



PREVENTION OF HIV AND ASSOCIATED INFECTIONS AMONG ADOLESCENTS AND YOUNG PEOPLE AT HIGH RISK OF INFECTION

Methodology Guide



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REGIONAL PUBLIC ORGANIZATION OF SOCIAL PROJECTS
IN SPHERE OF POPULATION'S WELL-BEING "STELLIT"

NATIONAL INSTITUTE FOR HEALTH AND WELFARE

KALININGRAD REGIONAL NON-GOVERNMENTAL YOUTH ORGANISATION
"YOUNG LEADERS ARMY" (YLA)

SOCIAL AIDS COMMITTEE

BALTIC HIV ASSOCIATION

**PREVENTION OF HIV AND ASSOCIATED INFECTIONS
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The Methodology Guide contains overview of theories applicable for addressing the priorities of HIV and associated infections prevention among adolescents and young people at high risk of infection, theories which might be used to evaluate the effectiveness of prevention programs. It provides the results of assessment of needs of children and young people at high risk of infection in prevention programs, overview of prevention programs implemented in Russia, Latvia, Poland, Finland and Germany which might be recommended to be spread to other countries of the NDPHS and examples of tool which might be used in prevention work.

The Methodology Guide might be useful for authorities, representatives of governmental organizations, NGOs, international organizations, public health specialists and other experts involved into HIV and associated infections prevention among children and young people.

The Methodology Guide is available for downloading at: <http://urn.fi/URN:NBN:fi-fe2015102715069>. Other methodological materials produced within the project can be downloaded at: <https://www.thl.fi/en/web/thlfi-en/about-us/organisation/departments-and-units/administration-and-development/planning/international-affairs-unit/projects>.

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ABBREVIATIONS

AI – associated infections

CIS – Commonwealth of Independent States

CSE – commercial sexual exploitation

CSEC – commercial sexual exploitation of children

NGO – Non-governmental organization

NWFD – Northwest Federal District of the Russian Federation

PAS – psychoactive substances

PLHA – people living with HIV/AIDS

PLHIV – people living with HIV

RF – Russian Federation

RF FMS – Federal Migration Service of the Russian Federation

RF MDMI – Main Department of the Ministry of the Interior of the Russian Federation

STI – sexually transmitted infections

TB – tuberculosis

INTRODUCTION

M.M. Rusakova, V.A. Odinkova

For more than three decades now, scientists and practitioners worldwide have been combating the spread of HIV infection. Despite solid achievements in HIV studies, no medical methods are yet available to prevent HIV infection, or destroy the virus that stays in the human body. It means that one of the key ways to prevent the spread of HIV is through changing human behavior which leads to contracting the infection. Over recent decades, HIV prevention has been increasingly focusing on the achievements of social sciences and surveys.

In the Northern Dimension Region, HIV and associated infections (AI) present a significant threat for young people. The risk zone includes primarily young people practicing risky sexual behavior and experimenting with various inebriating substance. The implementation of prevention programs increasingly more often becomes the responsibility of specialists from educational institutions, social protection agencies, youth policy and other government bodies. A large number of prevention programs are carried out by non-governmental organizations.

In their attempts to prevent the spread of HIV and AI among young people i.e. make human behavior safer, a large number of practitioners are guided by common sense and available methods to reach out to young people including lectures and mass-scale activities. Such methods do have their advantages but often times prove ineffective since they ignore the sophisticated determination of health behavior in health domain.

Our aim in project "Building capacity in prevention of HIV and associated infections among youth at high risk in the Northern Dimension area" was to identify the best practices of HIV and AI prevention targeting adolescents and young people at risk of contracting HIV and AI, which could be recommended for public dissemination in the Northern Dimension Region. For this purpose, we conducted baseline studies of the situation with HIV and AI in the project participating countries, evaluated the HIV and AI prevention needs of adolescents and young people, identified the best practices in HIV and AI prevention, and piloted certain elements of efficacious programs for the prevention of HIV and associated infections in St. Petersburg and Kaliningrad in order to understand how suitable they are for prevention outreach with adolescents and young people at high risk of HIV and AI infection.

Project "Building capacity in prevention of HIV and associated infections among youth at high risk in the Northern Dimension area" was implemented from 1 September 2013 to 31 August 2015, with funding provided by the European Union. Project Coordinator is the Secretariat of the Northern Dimension Partnership in Public Health and Social Well-being (Sweden), Project Methodology Leader is Regional NGO "Stellit" (Russia). Project partners are National Institute for Health and Welfare (Finland), Kaliningrad regional non-governmental youth organisation "Young Leaders Army" (YLA), Social AIDS Committee (Poland), Baltic HIV Association (Latvia).

In this guide, we impart our experience and findings gained through developing a project related to prevention outreach with adolescents and young people at high risk of contracting HIV and AI so that this work could be scientifically substantiated ensuring high quality, efficacy and cost-effectiveness. It is the authors' hope that this guide and methodological materials will be helpful for all the specialists dealing with planning, implementation and effectiveness estimation of prevention programs for adolescents and young people.

EXECUTIVE SUMMARY

M.M. Rusakova, V.A. Odinkova

Chapter I focuses on the most widespread theories applicable for addressing the priorities of HIV and AI prevention among adolescents and young people at the greatest risk of contracting these diseases. They include the Health Belief Model, model predicting early age at first sexual intercourse, AIDS Risk Reduction Model, and Diffusion of Innovations Model. In the same chapter, we provide an overview of modern approaches to the assessment of prevention programs including evidence-based prevention approach, approach based on assessment methodology and quality management, and economy-based approach.

Chapter II discusses the methods and results of the assessment of the needs for prevention activities among young people aged 15 to 24 at risk of HIV and AI infection in the Northwest Federal District of the Russian Federation (St. Petersburg and Kaliningrad), Poland, and Latvia. The chapter describes the results of the assessment of prevention activity needs of young people. According to the assessment, a considerable number of adolescents and young people in the region are covered by prevention activities. The adolescents and young people assess their own knowledge about HIV as high but an objective assessment of their knowledge has shown that misconceptions and myths about HIV and AI are widespread among young people. The risks of HIV infection are linked to unprotected sex and lowered self-control of young people in intercourse situations. One of the key reasons preventing adolescents and young people from proper HIV protection is a formal, boring format of prevention activities, lack of focus on the available experience and youth needs in the content of the activities.

Chapter III provides an overview of the programs for the prevention of HIV infection and AI among adolescents and young people at high risk of infection, which were identified by us in the project participating countries. These programs feature the best practices that could be extended to other parts of the Northern Dimension Region.

Chapter IV deals with specific prevention exercises which can be used for making up a prevention program for adolescents and young people taking into account their prevention needs. The chapter includes exercises helping to advance towards the achievement of at least one of the objectives to be guided by in HIV prevention outreach among adolescents and young people practicing risky behavior; they are interesting and comfortable for the participating adolescents and young people; adolescents and young people can influence the exercise content and process; specialists feel confident when conducting these exercises. In conformity with the objectives, the chapter includes exercises aimed at raising the awareness about HIV infection pathways and prevention methods, at removing misconceptions and myths about HIV transmission; exercises aimed at forming a realistic assessment of one's risk of contracting HIV; exercises aimed at shaping a positive mindset with respect to the methods to be used to avoid risky behavior; exercises aimed at developing a tolerant attitude to HIV-positive people; and exercises aimed at developing the skills required to avoid risky situations.

