between service providers. Due to lack of funding and human resources, especially in the social and health care sectors, the role of governmental agencies was considered to be more that of a facilitator than of a fully-fledged partner, with cooperation often limited to not interfering or to providing only administrative support, if any. Ministries such as the MoH and the MoFYS are however increasingly consulting non-governmental and faith-based service providers.

The results of the interviews demonstrated that many government employees, particularly at the local level, and non-governmental service providers still regard each other with certain degree of wariness. The lack of interaction between governmental and non-governmental service providers in Ukraine, and in many other former Soviet Union countries, has a long history that is prejudiced by many stereotypes and some strong opinions.³² Some governmental interviewees expressed their concerns that non-governmental service providers were not ‘sharing’ with them information on the amount and purpose of international grants received, would not take up offers of joint programme implementation, receive salaries two to three times greater than those within the government system, were not always able and willing to demonstrate the results of their work, but would make very high demands on the government, for instance in terms of the provision of premises free of charge. Some non-governmental service providers on the other hand said that governmental service providers are also unwilling to share any budgetary information with them, would leave them out of decision-making and planning processes, would cling to ‘old beliefs’ and see the target group more as a ‘nuisance’ than people in need of support and care. While this kind of ‘blaming one another’ is not uncommon among different sectors, particularly in the face of a crisis, it is not helpful in solving existing problems. Many service providers are, however, trying hard to work together to make the best of the little resources and capacities they all have.

There are also internal cooperation structures among governmental service providers such as the CSSFCY and others, set up to coordinate activities and to provide a forum for the exchange of experiences. However, the director of one of the state-owned rehabilitation centres mentioned when interviewed that besides formal meetings where different governmental services are gathered to report on their activities, no real discussions on the exchange of experience had taken place for over 10 years in any of the meetings which the director had attended.

Most of the laws assume inter-ministerial cooperation and coordination of activities. But, as in most countries, this remains a major challenge because there is also competition among ministries for available state funding, and different, sometimes conflicting, competencies. The latter might be illustrated by a tension that arose between the MoH and the MoES concerning the approval of materials on health issues. While the MoH has the competency to evaluate the health-related content, the MoES has the competency to evaluate the most appropriate way to communicate the health messages to children. While this sounds like an easy problem to solve, such tensions can delay the implementation of activities for months.

Other efforts to coordinate activities comprise for example:

- Cooperation between various service providers with local schools and medical facilities to provide access for the target group to education and medical services;
- Cooperation among service providers in various cities to recover lost passports and other legal documents for the target group; or in the area of registration in the place of residence and restoration of parental rights for injecting drug users;³³
- Kyiv City CSSFCY actively cooperates with various international and local non-governmental service providers to avoid duplication of activities and to ensure joint implementation of social programmes in the community, particularly in the area of harm reduction and HIV prevention;³⁴
- A national, multi-sector working group that, with the support of UNAIDS, developed the *Road Map* to providing universal access to HIV/AIDS prevention, treatment, care and support by 2010, which also targets children and young people living on the streets; or
- A group of non-governmental service providers working in the field of HIV and AIDS in Odesa currently developing a joint strategy and implementation plan to ensure better outcomes of their activities.

There are of course many more such examples that cannot all be listed in this report. However, despite many efforts, coordination and cooperation has been mentioned by almost all service providers interviewed, as well as in the literature reviewed, as one of the key areas for improvement. In relation to the target group, cooperation and coordination mostly lack:

- The specific focus of coordination bodies and committees on vulnerable children and young people, including the target group, engaging in risk behaviours and living in risk situations;
- A systematic, nationally coordinated and multisectoral approach and response (strategy);
- Effective mechanisms to coordinate the activities of different ministries and coordination bodies addressing topics relevant to the target group (such as drugs, sexual exploitation, trafficking, children and young people in the criminal justice system, HIV and AIDS, TB and others);
- National guidelines and regulations concerning mechanisms for coordination, especially between organizations from different sectors;
- Clear guidelines, regulations and open tenders for funding non-governmental and faith-based service providers, including the guarantee of state funding once a pilot project has been completed successfully within the frame of a state or national programme and once international funding runs out, to protect the service provider and its clients;
- A strategy for better coordination of the activities and resource allocation of national and international donors, who are primarily funding non-governmental and faith-based service providers and many pilot projects;

- Improved, multisectoral cooperation and collaboration on the local level, including particularly the health, social and education sectors, law enforcement bodies and key representatives of the private sector (local businesses, including pharmacies and computer clubs) and local community leaders;
- A forum that would allow for the exchange of experience and information, and the collection and distribution of evidence-based best-practices relating to the target group; and
- A national body responsible for the collection, analysis and dissemination of information and data on the target group, enforcing a national reporting, monitoring and evaluation strategy encompassing all service providers dealing with the target group. A national strategy and implementation plan would need to include quantitative (input, processes, output), as well as qualitative (outcome, impact) indicators to enable an evaluation to be made, in particular of the coverage and the cost-effectiveness of interventions implemented.

The effectiveness of existing cooperation and coordination mechanisms was criticised by most of the service providers interviewed. One service provider even stressed that there are enough coordination groups, round tables, conferences and similar events taking place that address the topic, but they lack concrete results, and tend to discuss the same issues over and over again. This points to a lack of structure and clear agendas, and the inefficiency of many existing coordination bodies.

7. Summary and conclusions

The report is based on the results of a situation analysis conducted by UNICEF in cooperation with *AFEW* via desk research, interviews with services providers, participation in relevant conferences and stakeholder consultations, and on a survey among children and young people living or working on the streets in the cities of Kyiv and Odesa. The analysis and survey were both executed between the autumn of 2005 and early summer 2006. The main purpose was to review the situation in the light of the growing HIV epidemic in Ukraine, to assess and present the needs and demands of this population group, to identify best practices and gaps in service provision, and to highlight areas for improvement and for scaling up and expanding the national response, taking into consideration existing capacity, finances and structures.

The survey that included children and young people aged 10 to 19 consisted of a quantitative part, based on a sample of 600 children and young people (300 in each city), and a qualitative part based on a sample of 50 children and young people (25 in each city). The survey assessed the behaviour, attitudes, practices and knowledge, in addition to the needs and demands of the target group in Kyiv and in Odesa, the attitudes of service providers toward the target group, and the availability and adequacy of existing support services to meet their needs in relation to health in general, sexual health and HIV and AIDS in particular, education and leisure activities, stigma and discrimination, exploitation and substance and drug use. The survey was conducted to complement the results of the situation analysis and to compare the view of the service providers with that of the children and young people interviewed. The situation analysis and the survey were restricted mainly by limited access to information sources, and by the lack of baseline data, which made it impossible to conduct a representative survey.

Given that the Ukrainian legislation uses several, differing terms to define the target group this report has used a definition, introduced by UNICEF, of ‘children living or working on the streets’. Young people aged 19 were included into the definition and the research for this report, given that many of them are members of the groups of children living or working on the streets in Ukraine.

The negative consequences of the former Soviet Union’s welfare and child protection system, and the socioeconomic difficulties of the transition process in Ukraine following the break-up of the Soviet Union, have had a severe impact on families and present a major threat to children and young people in terms of risk situations they may face and of risk behaviours they may adopt as a ‘coping mechanism’. The phenomenon of children and young people living or working on the streets re-emerged in the early 1990s in Ukraine as a direct result of this.

The attitude that the state is responsible for the wellbeing of its citizens is still prevalent across Ukrainian society, and has made it harder for people to adapt to the current situation. The state’s role has changed and many state sectors, particularly the health and social care sectors, are too depleted to meet the increasing needs and demands of its citizens, especially in the face of epidemics such as HIV and TB.

According to the findings of the survey conducted in Kyiv and in Odesa, which were compared with results of surveys conducted in other countries of the world, the majority of the target group in these two cities are aged between 10 and 15, are boys, have lived on the streets less than two years, and sleep primarily in 'hideouts' on the streets. The children and young people usually have low levels of education and mostly dropped out of school at the time that they took to the streets. Many of the children and young people in Kyiv and in Odesa come from other regions and from neighbouring countries. They are a highly mobile group, making it difficult to keep track of them. Most of them end up on the streets through a combination of factors, with problems in the families and poverty dominating, coupled with the lack of a supportive and protective environment in the communities they live in. Quite a few reported having been cheated out of their right to housing when a parent died or when the family wanted to move.

All those interviewed reported a number of health problems, which increase with age and the number of years spent on the streets. The main categories include respiratory and gastrointestinal problems, infectious diseases such as hepatitis, TB, HIV and STIs, bodily injuries and bruises, developmental delays and mental health problems, as well as skin rash, scabies and abscesses, among others. Boys and young men reported bodily injuries and bruises more often than girls and young women. This seems to be linked to the higher risk they have of being beaten and their greater use of substances and drugs which increases their risk of accidental death or injury due to a lack of coordination. Most children and young people rely on self-treatment and few seek medical treatment, mostly only in emergency cases. There are no official statistics on the health problems of this target group.

Some members of the target group still have contact with home but the greater part are 'social orphans', as demonstrated by findings of the survey. For example 60 per cent of the children and young people interviewed in Kyiv reported that their mother was still alive, as did 43 per cent of the respondents in Odesa.

All of the children and young people have been subject to some form of serious trauma, such as violence, abuse and sexual or labour exploitation, at some stage in their lives. Boys and young men predominantly reported experiences of violence, especially beatings and even torture. The younger group said they were often beaten by their peers on the street or by their parents. The older group, of which many have been living for quite some time on the streets, reported more beatings by law enforcement officers. The latter took second place among those beating the target group in both cities in which the survey was conducted. Girls and women reported sexual violence more often than boys and young men.

The main source of income seems to be from begging, followed by help from others and by theft. The older the children and young people are and the longer they live on the streets, the more often they reported being involved in criminal activities to make a living, though rarely regularly. Boys and young men interviewed were involved in criminal activities such as thefts more often than girls and young women. They also reported working more often than their female peers. Quite a few of the older children and young people recognised the need for an education and vocational training in order to have access to regular jobs.

Besides the many risk factors in their environment, the group is also involved in a wide range of risk behaviours. Quite a few of the girls and young women for example reported being involved in exploitative sex. Almost all of the target group smoke and drink alcohol. Substance and drug use usually starts early with the use of solvents such as glue, but over time an increasing number of the target group appears to be moving toward injecting drugs and very often a combination of substances and drugs is used. Boys and young men interviewed reported using more substances and drugs than girls, and also injecting more often. First injections are rarely within the control of the child or young person, but are made by older peers. Substances and drugs are easily available, especially in neighbourhood pharmacies, as well as on the streets. The borrowing of used needles and use of non-sterile injecting equipment is widespread. Sexual contacts also start earlier among this group than among other peers and the majority of them do not use condoms regularly and change their partners frequently. The group also engages in other risk behaviours such as tattooing using non-sterile equipment and 'blood fraternisation', though this seems to be less common than substance and drug use with non-sterile equipment.

The level of risk awareness is low. Many of those interviewed mentioned their 'trust' in their peers to be 'clean' as one of the reasons for borrowing syringes that might be contaminated and for having unprotected sex.

The awareness of diseases such as HIV or STIs and of the ways of transmission is also low, and many myths and misconceptions persist. Those participating in the survey who had received proper prevention information usually knew more than those who had not been reached by prevention programmes. However knowledge did not necessarily lead to a change in behaviour, as only 46 per cent of those in Odesa who knew about the risk associated with unprotected sex had used a condom the last time they had sex. Another problem seems to be that many do not know how to use a condom properly. Younger children usually know less than older children or young people. The same holds true for HIV testing. More of the senior children and young people and more of those who have already lived on the streets for over a year had been tested for HIV than of the younger children and those having lived less than a year on the streets.

Most of the information this group receives is either by word of mouth, at mass youth gatherings or via outreach and social workers.

Reviewing the findings of the survey, particularly the number of injecting drug users and children and young people exploited for sex, and comparing it with results of other studies, it can be said that the number of children and young people in the most extreme risk situations, i.e. living and working on the streets, being exploited for sex and being involved in crime, and injecting drugs, is overall probably relatively small, even though significant. But considering the children and young people in the most extreme situations as the 'tip of the iceberg',¹ the number of those exposed to risks, because they live in impoverished environments, or experience violence and abuse at home or in a child-care facility, or have dropped out of school or are at risk of dropping out, or have friends who are involved in substance and drug use, seems to be large.

Street life in Ukraine is characterised by laws of ‘force and power’. Older children and young people often both ‘protect’ and exploit younger ones at the same time, and tend to be group leaders. Children and young people interviewed reported spending their ‘free time’ primarily in computer clubs, using slot machines, walking the streets or engaging in recreational activities offered by social services.

The findings of the research clearly show that neither the basic nor other, more specialised needs of this target group are being met, including food, clothing, accommodation, medical care and education, among others.

Access to support services, particularly education, health care and medical treatment, is very restricted. There are many reasons for that, the main ones being children and young people’s lack of official documentation, the lack of clarity concerning consent of a parent or a guardian, the fact that most health care services are not free of charge, and the lack of an actively support-seeking behaviour among this population group based primarily on their negative experience with adults. Other problems related to accessing necessary care include very slow legal processing of official documentation and of decisions regarding the whereabouts of the child or young person.

Some of the children and young people dream of a better future, but many find it difficult to think long-term and quite a few expect to die on the streets. Deliberate self-harm seems fairly common, but there are no official statistics on the number of children and young people living or working on the streets who commit suicide or overdose on drugs.

Most members of the target group interviewed reported receiving some help, primarily from faith-based service providers, social workers, peers and relatives. Girls and young women reported receiving more support from service providers, family and relatives than did boys and young men.

The quality of service varies greatly. Overall, it is low. Most services reach only small numbers of the target group. Many services targeting children and young people were not designed to accommodate the specific needs of this particular group and therefore are rarely accessed by them. HIV, TB and STI services in particular have yet to reach out actively and include this group into their list of clients.

Children and young people using substances and drugs are excluded from most of the residential, psychosocial rehabilitation and family type care services that exist. Given that there are an insignificant number of drug rehabilitation centres that cater for them, one can say that those using drugs and substances are the most excluded of all the children and young people living or working on the streets in Ukraine.

In addition, many of the services provided by non-governmental providers suffer from a lack of sustained funding, while governmental services are usually not only under-funded, but also often lack qualified staff.

The biggest gaps are in prevention services for children and young people coming from families in crisis and those living in high-risk environments, and drug rehabilitation, mental health and psychological support services for those who are already living on the streets.

There are also no uniform standards and, due to the lack of a national monitoring and evaluation system and an agreed set of national impact and outcome indicators, it is difficult to assess how effective the services and the overall national response are. Still, there is a lot of anecdotal evidence from Ukraine and from other countries, particularly related to residential care facilities, demonstrating that these types of services are not very effective. For example one third of the children and young people interviewed in both cities have experienced living in a children's home, and many of them escaped again for various reasons (beatings by other children, 'boredom' or verbal and physical abuse by staff).

Cooperation and coordination of services can be improved at all levels. Many efforts are being made, but the lack of a single coordination mechanism and a corresponding strategy addressing the needs of children and young people living in risk situations and engaging in risk behaviours reduces their effectiveness.

By shifting the responsibility for the majority of child-care services to the MoFYS one major, positive step was made towards centralising national coordination of services provided to children and young people. However, more research is needed to provide the Ministry with adequate information for planning and decision-making. The Ministry also needs a more comprehensive system to control, guide, monitor and evaluate the quality of services delivered and to oversee rights protection. A major challenge is the management of the transition process from a child-care system characterised primarily by residential care to a more family- and community-based system. To date, there are few formal partnerships at national, or at community level in terms of complementary funding and involvement to ensure that the plans set out in the '2006 State Programme Aimed at Fighting the Homelessness and Neglect of Children 2006-2011' can be implemented, adequately managed and financed.

Attitudes among professionals toward the target group vary greatly. While there is an increasing number who sees them as individuals with rights who must be given a 'voice' and should not be forced into care, there is still a significant number of professionals in Ukraine, particularly working in the governmental sector, seeing these children and young people primarily as 'criminals', or as a group that needs to be taken off the street forcibly for their own wellbeing and for the protection of the society, for example from the further spread of HIV.

Stigmatisation of and discrimination against this group is widespread throughout Ukrainian society, and discussions of the problems in civil society and in the media in Ukraine are too few still to carry weight.

Capacity-building is fragmented and not institutionalised. There are as yet few social workers qualified to work with the target group in Ukraine, given that it is still a relatively new profession and interdisciplinary training is rare, as are mentoring schemes.

The rights of children and young people living or working on the streets are heavily violated and they are often criminalised, especially when involved in substance and drug use, instead of being protected from exploitation and self-harm.

At the moment, the amount of laws and state and national programmes relating in one way or another to children and young people in general, and some to those living or working on the streets in particular, makes it difficult for service providers to decipher what these children and young people are entitled to. Children are not at the centre of public policies and state and national programmes in Ukraine. In addition, law enforcement is weak and even though there are some legal support services, the target group is often too afraid to speak up, particularly when law enforcement officers or staff in child-care facilities have violated their rights.

While political stability is only slowly returning to Ukraine, the efforts made recently by the Ukrainian President and by the MoFYS in cooperation with other ministries which were formerly responsible for services for children and young people and with non-governmental and faith-based service providers, give hope that the new child-friendly and child-centred course that has been set will take off and, in the long-term, lead to tangible results, from which children and young people living or working on the streets will also benefit.

8. Recommendations

Public resources are scarce in Ukraine as in most countries and the variety of needs of the population is extensive. Because of that, a rationale must be established for a national response which enlarges on and in some areas deviates from the existing response and from traditional approaches. It should include policies and strategies focusing specifically on the target group, as well as for a greater investment into a relatively small group of the population in comparison to other priority areas and perhaps larger population groups. For this need to be widely accepted and jointly addressed, it will further be vital to develop a greater institutional and political awareness and understanding of it.

The introduction to this report has highlighted some of the demographic, social and health challenges that the country is facing. Many of these are placing increasing pressures on the labour market and on social and health care services in Ukraine. It is a cliché, however a true one, that the children and young people of today represent the future of the country and the workforce of tomorrow. It is therefore vital to ensure that they acquire the necessary skills and characteristics to participate fully and to function in modern society and to generate the income and level of growth that is needed for ensuring their own welfare, as well as that of the society and future generations. There are other reasons for investing in a group that is exposed to many risk factors, which have to do with avoiding the further spread of infectious diseases such as HIV, TB and hepatitis, to the general public, with reducing violence and crime on the streets and the number of minors imprisoned, with alleviating poverty (one of the eight ‘Millennium Development Goals’), with strengthening ‘social capital (family environments, community networks and positive role models)’, and with ensuring the preservation of human rights and social justice.¹

‘The healthy development of children not only safeguards their own wellbeing, it is also the best guarantee of the future peace, prosperity and security that are central ambitions of the Millennium agenda’.²

The 2006 report of UNICEF on *The State of the World’s Children* describes broadly the key strategies of a national response to protect children:³

- ‘Strengthening the caring and protective capacity of families and communities;
- Commitment of the government to child protection by providing budgetary support and social welfare policies targeted at those children most at risk;
- Avoiding the criminalisation of child victims and prosecuting perpetrators of crimes against children;
- Involving the media in an open discussion led by civil society of attitudes, prejudices, beliefs and practices that facilitate or lead to abuses; and
- Transparent reporting, monitoring and overview of abuses and exploitation’.

‘Key to building the protective environment is responsibility: All members of society can contribute to ensuring that children do not become invisible’.⁴

While most of the existing laws and especially the new ‘2006 State Concept’ and the ‘2006 State Programme on Homelessness and Neglect of Children’ demonstrate a clear commitment of the Ukrainian Government to child protection, to strengthening the capacity of families to care for and protect their children, and to ensure the necessary legal and financial base, there is still work to be done to ensure that children and young people involved in drug use are not criminalised in Ukraine, that perpetrators, including those working for state-run institutions and law enforcement agencies are prosecuted, and that there is transparent reporting of abuse and exploitations.

In addition, there is no specific mention in the Programme of the need:

- To put children at the centre of public policies and decision-making in Ukraine, ensuring that public frameworks are enhancing the wellbeing and opportunities of children;
- To increase the understanding among policy-makers, service providers and the general public of the particular needs, risks and vulnerabilities of the target group, including their risk of acquiring diseases such as HIV, TB and STIs;
- To scale up quality services and to increase the range and the accessibility of mainstream and special services for the target group;
- To ensure that all services provided to the target group are free of charge at the point of entry; and
- To strengthen the involvement and support of ‘gatekeepers’ (see chapter 6.2), communities and the private sector in the national response.

However, these additional objectives address some of the key barriers to successfully implementing the Programme. In order to overcome these and other barriers, and to achieve all objectives, a set of strategic recommendations is presented below.

It should be noted that these recommendations do not present a national, multisectoral strategy nor an action plan for an extended, national response to vulnerable children and young people. Instead, they are presented here as a potential framework highlighting key strategic areas that need to be addressed by an extended national response.

The primary audience for these recommendations is the MoFYS, as it carries the overall responsibility for activities related to vulnerable children and young people and for coordinating the activities of other ministries and state departments in this matter, but local administrations responsible for the implementation of the national response at the local level and service providers are also addressed.

However, it must be stressed that given the need for a multisectoral, national response, the input of all sectors at the national and local level is required for its development, implementation and evaluation.

The recommendations are presented in the following order of importance:

1. Policy and legislation
2. Coordination and cooperation
3. Strategic planning and resource mobilisation
4. Capacity-building
 - a. Planning
 - b. Training
 - c. Management
5. Service standards and range of services.

Under each recommendation, it is indicated whether the recommendation is relating to the national level (i.e. to the MoFYS and all other relevant state agencies), to the local level (i.e. to the local administration) or to the level of service providers (for example to non-governmental service providers only).

**Policy and legislation:
Putting the child at the centre of policy-making**

The many laws and regulations in Ukraine concerning the protection of and the support for children and for ‘families in crisis’ are a challenge when trying to decipher what exactly they are entitled to, what is ‘best’ for a child or young person and what mechanisms are in place for them to access these benefits and support services.

**Recommendation 1
(National level)**

A review of all existing legislation relating to family law and children, with a view to harmonisation and possible reformulation of legislation, based on the *UN Convention on the Rights of the Child*, national and international best practice and the principles of putting the interests of the child at the centre of legislation and national policies and of providing vulnerable children and young people and ‘families in crisis’ with universal access to high-quality prevention, treatment, care and support services.

The lack of explicit family- and child-centred social and health policies in Ukraine and the low coverage and fragmentation of existing services seem to be closely correlated and therefore the need to harmonise existing policies and laws seems to be indicated.⁵

According to the *Final Report: Children in institutions: prevention and alternative care* that was approved by the European Committee for Social Cohesion in May 2004,⁶ an effective child protec-

tion system is key to implementing successful interventions for the target group. There are different belief models underlying child protection systems. As can be seen from chapter 6.3, the two conflicting models that exist in Ukraine are reflected even in national policies (as demonstrated in chapter five) and need to be harmonised. On the one hand there are people in Ukraine, particularly government employees, supporting the ‘child rescue’ model that aims to ‘rescue’ the child from any apparent danger and focuses more on out-of-home services, and on the other hand there are supporters, such as the Head of the Department of Children in the MoFYS and the Head of the State CSSFCY, of the ‘family support’ model that is dominant in Western Europe and reflected in the ‘2006 State Programme on Homelessness and Neglect of Children’. This model focuses on working in partnership with and on empowering families and other caregivers such as guardians to enable them to function properly and to take up their responsibility for caring for the child or young person. It also limits the role of the state to supporting local authorities and service providers in developing support networks and emphasises the involvement of non-governmental and faith-based service providers and the private sector in community-based responses.⁷

Existing laws and policies should be reviewed in terms of their consequences on child protection and with the aim of removing obstacles for children and young people living in a risk environment and engaging in risk behaviours and for ‘families in crisis’ to access needs-based, high-quality services and to receive adequate support. Existing legal obstacles are particularly linked to:

- The age at and the circumstances in which children and young people can access support services without the consent of a parent or a guardian;
- The lack of universal and free-of-charge access to services. For children and young people living with HIV, this includes in particular the access to confidential and voluntary HIV testing, to antiretroviral therapy and the treatment of co-infections and to substitution therapy for active drug users to enhance their adherence to treatment;
- The level of social assistance provided, particularly to one-parent families and to ‘families in crisis’;
- The lengthy legal processes when deciding on the placement of a child or when issuing new documents;
- The lack of possibilities of hourly employment for the benefit of this group of children and young people, who are often not able to work full-time due to their age, health, or involvement in rehabilitation programmes;
- Discrimination in health care, schools, employment, the juvenile justice system or other areas, especially based on actual or presumed HIV status;⁸
- Housing policies and legislation protecting the rights of the children and young people to housing, especially in the case of the death of the parents, and to other inheritances;
- Sustainable funding from the State for effective services provided by non-governmental and faith-based service providers; and
- Regulations preventing the sharing of information among service providers, particularly among service providers from different sectors (see chapter 6.2).

The biggest obstacles to enforcing the rights of the target group in Ukraine are the lack of an adequate law enforcement mechanism and the attitudes of a number of governmental employees (see chapter 6.3), who view these children and young people as ‘criminals’ or ‘hopeless cases’, and ignore the fact that they not only have rights too, but have usually been badly traumatised and often exploited, and deserve the same respect and legal support as any other citizen of Ukraine. The ‘2006 State Programme on Homelessness and Neglect of Children’ is not very clear on how it will work toward enforcing laws to protect the rights of this group and toward prosecuting those who violate their rights. However, this goes way beyond the remit of the MoFYS and needs a major governmental commitment at all levels, starting with an in-depth review of the legal system, as recommended.