Links to all the methodological materials produced within the project, including the forms for analyzing statistical information, guides to conducting surveys of adolescents and young people, focus group guides, and assessment forms for prevention tools, are available for downloading at: <https://www.thl.fi/en/web/thlfi-en/about-us/organisation/departments-and-units/administration-and-development/planning/international-affairs-unit/projects>.

CHAPTER I. SCIENTIFIC APPROACH TO THE PREVENTION OF HIV INFECTION AMONG ADOLESCENTS AND YOUNG PEOPLE

K.Yu. Eritsyun, M.M. Rusakova

1. Theoretical basis of prevention programs

Disease prevention has traditionally been the exclusive domain of medicine. For the HIV infection epidemic when medical prevention tools (e.g. vaccines) are currently non-existent, moving away from risky behaviors to develop safe behavioral patterns is turning into the key opportunity for preventing further spreading of HIV infection.

Changing human behavior is possibly a most challenging, non-trivial and interesting objective that science and practice can set out for themselves. However, changing sexual behavior and preventing and eliminating addictions – the main infection risk factors – are truly highly complex tasks since such types of behavior are strongly motivated both culturally and biologically, and are often highly stigmatized.

“There is nothing so practical as a good theory” – this phrase ascribed to famous psychologist Kurt Lewin is now considered an aphorism. However, when trying to prevent the diffusion of various diseases i.e. in most cases drastically change human behavior, a large number of practitioners are based on their day-to-day perceptions rather than theoretical knowledge. At present, there are over sixty different psychological theories explaining health behavior and the ways to develop and change it.

For convenience, they can be divided into those

- predicting the natural forming of certain behavior (*explanatory, problem-oriented theories*). In HIV context, they may be particularly helpful for primary prevention of drug and alcohol addiction, involvement into prostitution, or promiscuous behavior;
- describing the capabilities for deliberately forming behavior, or changing already formed behavior (*change theories, action theories*). This kind of models may help disseminate protective behavioral practices, e.g. for using condoms or sterile injection equipment, getting tested for HIV/STIs etc.

In addition, various theories explaining health behavior or helping to change it, were developed for different levels of intervention: individual, group, or a large territorial community level (district, city, country).

What are these theories intended for? Theories explaining health behavior and the opportunities for forming and changing it, help:

- to plan a sound assessment of the prevention needs of adolescents and young people;
- to identify the targets for prevention activities;
- to improve prevention quality and efficacy from the perspective of its objective (behavior change);
- to increase prevention cost-effectiveness (in terms of the ratio between the costs and results).

In continuation, we will discuss the key elements and several case studies of theoretical models which can be used to develop programs for the prevention of HIV and AI among adolescents and young people at high risk of getting infected with HIV and AI.

Health behavior theories: key constructs¹

Despite a significant number of theoretical models, there are several elements, or key constructs which are particularly popular and can be found in many of them.

1. Threat. A certain external factor (e.g. HIV infection epidemic) the impact of which may result in adverse consequences for a particular person or community. The threat commonly features two dimensions:

- **graveness:** if this threat (e.g. getting HIV infection) does occur – how significant would the adverse consequences be?
- **vulnerability:** how likely am I to get HIV?

¹ Adapted from Witte, Kim. Theory based interventions and evaluations of outreach efforts. Seattle, WA: National Network of Libraries of Medicine (1998).

It should be noted that there are objective answers to the above questions based on scientific data or prognostic calculations but in real life much more important is how this threat is perceived by the people – whether they underestimate their vulnerability or the graveness of possible consequences?

2. Fear. High level of emotional excitement due to a threat perceived. It is important to understand that it is not always when aware of a threat we nevertheless experience strong negative emotions. For instance, a long ride by car statistically involving the risk of having an accident, is not however normally accompanied by the same level of fear as an air flight which is objectively less dangerous. Fear may have a substantial effect on behavior but depending on the circumstances its impact may be both positive (e.g. resulting in minimized risk behavior) and adverse (e.g. resulting in the use of psychoactive substances to remove negative emotional responses).

3. Efficacy. Even if there is a scientific and empirically verified assessment of the fact that specific preventive measures are really efficacious, in real life each member of the target group will conduct his/her own assessment applying two parameters:

- response efficacy: is it true that if I do it the threat will pass over? For instance, is it true that I will not get HIV if I keep using condoms for intercourse? By extension, this type of efficacy is often called *benefits*: what kind of benefits do I get if I keep using condoms? In addition to protection against HIV infection, this type of behavior has quite a number of benefits – e.g. prevention of unwanted pregnancy and STIs, freedom from worries about the consequences which may follow unprotected intercourse, additional opportunities to experience sexual pleasures when using condoms of uncommon texture/fragrance etc.;
- self-efficacy: am I capable of following prevention recommendations? Am I capable of standing by my decision to use a condom if my partner does not want to? Can I dare to buy condoms at a chemist's on my own?

4. Barriers. The notion of barriers is all about the things that impede the implementation of a specific preventive technology. When thinking about changing their behavior, people would keep evaluating: "What would it cost me?" In the example with using condoms, there may be quite a few perceived barriers: the price, partner's unwillingness, lack of skills in condom use, reduced intensity of sensations etc.

5. Perceived norm (normative belief). To some extent, all people in their behavior are guided by the opinion of other people. The notion of perceived norm shows how strong is, according to the individual, the social pressure which encourages or discourages certain behavior. What matters in this term is the word "perceived" – and indeed, people strive to comply not with any real norms existing in their reference group but rather their perception of the norm concerned. E.g. school students often overestimate the percentage of their classmates with alcohol use or sexual experience. Such subjectively perceived norms may in their turn make adolescents start practicing this kind of behavior.

6. Action keys. It is external (e.g. television social advertising, friends' reminders) or internal (e.g. perceived disease symptoms) stimuli that trigger the desired action.

All of the above listed components may be deemed as factors forming or changing behavior. As a matter of fact, it was not all at once that scientists and practitioners understood that it is behavior change that should be the key outcome of prevention interventions. Probably, we all of us, both as professionals and ordinary people, have come across prevention programs aimed at providing certain information about a disease or its prevention. It was assumed then that this knowledge would somehow cause behavior change. However not everything is that simple. Behavior change is normally preceded by forming or changing:

- the mindsets or attitudes towards a particular problem and its possible solutions,
- the motivations to change behavior,
- the intention to change behavior,

and all of them may or may not result in real actions. To make the picture even more complicated, it may be added that changing behavior is only the first step. In most cases, the desired outcome of prevention interventions is regular actions to be performed, or alternatively not performed, by the person. It is much easier to make a person perform a short-time or one-time action (e.g. one-time HIV

testing) than drastically change the usual way of life (e.g. reduce the number of sexual partners or stop using drugs).

In continuation, we will discuss some of the most common health behavior theories. We have selected them for this book based on two key factors: their applicability for developing HIV infection prevention programs, and their heterogeneity i.e. the representation of absolutely different approaches to the problem.

The health belief model is a classical psychological theory describing the basic (primarily cognitive) factors that may cause people to use particular preventive methods.

The model predicting early age at first sexual intercourse is the model for predicting a particular type of behavior based on the analysis of the existing research and theoretical studies. The application of this approach has made it possible to validate the model actually concurrently with its development.

The AIDS Risk Reduction Model is one of the first models developed specifically for the HIV infection issue. It is based on an entirely different principle, which describes behavior change phases.

The Diffusion of Innovations model directly focuses on the properties of a specific preventive technology rather than on individual, personal factors. It does not predict if a specific individual will change his/her behavior but rather whether a specific preventive technology will be successful and popular in a particular society.

Health Belief Model

This model (Fig. 1; Rosenstock, 1969) is one of the first complex models explaining individual human health behavior. It includes most of the above theoretical constructs. For brevity, it may be presented as follows. A person is highly likely to follow certain preventive measures if

- he/she believes that there is a considerable threat to his/her health i.e. he/she is highly likely to fall ill ("vulnerability"), and this illness is perceived by him/her as grave and/or unpleasant ("graveness");
- the proposed preventive action appears to be efficacious enough ("benefits") and does not require significant efforts, or at least the benefits from this behavior are by far higher than the costs incurred ("barriers");
- on the whole, the person is confident that he/she is capable of performing the action concerned, or if necessary performing it on a regular basis ("self-efficacy");
- somebody or something regularly reminds him/her of the necessity to perform this preventive activity ("action keys").

The above factors and their proportions may have different weights depending on the basic personal and sociodemographic characteristics of the individual and his/her social environment.

Generally speaking, the model is extremely popular, in particular, since it is simple enough to use in different awareness campaigns.

However, some of the influential researchers argue that when using it for prevention purposes among adolescents and young people it is necessary to take into account the specific features of this target group that are not fully reflected in the model: cognitive immaturity, striving for psychological autonomy, and age peers' influence (Brown, DiClemente, Reynolds, 1991).

Model predicting early age at first sexual intercourse

It is known that early age at first sexual intercourse is a high risk factor. The research has shown that people who started having sexual intercourse early are much more likely to practice behavior related to HIV risk (a large number of partners, unprotected sex etc.) as well as have more chances to face adverse health effects. For teenagers, delaying the first sexual intercourse is possibly one of the most potentially efficacious prevention strategies.

After evaluating a considerable amount of scientific data, Eric R. Buhi and Patricia Goodson (2006) identified the below theoretical predictors of first intercourse:

1. Intentions: intentions or motivation toward first sexual intercourse.
2. Skills (of negotiations, interpersonal communication, refusal).
3. Environmental restrictions: relations with parents, rules and restrictions imposed by parents or other important persons, parental control.

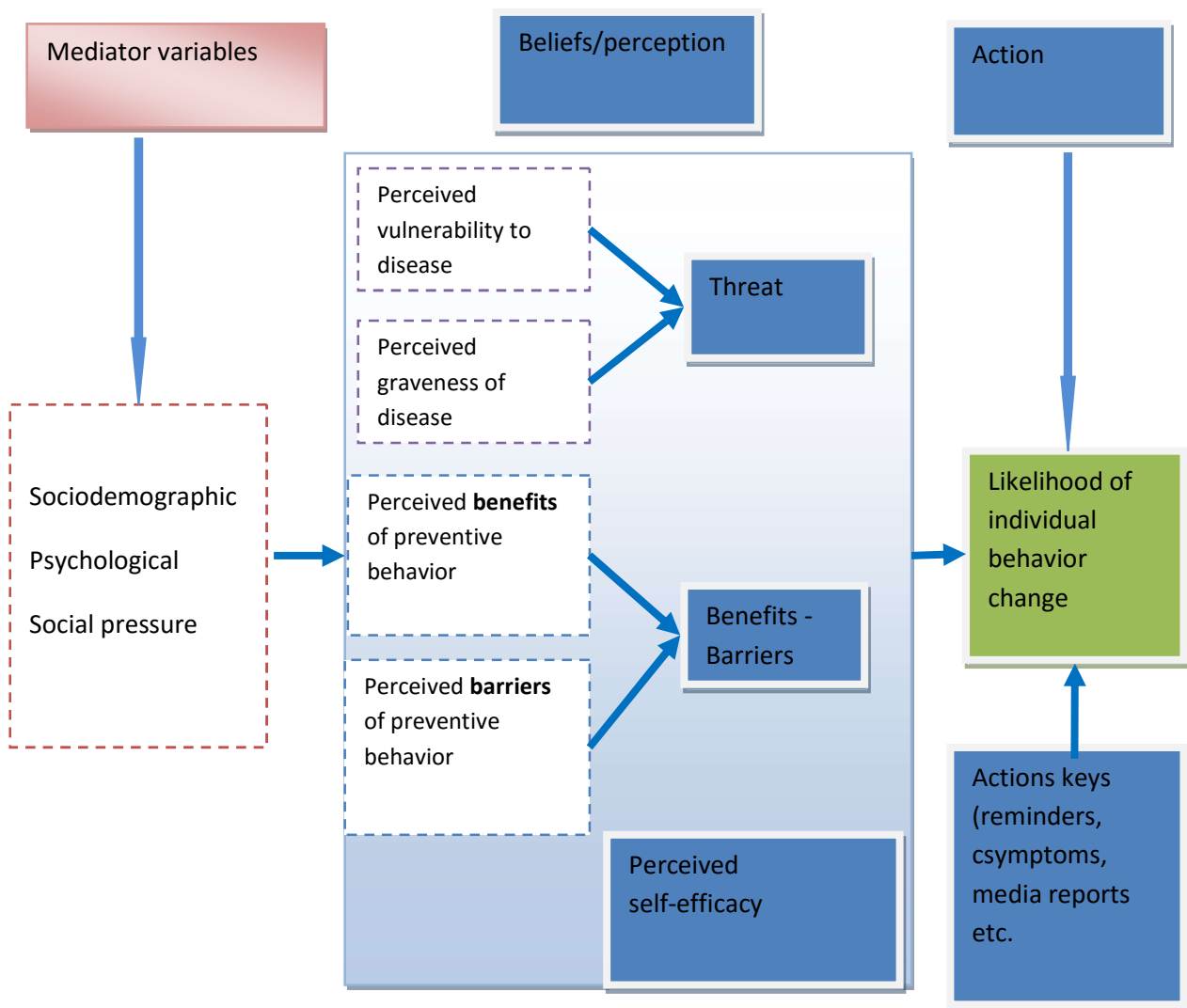


Fig. 1. Health Belief Model.

4. Perceived norms: adolescents' perceptions of incidence of sexual intercourse among their peers, of their mindsets (approval or disapproval) toward intercourse, and relevant mindsets of parents.
5. Self-efficacy.
6. Standards (perceptions of ideal behavior/ideal norms).
7. Emotions (emotional overtone of sex and abstinence perceptions).
8. Beliefs/mindsets toward sexual behavior and abstinence.

The analysis of empirical research has shown that there are plausible data confirming the impact of only three out of eight hypothesized factor classes. Early age at first sexual intercourse is indeed linked to intentions (1), perceived norms (4) and only some of the environmental restrictions, particularly, adolescents' long stay at home alone.

AIDS Risk Reduction Model (ARRM)

This model is a fairly good example of theories where stages of health behavior change are described. Unlike the theories discussed above, such models are distinguished for identifying different stages of behavior change, systematizing them by a hierarchy, and usually emphasizing the existing factors and barriers which predetermine the transition from one stage to another. The most widely recognized model of this type is the Transtheoretical model (TTM) or the Stages of Change (SOC); J.O. Prochaska, R. DiClemente et al.), which identifies five stages of behavior change and ten change processes facilitating the transition from one stage to another.

The ARRM model suggested in 1990 (Catania, Kegeles and Coates) is yet another example of a stage model but it also includes certain components of other theories such as the Health Belief Model, and self-efficacy and interpersonal processes theory. It may be noted that this model was primarily

suggested to describe the opportunities for reducing harm from sexual behavior i.e. it is only applicable to sexually active young people.