Recommendation 2

(National and local level)

Strengthening law enforcement with regard to child protection through:

- 1. Targeted information and education campaigns on the rights of vulnerable children and young people and on the risks they face;**
- 2. Developing and implementing zero tolerance policies with regard to rights violations within all sectors and institutions working directly with children and young people;**
- 3. Increasing state control of: (a) advertising of (potentially) harmful lifestyles and products, (b) computer clubs that provide minors with access to harmful information, and of (c) pharmacies that provide potentially harmful substances to minors; and**
- 4. Increasing the access of children and young people and their representatives to services responsible for registering and pursuing rights violations.**

The harmonisation and adaptation of national policies and legislation is a long-term undertaking and it must be clear that while there might be the will to improve the system of law enforcement and to ensure security, safety and protection of all citizens in Ukraine, there will be many more cases of rights violations along the way that will go unnoticed and unpunished. These will leave more children and young people traumatised, mistrusting adults, fearing the state that is supposed to protect them, and turning to risk behaviours to escape this gruesome reality. Vulnerable children and young people such as the target group must therefore be made aware of their rights and of places providing legal support. However, it often takes a long time for them to trust anyone, so it cannot be expected that the provision of legal support in every social service, for example, will immediately and significantly increase the number who are willing to come forward and point a finger at a perpetrator, particularly if the perpetrator is a state employee and working in the same location. It is primarily the responsibility of the state to ensure that these children and young people are protected, not only while they are at home and living in risk situations or in a child-care facility, but also while they are on the streets.

COOPERATION AND COORDINATION

Recommendation 1

(National and local level)

Assessing current coordination mechanisms and structures for issues related to the health and development of children and young people, with a view to creating a multisectoral coordination mechanism at the national, as well as at the local level, the role of which is to address issues for the most vulnerable children and young people, particularly for those living or working on the streets.

As chapter 6.4 showed, a lot needs to be done to improve cooperation and coordination of activities among the different sectors. While it is unhelpful to set up additional coordination structures when several are already in place, consideration should still be given to agreement on a single national mechanism that focuses particularly on the issues of vulnerable children and young people, and which will be used to develop a national, multisectoral strategy and action plan to implement an extended national response. The two coordination bodies described in brief in chapter 6.4, the ‘Inter-departmental Commission on the Protection of Childhood’ and the NCC Committee on ‘Work with vulnerable groups, including prevention’ seem to be best placed to agree on a suitable national mechanism to address specifically the needs of the most vulnerable children and young people. Given the wider multisectoral character of the NCC Committee and in view of the planned changes to the NCC membership such as strengthened inclusion of the private sector and of TB and drug-related issues, this Committee might be the most suitable to support the ‘Inter-departmental Commission on the Protection of Childhood’ in developing a national, multisectoral strategy and action plan to implement an extended response.

A similar mechanism should be established at the local level to facilitate, coordinate, develop and implement an extended, multisectoral local response and strategy. These are to be based on the national framework and on a review of the existing processes and coordination mechanisms for dialogue and involvement of non-governmental and faith-based service providers in planning, decision-making and evaluation of the local response.

Recommendation 2

(Local level)

Developing and mobilising communities in rural and urban areas to participate actively in the development, funding and implementation of the local response, addressing issues for the most vulnerable children and young people, particularly those living or working on the streets.

This may be achieved through the following strategies:

1. 'Raising the awareness and building the capacity of local authorities in local planning, monitoring and evaluation based on a participatory assessment of local needs identifying vulnerable children and young people, households and communities, and working collaboratively with non-governmental and faith-based service providers to build the capacity of local staff and to extend or to develop alternative services, as needed;
2. Mobilising influential community leaders and the local mass media in responding to the needs of vulnerable children and young people, in raising awareness of the risks they face and in reducing stigma and discrimination;
3. Organising activities that create a safe environment for community members to talk more openly about 'taboo' topics such as HIV, domestic violence, drug use etc.; and
4. Targeting vulnerable children and young people in two stages to avoid further stigmatisation and discrimination: (a) geographically targeting areas where families and communities are in greatest need, and (b) within these areas, targeting individuals and families in greatest need and at greatest risk'.⁹

In some communities in Ukraine, local non-governmental and faith-based service providers already receive support from private individuals, local churches or businesses. These ties with the local community are very important, not only in terms of financial support, but also relating to assistance in job placements or provision of in-kind services such as donations of time and space. A key element in acquiring such support is the ability to 'sell' the benefits of the activities based on documented outcomes.

Community-wide, multisectoral collaborative programmes also tend to be very successful.¹⁰ However without a 'case manager', a local network of service providers or an 'umbrella organization' that can access the required resources which are available both within a community and from different organizations, it is difficult to utilise potential economies of scale.

Recommendation 3

(Service provider level)

Reviewing coordination mechanisms of the non-governmental and faith-based sector at the local level with the aim of developing a sectoral strategy and action plan to be used in discussions and negotiations for increased funding and support from local authorities and donors, and in order to sustain and expand evidence-based and cost-effective services provided by the sector.

A functioning coordination mechanism of the non-governmental and faith-based sector would also contribute to donor programme coordination at the local level and to greater transparency within the sector with regard to resource allocation and distribution of funds.

Experience in the area of HIV and AIDS work demonstrates that the stronger the cooperation and coordination among non-governmental and faith-based service providers and the more united they are in their advocacy and lobbying efforts, the more likely it is that their ‘voice’ will be heard by the governmental side.

Recommendation 4

(National and local level)

Strengthening the participation of representatives of the target group¹¹ in decision-making processes and coordination mechanisms that have a bearing upon them and their health, development, care and protection.

There is an increasing need to listen to the ‘voice’ of the target group, and particularly to the voice of those who present good role models, as they have managed to change their lives. This requires however that the overall strategic plan make provision for helping the target group in voicing their needs, experiences and concerns. This can be achieved for example by inviting and helping representatives of the target group to participate regularly in national and local coordination mechanisms. As another example the MoFYS, in cooperation with the all-Ukrainian non-governmental organization ‘Debates’ and with support from UNICEF, demonstrated good practice in participative decision-making by implementing projects allowing young people, including members of the target group, those living in institutions, in rural areas, those with HIV, injecting drug users, and sex workers to voice their views on HIV and related issues through a participatory process of public hearings and debates. The participants were also invited to review the ‘National HIV/AIDS Programme’ during consultations in selected regions. The results and recommendations were presented to the central Government via the MoFYS and at the ‘IXth International Conference on HIV/AIDS’ in Bangkok, Thailand.

Recommendation 5

(National and local level)

In order to maintain an overview of service providers from all sectors, it is recommended that a national database of service providers be created and maintained and that an open access compendium¹² to support networking and improve efficient case referral be developed.

Having a database and information on the number and activities of service providers at the national and regional level can also serve as a basis for developing a network among service providers (an objective of the ‘2006 State Programme on Homelessness and Neglect of Children’) and for strengthening referral systems at the regional level.

Interviewees also suggested the development of a comprehensive compendium on legislation, resources and social services pertinent to the target group. This would also include health-related issues such as substance and drug use, HIV and STIs, so that services could be linked, coordinated and systematised into a ‘continuum of services’, especially since most organizations have a limited menu of services. The compendium could further provide guidelines as to where children and young people could be referred, instead of letting clients go with only part of their problems solved.

STRATEGIC PLANNING AND RESOURCE MOBILISATION

The initiative to bring together all children’s facilities and assistance programmes under the auspices of the MoFYS is a beneficial first step in clarifying and improving strategic planning. Strategic planning is an ongoing process that usually starts with an analysis and a review of the situation, followed by the development of objectives, of strategies to achieve the objectives and of an action plan for implementing the strategies. The strategies and the action plan must focus on key areas and interventions such as legal reform, capacity-building, the development of service standards and the improvement of the quality of services, organizational development, resource mobilisation, and monitoring and evaluation. Resource mobilisation as well as monitoring and evaluation are an integral part of strategic planning and ensure that the strategy and action plan can be implemented and that activities can be monitored and evaluated based on an agreed set of indicators.

At the end of one strategic planning cycle and in order to continuously improve planning, the process should be evaluated with regard to its effectiveness in terms, for example, of the in-

volvement of all sectors and members of the target group and of the tools used for consultations and planning etc.

Recommendation 1

(National level)

In order to develop a national, consolidated and multisectoral strategy and action plan for implementing an extended national response addressing issues for vulnerable children and young people, particularly those living or working on the streets, it is recommended that the MoFYS facilitates and coordinates a multisectoral strategic planning cycle. The strategy and action plan need to address key interventions (such as capacity-building, development of national service standards, monitoring and evaluation etc.) and to specify the responsibilities of all stakeholders in the implementation, monitoring and evaluation of the national response.

(Regional level)

The national strategy needs to be supported by information and input from the local level. It should be considered as a starting point for local administrations to facilitate and coordinate a similar process at their level with the aim of developing a local, consolidated and multisectoral strategy and action plan based on the national framework.

To estimate the actual needs, to plan services accordingly, and to monitor the achievement of a 50 per cent reduction in the number of children and young people living on the streets (a key target of the '2006 State Programme on Homelessness and Neglect of Children') and of other set targets, it is necessary to establish a baseline. Table 19 in annex X provides a good practice example of how to reach a consensus and arrive at a joint estimate.

The strategic planning process should include the private sector, national and international donors to ensure that they can contribute to the action plan, are aware of the needs and planned activities, and can consider those within the frame of their own strategies and development programmes. It should also ensure that there is a forum to for joint discussions on complementary funding from these sources for the implementation of the strategy.

Within the frame of the strategic planning process, opportunities for pooling resources with other sectors should also be reviewed and agreements made on joint actions with related sectors such as health (particularly HIV and TB) and the juvenile justice system, to avoid duplication.

Step 1.1

Within the framework of the national strategic planning process, it is further recommended that the costs of current service provision be analysed and a comparative analysis be conducted of services delivered in different settings. The optimal strategies to improve service quality and to scale-up services can then be decided.

In particular, a cost-benefit and cost-effectiveness analysis of the current system of child-care facilities run by the state, by local administrations and by non-governmental and faith-based organizations should be conducted.

Research is further needed to compare costs between different kinds of service models, for example the cost of providing integrated or stand-alone services. This is also needed to confirm the importance of greater investments in this area, particularly in the amount to be invested into prevention versus treatment and rehabilitative measures.

Developmental psychologists and authors of different studies have repeatedly pointed out the importance of protective factors and special support during childhood and the early years of adolescence, as the environment strongly influences future behaviours, life choices and life patterns relating to the risk behaviours and risk situations mentioned above.¹³ Many studies have further revealed the importance of investing more in prevention than in treatment, because treatment is usually difficult at such an early age, time-consuming and costly, despite being vitally important once damage has been inflicted. Costs of treatment for substance and drug use, treatment for infectious diseases such as HIV or even the cost of imprisonment and other rehabilitation programmes are usually high and in most cases higher than for prevention and health promotion programmes.¹⁴ This means that investing in the latter can help mitigate damages caused by a harmful environment at home and can prevent behaviours and practices that are self-destructive and that can put the child or young person at risk of ending up on the streets.¹⁵

Step 1.2

Within the framework of the strategic planning process, a review of existing national and local targets should be conducted, prior to setting realistic 10-year targets for service coverage and quality for the target group. Targets are to include such issues as children and young people in foster homes or returned to the parental home, access to treatment, sustainable contact of follow-up services with target group after leaving institutional care and custodial institutions.

Despite the lack of a baseline figure, the findings presented in this report demonstrate the need to increase the coverage of the target group as well as of ‘families in crisis’ with high-quality services in prevention, treatment, care and support. However, the ‘2006 State Programme on Homelessness

and Neglect of Children’ does not set any targets for scaling up the national response. Also, as mentioned before, a baseline needs to be established first, based on which targets can be calculated and agreed by key stakeholders. It is unrealistic to expect that progress will be quick and targets can be high in the first years, given that there are still many barriers to scaling up services. Among them are the need to restructure the existing child-care services and the need for capacity-building so as to have a pool of human resources capable of providing new and high-quality services.

Step 1.3

The implementation of international guidelines and methodology for reducing the number of institutional care systems for children and young people, and for expanding in parallel the family type care system in Ukraine, should become a planned and systematic process over an agreed timeframe, with a structured monitoring and evaluation apparatus, led by the MoFYS, accomplished with the support of international experts, and integrated into the national strategic action plan.

Setting targets for scaling up services will mean reviewing existing services and eventually widening the range of available services to meet existing needs adequately and to provide alternatives to residential care, which is another objective of the ‘2006 State Programme on Homelessness and Neglect of Children’. This presents one of the greatest challenges for Ukraine, as the national response must answer the question of how families can be empowered and supported to fulfil their role in bringing up their children while at the same time ensuring that an effective mechanism for intervention is in place so that failing families can be supported in a way that is in the ‘best interest’ of the child.¹⁶

The arguments against the residential child-care institutions that were for a long time considered the optimal solution, not only in the former Soviet Union, but all over Europe, are many. The awareness has existed for many years that these institutions have shortcomings, and often even negative effects on the wellbeing and development of children and young people in the short as well as in the long term, with regard for example to social exclusion, additional risks and stigmatisation, and surveys in various countries have supported these observations.¹⁷ Chapter 6.2 gives statistics on suicide attempts by those leaving children’s homes in Ukraine that further show that most residential institutions in the country fail to properly prepare those in their care for independent life in the Ukrainian society. This also obstructs the healthy development of communities.

The *Final Report: Children in institutions: prevention and alternative care* of the ‘Working Group at Risk and in Care’ that was approved by the ‘European Committee for Social Cohesion’ at its 12th meeting in Strasbourg in May 2004 demonstrates that in most Western European states small family type residential homes linked to a system of foster care and adoption are increasingly replacing large-scale residential institutions.¹⁸ This process is still ongoing and has been slow and uneven, despite good progress being made.

Recommendation 2

(National and local level)

In order to address the immediate needs of children and young people living or working on the streets in Ukraine at the current moment and to protect them from further harm, a multisectoral emergency plan should be drawn up. It should be developed by the MoFYS in consultation and cooperation with international and national service providers at all levels and with international and national donors and representatives of the private sector. The plan should focus particularly on increasing the accessibility of existing outreach, drop-in, harm reduction and social services in regions with the highest prevalence of children and young people living or working on the streets and on scaling up these services, utilising additional resources that can be made available at short notice.

This recommendation is based on the results of the consultation meeting in Kyiv on 23 October 2006, during which it was pointed out that many of the children and young people who are living or working on the streets at the current time will benefit either very little or only in the medium or long term from most of the recommendations set out in this report.

The emergency plan must become an integral part of the multisectoral, national strategy, once it is drawn up.

Recommendation 3

(National and local level)

Mobilise additional resources to ensure the implementation of an extended national response and to sustain and scale-up high-quality services, through:

- 1. The development and implementation of a national, multisectoral resource mobilisation strategy;**
- 2. The strengthening of multisectoral partnerships through the recommended national and local coordination mechanisms; and**
- 3. Under the leadership of the MoFYS and with support of the national coordination mechanism lobbying the government for an earmarked¹⁹ and performance-based²⁰ budget for services provided to the most vulnerable children and young people and to ‘families in crisis’.**

Developing, monitoring and evaluating new and existing services, scaling up the national response and managing the whole process, all costs money that is currently not in the state or local budgets. Therefore, it is extremely important to consider finances and include a resource mobilisation strategy and action plan in national and local strategies. It cannot be left to each individual organization or to local administrations alone to generate the additional funds necessary for the expansion and improvement of services on the currently required scale.

The private sector in particular needs to be motivated to fund and support services provided to the target group. This can include foundations, businesses and private individuals, among others. Despite the fact that experiences of acquiring funding from private sources differ greatly among organizations in Ukraine, there are some examples of good practice, such as the Charitable Fund 'Ukraine 3000' headed by the Ukrainian First Lady, Kateryna Yushenko, or the 'Anti-AIDS Foundation' of Olena Franchuk. Both these organizations have provided support to facilities and services working with children living with HIV or with children living on the streets, and have solicited support from Ukrainian sponsors, for example to renovate child-care facilities.

Public-private partnerships have also in many countries²¹ proved able to meet the needs of the target group adequately, utilising the advantages of both parties. However, there are still some open questions concerning these forms of cooperation (see chapter 6.4) and regarding regulation of this type of partnership in Ukraine, that would need to be solved first before progress can be made.

It will also be necessary to continue applying to international and national donors for complementary funding for the implementation of an extended national response. Experience shows that in Ukraine, as in many other countries, these donors prefer to support community-based prevention, care and support interventions rather than large institutional or residential programmes. The latter, while they have done much to care for and support children and young people, tend to be costly and to separate children and young people from their communities, often increasing their dependence on state support and welfare structures well beyond the duration of their stay.²²

Regular meetings with donors might be a useful tool, not only in terms of trying to generate additional funds, but also to start aligning and standardising requirements for reporting, monitoring and evaluation. Many of the service providers interviewed, particularly those from the non-governmental sector, felt that they spend too much time on reporting, especially when more than one donor is funding a project, each with their own reporting deadlines and standards.

For non-governmental service providers, the diversification of funds to support their work is vital for long-term survival. Larger and more established support programmes and service providers almost all rely on a mixture of private and public funding, or have acquired one or more permanent funding source(s).²³

Table 19 in annex X provides some good practice examples of non-governmental service providers generating alternative sources of income and of governments generating revenues for the social sector.

Recommendation 4

(Local and service provider level)

‘Social contracting’ mechanisms used by local administrations to engage non-governmental service providers for the provision of social services should be reviewed jointly through the recommended local coordination mechanism, in terms of:

- 1. The adequacy of the level of funding, taking into consideration the major role that the non-governmental sector plays in prevention, care and support services for the target group; and**
- 2. The transparency of decision-making processes and the monitoring and evaluation of resources allocated and of their distribution.**

At the regional level, many non-governmental service providers have stressed the need to extend the possibilities and the funding for ‘social contracts’ with the local administrations, and to ensure their involvement in a more transparent decision-making processes.

Recommendation 5

(National and local level)

A review, through the recommended national coordination mechanism, of the existing data for the target group and of the data gathering, analysing and disseminating process, in order to:

- 1. Inform the creation of a standardised data collection methodology for all service providers;**
- 2. Develop a set of national monitoring and evaluation indicators;**
- 3. Develop standardised processes for monitoring and evaluating the provision of services and the allocation and distribution of funds; and**
- 4. Decide on a systematic process by which relevant information can be disseminated at the national and local level and accessed by decision-makers and service providers.**

There is no adequate national monitoring and evaluation system yet in place in Ukraine. Within the framework of the ‘National HIV/AIDS Programme’ the development of such a system is envisaged. A comprehensive strategy and action plan were developed and progress is evident. For example, a list of national monitoring indicators for HIV and AIDS has been officially approved this year. A similar system, without duplication of existing or planned structures, would need to be established to systematically collect and analyse data and information on children and young people in Ukraine, with a particular focus on those most exposed to risk factors, including the target group. A first step in this direction has been taken by the MoFYS by planning to develop a database of ‘homeless children’ and ‘orphans’. However, this data-

base will not be sufficient to provide the data needed for decision-making and strategic planning in the future.

In 2003, the UNAIDS 'Inter-Agency Task Team on Orphans and Other Vulnerable Children',²⁴ in collaboration with a broad coalition of stakeholders, developed a core set of indicators to measure progress at the national level with regard to improving the welfare of orphans and vulnerable children, that might serve as a basis for creation of sets of national indicators for the target group.²⁵ See table 20 in annex XI for an overview of these core indicators.

Data will also need to be collected systematically and analysed on a national basis on service quality including service inputs, outputs, outcomes and impact, on the behaviour, attitudes, knowledge and practices of the target group, on the number of service providers and the range of services provided and on finances available, planned and spent for the national response.

In addition, a strategy for data and information dissemination should be developed to ensure that service providers at all levels across Ukraine have access to data and information vital for decision-making, planning and service monitoring and evaluation.

CAPACITY-BUILDING

I. Planning

Recommendation 1

(National and local level)

As part of the strategic planning process, a multisectoral, national capacity-building strategy and plan should be developed, based on an assessment of competence and of training needs, and including an estimate of the number of trainees.

II. Training

Recommendation 1

(National level)

The relevant national authorities in charge of education and training for students and professionals from the health, social, law and education sectors should ensure that all initial, or pre-service, as well as in-service training and education programmes contain basic (pre-service) and comprehensive (in-service) elements that develop skills, attitudes and knowledge about working with vulnerable children and young people, including the target group.

In terms of changing attitudes, training programmes often have only limited success, especially when prejudices and fears go deep, as in the case of the target group. The Head of the Department of Children in the MoFYS stressed the need to start by working with government employees who are responsible for decision- and policy-making in order to change their state of mind, their conceptualisation of the problems, and even their vocabulary if necessary. Another group of professionals that needs to be specifically targeted are judges, law enforcement and correctional officials and officers. A comprehensive advocacy project, ‘Strengthening Child Rights in Guatemala’, could serve as an interesting example for Ukraine. The purpose of this project is to train the national civil police force in child rights and child protection, and to integrate this topic into the national curriculum of the Guatemala Police Academy. It aims to strengthen the cooperation with service providers thereby changing attitudes, reducing stigma and discrimination, promoting a zero tolerance policy concerning police abuse and steadily reducing the number of cases of police abuse.²⁶ A similar promising initiative, but on a much

smaller scale, has been started in Odesa, where an education centre was set up at the Odesa narcological dispensary for law enforcement officers and health and education professionals in order to promote new methodologies on working with young injecting drug users and prevention work among children and young people.²⁷

Recommendation 2

(National level)

Following the guidance from UNAIDS concerning the response to concentrated HIV epidemics, training programmes should be focused at service providers working most closely with the target group. Guidance for training centres providing training for such service providers should be developed. Wherever possible, multidisciplinary and competency-based training should be conducted. Co-ordination of such training should be the responsibility of the main training provider decided by, for example, the MoFYS and the MoES.

Multidisciplinary teams already work in many of the psychosocial and medical-social rehabilitation and AIDS centres providing a comprehensive set of services to their clients. Such teams would also be useful in residential child-care facilities where at this moment the access to psychological support, for example, is often highly restricted (see chapter 6.2 and table 17 in annex IX).

There is further a particular need in Ukraine to improve the competence and to increase the overall number of experienced social workers to work with the most vulnerable children and young people and with ‘families in crisis’. Social work is still a relatively new profession in Ukraine, and there is a limited number of fully qualified social workers in the country, as well as of graduates. While there are various universities providing pre-service and in-service training for social workers, such as pedagogical and polytechnic universities and faculties, not all curricula cover the relevant topics adequately, particularly with regard to health problems such as mental health, HIV, STIs and TB. A comprehensive HIV/AIDS curriculum, including related topics, was for example only recently developed and has now been integrated into the curriculum of the Kyiv Mohyla Academy School of Social Work.²⁸

Training should further target potential ‘gatekeepers’, such as:

1. Staff of primary health care facilities, including those in rural areas, which might be accessed by a child or young person living or working on the streets;
2. Health nurses and nurse-paediatricians that may have access to ‘families in crisis’ and can play an important role in early detection and assessment;
3. The ambulance services that the children and young people sometimes call in emergencies;
4. Owners and staff working in computer clubs that are regularly frequented by the target group; and

5. Staff working in pharmacies; these are one of the main providers of syringes and of many of the substances that are being injected. There are currently about 11,000 pharmacies in Ukraine under different ownership. The easiest to target will most likely be government-owned pharmacies, for example those in community ownership, which represent almost 40 per cent of all pharmacies in Ukraine, or those run by a public-private partnership, which represent another 37 per cent of all pharmacies in the country.

As there are many training providers in Ukraine, national, international, non-governmental and private, who all run training on often very similar topics, it is also important to ensure that duplications will be avoided and that training will be consolidated within existing education structures.

Recommendation 3

(National level)

A review of existing training and development materials should be undertaken to ensure that international standards and good practice are integrated into the development of Ukrainian education and training materials about the target group.

In terms of training materials, there are various internationally tested and implemented training manuals that were specifically developed to address the target group and risk factors and health issues, such as substance and drug use, sexual and reproductive health including HIV and STIs. The Department of Mental Health and Substance Dependence of WHO in Geneva has developed a set of ten training modules focusing on the target group.²⁹ Other useful publications, training materials and manuals can be found on the websites of various large international service providers working with the target group across the world (see for example:³⁰

Recommendation 4

(National level)

A national training forum should be created for collecting and exchanging best practices and international experiences.

Such a forum could be integrated into an existing training and resource centre and could take the form of a(n) (electronic) newsletter, for example.

III. Human resource management

Recommendation 1

(Service provider level)

The following elements should become an integral part of the human resource management strategies on the provider level:³¹

1. Recruiting and retaining qualified and motivated staff, looking also at personal qualities of staff such as creativity, resourcefulness, persistency, emotional warmth, non-judgemental attitude, among other things;
2. Offering job previews and regular job evaluations including personal development plans and exit interviews;
3. Providing psychosocial support to staff and readjusting 'caseloads', if necessary, to prevent burn-out and to reduce high turnover rates;
4. Ensuring a high level of health and safety in the workplace and provide access to prevention means; and
5. Keeping staff informed about service evaluation results to make them part of the success story of the organization.

Recommendation 2

(National, local and service provider level)

A thorough review of the pay and benefits system for service providers working with the target group in the governmental and non-governmental sector should be undertaken. In view of the high priority of reaching and addressing this target group, incentive schemes should be created to ensure higher quality staff are recruited and retained.

As previous chapters and annex IX showed, staff not only lack appropriate training in many areas, but also have no other incentives. They have, on average, very low salaries, a high workload coupled with high levels of stress, restricted access to psychosocial support and, in most cases, not even access to means of protection, not to mention the lack of additional benefits, such as a health insurance. Low salaries make it difficult for service providers to attract more qualified and experienced staff. In addition, this type of work has low prestige in Ukraine. Therefore, there is a need to create new incentive schemes so that salaries properly reflect performance, knowledge and skills; staff are protected via adequate health and safety measures in the workplace; measures are put in place to prevent burn-out syndrome; and provision is made for personal development plans. Again, this is an issue that cannot be solved by one ministry alone, but needs a governmental review and the commitment to ensure a competitive salary package.