Stage 1: recognition and labeling of one's behavior as high risk. It is supposed that the person's awareness or unawareness of his/her behavior as high risk in relation to the likelihood of infection is linked to several factors:

- knowledge that this kind of sexual activity is linked to the probability of contracting HIV;
- perception that he/she may be personally vulnerable to this disease;
- existing social norms and social environment.

Stage 2: commitment to achieve harm reduction (reducing or excluding high-risk sexual activity, in particular, through expanding the types of low risk sexual activity). So what influences decision-making at this stage?

- proportion of costs (barriers) and benefits from such changes;
- change in satisfaction obtained (enjoyment from intercourse);
- perception of response efficacy (the extent to which the measures provide protection against HIV);
- self-efficacy level.

The above factors are in their turn influenced by the knowledge about one's health and opportunities to obtain sexual satisfaction, and by social factors such as peer norms and social support.

Stage 3: it is the action itself. It can be broken down into three components: seeking information as to how and what has to be done, looking for solutions on specific steps to take, and enacting solutions. In each particular case, such phases may be completed consecutively or concurrently, and some phases can be simply skipped. The following factors are important at this stage:

- social networks in which the person is involved, and the opportunities for solving the problems (e.g. the opportunity to formally or informally ask for help);
- previous experience of problem solving;
- resources required to get help;
- self-assessment level;
- abilities and skills for verbal communication with the sexual partner;
- perceptions and behavior of the sexual partner(s).

Just like other theoretical models, the approach being discussed has its limitations. For instance, unlike the transtheoretical model, the description of stages is culminated by taking action though change of sexual behavior is a lengthy process so it is always possible that after several attempts the person may get back to Stage 1 or Stage 2.

Diffusion of Innovations Model

Spreading of efficacious preventive practices is a major public health issue. Every new preventive innovation, be it industrial products, technologies, ideas or behavioral norms, will either gain its supporters and become popular sooner or later, or will actually get buried.

Diffusion of innovations is the process of spreading novelties across society among potential consumers (users) from their inception. The model was developed by E. Rogers in 1995 and got its name by analogy with diffusion in physics – the process of mutual penetration (mixing) of molecules of one substance and those of another substance. Initially, the model was widely spread in marketing but, of late, it is increasingly used in public health.

In HIV infection prevention, various innovations emerge almost every year. The examples include female condoms, circumcision, *pre-exposure* prophylaxis (PrEP) and special smartphone applications². Someday, an HIV prevention vaccine will become such innovation. Any idea, for instance, “premarital abstinence from sex” may be regarded an innovation just as well in certain societies in a particular historical period.

² For more details see *Muessig K.E. et al.* Mobile phone applications for the care and prevention of HIV and other sexually transmitted diseases: a review //Journal of Medical Internet Research. – 2013. – V. 15. – No. 1.

Now then, a certain innovation was developed, is known to be efficacious but how could we make our target group use it?

According to the model authors, the general population can be subdivided into five subgroups depending on the extent to which they are "open" to a new experience: innovators, early adopters, early majority, late majority, and laggards.

The biggest difference is between the polar different groups – innovators i.e. those who are the first to adopt the new and strive for it (they are in a minority – 2.5%), and conservatives – those actively opposed to everything new and unusual (their number is much higher, around 16%). A majority of people in a population are in an intermediate state. In an ideal case, the process of diffusion of innovations in society starts with innovators, then extends over a majority, and finally is adopted by conservatives when the innovation finally ceases to be such and turns into a norm. Innovators as well as members of society who are reputable and influential (public opinion leaders) are instrumental for accelerated diffusion of any novelties be it risky behaviors or, on the contrary, health protecting behaviors. If an innovation is not adopted at this stage, its diffusion would hardly be a success.

S-curve (Fig. 2) shows three phases of new products introduction: Phase 1 – getting the first consumers involved (slow growth), Phase 2 – sharp growth, Phase 3 – saturation (decelerated growth).

The velocity of this process according to E. Rogers depends on five key attributes of innovation (new product) but it is natural that in most cases we do not speak about absolute attributes but rather about their perception by the users:

1. Relative advantage is the degree to which an innovation is superior to other (often similar) types of products; it is often expressed in economic, social, behavioral categories (profitability, cost effectiveness, enhanced social status etc.).
2. Compatibility is the degree to which an innovation is consistent with the existing system of values (determined by the cultural norms, past experiences etc.), and the technical development of society. E.g. if a person from the very beginning does not aim at getting married and having a monogamous union in the short term, the suggestion for him/her to abstain from intercourse before marriage would be incompatible with his/her system of beliefs. Another example, prevention information spread via the Internet will not be compatible for the members of the target group with no access to the Internet.

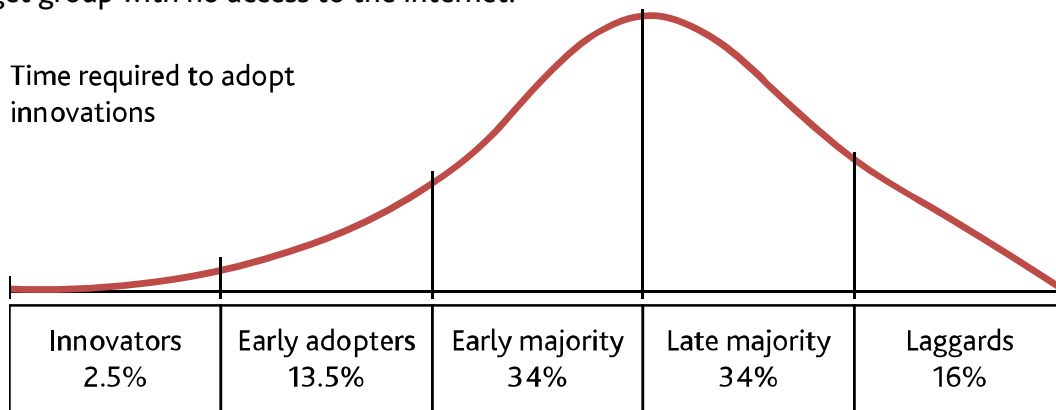


Fig. 2. Diffusion of Innovations curve.

3. Complexity is the degree to which perception is simple and easy, the degree to which an innovation is easy to use or get adapted to; complexity of innovation is supposed to be negatively linked to its diffusion. E.g. if the medicine-taking schedule is simple, adherence to medication therapy will be achieved quicker.
4. Trialability means the ability to experiment with an innovation or its modification on a limited basis. Sometimes this attribute of innovation is homologated with innovation's divisibility. Free samples of products (e.g. condoms), the opportunity not to take part in the full range of preventive activities but select certain portions of interest, probably change the settings and personalize a mobile application – those are good examples to illustrate this attribute.
5. Observability is the degree to which the results of an innovation are "visible" for the other people. Observability of an innovation stimulates discussion with target group members

contributing to the diffusion of the innovation. That is why, for instance, promoting the idea of condom use within the framework of this model is likely to be difficult since it is quite difficult to understand through day-to-day communication whether the person is planning to delay his/her first sexual intercourse, or is apt to use condoms on a permanent basis. While, for instance, cigarette smoking is, on the contrary, quite a noticeable practice. That is why it could be so important for the supporters of a particular idea or technology to use certain identification signs such as branded wristbands, T-shirts with slogans, special format avatars in social networks etc.