It is also not acceptable that state employees sometimes earn two to three times less than their colleagues working for non-governmental service providers, despite having the same educational background. To some degree, there is a ‘brain drain’ taking place from governmental to non-governmental service providers in Ukraine, particularly those funded by international donors, that might cause problems in the long term, as an increasing number of the newly trained social workers and psychologists will decide to join the non-governmental sector and leave the governmental sector increasingly deprived of qualified staff.

Recommendation 3

(National and service provider level)

As part of succession planning, training in business management and strategic planning should be offered to organizations and to staff, especially non-governmental service providers, in order to improve professionalism and build capacity within them.

In case of non-governmental organization, this will further help to reduce the risk of becoming too dependent on one central figure, usually the founder of the organization, and leaving junior staff untrained and unable to replace this person in case of absence or change in management.

SERVICE STANDARDS AND RANGE OF SERVICES

Recommendation 1

(National level)

Creating a set of agreed and approved national standards for the provision of education, health and social care to the target group, and a service accreditation process, which includes in-service training programmes, to ensure standardised service provision and professional development. Furthermore it is recommended that national standards for health and safety at the workplace in those facilities which provide services to the target group, be reviewed and increased.

The standards of services delivered vary from programme to programme, as evidence from Ukraine shows. There is a need to bring the quality provided into line, to press for higher standards and to apply efficient management techniques, including evaluation measures. Many service providers interviewed requested that all service providers should be licensed and accredited, especially to prevent well-intentioned volunteers from doing more damage than good, however such a system is not yet in place. An accreditation system must be transparent; for example the list of criteria used for accreditation should be made publicly available.

During the consultation meeting in Kyiv on 23 October 2006, service providers further raised the issue that there is no adequate mechanism in place to monitor and supervise the work of child-care facilities in Ukraine and the work conducted with 'families in crisis'. It is therefore recommended that these mechanisms be reviewed within the frame of developing a service accreditation process through the recommended national coordination mechanism.

Recommendation 2

(National level)

A basic package of services should be defined for the target group, ensuring that service providers know what services they should be providing, and the main methods and processes to be used in their delivery. Service package standards (as part of the national service standards) should be developed through a participatory process, ensuring that the needs of the target group are identified and met.

Neither the '2006 State Programme on Homelessness and Neglect of Children' nor any of the laws and other state or national programmes described and analysed in chapter five define a

basic package of services for the target group. They only provide a framework of social and other support services for children and young people in general. Defining such a package could however help to focus and align current activities and could serve as the basis for the development of a national, multisectoral strategy and action plan. To define a basic package of services has also been recommended in relation to HIV and AIDS prevention, treatment and care services for this target group in the *Road map*.³²

A basic package of services needs to address the ‘continuum of risks’ via a ‘continuum of care’. ‘Continuum of risks’ means that children and young people face different risks at different stages of their lives and in different settings. Barker and Fontes describe the ‘continuum of risks’ faced by children and young people as being in three categories:³³

1. Primary risks include general risk factors such as poverty, the risk of dropping out of school and of losing attachments to the family and community, and similar situations (environmental, familial and social factors) that might compromise a healthy development and a successful integration into society. Risks have usually not yet manifested themselves in risk behaviours.
2. Secondary risks comprise specific factors, such as dropping out of school, associating with a group of peers involved in risk behaviours, facing enormous stress at home, such as violence or abuse. The degree of attachments with families, communities and social institutions has considerably weakened.
3. Tertiary risks mean a child or young person has been exposed to a combination of risk factors, traumas and highly stressful situations (including such situations as having been abused or repeatedly beaten, having been orphaned by AIDS or having received a positive HIV test result) and is now experiencing the impact, is engaging in risk behaviours and relationships with families, communities and social institutions are severed. This is the point at which they may leave their home or child-care facility and start living on the streets.

While the research for this report primarily dealt with children and young people in category three, services must also target children, young people and their families in categories one and two. As shown in previous chapters, children and young people have different needs at different stages in their lives and are not a homogenous group,³⁴ which means that there are no easy solutions. Addressing the ‘continuum of risks’ via a ‘continuum of care’ means developing for each child or young person a community-based, long-term plan that addresses his or her different needs and may include primary, secondary and tertiary prevention interventions, as well as a set of treatment, care and support services.

Step 2.1

Primary prevention of the phenomena of children and young people living or working on the streets must focus on developing or strengthening parenting skills, on helping sick parents to become healthier and to live longer, on securing basic aspects of family life and on creating a supportive and safe environment for families and caregivers (parents and guardians, among others) to raise children.

Primary prevention aims to prevent harm before it happens. One way of preventing harm is by securing basic aspects of family life such as access to appropriate housing, education, health care services and social security. Another is by offering social services, income-generating programmes for disadvantaged families and welfare provisions, particularly to single-parent families. These might include adequate child benefits or family allowances, child maintenance and day-care services for working parents, and parental leave and work schemes allowing for flexible working hours, especially in case of illness of a child.³⁵ In view of the fact that some guardians and caregivers in Ukraine are older people, positive international experience in tailoring support programmes specifically to the needs of older caregivers should also be reviewed.³⁶

Evidence further shows that the following factors at school and in the community can assist in strengthening protective factors and reducing the risks especially of violence: school-wide policies and curricula that support the development of non-violent and non-discriminatory attitudes and behaviours;³⁷ including well-lit and safe public meeting places for children and young people³⁸ in local, urban planning; local and national media campaigns sensitising the public to the harmful effects of violence, abuse and exploitation on children and young people;³⁹ and efforts by the state as well as by local administrations to establish confidential, well-publicised and easy-to-access mechanisms for children and young people at home, on the streets or in child-care and justice institutions, and for their representatives, for reporting of any form of violence, abuse or exploitation.⁴⁰

All such measures help to create a supportive and safe environment for families or caregivers to raise children. Some of these measures are already an integral part of the Ukrainian legislation or state or national programmes. As this report has shown, the problem often lies more in the implementation and enforcement of the legislation and policies than in their absence.

Other core services of primary prevention include education, information and awareness raising programmes for new parents and parents-to-be. These cover the wide range of issues that may affect the wellbeing of families and at the offerings of social and health care services in the community, as well as early childhood development programmes, home visits, pre- and post-natal services, and gender-sensitive parent education programmes focusing especially on non-violent forms of discipline.⁴¹ Health nurses and nurse-paediatricians could play an important role in the provision of these services.

A particular focus should be given to helping sick parents to become healthier and to live longer for the benefit of their children. With regard to HIV this means providing a supportive environment that encourages the parent to test for HIV and to seek treatment,⁴² which will also help to reduce the long-term impact of the HIV epidemic for children.

Recommended set of prevention, treatment, care and support services for children and young people at primary risk

- **Social support services for the child or young person, the parents and the community, focusing on school drop-out prevention, after-school activities, psychosocial support, parenting education programmes, job placement and vocational orientation and training, and crisis prevention and intervention;**
- **Sex and relationship education. This includes the prevention of substance and drug use, of violence and trafficking, of unwanted pregnancy, of HIV and of STIs. It might or might not include the distribution of free condoms. It should include information on where to purchase contraceptives, including condoms, and how to use them properly;**
- **Community-based health promotion programmes focusing on healthy lifestyle education, on training for life-skills and on creating a healthy environment in the community; and**
- **Free, youth-friendly services (including confidential voluntary testing and counselling for HIV and STIs).**

Table 19 in annex X presents selected international examples of best practice in this area. Based on the evidence reviewed, early detection, assessments and interventions for children and young people at primary risk are necessary and should be offered in a package integrating identified needs with health issues, and implemented by specialised professionals such as social workers. If feasible, a peer education approach should be used for disseminating the messages in settings most frequented by children and young people.⁴³

Peer-to-peer approaches have shown an increase in the acceptability of messages. The success of programmes implemented by non-governmental service providers in Ukraine such as ‘Steps’ in Odesa, the ‘All-Ukrainian Network of People Living With HIV/AIDS’ and ‘Club Eney’ in Kyiv attest to the fact that when people who are dealing with issues such as substance and drug use or HIV reach out to help others, they are not only helping their clients, but they are also helping themselves in a couple of ways. Foremost, by their own proactive approach, they are demonstrating to their community that these problems are not necessarily fatal, that life needs to and does go on, and that people who are afflicted are still valuable members of their community who can make a difference. This helps to raise awareness, to encourage a better understanding of the problems they are all faced with on a wider scale and to combat stigmatisation. They are also helping themselves to turn their negative experiences into something positive, which not only helps put the past into perspective, but also helps to raise self-esteem. Peer counsellors also serve as good examples to others; however, complications with the peer model must also be noted, including the risk of exploitation of peers, difficulties with establishing boundaries and the need for high-level support.⁴⁴

Step 2.2

Mechanisms in place for the early detection and assessment of risk behaviours and risk situations (secondary prevention) should be reviewed in terms of their efficiency and effectiveness, including the follow-up system for each child or young person identified as being ‘at risk’. The coverage, effectiveness and accessibility of prevention, treatment, care and services for children and young people both at secondary and tertiary risk must be assessed and expanded; those evaluated as effective are to be strengthened.

The boundaries between secondary and tertiary risks and prevention measures are often not clearly drawn. Secondary prevention measures focus on early detection and assessment of risk behaviours and risk situations to minimise the significant harm that may occur, if no intervention takes place, while tertiary prevention includes interventions once risk behaviours and risk situations have already resulted in harm such as an STI and aim to prevent re-infection and worsening of the condition.⁴⁵

Recommended set of prevention, treatment, care and support services for children and young people at secondary and tertiary risk:

- **Recreational and after-school activities;**
- **A minimum package of social, legal, material (food, clothes, hygiene, overnight shelter) and psychological support services;**
- **Social support including help with documentation, social benefits, rights information, referrals to other services, crisis intervention and management, community mobilisation, behavioural change communication, outreach work and, if feasible, peer education;**
- **Health promotion activities as part of social support, focusing on healthy lifestyle education and on training on life-skills;**
- **Educational and vocational training, combined with providing viable income-generating possibilities in collaboration with local businesses;**
- **Prevention of substance and drug use, of violence and trafficking, of unwanted pregnancy, of HIV and of STIs and the distribution of free-of-charge condoms. It should also include information on how to use contraceptives and condoms properly. For those already using substances and drugs, prevention should further focus on the prevention of HIV co-infections, hepatitis, TB and drug-use associated diseases, and harm reduction measures including the distribution of clean needles;**
- **Targeted prevention of abuse and violence, sexual exploitation and crime;**
- **The provision of free access to health care services (including mental health services);**

- **Confidential HIV voluntary testing and counselling services, including tertiary prevention, and linked to STI treatment and access to free means of protection;**
- **Free treatment of HIV and AIDS-related diseases (including TB), hepatitis, STIs and any other health problems, including substitution therapy for active drug users to increase adherence;**
- **Free access to rehabilitation services (psychosocial and for substances and drugs);**
- **Centres for (pregnant) girls and young women in crisis situation to raise their child in a safe environment; and**
- **Open and residential child-care programmes linked to follow-up programmes after leaving care.**

For selected examples of international best practices in this area, see table 19 in annex X. The evidence shows that these interventions are best provided based on ‘case management’, outreach work and a ‘drop-in’ approach using collaborative arrangements among various social, health and other service providers, establishing a service network and assuring a ‘continuum of care’. This also means avoiding fragmentation of services. Some of the psychosocial rehabilitation centres in place in Ukraine for the target group function for example as so-called ‘one-stop-shops’ centres, in which children and young people can access a comprehensive package of social, health, psychological, vocational and legal services without needing to access other facilities. This increases trust and decreases the risk of the child or young person ‘getting lost in the system’.

It is widely accepted that open and easy-to-access services with few restrictions such as ‘drop-in’ centres that also provide outreach services and accept children and young people using substances and drugs too, are one of the most important service entry points for the target group. There are some good practice examples of centres using a ‘drop-in’ approach in Kyiv and in Odesa. The number of children and young people reached by these centres is limited though.

‘Case management’ (also known as ‘client management’) ensures individualised care and is usually provided by a social worker in collaboration with other professionals (team-oriented, multidisciplinary approach). It is a method of offering services based on a needs assessment of clients and their families and of jointly planning, coordinating, monitoring, and evaluating a package of services, as required. At the core of case management is the relationship between the ‘case manager’ and his or her clients and their families. The case manager assures a ‘continuum of care’ and fully involves clients and families in decision-making or readapting the jointly developed care plan. The plan includes agreed objectives and outcome measures.⁴⁶

It is also important to address immediate needs first, for example with assistance in finding work for immediate (i.e. for survival and to meet basic needs while living on the streets) as well as ongoing income needs. This means vocational orientation and training has to consider short-term as well as long-term employment needs and interests. Best practices stress the importance of paying young people for participation in vocational training activities or produc-

tion workshops, if possible, or finding options in which the young person can work and still participate in rehabilitation and reintegration activities. They also stress the need to combine vocational training or school education with life-skills education to assist in thinking about long-term interests and options, which might differ from immediate needs, and with other interventions, such as counselling, addressing the psychosocial needs of clients and recognising their limitations based on age and developmental status;⁴⁷

Evidence further points to the need for group activities to create solidarity and support, to cooperate with local businesses to overcome the stigma associated with recruiting children and young people who have previously lived on the streets⁴⁸ and to use an empowerment approach. Empowerment and participation of children and young people in the development, implementation and evaluation of programmes have been shown to be essential to their success, particularly when working with older children and young people. Involvement of children and young people should support autonomy, giving responsibility and meaningful challenges. As part of empowerment, it is important to develop critical thinking, which helps to reduce dependence on the welfare system. Creative and innovative approaches, such as the use of theatre productions, and other participatory methods (including art therapy, forum theatre, dance movement therapy), also help to raise self-esteem, which has been demonstrated for example by shelters in Ukraine or by the Foundation ‘Arts, Culture and Science – Netherlands/Ukraine’ in their work with the target group.

It should further be ensured that there are alternative to institutionalising or removing children and young people from home and placing them in residential care.⁴⁹ However, in the light of the limited resources in Ukraine and the costs of restructuring and dismantling big residential child-care institutions, while at the same time developing alternative care options, it is advisable to opt initially for a ‘mixed model of child-care programmes’.⁵⁰ This means residential as well as open care options, such as guardianship and adoption, that already exist in Ukraine, down-sized children’s homes, overnight shelters, semi-independent living schemes such as community-based group homes and halfway homes,⁵¹ family type homes and foster care. The latter is generally seen to be the least restrictive and most supportive out-of-home placement for children and young people who are in need of temporary care. Fostering can be divided into ‘short-term’ (temporary) and ‘long-term fostering’, ‘emergency fostering’ (removal from a particular situation), ‘short-break fostering’ (respite care for example in the case of a family member being ill or disabled), ‘remand to fostering’ (a child or young person placed temporarily by the courts in a foster family and in the care of a local authority), ‘pre-adoption fostering’ and ‘mother and baby fostering’ for school-age mothers.⁵²

For children and young people who are detained or imprisoned, a basic service package must also be in place reflecting the key elements of secondary and tertiary prevention and treatment, care and support services set out above. Furthermore, it is important to continue efforts to establish a comprehensive, child-centred and restorative juvenile justice system in Ukraine and to reduce the numbers of children entering the Ukrainian justice system by decriminalising so-called ‘status offences’ such as survival behaviours of the target group (begging, selling sex,

loitering) and substance and drug use, as well as victimisation by trafficking or criminal exploitation.⁵³ Table 19 in annex X highlights some international best practices in the institutional and community-based treatment of young offenders.

In planning and improving service quality, the principle of equality in terms of location, gender, legal status, religion and culture should be taken into consideration.

There are still many challenges ahead for Ukraine. These include making children the centre of public policies and developing an affordable and effective national response matching the scale and longevity of the crisis,⁵⁴ collecting more data to ensure informed decisions, shifting the current focus from tertiary risks to more primary and secondary prevention and individualised services, while strengthening the overall quality of the services provided. Another challenge is the reduction of the huge residential child-care system in Ukraine, while developing in parallel alternative care options. Scaling up services to meet an increasing need and involving the local communities, while shifting attitudes within communities and the government towards advocacy and protection of this group and creating an enabling legal and social environment for the children and young people, as well as their families and communities is another difficult task ahead.

All this can only be achieved through partnerships between all sectors. However, while it is vital that international and national donors and the private sector will get involved and provide complementary funding, the government's facilitating, normative and funding functions must be increased too, as well as the responsibilities of the children, young people, their families and communities for the outcomes of services provided.

The experience gained in Ukraine over the past years in addressing the HIV epidemic in particular provides a basis for expanding and accelerating the national response.⁵⁵ National leadership has increased, new partnerships have been formed and pressure and action have made HIV testing and treatment, for example, more widely accessible and available. Still, the experience has also shown that it is not enough to demonstrate willingness by acknowledging the problem and by developing strategic documents. Without the provision, mobilisation and development of sufficient financial, technical and human resources for the implementation and evaluation of the national response, national and local strategies will remain mere paper work and hundreds of children and young people in Ukraine will continue to take to the streets each year, because society, including the Ukrainian Government, fails to protect and care for them adequately.

Glossary¹

Acquired Immunodeficiency Syndrome (AIDS): a disease of the body's immune system caused by the human immunodeficiency virus (HIV). AIDS is characterised by the death of CD4 cells (an important part of the body's immune system), which leaves the body vulnerable to life-threatening conditions such as infections and cancers.

Adherence: following a prescribed treatment regimen, including correct drug dosages, medication schedules, and food restrictions.

Antiretroviral: an agent that suppresses the activity or replication of retroviruses such as HIV by interfering with various stages of the viral life cycle.

Antiretroviral drugs: treatment medications that work to suspend the reproduction of HIV and thus prevent the destruction of the immune system.

Antiretroviral therapy: treatment that slows down the reproduction of HIV, allowing a considerable prolongation of life in case of HIV-infection and the development of AIDS.

Baseline: an initial or known value against which later measurements can be compared.

Behavioural Surveillance Study: a study that is systematically monitoring HIV trends in HIV risk behaviours over time in a target group. These types of studies are usually carried out through a series of repeated cross-sectional surveys at regular intervals.

Best practice: best practice, along with benchmarking, is an organizational concept deployed in the industrial sector and increasingly related to management and administration. In this context, 'best practice' means a process-oriented concept to achieve improvements within individual agencies or settings over time. Improvements are characterised by measurement of quality, effectiveness, cost-effectiveness, and productive output. Best practice, which consists of examining methods for achieving optimal outcomes, is increasingly being used to improve quality and effectiveness of health programmes.

Brain drain: an emigration of trained and talented individuals ('human capital') to other organizations, sectors, nations or jurisdictions, due to better salaries and a better work environment, lack of opportunities in their current environment, health hazards where they live etc.

Burn-out syndrome: occurs when committed people lose interest and motivation in their work, the volume and quality of their work performance is decreasing, and they are emotionally, psychologically or physically exhausted. It can result in dissatisfaction with or departure from their work altogether.

Case management: case management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet a client's human and health service needs. Case management facilitates the achievement of client well-being and autonomy by advocacy, assessment, planning, communication, education, resource

management and service facilitation. It further promotes quality and cost-effective interventions and outcomes. Based on the needs and values of the client, and in collaboration with all service providers, the case manager links clients with appropriate providers and resources throughout the continuum of health and human services and care settings, while ensuring that the care provided is safe, effective, client-centred, timely, efficient, and equitable.

Civil Society: seen as a social sphere separate from both the state and the market. The understanding of the term civil society organizations is that of non-state, not-for-profit, voluntary organizations formed by people in that social sphere. This term is used to describe a wide range of organizations, networks, associations, groups and movements that are independent from government and that sometimes come together to advance their common interests through collective action. Some definitions of civil society also include certain businesses, such as the media, private schools, and for-profit associations, while others exclude them. By definition, all such civic groups are non-governmental organizations (NGOs), in that they are organizations not affiliated with government. However, in practice, the term 'NGOs' is used to describe non-profit making, non-violent organizations, which seek to influence the policy of governments and international organizations and/or to complement government services (such as health and education).

Co-infection: concurrent infection with more than one disease-causing organism; often refers to infection with both HIV and hepatitis C or B.

Community-based group homes: these are similar to the concept of semi-independent living schemes, however these homes provide a more long-term living option for people without a home. They are further integrated into their local community and house a larger group of people than a semi-independent living scheme that is often offered in the form of supervised apartments.

Community participation and mobilisation: means involving the community in an activity such as the planning and implementation of projects or carrying out a community needs assessment.

Continuum of care: the 'Continuum of Care' is a community-based, long-range plan that addresses the needs of people in order to help them reach maximum self-sufficiency and well-being. It is developed through collaboration with a broad cross-section of the community and based on a thorough assessment of needs and resources.

Dependence: a state in which a person becomes reliant on a substance and experiences withdrawal symptoms (e.g. sweating or tremors) when the substance is abruptly stopped.

Depression: a chronic or recurrent mental state characterised by hopelessness and lack of motivation and energy. Other major symptoms may include loss of appetite and either excessive or inadequate sleep.

Drop-in centre: an open, non-restrictive environment where people can 'drop in' to meet some of their basic needs in terms of food, clothing and hygiene, as well as take advantage of

psychosocial support services that are offered, and recreational activities etc. Often serves as a point of entry to other services such as rehabilitation programmes.

Drug addiction: a disease which is accompanied by complicated disorders of physical and mental functions as a result of acutely expressed propensity to take narcotic drugs.

Drug user: an individual who consumes narcotic drugs and psychoactive substances for non-medical purposes.

Drug scene: the circulation of drugs and all related processes in a specific region of a country, district, or city. Characteristics of a drug scene include: the most widespread narcotic substances; social and demographic characteristics of a drug-user community; availability of medical, social and other services for drug users; economic situation; presence of a policy on drugs or an anti-drug policy; activities of civil society organizations etc.

Economic analyses: analyses of the allocation of scarce resources among competing alternative uses and the distribution of the products from these uses among the members of the society. Three common types of economic analysis are: **cost-effectiveness analysis**, a type of analysis that compares interventions or programmes having a common measurement of health outcome in a situation where, for a given level of resources, the decision-maker wishes to maximise the health benefits conferred to the population of concern; **cost-utility analysis**, a type of analysis that measures benefits in utility-weighted life-years (QALYs) and which computes a cost per utility-measure ratio for comparison between programmes; and **cost-benefit analysis**, a type of analysis that measures costs and benefits in monetary units and computes a net monetary gain/loss or a cost-benefit ratio.

Economies of scale: the average cost per unit decreases as output increases. This definition has to do with the optimal type and size of a service, which tends to have lower costs by offering a comprehensive package of services.

Effectiveness: the extent to which objectives are achieved and a specific intervention, procedure, or regimen of service does what it is intended to do for a defined population in terms of outputs, outcomes and impact.

Epidemic: a disease that spreads rapidly through a demographic segment of the human population, such as everyone in a given geographic area, a military base, or similar population unit, or everyone of a certain age or sex, such as the children or women of a region. Epidemic diseases can be spread from person to person or from a contaminated source such as food or water.

Epidemiology: the study of the frequency, distribution, and behaviour of a disease within a population.

Evidence-based: evidence-based care is the conscientious use of current best evidence and practice in making decisions about the care of an individual or the delivery of services. Current best evidence is up-to-date information from relevant, valid research about the effects of different forms of care, the potential for harm from exposure to particular risk factors, the

accuracy of diagnostic tests, and the predictive power of prognostic factors. Evidence is gathered systematically. For example, in the field of housing and health there are a number of studies that demonstrate the links between damp and cold housing and respiratory disease and, increasingly, the links between high quality housing and quality of life.

Exploitative sex: used in this report to describe sexual services provided by children in exchange for money, drugs or other things. Children involved in exploitative sex are not subsumed under the term of ‘sex workers’ given that this form of sex typically includes adults and older youth who exploit the children and the children usually only provide these type of sexual services to survive on the streets or to cope with their lives on the street (for example through the use of substances and drugs bartered against sexual services).

Faith-based service provider: a term preferred instead of, for example, ‘church’ or ‘religious organization’, as it is inclusive (non-judgmental about the validity of any expression of faith) and moves away from historical (and typically European) patterns of thought.

Foster families: the word ‘foster’ means ‘to help someone (or something) grow and develop’ and ‘to take care of someone’s needs’. Foster parents are people - other than a child’s parents - who provide a safe place for children to be cared for temporarily, usually until a child’s parents or another relative can care for the child properly or until the child is adopted. A child might stay with a foster family overnight, or it might be for a few months or several years.

Gatekeeper: while it usually relates to a primary care provider who is responsible for overseeing and coordinating all the medical needs of a patient, including referrals to other services, the term is used in a wider sense in this publication to include any professions and locations, such as pharmacies, that are frequented by a specific target group, and can therefore reach out to them, provide prevention information and refer them onto other services.

Gross primary school enrolment ratio: the gross ratio is the number of children enrolled in a primary level, regardless of age, divided by the population of the age group that officially corresponds to the same level.

Harm Reduction: a term that defines policies, programmes, services and actions that work to reduce the health, social, and economic harms to individuals, communities, and society that are associated with the use of drugs, including the risk of HIV infection, without requiring the cessation of drug use. In practice, harm reduction programmes include services such as syringe exchange, drug substitution or replacement therapy using substances such as methadone, health and drug education, HIV and STI screening, psychological counselling, and medical care.

Health promotion: a concept developed by the World Health Organization (‘The Ottawa Charter on Health Promotion’) that focuses on a process of enabling people to increase their control over, and to improve, their health. Health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing. It is build upon the following cornerstones:² building a healthy public policy;³creating supportive environments;⁴ strengthening community action;⁵ developing personal skills; and ⁶ reorienting health services.

Hepatitis: inflammation of the liver. Hepatitis may be caused by several factors, including viruses (hepatitis A, B, C, D, and E), toxic substances, heavy alcohol use, and certain drugs. Hepatitis symptoms may include fatigue, loss of appetite, abdominal tenderness, jaundice, and elevated liver enzymes (ALT and AST).

HIV incidence: HIV incidence (sometimes referred to as cumulative incidence) is the proportion of people who have become infected with HIV during a specified period of time. UNAIDS normally refers to the number of people (of all ages) or children (aged 0–14) who have become infected during the past year.