6. To conclude this section, it should be noted that according to numerous surveys of prevention programs effectiveness, the use of a theoretical model as a basis for the program ensures a statistically significant increase in its efficacy probability (Nation et al., 2003). In reality, there is no need to be limited to a particular model in a prevention program, on the contrary, provisions of different theoretical approaches may, and even should, be used.

2. Approaches to quality assessment of prevention programs³

It goes without saying that every activity should be preceded by information search, and prevention is no exception.

At the first stage, it should be searching for information about the current situation in the target group (HIV and STI incidence, knowledge spread among the youth, mindsets and behavioral patterns) as well as about the models that can help to solve a task faced by practitioners.

At the second stage, it would helpful to look for the available prevention programs on the subject concerned, evaluate them and take the decision which of them could be used and whether any amendments or additions are required.

Since the start of the age of energetic HIV prevention outreach, each country has developed tens and hundreds of prevention programs and projects quite different from each other by their approaches, used methods, required resources, and certainly effectiveness.

So how could we distinguish between a good prevention program and the one which is potentially less effective?

Several different approaches are available.

Evidence-based prevention approach

The concept of evidence-based prevention was developed by analogy with evidence-based medicine. The principles of evidence-based medicine reflect the bona fide, explicit and reasonable use of modern scientific data to make decisions related to the care of particular patients, establishment of scientifically sound standards for providing health care and objective investigation into the effectiveness of new treatment methods, and medical and social rehabilitation. Put simply, prescription of any interventions should be based on scientific data confirming that the interventions will be really effective.

Evidence-based prevention should:

- be based on the data of research conducted in compliance with all recognized standards of the scientific community;
- in all cases include a detailed efficacy assessment research;
- apply the principles, strategies and programs which are theoretically substantiated, implemented at a high quality level, and, according to the performance assessment, influence exactly the behavioral patterns which they aim to change, or the factors influencing this behavior (Prevention by design, 2006).

What methods are normally used by the authors to make sure that their program works? We will list them in the order of increasing extent of evidence availability.

³ To prepare this section, materials were used from Metodologiya razrabotki profilakticheskikh proektov v sfere zdoroviya (Methodology for developing prevention projects in health care: Learning aid)/ L.A. Tsvetkova, N.A. Antonova, K.Yu. Eritsyanyan; St. Petersburg State University – St. Petersburg: Publishing House of St. Petersburg State University, 2013.

1. *Satisfaction assessment.* The indicator of subjective satisfaction of prevention program participants by its particular aspects is quite often used for efficacy assessment. Phrases such as *"95% of program participants gave it 5 points out of 5, and expressed their willingness to take part in such activities in the future too"* are often used to embellish various reports. However, it only can be perceived as a supplementary rather than key performance parameter because it does not help us to understand whether the project objectives have been achieved. In fact, it only characterizes the acceptability and attractiveness of particular prevention technologies for the target group but not the performance of the project.
2. *Post-assessment (self-assessment of changes).* The post-assessment indicator reflects subjective change in respondent's knowledge, mindsets and behavior as a result of his/her participation in the prevention program: *"95% of students reported that participation in the workshop raised their HIV infection awareness level."* However, in real life this indicator does not help us to statistically prove that there is a change in target indicators, and in addition, it is quite highly susceptible to the social desirability phenomenon.
3. *Pre/post assessment with no control group.* To increase the evidence availability for program assessment, it is necessary at the very start of (before) the program to measure the target indicators to be targeted by our prevention intervention, for subsequent comparison (after). Information on such basic indicators may be obtained from earlier research, or published statistical data, or from a baseline research carried out at the initial stage of our prevention project. This method will enable us to see if there really are any statistically significant differences between the situations before and after the intervention: *"The percentage of students aware of HIV infection transmission routes and prevention methods has grown from 15% up to 35%, and this variance is statistically significant at $p \leq 0,001$."* Indeed, when looking at this evidence it can be supposed that the program is efficacious, at least in terms of raising awareness. But such changes may be due just as well to something else: a program or film shown on TV where the subject was discussed, other interventions, or simply due to the general ageing of the target group. At their adolescence age, when they take great interest in sexuality themes and anything related to them, young people learn a lot of new things while seeking information on the subject by themselves or simply meeting with their friends. To make sure that the effect is really due to the program, a control group is required i.e. people who have not been exposed to its impact.
4. *Pre/post assessment with control group.* This is a case-control research when prevention program participants are compared with their peers not involved in the program, to identify any links between prevention outcome and direct impact of the prevention program. The outcome of this design may be as follows: *"The percentage of persons aware of HIV infection transmission routes and prevention methods has grown for program participants from 15% up to 35% ($p \leq 0,001$) while in the control group the growth was from 10% to 15% ($p \leq 0,05$)."* Now we know for certain that awareness among the members of the prevention program over the period concerned has grown much more than among those who did not take part in it. However, the initial parameters were also different. Probably, it was not due to the prevention program itself but rather due to the fact that from the very beginning it was made up of people who were better informed and possibly more interested in the subject compared to the control group? We may not fully exclude such concerns when assessing programs that used this kind of design for efficacy assessment.
5. *Pre/post assessment with control group + randomization.* This assessment is also of the case-control type but using randomization which means that program participants are randomly distributed between the main group and control group, and each of them has known and equal chances to find him/herself in one of them. One of the effective randomization techniques consists in generating random numbers using relevant computer programs. It may be summarized that if there are available culturally relevant programs that proved to be effective when using this assessment methodology, they should be the first choice for decision-makers⁴.

⁴ It should be noted that in evidence-based medicine the benchmark design (so called gold standard) of clinical research is randomized controlled double-blind trial. A trial where the patient does not know but the researcher knows what treatment is

6. However, the list of requirements for prevention programs is not, by far, limited to the presence of an efficacy assessment scrupulously designed. Different organizations normally set out their own criteria which are more or less strict but the general approach is rather similar. The below criteria were elaborated based on the approach of several reputable international organizations to prevention program assessments⁵:

- availability of a clear-cut description of intervention;
- availability of some kind of theoretical model, a clear logical or conceptual model of the program;
- availability of experimental (with control group, randomization of participants and pre/post assessment), or quasi experimental (the same but without randomization) research design. In the event that a quasi experimental design is used, the groups should show similar levels of target indicators at the pre-stage otherwise the differences should be taken care of during statistical processing. It should be noted that "after" usually implies a rather lengthy period (e.g. at least three months after prevention impact is finished);
- availability of statistically recorded (usually at the level of at least ($p \leq 0,05$)) positive effect of the program on at least one of the key indicators. Key indicators are usually deemed as either a certain type of behavior or the disease incidence rate;
- absence of any adverse effects of the program (also assessed by statistical methods);
- cultural relevance (this attribute should be assessed by members of the local community before the program is implemented in another area or group).

Adhering to all of the above requirements is not just a challenging task, it also involves significant costs. No wonder that there are very few programs meeting all these requirements: for a program to be considered as having not an excellent but at least any level of evidence, its design may be a bit simpler. But statistically confirmed positive effect and absence of negative effect should be retained.

An additional criteria for evaluating health intervention efficacy is provided by its *efficacy assessment*. An intervention is more efficacious than another if:

- a) it requires less money while is at least as efficacious as the other;
- b) is more efficacious but also more expensive but its additional advantages justify additional costs;
- c) is less efficacious but also less expensive while the additional costs incurred in a competing intervention do not justify additional costs.

provided to the patient is called single-blind. If neither the patient nor the researcher know what treatment was prescribed the trial is called double-blind. Blind trials make it possible to minimize the probability of intended distortions while unintended distortions can be equally distributed between the groups (i.e. minimizing the influence of subjective factors). In addition, there is placebo effect to be taken into account, i.e. the treatment course prescribed to a patient may have an effect regardless of whether or not he/she receives the active medicine. Placebo control means that control group patients are given a placebo – a product that does not contain any active substance and by its form, colour, taste, smell fully imitates the medicine being tested. Given that placebo control is often irrelevant for assessing prevention program effectiveness, active control is used i.e. the methods of prevention intervention being tested are matched versus those already known and widely used today.

⁵ For more details on the criteria set out by each of the organizations please use the links below:

- Centres for Disease Control and Prevention: HIV Risk Reduction (RR) Efficacy Review: Efficacy Criteria: <http://www.cdc.gov/hiv/dhap/prb/prs/efficacy/rr/criteria/index.html>;
- European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Best Practice Portal. <http://www.emcdda.europa.eu/themes/best-practice/examples/quality-levels>;
- US Department of Health and Human Services. National Registry of Evidence-based Programs and Practices (NREPP): <http://www.nrepp.samhsa.gov/ReviewSubmission.aspx>;
- Center for Substance Abuse Prevention. Identifying and Selecting Evidence-Based Interventions Revised Guidance Document for the Strategic Prevention Framework State Incentive Grant Program. HHS Pub. No. (SMA) 09-4205. Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, 2009: <https://store.samhsa.gov/shin/content/SMA09-4205/SMA09-4205.pdf>;
- FRIENDS National Resource Center for Community-Based Child Abuse Prevention (CBCAP) Evidence-Based and Evidence-Informed Programs: Prevention program descriptions classified by CBCAP evidence-based and evidence-informed categories. 2009: http://friendsnrc.org/direct-download-menuitem/doc_download/48-click-here-to-open-the-document-inpdf-format.

Approach based on assessment methodology and quality management

This approach is a bit gentler, with a considerable focus on qualitative rather than quantitative analysis tools⁶. Special attention is paid to each of project stages:

- assessing the situation and needs;
- getting the target group involved in the program;
- setting the goals and objectives;
- selecting the methods;
- planning the project;
- developing and assessing materials quality;
- selecting and training the personnel;
- implementing the project;
- assessing its performance.

It also takes into account all possible program aspects related to prevention intervention: adherence to ethical principles, financial transparency, stakeholders' involvement in the program, project adaptation for replication in a specific environment etc.

As can be seen, the focus of this approach is shifted from the result to the process. The cited sources show that this process has a great deal of aspects. This approach is to a greater extent applicable for prevention specialists (or their donors) themselves to be able to assess the quality of project planning and implementation. However, this approach does not make unnecessary a qualitative assessment of the effectiveness of evidence-based intervention.

Economy-based approach

Even if a program really works is it worth its costs? This approach may appear blasphemous from the perspective of humanistic knowledge but, given the limited resources, it is indeed necessary to think how to use them in the most efficacious way. An intervention is more efficacious than another if:

- a) it requires less money while is at least as efficacious as the other;
- b) is more efficacious but also more expensive but its additional advantages justify additional costs;
- c) is less efficacious but also less expensive while the additional costs incurred in a competing intervention do not justify additional costs.

By analogy with medical intervention assessment, there may be several scientific approaches to such assessment including the following:

- cost benefit analysis which measures the aggregate costs and benefits of each project alternative using one measurement unit typically expressed in monetary terms. It provides an answer to the question: "Is this project worth its costs?" or "Which of the options has the highest benefits-to-costs ratio?" It does not take into account the time, ethical, and aesthetical components;
- cost-effectiveness analysis has a wider scope than cost benefit analysis. It helps to assess the ratio between the project costs and its results (cost-effectiveness). The gain from a project and its costs can be expressed through a set of amenities such as space, time, experience, increased clinic attendance, enhanced life quality etc. E.g. the method makes it possible to compare the economic effectiveness of two treatment techniques based on the so called incremental analysis which helps to determine the additional amount of money to be paid for obtaining the advantages provided by a more expensive treatment technique;
- cost utility analysis provides for determining the monetary equivalent of the effect of intervention on the quality adjusted life years (QALY). The key feature of the method is selecting utility indicators which reflect the health-related quality of life (Gilyarevsky et al., 2002).

⁶ For more details about examples of such approach please see the sources below:

- Project "Quality action. Improving HIV prevention in Europe:" <http://www.qualityaction.eu/tools.php>;
- Best Practice Portal, EMCDDA: <http://www.emcdda.europa.eu/best-practice/guidelines>.

CHAPTER II. ASSESSMENT OF THE NEEDS OF YOUNG PEOPLE AT HIGH RISK OF HIV INFECTION IN RUSSIA, LATVIA, AND POLAND

A.I. Lyubimova, V.A. Odinkova, M.M. Rusakova

As part of project "Building capacity in prevention of HIV and associated infections among youth at high risk in the Northern Dimension area" a prevention needs assessment was conducted among young people aged 15-24 at risk of HIV infection in the Northwest Federal District of the Russian Federation (St. Petersburg and Kaliningrad), Poland, and Latvia. The whole cycle (tools development, and data gathering, processing and primary analysis) lasted from March 2014 to March 2015. The assessment studied the needs of adolescents and young people (aged 15-24) for prevention interventions related to HIV and associated infections. The target group was subdivided into subgroups as follows: 1. Individuals who started using various psychoactive substances (injected and non-injected); 2. Young migrants; 3. Individuals involved in commercial sexual exploitation (both clients and sex workers).

Key objectives of the assessment:

1. Assess the epidemiological situation with respect to HIV and associated infections as a whole and with respect to the target group. The main focus of assessment is identifying the existing knowledge and official statistics gaps in order to understand the development of HIV epidemic in the target group.
2. Study the factors affecting the spreading of HIV and associated infections among young people (behavioral risks, mindsets, knowledge, testing access, coverage of prevention activities). The factors were identified based on the results of a survey conducted among young people aged 15-24 and focus groups with experts and specialists working with young people.

1. Methodology

Research tools were developed taking into account the experience of project participants in the prevention of HIV and associated infections. The project participants discussed the tools during their development. During the development of tools, the current epidemic situation in the project member-countries was also taken into account. The research strategy included three components: statistics overview, behavioral survey among young people, and focus groups with experts. The above strategy made it possible to provide a most complete assessment of the situation in the countries surveyed.

Desk research. Statistics overview

Research teams used a unified strategy to gather data. To describe the situation a special MS Excel form was developed where the available statistical and research data were recorded. The form was developed in order to take into account the period from 2010 to 2013, research teams could also include the 2014 data available to them. Both country-specific general statistics and target group statistics were to be used for all the indicators. The form included components as follows: 1. Statistics on HIV, AIs and TB; 2. Statistics on migration; 3. Statistics on the use of alcohol and drugs; 4. Statistics on commercial sexual exploitation of children (CSEC). Each section included a list of indicators as follows:

- HIV, AIs and TB. Prevalence per 100,000 of population, incidence (understood here as number of new registered cases per 100,000 population) per 100,000 of population, transmission routes as percentage of newly registered cases;
- Migration. Total number of migrants by type of migration (labour migration, refugees, relocation for permanent residence etc.), statistics on countries of departure, estimated numbers of illegal migrants, statistics on HIV among migrants, statistics on departure countries for HIV-positive migrants, number of emigrants;
- Alcohol and drug use. Official statistics on incidence of alcoholism and drug abuse as well as data on their annual growth. Data on the types of used drugs, age of first use of alcohol and drugs; special features of use etc.;

- CSEC. Data on the number of sex crimes against children, involvement of children in prostitution and pornography, child trafficking. Research data on different types of CSEC (prostitution, pornography, trafficking, sex tourism). In addition, if possible, available estimates made by experts regarding the number of young people under 24 who had experienced sexual exploitation. Number of children at orphanages, foster families etc. Number of families in socially dangerous situations (children living in a dysfunctional family, with one of or both parents suffering from alcohol or drug addiction).