HIV-infected: as distinct from HIV-positive (which can sometimes be a false positive test result, especially in infants of up to 18 months of age), the term HIV-infected is usually used to indicate that evidence of HIV has been found via a blood or tissue test.

HIV prevalence: usually given as a per centage, HIV prevalence quantifies the proportion of individuals in a population who have HIV at a specific point in time. UNAIDS normally reports HIV prevalence among adults, aged 15 to 49.

HIV sentinel surveillance studies: studies that regularly test selected groups of people for the presence of antibodies to HIV and aim to monitor trends in HIV infection prevalence in population groups. The surveillance is usually repeated at the same sites in regular intervals.

HIV voluntary counselling and testing: counselling prior to HIV test, testing itself, and post-test counselling conducted when results of the HIV test are given to the patient.

Hotline: a hotline is a telephone helpline established usually by a governmental or non-governmental service provider that people can call (usually free of charge) to receive different kinds of help such as counselling, information on available support services etc.

Hryvna (UAH): Ukrainian currency. The official exchange rate used in this report is: US\$ 100 = UAH 505, as of 6 September 2006.

Human Immunodeficiency Virus (HIV): the virus that causes Acquired Immunodeficiency Syndrome (AIDS). HIV is in the retrovirus family, and two types have been identified: HIV-1 and HIV-2. HIV-1 is responsible for most HIV infections throughout the world, while HIV-2 is found primarily in West Africa.

Impact: The total, direct and indirect, effects of a programme, service or institution on health status and overall health and socioeconomic development.

Indicators: Identified and measured variables that help to show changes directly and indirectly relevant to the achievement of goals, objectives and targets.

Integrated services: availability of multiple services (health, social, education etc.). For instance, the provision of family planning, voluntary testing and counselling and STI treatment services through a single facility or at a single visit.

Life-skills: this term refers to a large group of psychosocial and interpersonal skills which can help people make informed decisions, communicate effectively, think critically and creatively, and develop coping and self-management skills that may help them lead a healthier and more productive life. Life skills may be directed toward personal actions and actions toward others, as well as actions to change the surrounding environment to make it conducive to health.

Millennium Development Goals: eight goals developed at the Millennium Summit in September 2000, focusing on ⁷ eradicating extreme hunger and poverty; ⁸ achieving universal primary education; ⁹ promoting gender equality and empowering women; ¹⁰ reducing child mortality; ¹¹ improving maternal health; ¹² combating HIV/AIDS, malaria and other diseases; ¹³ ensuring environmental stability; and ¹⁴ developing a global partnership for development.

Morbidity rate: a state of disease. Measured by prevalence and incidence and the number of registered or confirmed cases.

Mortality rate: the estimated total number of deaths from a disease in a population of a given age, divided by the total number of this population, expressed per 100,000 population, for a given year, in a given country, territory, or geographic area.

Mother-to-child transmission: transmission of HIV from a HIV-infected mother to her infant during pregnancy, labour or after delivery through breast milk.

Needle or syringe exchange points: projects that provide sterile syringes and/or needles in exchange for used ones. In addition to exchanging syringes and/or needles, the exchange points often provide HIV and STIs prevention information in Ukraine, free condoms and referrals to other health and social services.

Opportunistic infections: illnesses caused by various organisms, some of which usually do not cause disease in persons with healthy immune systems. Persons living with advanced HIV infection often develop opportunistic infections of the lungs, brain, eyes and other organs. Opportunistic illnesses common in persons diagnosed with AIDS include 'Pneumocystis carinii' pneumonia, cryptosporidiosis, histoplasmosis, other parasitic, viral and fungal infections; and some types of cancers.

Outpatient: a patient who receives treatment without being hospitalised.

Perpetrator: a person who has committed a crime, or a violent or harmful act.

Primary health care: the first level contact with people taking action to improve health in a community or all initial (non-emergency) consultations with doctors, nurses or other health staff. In systems with direct access to specialists, the distinction is usually based on facilities, with polyclinics, for example, providing primary care and hospitals secondary care.

Primary prevention: primary prevention interventions aim to prevent harm before it happens. Implementing an information, education and awareness raising programme in schools on topics such as HIV, drugs or trafficking is for example a primary prevention intervention.

Public Health: refers to all organised measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole. Its activities aim to provide conditions in which people can be healthy, and focus on entire populations, not on individual patients or diseases. Thus, public health is concerned with the total system and not only the eradication of a particular disease. The three main public health functions are:¹⁵ the assessment and monitoring of the health of communities and populations at risk to identify health problems and priorities; ¹⁶ the formulation of public policies designed to solve identified local and national health problems; and ¹⁷ to assure that all populations have access to appropriate and cost-effective care, including health promotion and disease prevention services.

Qualitative and quantitative: quantitative evidence is based on what can be counted or measured objectively whilst qualitative evidence cannot be measured in the usual ways and may be more subjective, for example, encompassing people's perceptions, opinions and views.

Rehabilitation: a generic term for any treatment or psychosocial rehabilitation programme to help people for example to cope with and overcome a drug addiction, to re-integrate into society, to enhance social skills, facilitate integration into working life and to develop independent living skills etc.

Reproductive health: Reproductive health is defined by WHO as a state of physical, mental, and social wellbeing in all matters relating to the reproductive system at all stages of life. Reproductive health implies that people are able to have a satisfying and safer sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this are the right of men and women to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice, and the right to appropriate health care services that enable women to go safely through pregnancy and childbirth. Reproductive health care is defined as the constellation of methods, techniques, and services that contribute to reproductive health and wellbeing by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and STIs.

Safer sex: sexual activities that reduce or eliminate the exchange of body fluids that can transmit for example HIV by means of barriers such as latex condoms, gloves, and dental dams.

Second generation surveillance: built upon a country's existing data collection system, second generation HIV surveillance systems are designed to be adapted and modified to meet the specific needs of differing epidemics. For example, HIV surveillance in a country with a predominantly heterosexual epidemic will differ radically from surveillance in a country where HIV infection is mostly found among men who have sex with men or among injecting drug users. This form of surveillance aims to improve the quality and diversity of information sources by developing and implementing standard and rigorous study protocols,

using appropriate methods and tools. These methods and tools include for example sentinel surveillance studies, screening of blood donors for HIV infection, HIV disease clinical surveillance or behavioural surveys. The overall aim of second generation surveillance is to identify and better understand trends over time, as well as the behaviours driving the epidemic in a country and to plan services.

Secondary and tertiary prevention: the boundaries between secondary and tertiary prevention are often blurred. Secondary prevention measures focus on early detection and assessment of risk behaviours and risk situations to minimise the significant harm that may occur if no intervention takes place. Tertiary prevention includes interventions once risk behaviours and risk situations have already resulted in harm, such as a sexually transmitted infection, and aim to prevent re-infection and worsening of the condition.

Self-help groups: groups established by people that have something in common and are affected by the same condition, for example a health condition, the loss of someone close to them etc. These groups can be facilitated by professionals, such as social workers, but are often run by the people who are affected. They are set up to provide mutual support, to share information and experiences and help each other cope with a condition or specific situation.

Service providers: individuals and/or organizations that are trained and have the capacity to provide a set of services and programmes for specific target groups.

Sexually transmitted infections: also called venereal disease (VD) (an older public health term) or sexually transmitted diseases (STDs). Sexually transmitted infections are spread by the transfer of organisms from person to person during sexual contact. In addition to the ‘traditional’ STIs (syphilis and gonorrhoea), the spectrum of STIs now includes HIV, which causes AIDS; ‘Chlamydia trachomatis’; human papilloma virus (HPV) which can cause cervical or anal cancer; genital herpes; chancroid; genital mycoplasmas; hepatitis B; trichomoniasis; enteric infections; and ectoparasitic diseases (i.e., diseases caused by organisms that live on the outside of the host’s body). The complexity and scope of STIs have increased dramatically since the 1980s; more than 20 organisms and syndromes are now recognised as belonging in this category.

Shelter: a building where people with no home can live for a short period of time.

Shirka: The popular name for one of the most commonly injected opiate derivatives used in Ukraine, a homemade preparation of acetylated or extracted opium. In the Odesa region, ‘shirka’ refers to a homemade amphetamine derivative known elsewhere in the country as ‘vint’ or ‘perventin’.

Social dormitories and semi-independent living schemes: these are places that focus on providing a base for people who have no home, where they can live semi-independently, which means even though they live there by themselves, they still receive as much psychosocial support as they need through a social worker and/or a psychologist. The main aim in these schemes

is to prepare the person for independent life, teaching him or her life and budgeting skills and helping him or her to complete education and/or to find a job.

Spontaneous abortion: an abortion that was not artificially induced, such as a miscarriage.

Stakeholder: those individuals, groups, and parties that influence and are influenced and affected by a particular organization or a particular topic.

Standard of care: the level of care that all persons with a particular illness should receive; the level below which care would be considered inadequate.

Stimulants: a substance, such as a drug, which makes the mind or body more active.

Substances and drugs: the terminology used in this report refers to ‘**psychoactive substances**’. This includes the whole class of substances, licit and illicit. Psychoactive substances are substances that, when ingested, alter mental processes, i.e. thinking or emotion. They have been used for hundreds of years for curative, religious and recreational purposes. At the end of the last century, however, stronger and highly addictive substances such as cocaine and heroin were synthesised. In addition, the invention of syringes enabled people to inject drugs, making their effects more powerful and increasing the risk of dependence and of acquiring an infectious disease when using contaminated injecting equipment.

The term ‘**drugs**’ is used in this report referring to the illicit use of psychoactive substances. Drugs can be harmful in a number of ways, both through immediate effects and through serious damage to health over time.

Although not regarded as illicit substances, ‘**solvents**’ (also known as ‘inhalants’, as they are usually being inhaled, that means being breathed in or ‘sniffed’ through the nose or the mouth) are widely used, especially by children and young people living or working on the streets worldwide. Solvents are volatile substances (chemicals), which are present in many products such as glue, paint, gasoline and cleaning fluids, are directly toxic to the liver, kidney or heart, and some of which produce progressive brain degeneration.

Substitution therapy: the administration of a psychoactive substance pharmacologically related to the one creating substance dependence to substitute for that substance. Substitution therapy seeks to assist drug users in switching from illicit drugs of unknown potency, quality, and purity to legal drugs obtained from health service providers or other legal channels, thus reducing the risk of overdose and HIV risk behaviours, as well as the need to commit crimes to obtain drugs.

Syphilis: a sexually transmitted infectious disease caused by the ‘*Treponema pallidum*’ bacterium; the disease progresses through several stages, including primary syphilis (characterised by a painless chancre, typically in the anogenital area), secondary syphilis (characterised by a skin rash that includes the palms and soles), a dormant stage, and tertiary syphilis (which may affect many organs, including the brain), leading to dementia (neurosyphilis) and death.

The Global Fund to Fight AIDS, Tuberculosis and Malaria: established in 2001, is an independent public-private partnership. It is the largest global fund in the health domain, and up to August 2005 it had committed over US\$ 3 billion in 128 countries. The purpose of the Global Fund is to attract, manage and disburse additional resources to make a sustainable and significant contribution to mitigate the impact caused by HIV, tuberculosis and malaria in countries in need, while contributing to poverty reduction as part of the Millennium Development Goals. www.globalfundatm.org

Trafficking: definition provided by the United Nations Trafficking Protocol, article 3: ‘The recruitment, transportation, transfer, harbouring or receipt of a child for the purpose of exploitation shall be considered ‘trafficking in persons’ even if this does not involve any of the means...’ including ‘...the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of other or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs’.

Tuberculosis: a potentially fatal infectious disease caused by ‘Mycobacterium tuberculosis’; TB that typically affects the lungs, but may also occur in other organs (extrapulmonary TB). Multidrug-resistant tuberculosis is resistant to several standard drugs and requires more aggressive therapy.

Umbrella organization: there is no clear definition of an umbrella organization in the international literature. The main distinguishing characteristic of an umbrella organization from other types of non-governmental service providers is that they are primarily member serving versus public benefit organizations. They provide a range of services to their member organizations and do not provide services to individuals or groups of clients. Some umbrella organizations can represent very specific interests and causes, whilst others consist of broad-based coalitions of non-governmental service providers. They can operate at local, state, national and international levels. Main tasks include for example information and dissemination services, membership support, coordination, advocacy and representation, research and policy development for their members or other interested parties, as well as grant support and sponsorship.

Unprotected sex: that means to have sex without using any protection, such as a condom.

Vocational training: a training that prepares people gradually for employment.

Vulnerable or marginalised groups: these terms are applied to groups of people who, due to factors usually considered to be outside their control, do not have the same opportunities as other, more fortunate groups in society. Examples might include unemployed people, refugees and others who are socially excluded, such as injecting drug users, sex workers and children and young people living or working on the streets.

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4. Centre for social expertise of the Institute of Sociology at the National Academy of Science of Ukraine, *a Review of Work with Injecting Drug Users in Ukraine in the Context of the HIV/AIDS Epidemic*, published with the support of the United Nations Children's Fund (UNICEF) in Ukraine and the Joint United Nations Programme on HIV/AIDS (UNAIDS) in Ukraine, Kyiv, 2005, pp. 57-58
5. According to the Head of the Department of Children at the MoFYS, the concept of a 'Children's Village' would mean uniting all current principles within one system offering a full menu of services, including the process of family re-adaptation. This approach has been criticised, in part because some interviewees feel that this model is already outdated, is not the best use of resources, and that the transition process between what currently exists and what is planned will take too long (according to the Programme, the full reform of the system would be completed in 2017). They feel that the 'Advisory Board' of non-governmental service providers of the MoFYS should have been consulted more in the development of this concept.
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Chapter 6: Services and activities targeting children and young people living or working on the streets

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4. United Nations Children's Fund (UNICEF), 'HIV Prevention Strategy for Young People in Pakistan', National AIDS Control Programme (NACP), National Institute of Health, the Ministry of Health Islamabad, Pakistan in collaboration with UNICEF Islamabad, Pakistan, Pakistan, 2006, pp. 11-12
5. 'Protection' is defined in article 19 as measures that 'should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment..., and, as appropriate, for judicial involvement'.
6. Ukraine, 'Proposal Form to the Global Fund to Fight AIDS, Tuberculosis and Malaria, Sixth Call for Proposal, 3 August 2006', Kyiv, 2006, p. 6

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Chapter 7: Summary and conclusions

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Chapter 8: Recommendations

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11. The 'target group' are vulnerable children and young people, particularly those living and working on the streets.
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19. 'Earmarked' means a requirement by the government that all or a portion of a specific source of revenue must be spent on a specific public expenditure or programme/project
20. 'Performance-based' means here: (a) allocating resources for achieving national objectives, (b) linking budgets to national performance indicators, and (c) presenting information on national objectives, the instruments, resources and measures to

- achieve them and their costs (action plan) in budget documents. Performance indicators look at the inputs, outputs, outcomes and impact of the planned national response¹⁹. 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, p. 102
21. Ibid., p. 104
 22. Ibid., p. 103
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 24. The UNAIDS 'Inter-Agency Task Team on Orphans and Other Vulnerable Children' is convened by UNICEF and includes all UNAIDS co-sponsors, International Federation of Red Cross and Red Crescent Societies, the Displaced Children's and Orphans Fund/United States Agency for International Development (USAID), Hope for African Children Initiative, Save the Children Fund (United Kingdom), USAID, and the International HIV/AIDS Alliance.
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33. Schneidman, M., 'Targeting At-Risk Youth. Rationales, Approaches to Service Delivery and Monitoring and Evaluation Issues', The World Bank Group, LASHC Paper Series No. 2, Washington D.C., 1996, p. 24
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37. Ibid., p. 41
38. Ibid., p. 34
39. Ibid., p. 35
40. Ibid., p. 38
41. Gulaid, L.A., 'The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS', UNICEF et al., Global Partners Forum, 2004, p. 18
42. Schneidman, M., 'Targeting At-Risk Youth. Rationales, Approaches to Service Delivery and Monitoring and Evaluation Issues', The World Bank Group, LASHC Paper Series No. 2, Washington D.C., 1996, pp. 12-13
43. Welch, J., 'Streetwork: A Comprehensive Service Model for New York City Homeless Youth', presentation given at the Technical Support Group meeting of the United Nations Children's Fund (UNICEF) on 'Accelerating HIV Prevention Programming with and For Most-at-Risk Adolescents' in Kyiv, Ukraine on 24-26 July 2006, Kyiv, 2006
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54. Ibid.

Glossary

1. The definitions provided in this glossary are adapted or directly copied from a wide range of health and social glossaries provided by UNICEF (www.unicef.org), WHO and the European Observatory on Health Systems and Policies (www.who.org), UNAIDS (www.unaids.org), the Centre for Social Expertise of the Institute of Sociology at the National Academy of Science of Ukraine in: *A review of work with injecting drug users in Ukraine in the context of the HIV/AIDS epidemic*, published with the support of UNICEF and UNAIDS, Kyiv, 2005, the Cambridge Advanced Learners Dictionary edition 2006, Gay Men's Health Crisis (GMHC) glossary (www.gmhc.org), the San Francisco AIDS Foundation (www.sfaf.org), AIDS info (www.aidsinfo.nih.gov), Human Rights Watch (<http://hrw.org/reports/2006/ukraine0306/1.htm>), the International Centre for Not-For-Profit Law (www.icnl.org), United Nations Office on Drugs and Crime (UNODC) www.unodc.org/unodc/en/drug_demand_abuse.htm, and the UK Harm Reduction Alliance (www.ukhra.org)

Annexes

Annex VIII, Table 16

1. The following list of national and local authorities and agencies is focusing only on those organizations that are involved, in one way or another, in policy-making and law enforcement or in the provision and/or oversight of services for children and young people living or working on the streets in Ukraine
2. In relation to children and young people living or working on the streets

3. Facilities and services provided for children and young people, particularly for those who are 'neglected', 'homeless' or 'without parental care'
4. The following list of programmes, activities and facilities of service providers working with the target group (non-governmental and faith-based) and potential service providers (i.e. organizations serving for example injecting drug users, sex workers, young people and children living with HIV and AIDS-related diseases, but which have so far not worked with the target group or only served a few members of the target group) is not exhaustive and focuses on service providers located in Kyiv and Odesa, given that a mapping of all existing services and activities in Ukraine was outside the scope of the assessment for this report
5. The following list of activities and programmes run by a range of international non-governmental or faith-based service providers is not exhaustive, given that a full mapping and analysis of all existing international stakeholders was outside the scope of the assessment for this report
6. Programmes and activities of INGOs aimed at supporting national and local service providers and policymakers and law enforcement agencies in providing services for children and young people. Some programmes and activities include or are particularly targeting children and young people living or working on the streets or in 'families in crisis' and some programmes include direct services to the target group.

Annex IX, Table 17

1. The target group are children and young people living or working on the streets in Ukraine
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3. Centre for Social Expertise of the Institute of Sociology at the National Academy of Science of Ukraine, *a Review of Work with Injecting Drug Users in Ukraine in the Context of the HIV/AIDS Epidemic*, published with the support of the United Nations Children's Fund (UNICEF) in Ukraine and the Joint United Nations Programme on HIV/AIDS (UNAIDS) in Ukraine, Kyiv, 2005, p. 106
4. Ukraine, 'National Report on the Follow-up to the UNGASS Declaration of Commitment on HIV/AIDS, Reporting Period: January 2003- December 2004', Ministry of Health of Ukraine, Kyiv, 2005, pp. 16-17
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12. Centre for Social Expertise of the Institute of Sociology at the National Academy of Science of Ukraine, *a Review of Work with Injecting Drug Users in Ukraine in the Context of the HIV/AIDS Epidemic*, published with the support of the United Nations Children's Fund (UNICEF) in Ukraine and the Joint United Nations Programme on HIV/AIDS (UNAIDS) in Ukraine, Kyiv, 2005, p. 43
13. United Nations Children's Fund (UNICEF), et al., 'Trafficking in Ukraine. An Assessment of Current Responses'. UNICEF in Ukraine, OSCE, USAID and British Council, Kyiv, 2005, p. 52
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15. Doctors of the World-USA, 'Drop-In Center for Street Children', Doctors of the World-USA representative office in St. Petersburg, St. Petersburg, 2004
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17. International HIV/AIDS Alliance in Ukraine, The World Bank: 'Socio-economic impact of HIV/AIDS in Ukraine', Washington D.C., 2006, p. X
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Annex IX, Table 18

1. Centre For Social Expertise Of The Institute Of Sociology At The National Academy Of Science Of Ukraine, *A Review Of Work with Injecting Drug Users in Ukraine In The Context Of The HIV/AIDS Epidemic*, published with the support of the United Nations Children's Fund (UNICEF) in Ukraine and the Joint United Nations Programme On HIV/AIDS (UNAIDS) in Ukraine, Kyiv, 2005, p. 121

Annex X, Table 19

1. Joint United Nations Programme On HIV/AIDS (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)', Ministry of Health of Ukraine and UNAIDS, Kyiv, 2006, p. 4
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6. Doctors of the World-USA, 'Drop-In Center for Street Children', Doctors of the World-USA representative office in St. Petersburg, St. Petersburg, 2004, pp. 2-3
7. Neiva-Silva, L., 'Open Service Centres to Children and Youth in Street Circumstances: The experience of Porte Alegre, Brazil', presentation given at the Technical Support Group meeting of the United Nations Children's Fund (UNICEF) on 'Accelerating HIV Prevention Programming with and For Most-at-Risk Adolescents' in Kyiv, Ukraine on 25-26 July 2006, Kyiv, 2006

8. <http://www.railwaychildren.org.uk/about.html>
9. <http://www.oregon.gov/OCCF/Mission/BestPrac/bestcc/mibestccCCPreschoolGC.shtml>
10. <http://www.cmhc-schl.gc.ca/publications/en/rh-pr/socio/socio041e.html>
11. 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, Strasbourg, 2004, p. 19
12. <http://www.cmhc-schl.gc.ca/publications/en/rh-pr/socio/socio041e.html>
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14. Ibid., pp. 24-25
15. Ibid., pp. 18-19
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Annex XI, Table 20

1. The UNAIDS 'Inter-Agency Task Team on Orphans and Other Vulnerable Children' is convened by UNICEF and includes all UNAIDS co-sponsors, International Federation of Red Cross and Red Crescent Societies, the Displaced Children's and Orphans Fund/USAID, Hope for African Children Initiative, Save the Children Fund – UK, USAID, and the International HIV/AIDS Alliance.
2. Gulaid, L.A., 'The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS', UNICEF et al., Global Partners Forum, 2004, p. 31

Annex I

List of interview partners

Non-governmental and faith-based service providers and international agencies in Kyiv

1. AIDS Foundation East-West (*AFEW*), Elena Voskresenska, Regional Director
2. All-Ukrainian Network of People Living with HIV/AIDS, (a) Olga Panfilova, NGO Support Specialist, responsible also for coordinating the work with children living with HIV, (b) Kostyantyn Ryzhkov, PR Manager and (c) Tetyana Bordunis, Head of the Legal Department
3. ASPERN, Vira Koshyl, President
4. Caritas Ukraine, Andriy Waskowycz, President and Dzvinka Czaykiwkska, responsible for social projects
5. Child Rescue Mission ('The Open Heart'), Konstantin Yakubenko, Deputy Director and Olena Morhun, Psychologist
6. Childhood Without AIDS, Natalia Adamets, Director and Victor Grachov, Social Worker and Volunteer
7. Christian Children's Fund, Halyna Laktionova, Director and Daria Nepochatova, Programme Manager
8. Compass Club (working group meeting for research on the rights of HIV-positive children), Lyudmyla Loginova, Project Director
9. Committee on 'The Protection of Children's Rights', Nataliya Maksymova, Head, Professor of the Kyiv National University
10. Doctors of the World, MAMA + project, Anna Shapoval, Project Director
11. ECPAT, Olha Shved, Director
12. Emmanuel / Christian Broadcasting Network, Steve Weber, Director and Vitaly Gornitsky, Media Programmes
13. Everychild, Halyna Hudz, Communication Manager
14. Help Us Help the Children, Maryna Krysa, Director
15. Holt International, Alyona Gerasimova, Country Director and Ella Skybenko, Programme Manager
16. IOM, Oksana Horbunova, Counter-Trafficking Programme Coordinator
17. International HIV/AIDS Institute, Eliot Pearlman, Head of Board

18. Kaiser Family Foundation, Natalia Feduschak, Grantee for journalism work on HIV/AIDS issues
19. Medecins Sans Frontiers, Zahedul Islam, Head of Mission
20. Otchiy Dim, (1) Ruslan Malyuta, Deputy Director, (2) Natasha Lutsenko, Psychologist, (3) Aida Halych, PR manager, (4) Serhiy Hlibovets, Street Volunteer Coordinator, and (5) other staff
21. Pohliad, Iryna Vollhina, Director
22. Policy Institute, Tamara Tretskaya, Advisor on Strategic Planning on HIV/AIDS
23. Sunshine House, Marek Vnuk, Director
24. UCAN, Valeriy Oliynyk, Director of Grants Programme
25. UCARE, Oleksandra Kosohor, President and Peggy Lynch Scholarship Programme Director
26. UNICEF Ukraine, Olena Sakovych, Project Officer Adolescence
27. Volunteer, Tatiana Zhuravel, Manager

Governmental agencies and service providers in Kyiv

1. Kyiv City Department for Minors, Ruslan Hrebniuchenko, Deputy Director
2. Kyiv City Shelter for Minors, Iryna Duvanska, Shelter Director and Raisa Safyanova, Psychologist plus other staff
3. Medical-Social Rehabilitation Center for Minors (Kyiv City Department of Minors), (1) Lyudmyla Prokhorenko, Director, (2) Olena Kasyan, Deputy Director and (3) Volodymyr Prykhodko, Head of Educational Department
4. Kyiv Centre for Social Services for Youth, Leonid Krysov, Senior Specialist and Dmytro Altman, Harm Reduction Specialist
5. Kyiv Detention Centre for Minors of the Ministry of Interior, Larysa Zub, Director and Olha Seryotina, Senior Counselor
6. Kyiv City Center for the Prevention and Fight of HIV/AIDS, E. Mamodev, Deputy Director
7. Berizka Orphanage in Kyiv, Oleksander Mohylnyy, Director

Central Government

1. Ministry of Family, Youth and Sports, Lyudmyla Volynets, Head of Department of Children

2. Ministry of Education and Sciences, Oleh Yeresko, Head Specialist, Department of General Elementary and Middle Education
3. Ministry of Health, Raissa Moiseyenko, Head of Department for the Organization and Development of Medical Assistance
4. Ministry of Interior, Serhiy Dideskul, and Oleksander Karamushka, Deputy Director of the Department of Criminal Police for Minors and Head of the division responsible for fighting crime and for searching for minors
5. Parliamentary Committee on Motherhood and Children, Lilia Hryhorowych, Head of Committee
6. State Centre of Social Services for Family, Children and Youth in Ukraine, Iryna Pinchuk, Deputy Director and Stanislav Kalnishenko, Head of Department of Preventive Work with Children, Youth and Families
7. Ukrainian HIV/AIDS Centre, Svitlana Komar, Paediatric AIDS specialist

Non-governmental and faith-based service providers and international agencies in Odesa

1. Alternativa, Natalia Rudaya, CIE (Communication, Information and Education) Officer
2. Faith Hope and Love, Tatiana Semikop Director, as well as various staff and volunteers
3. Future Without AIDS, Valeriy Pakholov, Director
4. Life Plus, Sergey Fedorov, Director, plus staff of the office and the resource centre
5. Medecins Sans Frontieres, Nino Chelidze, Project Coordinator
6. Mozhlyvist, Valentyna Patsula, Director
7. Our Children, Vadym Heorhiyenko, Director
8. Steps Rehabilitation Centre, Aleksandr Akhmerov, Vice President and Acting Director
9. Svitlyy Dim, Father Oleksandr Chumakov, Director
10. The Way Home, Serhiy Kostin, Chairman of the Board and other members of staff

Governmental agencies and service providers in Odesa

1. Odesa City Department of Youth, Victor Aksaniuk, Head of Department
2. Odesa Criminal Police for Minors, Tatiana Semikop, Colonel, Chief of Criminal Police for Minors

3. Odesa Oblast Centre of Social Services for Family, Children and Youth, Tatiana Horina, Department of social inspection, Senior specialist, and Oksana Valentinivna, Specialist
4. Odesa Oblast Department of Health, Hanna Lunyova, Head Paediatrician
5. Odesa Oblast Services for Minors, Valentyna Kudimova, Department Head
6. Odesa Shelter for Minors, Tatiana Zhadan, Director
7. Odesa Regional AIDS Centre, Stanislav Servytsky, Chief Doctor

Annex II

List of participants and minutes of the consultation meeting held in Kyiv on 23 October 2006 with key stakeholders to discuss the findings and recommendations of the draft report

Consultation meeting with counterparts on the findings and recommendations of the draft report

‘CHILDREN AND YOUNG PEOPLE LIVING OR WORKING ON THE STREETS: THE MISSING FACE OF THE HIV EPIDEMIC IN UKRAINE’

23 October 2006, 14:30
Hotel ‘Rus’, Kiev

List of Participants

Government and State Organizations

Ministry of Family, Youth and Sport	
1. Oksana Burkal	Department of Children, Senior Specialist
Ministry of Health	
2. Alla Sherbinska	Ukrainian AIDS Centre, Director
3. Svetlana Komar	Consultant of Ukrainian AIDS Centre
Ministry of Interior	
4. Borys Shylin	Senior Specialist, Department of Juvenile Criminal Police
Social Services for Family, Children and Youth	
5. Olena Tsypko	Senior Specialist, State Social Service for Family, Children and Youth
6. Tatiana Horina	Senior Specialist, Department of Social Inspection, Odesa Oblast Social Service for Family, Children and Youth
State Department of Penal Implementation	
7. Oleg Yanchuk	Head, Department on Educational Activity in Colonies
Odesa Criminal Police for Minors	
8. Tatiana Semikop	Colonel, Chief of Criminal Police for Minors
Kyiv City Shelter for Minors	
9. Raisa Safyanova	Senior Specialist

NGOs

All-Ukrainian Public Centre ‘Volunteer’	
10. Tetiana Zhuravel	Programme manager
AntiAIDS Foundation	
11. Olga Rudneva	Executive Director
Charity Foundation ‘Aspern’	
12. Vira Koshil	President
13. Mariya Leonova	Young volunteer

Charity Foundation ‘Way Home’ (Odesa)	
14. Natalia Vegryan	Project manager,
15. Olena Barbul	Young inmate
16. Samir Chebotar	Young inmate
‘Compass Club’	
17. Taras Loginov	Head
‘Life Plus’ (Odesa)	
18. Olga Alexandrova	Project manager
Network of PLWHA	
19. Nadya Libanova	Project manager
Coalition of HIV –service organizations	
20. Oksana Lisovska	Manager
‘Open Heart’/‘Child Rescue’	
21. Svitnenko Olesya	Head
22. Galina Gerassimenko	Manager
Ukrainian Institute of Social Research	
23. Olga Balakireva	Head of the Board
‘Living Hope’	
24. Nicole Borisuk	Manager
‘Child Rights Protection Committee	
25. Nataliya Maksymova	Head
SOCIS	
26. Ekaterina Maksimenko	Project manager
Childhood without AIDS	
27. Grachov Victor	Project manager
Youth Movement ‘Kvartal’	
28. Olexandre Kvashuk	Manager

International NGOs/projects

Christian Children’s Fund	
29. Olexandra Vinogradova	Project assistant
AIDS Foundation East-West	
30. Elena Voskresenskaya	Regional Director
Caritas Ukraine	
31. Andriy Waskowycz	President
Sunshine House	
32. Kulbaba Ganna	Director of the Centre
EveryChild	
33. Halyna Hudz	Communication Manager

Policy Project/Health Policy Initiatives	
34. Olexandra Yatsura	HIV Positive Children Coordinator
International Harm Reduction OSI-Ukraine'	
35. Maria Savchuk	Coordinator of public health programmes
International Federation of Red Cross	
36. Geraldine Cazorla	Project manager of the joint project Ukrainian Red Cross, French Red Cross, Italian Red Cross Regional public health officer Project coordinator
37. Iryna Nahorna	
38. Olga Dieieva	
International HIV/AIDS Institute	
39. Eliot J.Pearlman	Head of Board
40. Lyudmila Dmitrieva	Project coordinator

UN AGENCIES

UNICEF	
Riitta Poutiainen	Programme Coordinator
Olena Sakovych	Project Officer, Adolescence
WHO	
David Rivett	Technical Adviser: Adolescent Health
UNDP	
Vladimir Gordienko	Programme Manager

**Consultation meeting with counterparts on the findings and recommendations
of the draft report on**

**‘CHILDREN AND YOUNG PEOPLE LIVING OR WORKING ON THE STREETS:
THE MISSING FACE OF THE HIV EPIDEMIC IN UKRAINE’**

23 October 2006

Consultation report (Minutes)

Group I Policy, Strategic Planning, Monitoring and Evaluation

1. Do you consider the recommendations made to be realistic, specific, and manageable?

General comments:

- How will the government consider the recommendations? How will the report be disseminated?
- Who is responsible for the implementation of the recommendations? It is suggested that the recommended ministries etc. be added.
- To use the recommendations when and if the ‘State Programme Aimed at Fighting the Homelessness and Neglect of Children (2006-2010)’ will be revised.
- There is a need to edit the Ukrainian text.
- Reinforce the issue of law enforcement in Ukraine (legislation is quite progressive but the implementation is weak as are the monitoring and evaluation mechanisms).
- It is advised that an All-Ukrainian conference be held to review/disseminate the results of the research and Report; to involve media to popularise results of the research.

2. What is missing?

1. How the recommendation will be implemented, monitored, evaluated?
2. Recommendations are not strong enough, should be less diplomatic, more concrete; to add/reflect responsibilities and accountabilities.

Group II Resource Mobilisation, Cooperation, Coverage

1. Do you consider the recommendations made to be realistic, specific, and manageable?

General comments:

- Some recommendations are principles of work and not strictly strategic recommendations (see recommendations 30 and 33 for example). Suggestion: to restructure

the recommendations and to put principles and recommendations separately. The introduction of Chapter 6 should explain that these are the strategic recommendations and that this is not a plan of action; introduction may also include the ‘principles’/‘strategic approaches’ (like recommendations 30 and 33 for example).

- There is a need to edit the Ukrainian text.

Specific comments to the recommendations:

#11. Looks like a very specific one that should be addressed to a particular ministry or organization. The description below is vague: what is meant by a ‘national approach’? It is suggested that there be a stronger focus on the involvement of business structures. It is suggested to advise on the creation of a state financial fund for street children.

#12. Add the protection of rights to the issues (‘related issues’). To specify whether or not only the current governmental/state coordination mechanisms are referred to? To accentuate the need to strengthen coordination between all state bodies concerned (inter-ministerial coordination as the weakest point).

#14. To add a description, explanation: how?

#27. To focus more strongly on the development of the adoption system, and on a government incentive system for parents who are willing to adopt and for foster parents; role of media.

#28. Wording (too straightforward and might be provocative?): to exclude the words ‘eliminating the majority of institutional care systems’ – and rather say ‘to enhance the reform of the state care system...’.

#30. and #33. – are principles/strategic approaches to work.

#31. To add: the personnel of the institutions, foster parents, guardians etc. (there is no proper translation of the word ‘caregivers’ in the text, so it must be specified that not only parents are meant, but other guardians as well and it would be important to underline their role in primary prevention).

#32. Wording:

Mechanisms in place for the early detection and assessment of risk behaviours and risk situations (secondary prevention) should be reviewed, including a follow-up system for each child or young person identified as being ‘at risk’, and the coverage, effectiveness and accessibility of prevention, treatment, care and services for children and young people both at secondary and tertiary risk must be assessed and expanded; those evaluated as effective are to be strengthened.

2. What is missing?

Cooperation and Coordination:

- With law enforcement agencies;
- With mass media;
- With state departments responsible for social advertising; and
- With owners and personnel of computer clubs, pharmacies, clubs etc.

Coverage:

- To add the role of mass media and stress the importance of developing social advertisements for healthy life styles in order to form public attitudes.

Legislation:

- State control should be strengthened over pharmacies, computer clubs etc. – not to sell drugs to minors, not to provide shelter and services for minors.

Group III Capacity building

1. Do you consider the recommendations made to be realistic, specific, and manageable?

General comments:

- Restructure the recommendations on capacity-building as follows: planning, capacity building, management.
- There is a need to edit the Ukrainian text.
- Specify recommendations. Mechanisms for implementation of recommendations are not defined. 'Recipients' of recommendations are not defined. To whom are these recommendations addressed?
- 'Call for Action' should be strengthened.
- It is necessary to engage the system of education (the Ministry of Education and Science of Ukraine).
- Recommendations are rather long-term. What should children and young people do in the meantime?
- Recommendation can be implemented at the regional level.
- Recommendations are quite reasonable. It is necessary to define short- and long-term recommendations.
- Continuum of care – supported!

Specific comments to the recommendations:

#15. Issue of social protection of personnel and their motivation – can be separated as a separate recommendation; focus more strongly on motivation.

Policy issues – work with family type children’s homes: it is necessary to develop mechanisms of case management for street children.

There is a need for a working group to be set up on capacity-building.

#17. Who is responsible for the implementation of this recommendation?

#18. Unclear recommendation. Maybe add a description.

Other issues raised:

- Define more exactly what kind of work should be conducted with families in crisis;
- HIV-positive children should be well taken care of; and
- Access to the treatment for HIV-positive children - adherence?

2. What is missing?

- Strengthening of the role of NGOs - social order;
- Changes in legislation, development of juvenile justice;
- Development of case management for children;
- Changes in legislation are a priority;
- Change management – describe the packages of services;
- What are the methods of motivation for service providers;
- Lack of health care centres for the target group (to treat drug use etc);
- Access to substitution therapy – additional research, improvement of legislation;
- Access to testing (legislation and regulation on HIV-testing, antiretroviral therapy etc.);
- Monitoring the work with HIV-positive street children;
- Work with crisis families – preparation of responsible parents. Coverage of crisis families with comprehensive supervision;
- Improve the mechanism for supervision of work with families in crisis (at the level of legislation);
- Education for social workers on the work with families in crisis;

- Protection of social workers;
- Role of health nurse in work with families in crisis.
- Raising the role of a nurse-paediatrician;
- Child-care facilities need to be supervised as well as families in crisis;
- Development of foster families – education of parents; and
- Establishment of a centre for (pregnant) women in crisis situation (families).

Give us up to five things/recommendations/ideas/steps that need to be done first:

- **Changes in legislation**

1. It is necessary to establish a specialised structure to monitor the implementation of legislation by state bodies.
2. It is necessary to develop simplified procedures for document renewal.
3. Recommendations #15, #16, #17 and #18: Legislation and financial support:
 - Support of families in crisis situation;
 - Human resource development (preparation of qualified personnel to prevent violence and other negative phenomena in families);
 - Education programmes for young families, students and senior school children;
 - Raising the status of a social worker: social package, medical protection, raising salaries subject to the workload; and
 - Universal access to medical access and treatment for homeless children.
4. Improvement of legislation with regard to the following issues:
 - Access to testing;
 - Case management for street children;
 - Primary, secondary and tertiary prevention;
 - Human resource development, development of infrastructure for support and rehabilitation of children and crisis families; and
 - Access to substitution therapy.
5. It is necessary to trigger changes in the legislation.
6. Development of the juvenile justice system.

- **Development of coordination mechanisms and establishment of new ones**

1. To develop the system of cooperation in the sphere of social and psychological supervision, crisis centres and foster education through development of an interdepartmental group.
 2. To develop mechanisms of cooperation among organizations working with street children.
 3. Recommendation #14. To establish the mechanism of participation in decision-making process for the representatives of target groups.
 4. Work with homelessness and people living with HIV.
 5. Cooperation and coordination between sectors (medicine, education etc).
 6. Survey among children.
 7. Human resource development.
 8. Reinforce cooperation between state and NGOs.
 9. Recommendation #12. Assessment and establishment of coordination mechanisms to solve the issues of vulnerable children and young people.
- **Human resource development (work with families, children, police and psychologists);**
 1. Recommendation #15. Provision of psychological and social support for medical workers and safe environment at work.
 2. Recommendation #24. Establishment of the incentives mechanism to employ qualified personnel.
 - **Standards of services and range of services**
 1. Recommendation #7. Development of state standards to provide target group with social and non-medical services.
 2. Establishment of special educational programmes.
 3. Establishment of clear education mechanism for the state officials, NGOs; development and implementation of special educational modules.
 4. Recommendation #22. Proposed change: To review educational programmes taking into consideration:
 - a. The common principle of STIs transmission, transmission of HIV and other STIs.
 - b. Formation of tolerant attitudes toward people living with HIV.
 5. Development of rehabilitation programmes.
 - **Mobilisation of resources and control over their distribution**

Annex III

Questionnaire of the quantitative survey conducted in the cities of Kyiv and Odesa

«SOCIS» - CENTER FOR SOCIAL AND POLITICAL STUDIES

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STREET CHILDREN				PROJECT P 0512130		
1. INTERVIEW NUMBER	2. INTERVIEWER'S CODE	3. DATE OF INTERVIEW		4. INTERVIEW STARTED		5. DURATION OF INTERVIEW (MINUTES)
		DATE	MONTH	HOURS	MINUTES	
6. City		Kyiv.....1		INITIATOR'S SIGNATURE:		
		Odesa.....2				

I guarantee that the information obtained during this interview will never be disclosed to any third party and will be used for general purposes only _____ (signature)

1. Your sex (NOTE WITHOUT ASKING)

1. MALE
2. FEMALE

2. How old are you? (NOTE) _____ years

3. Place of interviewing: city district and situation (NOTE)

4. Where have you been sleeping lately?

1. At home
2. In rehabilitation center
3. In the shelter/ reception ward
4. In my hideaway (attic, basement, construction site, train station, sewer manhole)
5. On the street
6. Other (What exactly?) _____ (NOTE)

5. Where did you sleep today?

1. At home
2. In rehabilitation center
3. In the shelter/ reception ward
4. In my hideaway (attic, basement, construction site, train station, sewer manhole)
5. On the street
6. Other (What exactly?) _____ (NOTE)

6. Did you eat anything hot yesterday (soup, meat, main course)?

1. Yes
2. No
3. NO REPLY

7. How do you make your living/earn your daily bread? (SEVERAL REPLIES ARE ACCEPTABLE)

1. Friends bring me food and money
2. Got home/ brought from home
3. In the shelter
4. Begged for it
5. Got in exchange for sex
6. Stole
7. Purchased / Earned
8. Other (What exactly) _____ (NOTE)

8. How long have you been living outside your home? (MONTHS, NOTE)

_____ months

9. Did you live in the orphanage before?

1. Yes
2. No

10. Did you ever go to school?

1. Yes but not now
2. Still attending school ⇒ SWITCH TO QUESTION NO. 12
3. No ⇒ SWITCH TO QUESTION NO.12

CHILDREN UNDER 16 ARE ASKED QUESTION NO. 11

11. Since what age have you quit school? (NOTE)

Since _____

12. In the last 12 months have you experienced any of the following (SEVERAL REPLIES ARE ACCEPTABLE):

1. Cough, pain in your chest, suffocation
2. Headache
3. Stomach ache
4. Toothache
5. High temperature
6. Skin eruption
7. Sores on genitals
8. Wounds, bodily injures
10. Nothing ⇒ SWITCH TO QUESTION NO. 16
11. REFUSED TO ANSWER

13. Have you consulted a physician during the last 12 months?

1. Yes, in the hospital
2. Yes, in dispensary
3. No ⇒ SWITCH TO QUESTION NO. 16
7. REFUSED TO ANSWER

14. Did the treatment help you?

1. Yes
2. No
3. Got no treatment
3. DON'T KNOW

15. Will you consult this medical officer again if anything hurts?

1. Yes
2. No
3. DON'T KNOW

16. Have you ever felt 'high' from drugs, glue, 'grass', alcohol or anything else?

1. Yes
2. No ⇒ SWITCH TO QUESTION NO. 21

17. How often did you feel high during the last six months?

1. Every day
2. More than once a week
3. Once a week
4. Once a month
5. Once or twice
6. Never during the last six months
7. Couple times in my life

18. What did you use last time? SEVERAL REPLIES ARE ACCEPTABLE

1. Inhaled glue
2. Drank wine/vodka
3. Took pills
4. Injected drugs
5. Smoked 'grass'
6. Other (What exactly?) _____ (NOTE)

CHILDREN WHO INJECTED DRUGS AND CHOSE CODE 4 IN QUESTION NO. 18
ARE ASKED QUESTIONS NO. 19-20

19. What needle did you use last time you injected drugs?

1. My own, clean that nobody used before me
2. Needle found on the street
3. Needle previously used by other boys

20. Did you clean the needle before injecting?

1. Yes
2. No

21. Have you ever had sexual contacts?

1. Yes
2. No ⇒ SWITCH TO QUESTION NO. 26
3. NO REPLY

22. How often have you had sexual intercourse in the last six months?

1. More than once a week
2. Once a week
3. Once a month
4. Less than once a month
5. No sex relations during the last six months

23. Did you use a condom during the last sexual contact?

1. Yes
2. No
3. DON'T REMEMBER/NO REPLY

24. Has anybody during the last 6 months forced you to have any sexual contact when you refused to?

1. Yes
2. No
3. No contacts
4. NO REPLY

25. Have you ever received money, food or other presents for having sex?

1. Yes
2. No

26. Do you know what HIV/AIDS is?

1. Yes, this is a disease (right answer)
2. Anything else (wrong answer) ⇒ SWITCH TO QUESTION NO. 30
3. DON'T KNOW ⇒ SWITCH TO QUESTION NO. 30

27. How is HIV transmitted? How may a person develop AIDS?
(SEVERAL REPLIES)

1. Through somebody else's 'dirty' (non-sterile) needle.
2. Sex without condom
3. OTHER (RIGHT ANSWER)
4. ANYTHING ELSE (WRONG ANSWER)
5. DON'T KNOW

28. Have you ever had an HIV test?

1. Yes
2. No ⇒ SWITCH TO QUESTION NO. 30
3. NO REPLY ⇒ SWITCH TO QUESTION NO. 30

29. Do you know its result?

1. Yes
2. No
3. NO REPLY

30. Do you have friends that help you out on the street?

(SEVERAL REPLIES)

1. Parents
2. Relatives, siblings
3. Boys and girls living on the street and just a little older than you
4. Boys and girls of your age living on the street
5. Adults living on the street
6. Members of organisations working with children (except police)
7. Police officers
8. Anybody from the church
9. Other adults _____
10. None

31. And what about your parents? Is your own mother alive?

1. Yes
2. No
3. DON'T KNOW

32. Is your own father alive?

1. Yes
2. No
3. DON'T KNOW

33. Do you meet your parents?

1. Yes
2. No ⇒ SWITCH TO QUESTION NO. 35
3. No parents ⇒ SWITCH TO QUESTION NO. 35
4. Live with both parents ⇒ SWITCH TO QUESTION NO. 35
5. Live with my mother only ⇒ SWITCH TO QUESTION NO. 35

34. When did you see your parents last time?

1. This week
2. A month ago
3. More than three months ago
4. More than six months ago
5. They live on the street with me

35. Did anybody beat you up during the last six months?

1. Yes
2. No ⇒ END OF INTERVIEW

36. Who was that?

1. Other guys living on the street
2. Parents
3. Police officer
4. Salesperson
5. Guard
6. Shelter staff member
7. Adults living on the street

THANK YOU!!!

INTERVIEWER'S FEEDBACK

(TO BE FILLED BY INTERVIEWER AFTER CONDUCTING THE INTERVIEW, IN THE ABSENCE OF THE CHILD)

37. In your opinion what important information relating to this respondent should be added?

38. How did the interview go? Did you encounter any difficulties?

**39. What information seemed to be unreliable?
(NOTE THE NUMBER OF QUESTIONS)**

40. In your opinion does the respondent inhale glue?

1. Yes
2. No

41. Did he/she wear winter clothes - boots, warm shoes and coat — or not?

1. Yes
2. No

42. Has the respondent requested any help?

Annex IV

Guidelines for the in-depth interviews conducted within the frame of the qualitative survey in the cities of Kyiv and Odesa

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STREET CHILDREN

PROJECT P 0512130

Plan of an in-depth interview

- I. **Life history.** How long have you been living on the street? Are your parents alive? Why did you leave your home? How did you live at home? Do you have any siblings? Any relatives? Where are they?
(If the respondent hasn't finally left the home yet): Why do you spend so much time outside your home?
(If the respondent ran away from an orphanage): Why did you run away from the orphanage?
(For those who studied at school): How long have you studied at school? How was your progress at school? How did you build relationship with teachers? Classmates?
(If never studied at school): Can you read? (Have the respondent read a passage)
- II. **Street life.** Do you eat something hot every day? How do you earn the food? Do you have money? (If yes): How do you make your money?
(If placed with a shelter): How did you make your money while living on the street?
What do you need the most other than food? How often do you change clothes? Do you have anything to cover yourself up when sleeping outside your home?
How do you feel? Does anything hurt you? When was the last time you consulted a doctor? What was the reason? Did you undergo any treatment? Did it help you?
(If never consulted doctors or refuses to): Why don't you consult a doctor? Who helps you out in your street life? Have you encountered organisations that help street children to survive? How did they help you?
- III. **Leisure, preferences.** What is your daily schedule? What do you do besides making your living? Do you play at anything? Do you have any friends? Who are they? Did you acquire blood brothers?
Who is your role model? Whom do you obey?
- IV. **Attitude to street children.** How do adults treat you? Police? Doctors? Vendors? Salespersons at the market? Parents? Have you ever been beaten up?

Victimization. Is it true that adults exploit street children for their own purposes?

Have you heard of situations when children are offered a job that is related to stealing and begging? Are you aware of cases when street children were forced to do so?

- V. **Risk behaviour.** Do you smoke? Do you inhale glue? (If yes): Where did you get the glue? Have you ever injected drugs? (If yes): Where did you get the needle and the stuff? Did you disinfect it?

Did your parents abuse alcohol? Did they take drugs? Where are they now?

Knowledge of HIV transmission risk. Are you aware of the consequences of using 'dirty' needles? What are the consequences of sexual intercourse without a condom? What do you know about AIDS?

- VI. **Future.** How do you plan to live in the future? Are you going to return home (for orphanage children – to the orphanage)? How should things be at home (orphanage) to make you come back? Do you want to go to school? (For young people of 16-19 years old): What do you want to be? Would you like to go to a summer camp?