Behavioral survey

The target group for the survey was a group of adolescents and young people aged 15-24, characterized by the risky behavior for being infected with HIV and AI, or in an unfavorable social environment which may have indirect effect for increased risk of HIV and AI.

A two-stage sampling method was used. At Stage 1, in each of the cities where data was gathered, "typical" educational institutions were selected i.e. the institutions which reflect the situation at similar institutions across the city. Sampling was conducted based on expert opinions of specialists from the educational sector (Ministry of Education, Committee for Education etc.), health specialists (Ministry of Public Health, Committee for Public Health etc.), interdepartmental commissions for drug traffic control, youth commissions, members of non-profit organizations focusing on HIV and drug addiction prevention. At Stage 2, all the available respondents were selected from the shortlisted educational institutions.

The criteria for selecting respondents were as follows: age correspondence, voluntary consent (stated during the informed consent procedure). The exclusionary criteria included mental disorders preventing individuals from complete awareness of the risks, and participation in the survey.

Survey procedure. The survey was conducted in classrooms (Russia and Latvia), in Poland it was conducted in a dedicated room, with no strangers present. Respondents were seated at separate desks, the questionnaires were handed out to the students' group after getting their informed consent. Each participant was given a questionnaire and a pen. In Russia and Latvia, the survey was conducted during classes.

The questionnaires contained information related to PAS use and sexual relations. The research team decided to hand out the prevention materials on the above issues once the questionnaire was filled out. The materials also contained the contact details of organizations that could be contacted for HIV testing and prevention purposes. The data input was held concurrently with data gathering using an MS Excel database.

Questionnaire. It took 45 minutes to fill out the questionnaire. In each of the countries the questionnaire was to be filled out in the native language, in Latvia the respondent had a choice between the Latvian and Russian version of questionnaire. The questionnaire included a few sets of questions with several answer options:

- 1) sociodemographic component (including migrant's status);
- 2) PAS use and addiction (tobacco smoking, alcohol drinking frequency and other characteristics, drinking large amounts of alcohol at one time (binge drinking as per WHO recommendations for assessments), alcohol addiction (CAGE test), experience in drug use, circumstances of first drug use including injected use, drug addiction (DAST test – 10 questions);
- 3) sexual behavior: associated experience and risks (first intercourse age, number of partners, use of condom at first intercourse and current use of condoms (with different types of partners), reasons for non-using condoms, commercial sex experience (buying or selling sex), sexual violence, experience in intercourse under the influence of alcohol and PAS (respondent him/herself, respondent's partner), pregnancy and STIs);
- 4) knowledge about HIV, AI, and places for their treatment. Knowledge about HIV testing places, HIV testing experience, own risk assessment of getting HIV, knowledge about HIV, knowledge

- about hepatitis and tuberculosis, knowledge about the places to receive assistance for alcohol and drug addicts;
- 5) social environment characteristics (alcohol abuse and drug addiction among relatives and friends, among respondent's school and/or home mates);
 - 6) scope of prevention activities (preferred sources of prevention information, potential of mobile and web applications to deliver prevention information).

Focus groups with experts

Focus groups with experts were intended to generate information on youth groups which are most vulnerable to HIV and AI (the most stigmatized and hidden youth groups). Even though a significant portion of information required to provide relevant prevention interventions was gathered through interviewing young people aged 15 – 24, focus groups with experts allowed to examine the issue from the specialists' perspective as well as gain more generalized practical information. Each group included from 8 to 10 experts. All focus groups were audio-recorded (after completing the informed consent procedure). Each focus group lasted for 60 to 80 minutes. All groups were conducted by a professionally trained moderator. Each expert was paid a participation compensation of 25 euros.

To make sure the information was complete the experts were divided into two teams: those working with young migrants, and those working with CSEC victims. The guidelines for focus groups were different.

The topic guidelines for the migrants' expert group contained thematic components as follows: regionally available programs for migrants (their content, efficacy, potential for improving and changing the programs), migrants' health problems (the most widespread health issues, ways to address them within the existing legislation, HIV and AI testing issues), tuberculosis, procedure for outreach to HIV, AI and TB-infected migrants, risky sexual behavior among migrants.

The focus group with experts on adolescents and young people at risk of getting involved in commercial sexual exploitation, was set up on the assumption that this youth group should include children and young people being brought up at orphanages and rehabilitation centers. This group may also include young people, whose parents are drug or alcohol addicted, and those living in economically and socially dysfunctional families.

The topic guidelines for the CSEC experts' group included the following sets of questions: forms of commercial sexual exploitation in the regions, characteristics of children and young people involved in commercial sexual exploitation (gender, age etc.), profiles of the organizers of commercial sexual exploitation, experience in alcohol and drug use among children and victims of commercial sexual exploitation, organizations helping such victims, content of services provided by these organizations, prevention programs for combatting commercial sexual exploitation, their presence in the region, access to HIV and AI prevention programs for sexual exploitation victims, approach to the development of such programs, potential organizational and political barriers.

2. Data analysis

Behavioral data analysis

Regional NGO "Stellit" has established a general database for all the participating cities. The database was then checked for possible mistakes by a statistician who prepared it for use in the SPSS.16.0 statistical package. Statistical research analysis focused on determining the risky behavior, family risks and wider social environment risks, risk self-assessment by respondents, their knowledge about HIV and AI, participation in testing and prevention programs, preferred sources of prevention information. In the course of baseline study, the frequency distribution of variables was studied for all the data gathering cities, and the sampling as a whole. Pearson's chi-square test (or Student's t-test) was used to analyze the differences in respondents' sociodemographic and other characteristics between countries (and cities) where the research was conducted.

Focus group analysis

All focus group records and transcripts were post-hoc coded using thematic codes developed on the basis of questionnaire sections as well as the topics discussed most during the interviews. The analysis aimed at identifying the conditions for and semantic content of HIV, TB and AI prevention programs that could be potentially successful for young people, migrants and victim of commercial sexual exploitation.

3. Results

Statistics overview results

HIV infection in Russia. According to the data of the Federal Scientific and Methodological Centre for AIDS Prevention and Control, HIV prevalence kept growing from 2010 to 2014. In 2010, the number of HIV infected per 100,000 of population was 345.8⁷, in 2011 – 370.7, in 2012 – 416.4, in 2013 – 468.8⁸, and in 2014, this number reached 494.6 persons per 100,000⁹. The cumulative number of registered cases of HIV infection among RF citizens (from 1987 to 31.12.2014) reached 907,607¹⁰. The number of new registered cases of HIV infection per 100,000 of RF population (excluding children with unidentified diagnosis) was in 2010 – 40.9; in 2011 – 43.6; in 2012 – 49.4; in 2013 – 55.6¹¹.