Annex V

Table 13: Status of ratification and adaptation of key international and United Nations documents protecting the rights of children and young people, Ukraine 2006

United Nations Convention on the Rights of the Child	Optional Protocol to the United Nations Convention on the Rights of the Child	United Nations Convention Against Trans-national Organised Crime (The Palermo Convention)	Annex II – Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, supplementing the Palermo Convention	The United National General Assembly Declaration of Commitment on HIV/AIDS	United Nations Resolution on Human Rights / Convention on Protection of Major Human Rights and Freedoms / International Guidelines on HIV/AIDS and Human Rights	ILO Convention Concerning the Prohibition and Immediate Action for the Elimination of the Worst Forms of Child Labour No C182
Ratified: 28 August 1991	Ratified: 3 July 2003	Ratified: 21 May 2004	Ratified: 21 May 2004	Adopted in 2001	Adopted in 1948 (UN Resolution) Ratified in 1997 (Convention) Adopted in 1996 (International Guidelines)	Ratified: 14 December 2000

Annex VI

Table 14: Overview of selected Ukrainian laws, decrees and resolutions pertaining to the protection and support of children and young people

The Constitution of Ukraine	Law 'On the Protection of Childhood'	The 'Family Code of Ukraine'	Law 'On the Safeguarding of Organisational-Legal Conditions for the Social Protection of Orphans and Children without Parental Care'	Law 'On the Basis of Social Protection of Homeless Citizens and Children'
28 June 1996	26 April 2001	10 January 2002	13 January 2005	02 June 2005
Decree of the Ministry of Youth and Sports and the Ministry of Health 'On adoption of measures for the development of 'youth-friendly' medical and social services for 2005-2010'	Decree No. 1209/228 issued by the Ministers of the Ministry of Family, Youth and Sports and the Ministry of Health 'On the Approval of Cooperation between the Centres of Social Services for Youth and Health Institutions in the Provision of Medical Assistance and Social Services for Children and Youth'	Law on 'Social Assistance to Children deprived of Parental Care'	Resolution of the Cabinet of Ministers of Ukraine No. 1200 'On Creation of a Multi-sector Commission on Child Protection'	Resolution of the Cabinet of Ministers of Ukraine No. 564 'On Approval of the Provision on Family-type Children's Homes' and No. 565 'On Approval of the Provision of Foster Families'
30 March 2005	17 April 2005	2 June 2005	3 August 2000	26 April 2002

Law 'On Social Services'	Law of Ukraine 'On the Prevention of AIDS and the Social Protection of the Population'	Resolution No. 264 of the Cabinet of Ministers of Ukraine 'On Approval of the Concept of Government Strategy Action to prevent HIV/AIDS Spread till the year 2011 and of the National Programme to prevent HIV infection, to support and treat People living with HIV/AIDS for 2004-2008'	Decree No. 415 of the Ministry of Health 'On the Protocol of Voluntary HIV Counselling and Testing'	Decision by the Cabinet of Ministers of Ukraine 'On the Common Regulation for Centres for HIV-Positive Children and Youth'
19 June 2003	12 December 1991	04 March 2004	19 August 2005	15 February 2006
Law 'On Government Standards and Guarantees'	Law 'On Charity and Charity Organisations'	The new Criminal Code of Ukraine	Law 'On Social Work with Children and Youth'	
5 October 2000	16 September 1997	5 April 2001	21 June 2001	

Annex VII

Table 15: Overview of key national concepts and programmes

‘Concept for a State Programme Aimed at Fighting the Homelessness and Neglect of Children for 2006-2010’	‘Concept for a State Programme for the Reform of the System of Children’s Institutions for Orphans and Children without Parental Care’	Resolution No. 14 of the Cabinet of Ministers of Ukraine on ‘On Approval of the Multi-Sector Comprehensive Programme ‘The Nation’s Health’ for 2002-2011’	Statement of the Cabinet of Ministers of Ukraine No. 956 ‘On the Experiment in the Allocation and Payment of State Social Assistance to Orphans and Children without Parental Care’	‘State Programme Aimed at Fighting the Homelessness and Neglect of Children 2006-2011’
7 December 2005	11 May 2006	10 January 2002	12 July 2006	11 May 2006
Resolution of the Cabinet of Ministers of Ukraine No. 264 on the ‘Concept of the Strategy of Government Action targeted at the prevention of the spread of HIV/AIDS’ and the ‘National Programme to Prevent HIV Infection, Support and Treat People Living with HIV/AIDS for the period 2004-2008’	‘State Programme of Support for Youth in 2004-2008’	Resolution of Collegium Number Five on a ‘Sectoral programme on HIV prevention, treatment and care for people living with HIV/AIDS in the criminal justice system’	‘State Programme to prevent the Homelessness of Children’	
4 March 2004	18 November 2003	16 April 2004	21 February 2003	

Annex VIII

Table 16: Overview of key organizations and agencies involved in policy-making and law enforcement, in capacity-building and in service development, funding and delivery

AGENCIES / ORGANISATIONS ¹	ROLE AND RESPONSIBILITY ²	SERVICES AND FACILITIES ³
GOVERNMENTAL SERVICE PROVIDERS (GOs)		
Ministry of Family, Youth and Sports (MoFYS)	Central governmental organ responsible for dealing with the issues of children and young people living or working on the streets of Ukraine. Responsible also for the coordination of activities of other Ministries in this respect.	As of 1 August 2006: <ul style="list-style-type: none"> • National network of 96 shelters; • 22 psychosocial rehabilitation and crisis centres, which sometimes are based in shelters; • 267 children’s homes (these are orphanages and they include the facilities that take care of children living with HIV); and • Foster families (256), family type homes (181).
Ministry of Health (MoH)	<ul style="list-style-type: none"> • Development of health policy. • Facilitating, coordinating and overseeing the development, implementation, monitoring and evaluation of national health programmes for Ukraine. 	<ul style="list-style-type: none"> • Health care facilities across Ukraine (state and community-based facilities).
Ministry of Education and Sciences (MoES)	Prior to 2006, the MoES shared responsibility for running the facilities for adoption, for orphans and for children without parental care with the MoH and the MoFYS. With the consolidation of all of those functions, the MoES is now involved in working with the MoFYS in providing educational opportunities for children in the care of the MoFYS, as well as providing educational materials.	<ul style="list-style-type: none"> • Schools across Ukraine, including specialised schools and boarding schools.

<p>Centre(s) of Social Services for Family, Children and Youth in Ukraine (CSSFCY)</p>	<p>The CSSFCY work with children and families in crisis. Even though they are an independent entity, they are closely linked to the MoFYS.</p>	<ol style="list-style-type: none"> 1. Support to children in child-care facilities, adopted families and family type homes; 2. Support to children leaving child-care facilities – reintegration into society or family environment; 3. Support to young mothers; 4. Prevention of homelessness, offences, violence and crime – support to families and children in crisis, in or released from prison and on probation; 5. Social support to people living with HIV and AIDS-related diseases and young drug users (harm reduction services); 6. Expansion of system of youth-friendly services; 7. Social rehabilitation of children and young people with disabilities; 8. Training and education for volunteers, social work students, CSSFCY specialists; 9. Social advertising; and 10. Development of a CSSFCY network. <p>Specific services and facilities provided by various CSSFCY across Ukraine include drop-in centres and ‘emergency’ centres for minors, mobile units providing outreach services, information services, referrals, recreational events and activities to engage children and young people, and the ‘Dovira/Trust’ counselling centres on STIs, HIV and other issues (the number will reach 216 in 2006), among others.</p> <p>The network of CSSFCY as of December 2005 comprised 1,119 CSSFCY, including:</p> <ul style="list-style-type: none"> • 27 regional centres and centres at oblast level; • 479 rayon level; • 108 branches of rayon centres; • 164 centres in towns; • 40 centres in city districts; • 279 centres in villages; and • 22 centres in rural settlements.
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<p>Ministry of Interior (MoI)</p>	<ul style="list-style-type: none"> • Main responsibility: Juvenile Division. • Carries responsibility for detention centres for minors. 	<ul style="list-style-type: none"> • Detention centres for minors providing psychosocial support and prevention activities, referring children onto other services as needed, or returning children to their homes or to child-care facilities. Children who have committed a felony are often being sent onto specialised schools, or vocational training schools. The detention centres also detain children in transit who have been returned from other countries or have come to the city from other regions or countries. The centres cooperate closely with programmes on missing children. • Conducts raids via the local police collecting children and young people off the street and referring them onto child-care and medical facilities. The MoI works closely with the Services for Minors (local administration's departments for children) and the CSSFCY on these raids and on determining where the children came from. In some cases, precinct officers investigate family situations on location. • Some raids are thematic, such as 'Urok' ('Lesson'), which is usually conducted in September in conjunction with the MoFYS and the MoES, with the purpose of understanding why children are not attending school.
<p>State Penitentiary Department</p>	<p>Responsible for penitentiary facilities for minors.</p>	<ul style="list-style-type: none"> • As of 1 October 2006 there were 11 'colonies' housing altogether almost 2,500 juvenile offenders in Ukraine. • There is a whole range of psychosocial, medical, prevention and rehabilitative services that shall be provided to minors in penitentiary facilities.

<p>Local Services for Minors (Department of Children of the local administration)</p> <p>Kyiv and Odesa Services for Minors</p>	<ul style="list-style-type: none"> • Work with families in crisis situations; • Response to appeals of citizens; • Protection of children's rights for housing and property; and • Monitoring adherence to labour laws regarding children. 	<p>Specific services include:</p> <ul style="list-style-type: none"> • Prevention of domestic violence; • Prevention work with children on the Department of Children's register; • Legal support for orphans and children without parental care; • Social and legal support to children living in foster care and family type homes; • Prevention of bad habits among adolescents; • Legal education for adolescents; • Psychological assistance; • Telephone consultations; and • Performing of raids together with the MoI and police to get children off the streets. <p>The various city services might offer additional services. The Kyiv Services for Minors offers for example:</p> <ul style="list-style-type: none"> • A social-medical rehabilitation centre (social, psychological and educational rehabilitation. Work with minors and families via early intervention); and • A city shelter for minors.
<p>Ukrainian AIDS Centre (= National AIDS Centre)</p> <p>Kyiv and Odesa City AIDS Centre</p> <p>Odesa Oblast AIDS Centre</p>	<p>One national centre that oversees, supports and directs the work of all oblast and city AIDS centres in Ukraine.</p>	<p>According to the Ukrainian AIDS Centre there are currently 35 AIDS centres in Ukraine, including 25 in oblasts and 10 in cities.</p> <p>Special programmes for children:</p> <ul style="list-style-type: none"> • Paediatric HIV/AIDS diagnoses, care and treatment; and • Monitoring and evaluation of HIV/AIDS among children and young people in the country. <p>Each centre provides a range of specialised services. For example the Kyiv City AIDS Centre offers:</p> <ul style="list-style-type: none"> • HIV voluntary counselling and testing (three offices, including one mobile unit); • An outpatient clinic and an inpatient facility; • A viral hepatitis facility for drug users; • A clinical diagnostics laboratory; • Administrative departments for example for epidemiology; and • A crisis hotline.

OVERVIEW OF PROGRAMMES, MAIN ACTIVITIES AND FACILITIES⁴	NON-GOVERNMENTAL SERVICE PROVIDERS (NGOs) AND FAITH-BASED SERVICE PROVIDERS
Shelters, drop-in and day-care centres	<p>Main roles:</p> <ul style="list-style-type: none"> • Complementary services to those offered by the Ukrainian State and local administrations; and • Filling gaps in governmental service provision. <p>Range of services provided:</p> <ul style="list-style-type: none"> • Psychological, medical, social, material and often also educational (schooling) and vocational assistance (such as sewing, pottery, hairdressing, computer and embroidery classes, drawing, metalworking, bicycle repair, woodworking); • Hygiene station; • Provision of food, sometimes via a café; • Referral services; • Counselling for children, young people and families in crises; • Some offer peer education programmes linked to the shelters or centres (outreach on the streets and at the shelter) including HIV/STIs prevention and health promotion information and first medical aid; • Most offer needs-based programmes for each child, as well as group activities and recreational outings; and • Some have a library and one (in Odesa) a sports hall.
Psychosocial rehabilitation centres	<p>These centres prepare children and young people who have been living on the streets for reintegration within their biological or a foster home, and for independent life through training and assistance to older children in their search for job opportunities etc.</p> <p>A comprehensive psychosocial rehabilitation programme is usually developed for each child.</p> <p>Support is also provided in restoring official documents and enhancing the overall physical and psychological development of the child.</p>
Family type programmes	<ul style="list-style-type: none"> • Identification, recruitment and support to foster families; • Family or family type services, including training and supervision of the caretakers, and prevention activities for the children; and • Workshops to enable sharing of experience among service providers.

Reintegration and semi-independent living programmes	Those programmes that could be identified primarily support those leaving child-care facilities. An example: one programme in Kyiv provides selected young people with an apartment, supporting them in trying out semi-independent living and in completing their education or finding a job.
Legal assistance to children and young people	Provided within the frame of many of the services set out above, especially in psychosocial rehabilitation centres and by other social services.
Outreach services (including peer-to-peer programmes)	<ul style="list-style-type: none"> • Providing food, clothing, medical assistance, counselling, support, and prevention services; • Referring children and young people to other services, as needed; • These services are sometimes offered via mobile units; and • They may or may not include peer-to-peer education and counselling.
Food services	Soup kitchens and similar feeding places or outreach services for children and young people living or working on the streets.
Hotlines	Helplines exist nationally and in different locations such as in Odesa. Some specifically focus on topics such as HIV and STIs, reproductive health, domestic violence and trafficking.
Medical care	<ul style="list-style-type: none"> • Identification of children and young people living or working on the streets who have medical problems and placement and support in hospitals until recovery; • First aid services (particularly via outreach services and at shelters and psychosocial rehabilitation and crisis centres); and • One Medical-Social Assistance Centre that is located at the Kyiv City Dermatological-Venereological Clinic and approved by the Kyiv Department of Health, which provides diagnosis and treatment for children and young people living or working on the streets, including dermatological problems, STIs and other health problems.
HIV testing, counselling and antiretroviral treatment	Some NGOs offer to support and take children and young people living or working on the streets to get HIV tested. They also provide follow-up services to them. Usually, this is done in cooperation with organisations of people living with HIV and a local AIDS centre.

<p>Harm reduction and HIV prevention</p>	<p>Harm reduction and HIV and other prevention services for injecting drug users and sex workers. No specific services for children and young people living or working on the streets. However, some services do have young clients who live or work on the streets. Cooperation with the police, CSSFCY and other social as well as medical services. Also training for other NGOs and governmental services.</p> <p>Service portfolio:</p> <ul style="list-style-type: none"> • Rehabilitation and re-socialisation of drug users and their relatives; • Self-help groups, peer counselling, participatory community assessment; • Advocacy at governmental level for injecting drug users and people living with HIV; • Improving public attitude toward ‘marginalised’ groups; • Implementation of harm reduction programmes (for example needle exchange services); • Raising awareness among injecting drug users and sex workers of HIV, STIs and hepatitis; • Advocating accessibility of substitution and antiretroviral therapy for injecting drug users living with HIV; • Developing adherence to antiretroviral therapy; • Training for medical professionals and the police on harm reduction; and • Protecting injecting drug users and sex workers from police abuse. <p>There are also various HIV prevention and health promotion services provided by NGOs focusing primarily on education sessions and the development and distribution of information materials to children and young people in shelters, orphanages and other child-care facilities.</p> <p>There are further mother-to-child HIV prevention programmes providing the following services to mothers living with HIV and to those working with them:</p> <ul style="list-style-type: none"> • Voluntary pre- and post-HIV test counselling (peer approach); • Partner counselling; • Support to parents and single mothers (care for children, prevention of HIV, how to be a parent); • Adherence support (antiretroviral therapy); and • Training for health professionals and counsellors.
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Support to children and young people living with HIV and AIDS-related diseases	<p>Care and support services, including home-care for terminally ill patients.</p> <p>The service portfolio includes for example:</p> <ul style="list-style-type: none"> • Day-care centres for children living with HIV (psychosocial, legal and humanitarian assistance, training for professionals and families on how to care for and support children living with HIV and AIDS-related diseases etc.); • Community centre for families in which one or more people are living with HIV; • Peer-to-peer counselling and support; • Training centre for professional development of those working in the field of HIV and AIDS; • Training for military, police and mass media; • Resource centres; • Information campaigns and awareness-raising events; • Prevention programme in schools; • Support to self-help groups; • Prevention programme among men who have sex with men and other ‘marginalised’ groups; • Antiretroviral therapy consultation and adherence support; • Legal consultations; and • Training for CSSFCY of Ukraine, as well as sharing experience of day-care centre and home-care programme with other post-Soviet countries.
Prevention of substance and drug use	Interactive training for children and for professionals working with children in schools and orphanages.
Drug rehabilitation	Service primarily for adult drug users. There are very few places for children and young people in Ukraine.
Recreation activities	Organised by various service providers. Children and young people living on the streets are collected and taken on field trips to various events such as concerts etc.
(Summer) Camps	<p>Services provided during the camps include recreation and sports activities, classes on hygiene, HIV/STIs and drug use prevention and health promotion, teaching of specific skills and topics like English, music or math, peer education etc.</p> <p>There are camps providing extreme sports within the frame of a psychosocial rehabilitation programme and there have been camps for drug users only as well.</p>
Survival training	Team building and planning exercises and strengthening of self-confidence and testing out of limits via activities like hang gliding etc. Only one programme could be identified.
Support to families in crisis situations (prevention and care)	Support to parents and families, particularly with substance and drug use or alcohol problems and in case of domestic violence. The ‘Centre of Family Care’ in Kyiv works for example towards the prevention of social orphans through interventions with families in crisis, and towards the preparation of biological and foster families for the reintegration of children who have gone through rehabilitation.

School education	Schooling is either provided via schools with which the service providers cooperate or via teachers or volunteers, who come to the rehabilitation centres to teach the children.
After-school programmes and activities	Various. One programme also includes a peer-to-peer programme, a youth club and café and a youth parliament, as well as an information resource centre for young people (including a TV and radio programme for young people). However these services are usually targeted at young people in general. Only two programmes could be identified that are targeting children and young people at-risk of taking to the streets or already living or working on the streets.
Children health and education centre	Still very few centres in Ukraine. The 'Education for Health Centre' in Odesa is an initiative that was supported by UNICEF, the EC and the Japanese Embassy, which addresses the needs of some 300 children and young people living or working on the streets with in-house and outreach HIV/STIs prevention activities. The Centre provides classes on Ukrainian, Russian, history, geography, biology and mathematics, so that the educational level of these children and young people is at par with the curriculum for their age.
Higher education	Within the frame of the assessment for the report, only one scholarship and another support programme for members of the target group and for students graduating from boarding schools and children's homes who are interested in pursuing higher education could be identified.
Special job programmes	NGOs support young people in finding jobs. One programme in Odesa could be identified that further runs a money-generating programme for people living or working on the streets, including young people (selling of a newspaper).
Support to children and young people in detention or penitentiary facility for minors	Support is provided in cooperation with the State Penitentiary Department, primarily psychosocial support and prevention and health promotion services.
Advocacy	Almost all NGOs are involved in advocacy in one way or another. The main focus is the change and development of adequate policies protecting and supporting children and young people engaging in risk behaviours and living in risk situations in Ukraine. One NGO could be identified that provides support for the 'All-Ukrainian Professional Association of Orphanage Workers', which aims to improve the living standards of orphans in Ukraine.
Database of children living or working in the streets	Very few NGOs have established an electronic database of their clients. There are no standards in Ukraine for recordkeeping in NGOs.
Volunteer programmes	Various training programmes for volunteers to work with the target group could be identified.
Media programmes	There are some youth television and radio programmes. Some also include voices of children and young people living or working on the streets. Some NGOs also provide training to the media and encourage the media to report on the situation of children and young people living or working on the streets of Ukraine.

Community mobilisation	There are various programmes and service providers that are trying to engage the local community in activities, particularly psychosocial rehabilitation centres.
Training for professionals	Training provided to the police force, health professionals, social workers, teachers and other professionals in contact with children and young people living or working on the streets, primarily by trainers from local NGOs who often participated in the train-the-trainer programmes of international NGOs.
Examples of services planned for the future	<p>For example for the whole of Ukraine within the frame of the '2006 Ukraine HIV/AIDS proposal to the GFATM' (services to be provided by non-governmental in cooperation with governmental service providers):</p> <ul style="list-style-type: none"> • Increasing the awareness and knowledge about HIV/AIDS and HIV prevention for around 58% of children and young people in four juvenile houses and detention centres in Ukraine and in 94 shelters across the country (reaching approximately 66,600 children and young people of which 95% will be under the age of 18, around 30% will be girls and young women and about 50% will come from rural areas) via education, attitude change, skills-building, individual information, education and counselling services, development of peer leaders and peer education. <p>For example in Kyiv:</p> <ul style="list-style-type: none"> • Centre for Emergency Assistance: round-the-clock assistance to children who have experienced domestic violence or other abuse, through a hotline and quick-response mobile unit in cooperation with the local government and the police; • Independent Living Centre for Street Children: a halfway house providing temporary housing and social support including legal advice and job search assistance for young people in crisis situations, who have already gone through initial rehabilitation; and • Home of Salvation Children's Village: a centre of ten homes, each of which shall house a professionally trained family, each of whom shall take in ten biological or social orphans. Plans also include the first family type home for HIV-positive children. <p>For example in Odesa:</p> <ul style="list-style-type: none"> • Expansion of support and prevention services in detention or penitentiary facility for minors.

OVERVIEW OF PROGRAMMES, MAIN ACTIVITIES AND FACILITIES⁵	INTERNATIONAL NON-GOVERNMENTAL SERVICE PROVIDERS (INGOs) AND INTERNATIONAL FAITH-BASED SERVICE PROVIDERS⁶ Main roles: <ul style="list-style-type: none"> • Grant management and implementing organisations; and • Providing primarily capacity-building and technical means for national and local service providers (governmental, non-governmental and faith-based).
Advocacy and policy development	<ul style="list-style-type: none"> • Aiming for example to improve and reform social policy and the child-care system, as well as the quality of services etc.; and • Advocating the enforcement of the rights of children and young people in Ukraine.
Qualification of professionals	<ul style="list-style-type: none"> • Training of trainers and a wide range of training, seminars, round tables and workshops for health and social care professionals, the police force, policy- and decision-makers etc.; and • Development of curricula for students of higher education, as well as training manuals etc.
Development of training and information materials	Particularly in the area of HIV, TB, STIs and drug prevention and care.
Research	<ul style="list-style-type: none"> • Quantitative and qualitative surveys among children and young people living or working on the streets; • Needs assessments (usually in one or more cities); and • Situation and policy analyses.
Awareness raising among the public	Primarily via information-education campaigns via the mass media and by training the mass media.
Working with the media	Various training programmes.
Development, implementation (usually in partnership with local entities) and monitoring of the implementation of prevention, health promotion, care, support and treatment programmes, and services and facilities managed and provided by national and local partner organisations	<p>Areas include for example</p> <ul style="list-style-type: none"> • HIV and AIDS and STIs; • TB; • Reproductive health; • Family planning; • Family type and foster care for children; • Social support to families in crisis; and • Sexual exploitation and trafficking.

Development of networks of services and integrated services	In different areas.
Support to coordination mechanisms	Via training and direct financial support for example.
Direct services	Usually provided by a range of churches and other faith-based service providers (includes social, medical and purely humanitarian assistance, as well as outreach programmes, volunteer programmes, management of drop-in and other type of centres including family type care, recreational and educational camps, art programmes etc.).

Annex IX

Table 17: Key services, programmes and facilities provided to children and young people living or working on the streets in Ukraine from the point of view of their accessibility, coverage, effectiveness and existing gaps

SERVICE, PROGRAMME OR FACILITY	ACCESSIBILITY BY THE TARGET GROUP ¹ , COVERAGE AND/OR EFFECTIVENESS AND GAPS
EDUCATION AND JOB PROGRAMMES AND FACILITIES	
Schools	<p>Access to schools is possible, however in some cases members of the target group are refused access, primarily due to the lack of official documents.</p> <p>Also, most teachers are not trained to work with this particular target group.</p> <p>Target group members visiting schools may have access to education on healthy lifestyles, which has been actively integrated by the MoES since 2000 into school curricula. The development and publication of corresponding handbooks, posters and manuals for students, teachers and parents are either completed or under way. Trainers for teachers on HIV prevention and related topics are currently being trained and special projects to involve school children actively in HIV prevention are under way. Work with parents to promote healthy lifestyles has also been started.</p> <p>However, most of these activities are recent initiatives and some, funded solely by international donors, may not be sustainable particularly if no incentives are provided to teachers to continue with them.</p>
Educational reintegration	<p>Many members of the target group come into the education system with much lower grade levels than their age might suggest, but receive school certificates according to their age, not their actual skills, making it very difficult for them to re-integrate into society. Even though most psychosocial rehabilitation centres and some of the shelters offer educational services many service providers and schools have limited teaching capacity due to a lack of specially trained teachers or volunteers, and therefore the majority of the children and young people living or working on the streets are not yet enrolled in school programmes. However there are some special and promising initiatives at the local level aiming to match the skills, age and grade level of the target group and enrol them again into schools. An example of this the 'Education for Health centres' one of which is based in the premises of the non-governmental service provider 'The Way Home' in Odesa and serves 300 members of the target group. The centre has managed so far to return 30 children and young people to regular schools.</p>

Higher education	Usually not accessible to members of the target group given that many of them do not finish primary education and lack the support (including financial support) to go on to secondary education. Within the frame of the assessment for the report, only one scholarship and one other support programme could be identified for members of the target group and for students leaving boarding schools and children's homes who are interested in higher education. No information could be obtained concerning the quality and coverage of these programmes.
Vocational training and special job programmes	Vocational training is on offer at almost all psychosocial rehabilitation centres, some shelters and other social services, but the overall coverage is too low to meet the existing and special needs of the target group, as is the range of vocations that can be studied. Furthermore, cooperation with local businesses in form of special job programmes still needs to be strengthened in many of the communities in which the target group lives.
Specialised schools	The Service for Minors of the MoI usually refers target group members to specialised schools. Many children and young people who were detained at the MoI detention centres are referred there after having committed a felony. No data were accessible concerning the quality of education provided by these schools.
Boarding schools	The fact that the '2006 State Programme on Homeless and Neglected Children' foresees the dismantling of the system of children's homes and boarding schools in Ukraine, the anecdotal evidence provided by children and young people interviewed in Kyiv and in Odesa who had run away from these facilities, coupled with the findings of international reviews on the effectiveness of these forms of residential care, ² provide sufficient evidence to conclude that this type of child-care facility is not the most effective and does not prepare children and young people adequately for independent life in today's Ukrainian society (for further details, see chapter 6.2).

HEALTH CARE	
<p>Access to health care facilities, diagnostics and treatment</p>	<p>If a member of the target group is in contact with social services, he or she might gain access to health care facilities. Most service providers have agreements with local health care providers, but the quality of health care is often low and in some cases treatment was refused either by staff or by the target group member.</p> <p>Gaining access to health care facilities without the help of social services is a major challenge for the target group. They rarely seek medical assistance by themselves, usually only in emergencies. This is also demonstrated by the fact that the youth-friendly clinics that were specially set up to serve children and young people are not accessed by the target group.</p> <p>Medical assistance is also quite often refused by many health care providers due to lack of official documents or based on issues relating to stigma and discrimination (see chapter four). Access is further restricted because the treatment is not free of charge and the target group usually lacks the money to pay the requested ‘fees’ or ‘charitable contributions’. Despite the state guarantee of access to free medical assistance, the majority of Ukrainians only receives this in part and there is a certain charge for the remaining part.³</p> <p>There is one centre for medical-social assistance (run by the non-governmental service provider ‘The Open Heart’) in Kyiv that is virtually the only medical center that will service the target group without any documentation. It is located at the premises of the Kyiv City Dermatological-Venereological Clinic and approved by the Kyiv Department of Health. Local law enforcement officers and social workers often refer children and young people living on the streets in Kyiv to this centre.</p> <p>Access to HIV and STI services is also limited, particularly to voluntary counselling and HIV testing. In addition to the reasons mentioned above, there is the issue relating to parental consent (see chapter five). Another obstacle is the time element involved for various stages of HIV testing. According to the Chief Specialist of the Kyiv City CSSFCY, even once target group members have been tested for HIV, it can be challenging to find them again to provide them with counselling, results and, if necessary, a follow-up with psychological support and/or treatment since, when they live on the streets, they rarely stay in one place.</p> <p>On the positive side, it should be noted that the coverage, i.e. the number of HIV testing sites, is slowly increasing in Ukraine. Behavioural surveillance studies conducted among injecting drug users and female sex workers in 2004 (including young people) demonstrate that harm reduction and prevention programmes have an impact on the number of these people getting HIV tested. For example, 61% of the female sex workers in touch with HIV prevention programmes were tested compared to 35% of those who were not in touch.⁴</p> <p>Services for STIs are provided by specialist STI clinics in all oblasts and STI departments at city and rayon hospitals. However, only 41% of individuals with STIs were appropriately diagnosed, treated and counselled at state-owned and community health care facilities in 2005.⁵ There are a number of problems with STI diagnosis and treatment, including the need to increase the number of outpatient treatment sites, to conduct further research on syphilis morbidity among the population, to strengthen cooperation with other services such as family planning, gynaecologists etc., and to ensure unconditional confidentiality.⁶</p>

<p>Services for children and young people living with HIV</p>	<p>There is a range of non-governmental and faith-based service providers that provide a very limited range of HIV prevention and support services for this target group. There is also one initiative in Ukraine that trains and motivates physical and speech therapists and massage specialists to provide their services at children's homes and orphanages, particularly to children living with HIV or with AIDS-related diseases. The extent to which the target group members can benefit from these services was not possible to assess at this stage.</p> <p>According to the '2006 Ukraine HIV/AIDS proposal to the GFATM'⁷ children and young people aged 10 to 18 who are living on the streets are currently not covered at all by HIV prevention, treatment, care and support services and there is a 100% service gap.</p> <p>Some of the key challenges identified by service providers interviewed and by desk research in relation to HIV services for the target group include:</p> <ul style="list-style-type: none"> • Very limited experience of child-care facilities in general or family type homes to take care of, support and manage children and young people living with HIV or AIDS-related diseases (or those whose parents are infected with HIV and are too sick to take care of them), as well as a lack of training and the fear of infection; • There are no specific medical programmes for the target group, but some AIDS centres (particularly in Odesa and in Kyiv) do support members of this target group. They are usually brought to their attention via social services, especially non-governmental service providers. But there are similar problems as with access to other health care facilities (see the box above); • Target group members also usually lack a consistent and strong advocate and guardian, guiding them through the process. A case management approach is not yet established within the system, even though there have been attempts to utilise this approach in the provision of care and support for people living with HIV by the 'All-Ukrainian Network of People Living With HIV/AIDS'; • Adherence to antiretroviral therapy (and any other drug regimen), which is usually impossible while a child or young person is living on the streets; • Insufficient infrastructure for HIV diagnostics and treatment (for example the lack of adequate referral and diagnostic centres for children); • Shortage of personnel in AIDS centres; • Insufficient coordination and cooperation between primary and secondary care, i.e. outpatients' departments, AIDS centers and children's inpatient departments, as well as with TB clinics;
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	<ul style="list-style-type: none"> • Lack of reliable information as to the level of HIV infections among the target group; • Lack of models and standards for support of children and particularly young people living with HIV in general and for the target group in particular; and • Other, general problems faced by all people living with HIV in Ukraine such as: <ul style="list-style-type: none"> ○ The limited number of HIV/AIDS prevention, treatment, care and support services overall in Ukraine, including substitution therapy for drug users. They need to be scaled up urgently;⁸ ○ Limited equality of access to antiretroviral and substitution therapy in Ukraine; ○ Prevention of stigma and discrimination and protection of the rights of people living with HIV need to be urgently improved (see chapter five); and ○ Cooperation and coordination of activities has improved since 2005 especially, but can further be strengthened, most of all at the regional level.
<p>Services for children and young people with TB</p>	<p>There are no data on the number of target group members who have TB and who access TB diagnostic and treatment services in Ukraine, only some anecdotal evidence of children and young people living on the streets who have or have had TB that were reported within the frame of the survey in Kyiv and in Odesa and by various service providers interviewed.</p> <p>In general, it is known however that there is still restricted access to adequate TB diagnostics and treatment and there is a particular problem with the introduction of the WHO recommended DOTS (Directly Observed Therapy, Short-Course) approach to TB. According to the WHO 2004 <i>Tuberculosis Control Report on Ukraine</i>, only 15% of the Ukrainian population was covered in 2004 by DOTS. Furthermore information provided by international non-governmental service providers working in this field demonstrate that there are many challenges in terms of communication between physicians and patients and that many patients fear discrimination. As TB treatment, like HIV treatment, depends greatly on adherence to a months-long drug therapy schedule, patients need to be supported throughout the process. A report published by ‘Human Rights Watch’ in March 2006⁹ highlights that not only are many people living with HIV denied care by health care providers, but that a particular problem exists for people living with HIV seeking treatment for TB co-infection at TB clinics in Ukraine, which often refuse to treat them, mostly out of lack of HIV-related knowledge. They tend to refer them to the AIDS centres that are not specialised in the treatment of TB, so that the patient often dies relatively quickly.</p> <p>Besides people living with HIV or AIDS-related diseases, there are many injecting drug users who are denied treatment for TB and other diseases according to the report.</p>

Mental health services	There are no specific mental health services for this target group and in the interviews, several service providers mentioned that these services usually do not exist or facilities refuse to accept this group, which means that this is a major gap in services.
Reproductive health and abortion services	A network of reproductive health services exists in Ukraine, but as mentioned previously, the target group does not usually seek them out. In terms of abortions, service providers interviewed stressed that pregnancies among the girls and young women of the target group are usually not carried to term, therefore there might be a low need for these services among the target group. The overall rate of abortions among women aged 15 to 44 has been slightly reduced over the past few years, but abortion still continues to be one of the main methods of contraception in Ukraine. ¹⁰
HEALTH PROMOTION AND PREVENTION PROGRAMMES	
After-school programmes and activities	Existing programmes that usually include a prevention aspect rarely include children and young people living or working on the streets, given that so few are still enrolled in schools. However, one programme in Odesa run by the non-governmental service provider 'Living Hope' is an example of a programme that targets children and young people from families in crisis to prevent them from ending up on the streets. It also includes children and young people who are already living on the streets and who could be reintegrated into regular schools.
Recreational activities	During the Soviet Union, pioneer clubs were prevalent and mandatory, keeping many children and young people busy with after-school activities and also in many cases helping to create a protective environment in terms of risk behaviours and risk situations. Although there are still a number of youth clubs available, they often do not function in the most-needed areas according to service providers interviewed, and membership or services may be on a fee basis, which excludes those children and young people who may be most in need. The lack of recreational services on offer is recognised by all social services, many of which try to offer ongoing activities as well as one-off events such as summer camps for members of the target group. However, the coverage is too low to meet the demand.
Parent education and prevention programmes	The report could not establish the existence of any national or comprehensive parent education and prevention programme in Ukraine targeting particularly young parents and parents who are in risk situations and demonstrate risk behaviours that might impact negatively on their wellbeing and on that of their children. An exception is perhaps some of the services that are provided by reproductive health care and an initiative of one of the international, non-governmental service providers. However, the latter seems to have had no practical implications and the target group rarely accesses reproductive health care services.

<p>Support to families in crisis</p>	<p>While most social services offer support to families in crisis, the services offered do not seem to meet the existing needs, otherwise the number of children and young people living or working on the streets would be smaller and the trend would have been reversed by now. There were also discussions with service providers concerning the lack of adequate assessment and crisis identification tools, the qualification of social workers, the problems in communication between parents, teachers and social workers (as mentioned in chapter four). There are selected cases of target group members having been successfully returned to their biological homes (i.e. to families able and willing to take care of them and the child not running away again). But according to shelter personnel interviewed, many of the children and young people are returned to family situations where the initial reason for their leaving has not been rectified, so they may end up back at the shelter three to four or even six times a year. The shelter personnel feel that social services do not follow through sufficiently on the support and guidance that is required, and that there is a lack of coordination between all the agencies involved in the psychosocial rehabilitation of children, young people and their families. The Head of the Department for Children of the MoFYS also criticised the current system for failing to recognise the family as the main source of the problems experienced by children and young people, as shown by the fact that about 80% of children are sent back to live at home after three months, despite the problems that abound there.</p>
<p>Prevention of HIV, STIs, hepatitis B and C, TB and related issues (including outreach services)</p>	<p>Many services working with the target group have by now included at least HIV and STI prevention and healthy lifestyle information and education into their programmes. On the street it is usually provided via outreach workers and volunteers. In terms of outreach services the coverage is way too low, as this is a target group with limited support-seeking behaviour. Existing services are restricted due to financial and human capacity constraints. The Kyiv CSSFCY for example mentioned the need to purchase a vehicle for outreach services which would enable them to bring a group of children and young people to their drop-in centres. Community centres for children living with HIV also highlighted the usefulness of mobile outreach, particularly to reach those in remote areas and to avoid additional transport costs for the patients and their families. In terms of TB prevention, most programmes fall short on integrating TB prevention with HIV prevention and are not targeted. Also staff, especially in state-run child-care institutions, require more training, particularly in interactive methods of effective communication of prevention messages and how to follow up on prevention measures. Non-governmental service providers are still mostly providing information materials and education sessions in state-run institutions.</p>

Given the high levels of HIV infections that were detected in two sections of the target group who had been tested for HIV in the last two years, it can further be assumed that HIV and STI prevention work is not sufficient and not reaching children and young people early enough. It might also be ineffectively communicated, as the risk factors are many for the target group and the motivation and incentives to protect themselves few.

In terms of the prevention of hepatitis B and C, participants at a meeting of the 'Technical Support Group of UNICEF on Accelerating HIV Prevention Programming With and For Most-at-Risk Adolescents' held in Kyiv on 25 to 26 July 2006, said that the lack of prevention programmes for hepatitis B and C were an 'opportunity missed' in the light of high numbers of injecting drug users who are already infected with hepatitis.¹¹

In general, target group members can access prevention means in Ukraine:

- Syringes are widely and legally accessible. They can be purchased in pharmacies throughout the country and are relatively cheap, ranging from UAH 0.20 to UAH 0.80 (approximately US\$ 0.04 and US\$ 0.16).¹² However, injecting drug users tend not to keep syringes on them or store them to avoid conflicts with law enforcement officers. Some also claim that they do not have the money to buy syringes.
- Condoms are also easily accessible and not very expensive, however there are often problems with the quality of the cheaper products that the target group tends to buy (if any) at markets and other places. Furthermore, free condoms provided within the frame of international projects need to be more widely distributed and target group members must be taught how to use a condom properly.
- According to social workers interviewed, most of the prevention information material available is targeted at youth in general or at specific groups such as injecting drug users. It does not take into consideration the reading and comprehension level of most children and young people living on the streets. The language is usually too sophisticated to be of any real benefit to them and the material that is available is usually limited in quantity and not widely accessible.

A good practice example: in 2003 to 2005 the staff of the state shelters for minors participated in UNICEF supported training aimed at teaching the principles of HIV prevention work with children. In November 2004 a 'Training Programme on Prevention of HIV/AIDS and risky behaviour' was developed by the All-Ukrainian Centre 'Volunteer' (NGO) for the state shelters with the support of UNICEF and approved by the MoFYS. As a result a set of illustrative materials on HIV prevention was developed and published with the participation of children, as well as methodological guidelines for the staff of the shelters. To date more than 15,000 children in the shelters received knowledge and information on how to protect themselves from HIV. It is hoped that since the Programme has been approved, HIV prevention work will be institutionalised and conducted on a regular basis in the shelters.

<p>Trafficking prevention and support</p>	<p>According to a report on ‘Trafficking in Ukraine’,¹³ there are no organisations which focus solely on countering the trafficking of children from Ukraine. Even though the capacity among law enforcement agencies is growing and the cooperation with non-governmental service providers improving, there are still many serious obstacles¹⁴ with regard to specialised training and support for different services to prevent, detect and support children and young people being trafficked. There is a need for a functional witness protection programme, clear guidelines on handling trafficking cases, better access to legal and medical assistance for those trafficked, and more research of trafficking in children, including the target group.</p> <p>The need to create a platform for policy-makers, government agencies and non-governmental service providers to exchange their experiences in anti-trafficking is currently being addressed by a project on ‘Sharing Experiences in Anti-Trafficking Initiatives. Policy and Practice’ (2005-2007) that is funded by the British Embassy under their ‘Global Opportunities Fund’ and implemented in three regions of Ukraine (Zhytomyr, Rivne and Lugansk). It aims to increase the awareness of trafficking of young women and children, and to improve the coordination and service delivery in relation to trafficking of this group from and through Eastern and South Eastern Europe. Project methods include training, seminars, round tables and discussions involving a large number of officials, law enforcements representatives, social workers and young women. In addition, training is provided in local schools, boarding schools and shelters by non-governmental service providers to raise the awareness of trafficking issues and of HIV among children.</p>
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<p>Health promotion, including life-skills education</p>	<p>Health promotion is a wide concept targeting the individual as well as the community and policy-makers. Most of the psychosocial and medical-social rehabilitation centres that were established to serve this target group have integrated some of the aspects of the health promotion concept into their work, such as the creation of an enabling and supportive environment, the development of personal skills of the child or young person, and the strengthening of community action by involving the community in volunteer programmes or in social events organised by the centres. The concept is however not yet fully integrated into national policies and the restructuring and reorientation of health services, particularly primary health care, and other sectors toward an approach including health promotion and prevention has still to be accomplished.</p> <p>In terms of developing the personal skills of target group members, most social services focus particularly on life-skills education, given that many children and young people, particularly those who have lived in children’s homes and boarding schools for a long time, are unprepared for an independent life once they have to leave the institution.</p> <p>In terms of promoting healthy lifestyles, particularly via mass media, too little has been done to make an impact. One of the reasons is that healthy lifestyle campaigns that include social advertising using the mass media have to exist alongside massive advertising of products such as tobacco and alcohol that can be harmful to the health, often coupled with a message that these products increase sexual potency. In addition, social ads are rarely shown at prime time on television or placed in the most effective places across urban and rural areas given that they are usually placed free of charge or at discount rates.</p>
<p>Peer-to-peer education</p>	<p>This is one approach to communicating prevention messages and to providing care and support services to the target group (for example within the frame of mother-to-child HIV prevention and care programmes). Although there are some examples of non-governmental and faith-based service providers using this approach, particularly in the frame of their outreach services, coverage of the target group by peer-to-peer programmes is very low, due to the challenges involved, such as the need for appropriate training and ongoing psychosocial support to peer educators and counselors, which often overstretches the already limited capacities of service providers.</p> <p>This approach is evidence-based and used by many service providers around the world to reach out to ‘marginalised’ groups, especially young people.</p>

ANTI-STIGMA AND DISCRIMINATION PROGRAMMES	
Protection against discrimination and anti-stigma campaigns	<p>There are national, as well as regional and targeted campaigns (including for example behaviour-change-communication measures targeting health and other professionals) for solidarity with people living with HIV. This target group or other affected groups were not specifically pointed out during those campaigns to avoid further stigmatisation. So far, there have been few campaigns, and stigma and discrimination of ‘marginalised’ groups and people living with HIV is still widespread in Ukraine as stressed in chapter four.</p> <p>A range of international non-governmental and UN organisations have been advocating for policy changes in this respect and many local service providers offer legal support in case of discrimination, however the up-take is low, as well as the coverage.</p> <p>Special programmes supporting and targeting children and young people living or working on the streets who belong to the Roma population, one of the most impoverished communities in Ukraine, could not be identified.</p>
Protection against breaches of confidentiality	<p>Although current legislation technically guarantees confidentiality on the part of medical personnel, this is not always enforced according to service providers interviewed, particularly for children and young people living with HIV.</p> <p>Besides medical personnel that may leak information informally, there are also examples of bureaucratic procedures undermining confidentiality. For example, when a HIV-positive mother gives birth, the polyclinic receives full information and the child’s medical card is coded red. This card follows the child to school and onward, carrying the information through to every level according to representatives of the ‘All-Ukrainian Network of People Living With HIV/AIDS’. An independent lawyer, who served as the legal expert on a project on the rights of children living with HIV in Ukraine, reported that there are hardly any legal precedents for suing for breach of confidentiality or even malpractice. Malpractice suits are very difficult to prove because falsification of medical documents is prevalent, among other reasons.</p>
Public awareness-raising via the media	<p>From time to time, the Ukrainian press covers problems related to this target group. There are also many journalists from abroad who visit Ukraine to write about the situation of the target group or to raise awareness in Western Europe or the United States of America of the issue.</p> <p>In the view of the Deputy Director of the ‘Ukrainian Institute of Journalism’, there is still the question in Ukraine of how to bring information to the public without violating the rights of the target group, especially of those living with HIV, and adhering to the journalistic ethic of maintaining anonymity and confidentiality where necessary. There is also always the risk, when reporting about groups most likely to be exposed to HIV and engaging in risk behaviours, of increasing stigma further and leading the public to believe that HIV, for example, only affects these groups and has nothing to do with them. However, there are many training programmes now for the media on how to write about HIV and related topics.</p>

PSYCHOSOCIAL AND LEGAL SERVICES	
Social services for children and young people	<p>The CSSFCY has a countrywide network of social services for children and young people. However, the biggest problem is that most of these services target children and young people in general and not those living on the streets in particular, and do not take their specific circumstances into consideration. Even specific services for young people most likely to be exposed to HIV offered by the CSSFCY, such as ‘Dovira/Trust’ counselling centres, do not yet reach the target group despite the fact that, thanks to increased state funding, their overall coverage is increasing greatly.</p> <p>Furthermore, according to representatives of the State CSSFCY and the MoI, many services lack staff to deal with the large numbers of children and young people in need of support and follow-up, and they are not properly equipped to cope with the problems faced by the target group. Among the agencies responsible for dealing with these children and young people, many complained that they have neither the facilities, personnel, nor time to dedicate to each individual child or young person for proper evaluation and care. Others feel that existing resources are spread too thinly in many places, with insufficient coordination and follow through, and are therefore ineffective.</p> <p>There are particular problems relating to obtaining official documentation for target group members by social services. Even though most existing social services will try to help the target group to restore official documents, the process is very lengthy and often hindered for months due to bureaucracy. This becomes even more complicated with children from other countries, a problem especially highlighted by non-governmental service providers during the interviews. There are also specifics concerning birth and death certificates. According to one Oblast Department of Children, birth certificates cannot be issued without the consent of parents or guardians, something members of the target group who need the document are usually without. Death certificates pertaining to parents can only be obtained by family members, and not minors, often making it impossible for the Department to ascertain the status of some children and young people. In the meantime, they may run away again and it is often impossible for the Department to track them down.</p>
Legal processing of matters related to the target group	<p>Many of the service providers interviewed stressed the inefficiency of the judicial system and the urgent need for reform in the area of juvenile justice, in order to better reflect the specifics of cases relating to the target group, and to help speed their cases through the system, so they are not stuck in temporary shelters or detention centres longer than absolutely necessary.</p>

Psychological support	<p>While all non-governmental service providers seem to have psychologists on their teams, there are technically no provisions by the governing body for psychologists in state-run shelters. Directors of various institutions reported in the interviews that they work creatively with their budgets in order to include psychologists on their own initiative, sometimes by cutting other salaries slightly to compensate for an additional staff member that is much needed for the mental health of the target group as well as for other employees within the institutions, who may need psychological support to deal with their own stresses on the job. Non-governmental and faith-based service providers also mentioned in the interviews the need for ongoing psychological support. They stressed that the needs are often greater than their organisational capacity.</p>
Telephone hotlines	<p>There are no statistics kept by the hotline service providers (due to anonymity) nor any other reliable evidence revealed by the survey and the interviews on whether or not the target group is using this service.</p> <p>According to statistics of the Kyiv Department of Children, calls received on their hotline are mostly from children though (aged 13 and older) and concern interpersonal relationships (primarily), problems with the family, classmates or teachers, problems with sex, health (pregnancy for example) and social isolation, requests for psychological and medical assistance, issues related to substance and drug use as well as other addictions, domestic violence and sexual abuse, threats of suicide and homicide etc.</p> <p>Interviewees noted the problems with calling an ‘8-800’ number, which cannot necessarily be easily accessed from any phone.</p>

SUPPORT FACILITIES	
Drop-in centres	<p>There are very few drop-in centres in Ukraine as of today. Those that exist are easily accessible for the target group in the immediate neighbourhood. For target group members who live further away, transportation costs can restrict access.</p> <p>The Kyiv City CSSFCY and various non-governmental service providers in Odesa are very interested in expanding this type of service and ‘Doctors of the World-USA’ is planning to create drop-in centres in Ukraine that will provide social and medical assistance to the target group based on their best practice model from St. Petersburg in Russia.¹⁵ The approach of ‘drop-in centres’ is evidence-based to reach out particularly to ‘marginalised’ groups. It is a ‘low level’ approach, allowing children and young people to come and go of their own free will until they have built up enough trust and are willing to try out other forms of support services, go into rehabilitation etc. Often, such centres provide a full package of social, medical, psychological, psychiatric, recreational and legal services in their premises in form of a ‘one-stop-shop’ to avoid losing the client during referrals to services located outside the centre. Sometimes they work based on ‘case management’, assigning a ‘case manager’ to each client who helps the client to access all the services he or she needs.</p>
Shelters	<p>There is a countrywide network of shelters run by the State, as well as a number of shelters managed by non-governmental and faith-based service providers. Within the frame of this report it was not possible to evaluate whether there are sufficient numbers of shelters, due to the lack of baseline data. There are also specialised shelters for trafficked people.¹⁶ The majority of shelters is easily accessible for the target group.</p> <p>Law enforcement officers sometimes pick up children and young people forcibly off the street during raids and take them to shelters or other child-care facilities for further support. Once traumatised by a police raid and brought to a facility against their will, many target group members try to avoid getting caught again and therefore might also avoid contact with social services altogether, as they have lost faith in the system.</p> <p>The target group can currently stay up to 90 days in a shelter (the length of stay will soon be extended though, in line with the ‘2006 State Programme on Homeless and Neglected Children’), but many stay longer, as often no other placement can be found.</p> <p>As highlighted in chapter four many children and young people who are taken to the shelters escape again at the first opportunity, questioning the effectiveness of the raids, as well as the support provided to them in the shelters.</p>

Children's homes (orphanages)	<p>Children's homes provide access primarily to younger children, also to those who are picked up on the streets and are then sent to an orphanage.</p> <p>The key problem is that often children are over the age category at the orphanages, as no other establishments could be found to take care of them - particularly if the child is living with HIV. Social workers interviewed further raised concerns about children living with HIV being sometimes quarantined and not allowed out for outings because the director is concerned they might easily get sick. However there are good practice examples such as in Donetsk, where intensive training provided by the British Council has improved the situation greatly and children living with HIV fully participate in social outings.</p> <p>Interviewees also felt that orphanage staff needs more specialised training in HIV.</p> <p>Like boarding schools, children's homes provide a residential, institutionalised environment that can have negative impacts on the wellbeing of the child, particularly in the long term (see chapter six).</p>
Psychosocial or social-medical rehabilitation centres	<p>These are either independent centres or centres integrated into shelters. They are usually accessible to the target group, but most exclude those who are using substances and drugs. Due to huge gaps in drug rehabilitation services for children and young people, many target group members using substances and drugs never have a chance to access this type of service. Coverage in general is insufficient to meet the demand, as with most services.</p> <p>One of the centres in Kyiv was recently closed down, as premises were taken back by Kyiv City CSSFCY to be used for other purposes without providing alternative premises, reducing the small number of services in the city further.</p> <p>In some centres, children and young people tend to stay longer than planned (as in shelters), due to lack of alternative care. In one centre assessed within the frame of this report, children and young people can stay until they are adult, but this again raises the question concerning the appropriateness of such long-term residential and institutionalised care.</p>
Day-care centres	<p>This is an overall term and includes some psychosocial rehabilitation centres as well as drop-in centres that provide services only during the day. There are also specialised day-care centres in Ukraine for children living with HIV, though they do not service the target group as of today.</p> <p>According to members of the 'All-Ukrainian Network of People Living With HIV/AIDS', these specialised day-care centres have proved effective in supporting children and their families and helping them to accept their status. Some have even decided to communicate their status within their communities to address the widespread stigma. The centres have also been successful in helping children living with HIV to access schooling, legal support etc.</p>

<p>Family type care and foster families</p>	<p>As of August 2006, there were 256 foster families and 181 family type homes in the whole of Ukraine. They are however not accessible to children and young people while they are living on the streets and using substances and drugs.</p> <p>After intensive psychosocial rehabilitation some members of the target group live in this type of care. One example of such support services is 'Father's House', a non-governmental service provider in Kyiv. The larger part living in family type care and foster families are children though from children's homes, who are under the age of 10.</p> <p>The coverage is still too low, but the '2006 State Programme on Homeless and Neglected Children' foresees an expansion of this type of services in the up-coming years in Ukraine.</p>
<p>Social dormitories, community-based group homes ('halfway homes') and semi-independent living schemes</p>	<p>These types of facilities are still very rare in Ukraine. Currently there are some pilot programmes, such as those in Kyiv run by the non-governmental service providers 'Sunshine House' and 'Child Rescue Mission'. They are based on a 'low level' approach, similar to 'drop-in centres', even though they are usually more restrictive with regard to substance and drug use (mostly they are only accessible after detoxification and after a first drug rehabilitation programme has been successfully completed) and focus strongly on teaching life-skills, creating an enabling and supportive environment, while preparing children and young people for independent life.</p> <p>As reported during the interviews the need for social dormitories was established particularly for the group of children and young people who have no documents and therefore no status. This can apply, for example, to orphans who come of age and leave their institution with no place to go. Similarly, older children and young people who have gone through a psychosocial rehabilitation process have more chance of success by living semi-independently and securely in the first few months while looking for a job and eventually more permanent housing.</p>
<p>Detention and penitentiary facilities for minors</p>	<p>As pointed out in chapter 6.3, colonies for children and young people have seen vast improvements over the last few years in Ukraine. One centre in Zhytomyr was even found to have exemplary conditions, i.e. living conditions and educational and recreational areas were meeting international standards and a structured programme of educational, recreational and social activities was provided, including psychological support. Increasingly, non-governmental organisations are providing recreational and social services in the penal colonies for minors and the State Penitentiary Department is further in the process of developing a strategy to reform the detention and penitentiary facilities for minors with the aim of turning them more into educational-pedagogical rehabilitation and reintegration centres.</p> <p>Overall, the conditions in terms of overcrowding, access to food, adequate sanitary facilities and health care services remain rather poor in Ukraine's detention centres and prisons according to the 2005 report of 'Human Rights Watch'. The report further stresses that torture and maltreatment continue to be a significant challenge. Some evidence on maltreatment and even torture was provided by children and young people who had been detained in Kyiv and in Odesa. Overall, the evidence of maltreatment, especially beatings or rapes among younger prisoners is mainly anecdotal and not researched adequately.</p>

	<p>Only one project on the human rights of children and young people in detention and penitentiary facilities, conducted in 2003 to 2004, could be identified within the frame of the assessment for this report. Human rights are monitored by a range of agencies however, including the Human Rights Ombudsman of Ukraine and other organisations such as various local and international NGOs and the ‘European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment’.</p> <p>There are some social workers specially trained to care for and support children and young people in detention and penitentiary facilities for minors, but the coverage is very low due to limited human capacity and the overall size of the problem. There are also sometimes problems with the follow up of children and young people upon release. However, social services tend to have agreements with prison personnel and are trying to keep track, especially of target group members known to be living with HIV.</p> <p>The access to adequate prevention and health promotion information and education is still limited. While information in general is being provided and some special materials were developed, there is a problem that the information is not always explained and followed up with the detainees or prisoners. There were various reports from service providers that information was simply ‘dumped’ in the facilities, which might be linked to the limited number of psychologists and specially trained social workers, as well as the lack of specially trained prison officers and medical or educational personnel, within the facilities. A project was started recently to try to improve this situation. The project is called ‘Prevention of HIV/AIDS and risky behaviour among young offenders’ and is being implemented from 2006 to 2007 in 11 colonies for minors. The project partners include the All-Ukrainian Centre ‘Volunteer’ (a NGO), the State Penitentiary Department, the British Council and UNICEF. The main aim of the project is to raise awareness about HIV prevention and to promote healthy lifestyles among young offenders. This is being done through the elaboration of a set of training materials for minors and professionals based on interactive learning methods and techniques (including board and card games). Young offenders are involved in the development of the training kit, and the materials will enable the young people to increase their knowledge, explore attitudes and values, and develop life-skills.</p> <p>Access to means of protection is also restricted (condoms, sterile injecting equipment) and harm reduction programmes have only recently started to work in some prisons.</p> <p>For those living with HIV, access to antiretroviral therapy was non-existent until recently and even though progress has been made, access is still extremely low, particularly for minors.</p>
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CARE AND SUPPORT	
Care and support to children orphaned by AIDS	<p>There are a growing number of orphans whose parents have died of AIDS-related diseases. AIDS centres familiar with the families try to keep track of these children, wherever possible referring them, usually to children's homes, so that they do not end up on the streets particularly if there is no extended family willing and able to take care of them. Still, service providers in Odesa cited cases in which children who were orphaned by AIDS had taken to the streets and entered their services.</p> <p>Estimates suggest there may be up to 47,000 dual orphans by 2014¹⁷ and the current support system is not yet ready to deal with even half of this number. Consequently there may be a growing likelihood of these children and young people ending up on the streets, especially given that stigmatisation is still very high and personnel in child-care facilities are not yet sufficiently trained to take care of them and address their specific issues properly.</p>
SERVICES FOR INJECTING DRUG USERS	
Harm reduction and HIV prevention services (package of services including primarily outreach, information and education, needle exchange, condom distribution etc.)	<p>Most of the existing services do not reach the target group yet, even though some needle-exchange points reported during the interviews that they serve some members of this group and outreach workers also sometimes encounter them during their work.</p> <p>Harm reduction services were evaluated several times and many proved to be effective.¹⁸ Behavioural surveillance studies¹⁹ among injecting drug users and female sex workers in 2004 demonstrated for example that of 3,542 respondents 24% of injecting drug users who had been reached by harm reduction/HIV prevention services followed behaviours reducing the risk of HIV-transmission and knew more about HIV/AIDS (67%), compared to 16% (concerning behaviour) and 41% (concerning knowledge) of those not reached. 80% of female sex workers who had been reached by the services reported using a condom when having sex with clients in the last 12 months, compared to 77% of those not reached.</p> <p>However the coverage in general is still too low. According to a recent study conducted in Odesa, harm reduction and HIV prevention programmes do not as yet cover the majority of the 'hot points' where injecting drug users meet. The study further concluded that many injecting drug users do not know enough about existing services and that their fear of the police is one of the most important barriers to access to prevention and harm reduction services.²⁰</p>

Drug addiction clinics and treatment centres	<p>Extremely limited access for the target group,²¹ not only because services are focusing primarily on adults, but also because they are usually not free at the point of entry and target group members cannot afford them.²²</p> <p>One good practice example is in Odesa, where a non-governmental harm reduction needle-exchange programme works closely with the local drug treatment centre. However, the centre only has capacity for five children at any given time, and many children refuse to remain there because of a lack of recreational activities. Consequently there is the usual relapse rate.</p> <p>A number of drug addiction clinics and treatment centres have established mobile groups, but they do not reach the target group.²³</p>
Substitution therapy programmes	<p>Only pilot projects are being implemented at this point in time. Therefore, the coverage is very low and the target group has no access to these services as of today.</p> <p>It is too early to evaluate the effectiveness of these programmes, but their quality might suffer from the absence of accompanying psychosocial and therapeutic drug rehabilitation measures, including social reintegration programmes for ex-drug users.²⁴</p>
HUMANITARIAN ASSISTANCE	
Humanitarian help in form of food, clothes etc.	<p>As this is a service provided also by many faith-based service providers, the coverage could be relatively high, but this has never been established. This kind of help is usually easily accessible to the target group and it meets one or two of their basic needs. However, it is often a ‘stand-alone’ service, failing to cooperate with other service providers and to utilise the opportunity for establishing a trusting relationship with the children and enticing them slowly to start using other support services.</p>
TARGET GROUP INVOLVEMENT PROGRAMMES	
Target group involvement programmes	<p>These are still rare. The MoFYS, in cooperation with the all-Ukrainian non-governmental organisation ‘Debates’ and with support from UNICEF, demonstrated good practice in participative decision-making by implementing projects allowing young people, including members of the target group, young people living in institutions, in rural areas, with HIV and injecting drug users and sex workers, to voice their views on HIV and related issues through a participatory process of public hearings and debates (see chapter eight).</p>

Table 18: Key support services, activities and programmes provided to service providers from the point of view of their accessibility, coverage, effectiveness and existing gaps

SERVICE OR PROGRAMME OR ACTIVITY	ACCESSIBILITY AND GAPS
Appropriate training	<p>Few social workers working for example within the CSSFCY system have yet had appropriate training on work with the target group, except for the Kyiv CSSFCY, according to the State CSSFCY.</p> <p>Coverage with training is limited, particularly in the light of high turnover rates. Another problem is lack of institutionalised training and the duplication of some training due to limited cooperation among donors and implementing organisations.</p> <p>Training is usually provided with international funding and covers selected groups or regions only.</p> <p>Three ‘Knowledge Hubs’ serving as a resource and training centre on HIV/AIDS-related topics were established, one in Kyiv (Care and Treatment), one in Vilnius (Harm Reduction) and one in Zagreb (Monitoring and Evaluation). However at this stage there is no training focusing on the target group available from the three ‘Knowledge Hubs’.</p> <p>And even though there is access to these ‘Knowledge Hubs’ and to training programmes at Pedagogical Institutes and at the School of Social Work at the Kyiv Mohyla Academy, overall the access to training and resources is very restricted due to limited budgets and the limited capacity, in terms of time and human resources, for freeing personnel to attend training.</p> <p>A specific problem exists in relation to the training of social workers. Even now this is a relatively new profession in Ukraine therefore the number of fully qualified social workers is still limited and so is the number of graduates. A comprehensive HIV/AIDS curriculum, including related topics, was only recently developed and integrated into the education at the Kyiv Mohyla Academy School of Social Work.¹</p> <p>Various training provided to date reported positive outcomes. One example:</p> <ul style="list-style-type: none"> • Training provided by the non-governmental service provider ‘Childhood Without AIDS’, teaching a multi-disciplinary team of professionals in various regions of Ukraine how to recognise clinical symptoms of HIV in children, encouraging them to get those children tested and teaching them how to work with children who test HIV-positive. The training resulted in the identification of 40 children who were living with HIV and were subsequently put on antiretroviral therapy.

	<p>Success of training can usually be ensured if training sessions are combined with ongoing mentoring programmes and consultations.</p> <p>Key topics that service providers (particularly from the social and health care sector) said during the interviews that they would like to see covered (a separate training needs assessment was not part of the assessment to this report) are:</p> <ul style="list-style-type: none"> • How best to work with the target group (best practice); • Outreach; • Youth-friendly approaches; • Community mobilisation techniques; • HIV/AIDS and related topics, particularly how to work with and care for children and young people living with HIV and how to deal with children and young people receiving antiretroviral therapy; • Reinforcement of prevention messages; • Monitoring and evaluation of services; • Management of services; • Health and safety in the workplace; and • How to teach about trafficking prevention.
Psychosocial support and burn-out syndrome prevention measures	As highlighted in chapters four and five there is a high turnover of staff in social services due to low salaries, high levels of stress and lack of psychosocial support for personnel leading to early burn-outs. The need for more support measures to prevent burn-out syndrome is clearly indicated.
A forum to exchange information, best practices and experiences	Service providers stressed several times in interviews that they would like to learn more about how others work with this target group, about best practices etc. Some said that during meetings and round tables, usually only the problems are discussed, but rarely the solutions.
International experience (for example via study tours)	Mentioned by the MoI, social service personnel and others as a gap.

<p>Sufficient financial, technical, human and other resources</p>	<p>During the interviews there were complaints from almost all services that they are understaffed. For example the staffing level of the Kyiv Department of Children should be 177 in its district offices in accordance with the law and 31 at the city offices, for a total of 208 staff members; however the number at the end of 2005 was only 127.</p> <p>Another example from Odesa City CSSFCY: the CSSFCY is involved in the implementation of a number of programmes addressing the needs of families and children in crisis. However, lack of financing has resulted in poorly paid social workers, who are overburdened and often burnt out due to the low number of personnel. Much of their work is very labour intensive, involving a lot of bureaucracy. The CSSFCY provides assistance to those being released from prison and looking for employment and documentation support. The process of helping a young man who has no documentation, and whose apartment was sold out from under him when he was seven years old, for example, can take many hours and days. Even though the young man has a job he has nowhere to live and, without proper identification, no way to defend his rights. It is therefore not realistic in the view of the Odesa City CSSFCY to expect that their few social workers can provide social guidance to families and children in crisis in all of Odesa city. Also, there is no funding available for Internet resources, office equipment and other support that would help streamline the work.</p>
<p>Adequate salaries</p>	<p>One example of salary inequalities in the social and education sector was provided by representatives of one of the social-medical rehabilitation centres in Kyiv, which has a high turnover of staff according to the Director of the Educational Department of the centre and the Deputy Director of the centre. This is due to high burnout rates and the fact that the salaries of pedagogues at the rehabilitation center are not on a par with other pedagogues in regular schools. They are not entitled to the same benefits, such as pensions, and are expected to work for a very low salary.</p>

<p>Health and safety measures in the workplace, including a health insurance package</p>	<p>Usually there is no access to health insurance packages for staff. Access to means to protect the health and safety of staff are extremely limited; for example many of the service providers interviewed who work in state-run facilities complained that they have no access to rubber gloves, even in health care facilities.</p>
<p>Data and information supporting planning and decision-making processes</p>	<p>There are no disaggregated data available for the target group. A national database of ‘homeless children’ and ‘orphans’ is only now being developed. Some non-governmental service providers such as ‘The Way Home’ have electronic databases on their clients, but there are legal issues concerning confidentiality and sharing information between service providers that prevent adequate use of the statistics collected. Also, record-keeping is not standardised across service providers and there are problems highlighted in the report concerning the sharing of data among different service providers.</p> <p>Research focusing on the target group has been very limited so far and surveys are usually not representative due to the lack of baseline data. None of the sentinel and behaviour surveillance studies within the frame of HIV second generation surveillance in Ukraine have yet included the target group.</p> <p>The results of needs assessments that were conducted by local non-governmental service providers are often not properly documented.</p>
<p>Adequate referral systems and information on other services</p>	<p>In general a gap, as highlighted in chapters four and five.</p> <p>CSSFCY workers have an internal referral system according to the State CSSFCY, but it does not necessarily encompass all institutions, governmental and non-governmental, dealing with children and young people, and is not specific to the target group.</p>
<p>Volunteers support programmes</p>	<p>Some volunteer programmes exist, however they usually require additional staff training and supervision of the volunteers. Volunteers also need psychological support, which is already inadequate for staff, therefore these programmes are still few.</p>

Table 19: Selected international and national examples of best practice

Establishment of a baseline
<p>An example of good practice in how to reach a consensus and arrive at a joint estimate were the efforts undertaken by the Ministry of Health of Ukraine in collaboration with WHO and other key stakeholders to establish estimates for the number of people living with HIV in Ukraine.¹ Such an exercise not only helps to reach agreement on a figure, but can also provide a platform for decisions on joint actions for reaching set targets. Prior to this exercise, targeted epidemiological and behavioural surveys may need to be conducted. These surveys should collect disaggregated data according to age, sex, urban/rural, family characteristics, education, if possible ethnic group and risk behaviours, such as injecting drug use and sexual exploitation.</p>
Generating funds for non-governmental organisations
<p>As long as governmental funding is insufficient to sustain the activities of non-governmental service providers, alternative sources of income should be considered. In many countries, non-governmental service providers are allowed to raise income without having to pay taxes, for example by selling products such as postcards, candles, note-paper and paintings which have been developed by children or by people with a disability. So far, this is not permitted in Ukraine.</p> <p>Governments in many countries also generate revenues for the social sector by providing tax benefits to well known, nationally registered and accredited non-governmental service providers that support activities for vulnerable populations.</p>
Primary and secondary prevention programmes
Strengthening parenting skills – the ‘Parent Management Training’
<p>The ‘International Federation for the Education of Parents’ has developed a best practice example based on studies of the various methods used in parenting education programmes. The training programmes focuses on providing directions, developing skills, problem solving, setting limits, controlling anger and positive involvement. The programme was originally developed in the United States of America (USA) and is implemented nationwide now, for example in Norway, Denmark and Iceland.²</p>
Child care and education – Preschool care programmes such as ‘Healthy Start’
<p>The programme was introduced in Oregon (USA) and is a universal voluntary home visiting programme for all families giving birth to their first child. Intensive home visiting is particularly offered to families in crisis. It also runs in other states and an evaluation of the programme in Hawaii demonstrated positive outcomes in the attitudes of parents toward their children, parent-child interaction, maternal involvement, sensitivity to children’s cues and a reduction of risk factors, particularly concerning physical child abuse.³</p>
Early intervention programmes – the ‘SOS programme’
<p>One example for a successful early intervention programme that aims to offset the problem of child abandonment is the ‘SOS Programme’ in Poland, where the reaction to crisis situations is quick and in the best interests of the child. For instance, if a child is abandoned at birth, that child is immediately placed within a foster family while an adoptive family is sought out, so that the child does not spend any unwarranted time in the hospital. In Ukraine, children abandoned at birth can spend weeks or even months in a hospital before being transferred to a children’s home when an adoptive family cannot be found. As a result, the child misses out on human bonding during the most critical stages of his or her initial development.</p>

Community-based prevention programme – the Project ‘STAR’ (Students Taught Awareness and Resistance) /Midwestern Prevention Project

A long-term project (usually over two years) developed in the USA. It is a comprehensive, community-based programme aiming to reduce substance and drug use among children and young people by addressing the many influences children and young people face in this area. It is based on an interactive, behaviour-change approach through teaching resistance skills (with the help of peer leaders), including role-plays and group discussions, while at the same time influencing the environment and involving the entire community in prevention activities. The project has various components, including a parenting programme (skills workshops, neighbourhood activities, planning meetings and educational seminars), a school programme offered to sixth and seventh graders, a community organisation programme, a programme aimed at changing local drug policy, and mass media events. The community aspect particularly targets community leaders, and local television, radio and newspapers are used to introduce the programme to the community, to inform them and to reinforce programme elements. Replicated around the country, this is an effective programme of the ‘American National Institute on Drug Abuse’, a demonstrated model programme of the US Department of Education, the Office of Juvenile Justice and Delinquency Programme and the ‘Centre for Substance Abuse Prevention’.⁴

Partnerships with families – the ‘Family Group Conference’

This best practice model was developed in New Zealand and is based on the principles of partnership and empowerment of families, and the understanding that each family is unique and has resources to offer. The main tool is to convene a conference involving the wider family in decision-making concerning the needs of a child or young person who is at risk or has already offended, and where services provided are either inappropriate, or families unwilling to engage in services. The facilitator of the conference also acts as the coordinator of information, counselling and services, and supports the family in developing a plan that is either aimed at reconciling the child or young person with the family or to support them within the family. This best practice model is widely accepted and is being used in many European countries.⁵

Programmes targeting runaways and children and young people living or working on the streets

The Doctors of the World-USA ‘Drop-in centre’ in St. Petersburg, Russia

The project is carried out in partnership with the state social and rehabilitation centre for minors ‘Almus’, and with financial support from Sweden. It is a first point of contact for any child or young person living or working on the streets in St. Petersburg and run by a multi-disciplinary team. It is based on voluntary self-referral and confidentiality but it does reach out to children and young people to attract them to the centre. Services are comprehensive, including a package of social, sanitary and hygienic, first aid and primary medical, prevention and health promotion, legal, psychological, referral, recreational, educational and vocational services.⁶

The ‘Open service centres’ in Porto Alegre, Brazil

These centres host ‘street social education groups’ reaching out to children on the streets and inviting them to the centres. These groups work based on maps of the places where the children usually stay. The centres offer a wide range of recreational, educational, health care, vocational, social and psychological services, as well as a night shelter. The centres help to reduce the time that the children spend on the streets, thus reducing the risks to which the children are exposed on the streets and opening the route for re-integration into society.⁷

The ‘Child Line’ in India

This is a national programme funded by the Government of India, a 24-hour, free telephone help line for children and young people living or working on the streets, that exists in all major cities of India. In Calcutta for example, the ‘Child Line’ is linked to four major non-governmental service providers working in the city. Some of the older children and young people who live on the streets have been trained to respond to the calls and to record the sort of problems that have been raised.

The Gloucester programme on preventing reoccurrence of running away from home

This is an example of best practice from Gloucester in the United Kingdom (UK) that was developed jointly by the local social services and the police to help children who have run away from home. A steering group has been created which includes a number of local non-governmental service providers and agencies, to coordinate the approach locally and to establish a system for the police to refer a child to a project worker who meets with the child offering support and eventually agreeing a personal ‘contract’ and action plan with them. To date the project has achieved a 60% reduction in the number of children repeatedly running away from home and has been recognised by the UK Government’s Social Exclusion Unit as a model of best practice, in its 2001 consultation document on runaways.⁸

The ‘Street Smart’ programme

This is an interactive skills-building programme for children and young people aged 11 to 18 and living or working on the streets in the USA. It aims to reduce and prevent unprotected sex, the number of sex partners, and the use of substances and drugs through intensive drop-in group sessions over a two- to six-week period. It includes video and art work-groups, as well as development of drama, public service announcements, commercials and rap songs. Trained counsellors deliver the sessions and individual sessions are offered too, while at the same time providing the children and young people with access to medical and mental health care services. The programme takes into consideration age and cultural background and has been recognised as an effective programme by the US Center for Disease Control.⁹

Long-term facility for children and young people living or working on the streets – the ‘Phoenix Youth Programmes’ in Halifax, Canada

Started in 1987, this programme includes a facility housing children and young people living or working on the streets long-term, supervised apartments (semi-independent living), a follow-up programme providing ongoing support to clients after leaving the residential programmes and a drop-in facility offering day-care services and advocacy for children and young people in need.¹⁰

Support for abused and neglected children – the ‘Tartu Child Support Centre’ (Tartu Laste Tugikeskus in Estonia)

A centre run by a non-governmental service provider offering support to abused and neglected children and their parents. The service portfolio includes counselling, psychotherapeutic support in crises, medical care and education sessions for parents, volunteers, university students, pedagogues and law enforcement officers concerning abuse and neglect. The centre also aims to develop psychosocial support networks for abused children and their families. Support is provided based on a multidisciplinary and multi-agency approach, which includes social workers, psychologists, paediatricians, prosecutors, juvenile police officers and volunteers.¹¹

Social and educational integration – the ‘Centre Jacques-Cartier’ in Quebec, Canada

The centre has been supporting children and young people aged 16 to 30 since 1992 in their social, educational and professional integration. It responded to the lack of affordable housing for young people in Quebec and houses up to 35 people in 27 permanent housing units. One of the key support measures is the development of a ‘life plan’ and the provision of individual support in achieving the plan. In addition, the centre has integrated three programmes; an experimental community farm, a restaurant and cultural centre offering recreational activities and group discussions, and a workshop that produces and markets products made of wood.¹²

Family type care – the ‘SOS Children’s Villages’

These villages started half a century ago, were established by an Austrian and can now be found across the world. They present one alternative to residential care institutions and provide a family type environment for children without parental care. In these villages, the children live together in small family type groups (up to ten children) with a ‘mother’ and support services are provided by professionals on the spot until the children are self-reliant. One village may consist of up to 15 families and children are admitted up to the age of ten, with their siblings so that they are not separated.¹³

Leaving support care programmes – the ‘Leaving care pathways’

These programmes focus on developing jointly with the child or young person a pathway support plan to ensure self-reliance. This usually takes the form of a formal contract or agreement between the child or young person, the personal advisor and supporting agencies. The programme is mainly aimed at enhancing life-skills, accessing appropriate housing, supporting further educational achievements and social integration.¹⁴

Community-based treatment programme for young offenders, substance and drug users and children and young people with antisocial behaviour – the ‘Multisystemic Treatment’ programme

Developed in the USA, it provides a comprehensive treatment package based on elements of family therapy, parenting techniques and focused interventions addressing the known causes of antisocial behaviour and sources of conflict within the families and schools. It has already been implemented nationwide in Norway and on smaller scales in other European countries such as the UK, Ireland and Sweden. It is based on a multidisciplinary team approach and has demonstrated over the past 15 years long-term reductions in drug-related arrests, criminal activity, violent offences, incarceration and out-of-home placements. The evaluation in the USA has further shown that it is less costly than traditional institutional treatment.¹⁵

Multidimensional Treatment Foster Care programme for children and young people with criminal behaviour

This is a multisystemic clinical intervention including behaviour-management and skill-focused therapy and targeting children and young people who have been involved in severe and chronic criminal behaviour. It is an alternative to incarceration, hospitalisation or residential treatment. Foster families are recruited, trained and supervised to offer children and young people intensive treatment and supervision at a home, in school, and in the community. The programme includes support services to the biological family of the child or young person, if reachable, aiming to improve family relationships and reduce delinquency upon returning home. This programme has been recognised as a ‘Blueprint model programme’ in Canada.¹⁶

Annex XI

Table 20: Core national level indicators developed by the UNAIDS ‘Inter-Agency Task Team on Orphans and Other Vulnerable Children’¹ in collaboration with a broad coalition of stakeholders to measure progress at the national level with regard to improving the welfare of orphans and vulnerable children²

CORE NATIONAL LEVEL INDICATORS	
Domain	Indicator
Policies and strategies	Policy and strategy index reflecting the progress and quality of national policies and strategies for the support, protection and care of orphans and vulnerable children
Education	School attendance ratio of orphans as compared to non-orphans
Health	Health care access ratio of orphans as compared to non-orphans
Nutrition	Malnutrition ratio of orphans as compared to non-orphans
Psychosocial support	Proportion of orphans and vulnerable children that receive appropriate psychosocial support
Family Capacity	Proportion of children that have three, locally defined basic needs met Proportion of orphans that live together with all of their siblings
Community Capacity	Proportion of households with orphans and vulnerable children that receive free basic external support in caring for the children
Resources	Government expenditure per child on orphans and vulnerable children
Protection	Per cent of children whose births are registered Per cent of widows that have experienced property dispossession
Institutional care and shelter	Proportion of children who are living on the street or are in institutional care (as an indicator of family breakdown)

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