In 2014, 50.7% of newly detected cases with established infection pathways accounted for drug use with non-sterile equipment, and 40.3% accounted for heterosexual intercourse¹². For 59.4% of HIV-positive test reports in 2012, the key infection risk factor was found to be drug use with non-sterile equipment (in 2011 – 55.9%, in 2010 – 57.2%, in 2008 – 58.8%)¹³. Over the whole period of observations, this infection risk factor was reported for 269,600 of HIV-infected individuals. Heterosexual intercourse as the key infection risk factor was reported for 38.9% of first HIV-positive test results in 2012 among individuals with identified infection causes (in 2011 – 41.6%, in 2010 – 40.4%, in 2008 – 38.1%)¹⁴. It may be noted that for more than a half of HIV-infected patients (54.6%), as of the end of 2013, the HIV transmission route was not established, and this situation is typical of all recorded years.

In the Russian Federation, HIV infection hits mostly young population: over the whole recorded period, 59.6% patients had this infection diagnosed at the age below 30. However, the percentage of young people out of first reported HIV-infected cases as well as in the prevalence rates tends to decrease (Fig. 3.a and Fig. 3.b).

However in the target groups, there is no significant growth of the number of infected individuals due to intravenous drug use, and the proportion of these groups is also decreasing in the general PLHA population infected through intravenous drug use (2010: 13.6% for the group aged 15-19, 61.1% for the group aged 20-30; 2011: 12.6% for the group aged 15-19, 59.4% for the group aged 20-30; 2012: 11.7% for the group aged 15-19, 57.5% for the group aged 20-30; 2013: 10.8% for the group aged 15-19; 55.3% for the group aged 20-30).

Associated infections in Russia. Over January – December 2014, compared to the same period of 2013, incidence in the Russian Federation dropped by 4.5% for acute hepatitis B, 6.6% for active TB forms, and by 12.3% for new onset syphilis .

⁷ Pokrovsky V.V., Ladnaya N.N., Sokolova E.V., Buravtsova E.V. HIV Infection. Information Bulletin No. 38/ Federal Scientific and Methodological Centre for AIDS Prevention and Control. – Moscow, 2013.

⁸ Pokrovsky V.V., Ladnaya N.N., Tushina O.I., Sokolova E.V., Buravtsova E.V. HIV Infection. Information Bulletin No. 39/ Federal Scientific and Methodological Centre for AIDS Prevention and Control. – Moscow, 2014.

⁹ Ibid.

¹⁰ Ibid.

¹¹ Ibid.

¹² Ibid.

¹³ Pokrovsky V.V., Ladnaya N.N., Sokolova E.V., Buravtsova E.V. HIV Infection. Information Bulletin No. 38/ Federal Scientific and Methodological Centre for AIDS Prevention and Control. – Moscow, 2013.

¹⁴ "Briefing Note on HIV infection in the Russian Federation in 2012"/ Federal Scientific and Methodological Centre for AIDS Prevention and Control – [Moscow, 2013]. URL: <http://www.hivrussia.org/stat/2012-3.shtml> (accessed date: 02.02.2015).

1. Tuberculosis. In 2014, compared to 2013, the overall Incidence of tuberculosis dropped by 5.6% (from 63.0 to 59.5 per 100,000 of population), and starting from 2008, when the indicator reached a maximum (85.1 per 100,000 of population), the reduction was 30.1% (Fig. 4).

People aged 18-44 are the most TB infected part of the population (in 2014 – 62.3%). The peak tuberculosis Incidence is reported for women 25-34 and men aged 35-44. Men accounted for 68.2% of newly-detected tuberculosis cases. TB Incidence for permanent residents was down by 5.1% (from 53.4 to 50.7 per 100,000 of population), and for newly registered patients – by 5.1% (from 51.1 to 48.5 per 100,000 of population).

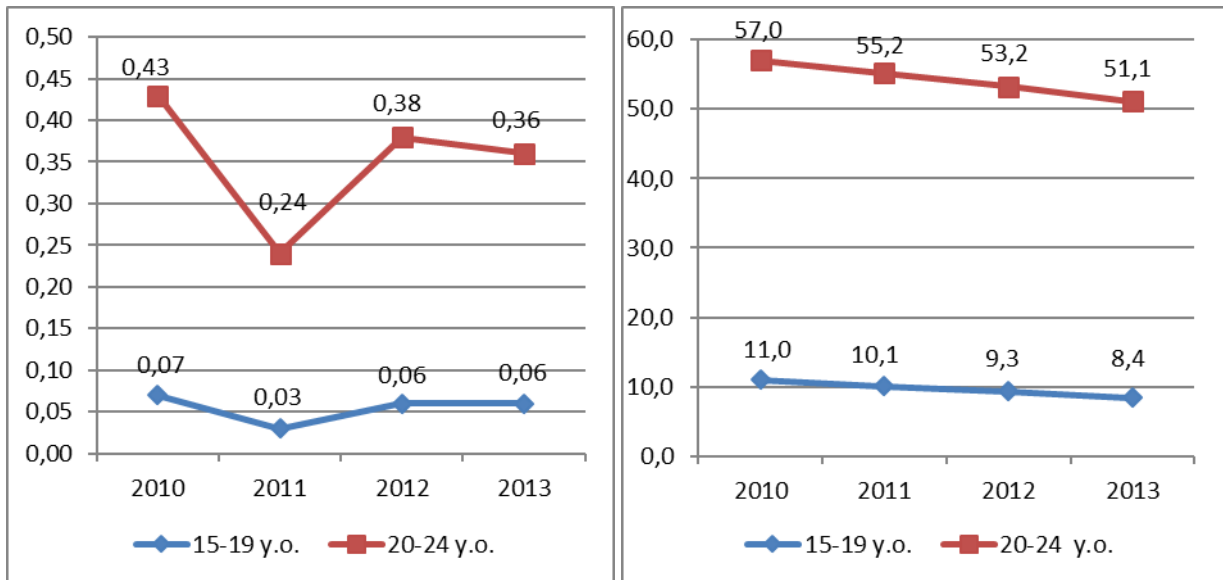


Figure 3.a. Proportion of PLHA in the age group (%).

Figure 3.b. Proportion of PLHA of the age group in the general PLHA population (%).

Among newly registered permanent residents, 15.1% were HIV-infected (in 2013 – 12.5%). TB Incidence combined with HIV infection is growing for Russia's permanent residents: 2009 – 4.4; 2013 – 6.5; 2014 – 7.4 per 100,000 of population.

TB Incidence for children aged 15-17 also dropped in 2014 compared to 2013 – by 12.6% (from 31.8 to 27.8 for 100,000 children). In 2014 compared to 2013, overall incidence of tuberculosis (as of the yearend) went down by 6.9% (from 147.5 to 137.3 per 100,000 of population)^{15,16}.

2. Viral hepatitis, syphilis and other AIs. The number of detected cases of viral hepatitis was declining from 2010 to 2014. E.g. the number of newly-detected cases of hepatitis C in 2010 was

2.1 per 100,000 people, in 2011 – 1.8 per 100,000 people, in 2012 – 1.5 per 100,000 people, in 2013 – 1.47 per 100,000 people, in 2014 – 1.55 per 100,000 people. The number of newly-detected cases of hepatitis B: in 2010 – 2.2 per 100,000 people, in 2011 – 1.7 per 100,000 people, in 2012 – 1.4 per 100,000 people, in 2013 – 1.33 per 100,000 people, in 2014 – 1.27 per 100,000 people.

¹⁵ "Otraslevyie I ekonomicheskiye pokazateli protivotuberkuleznoy raboty v 2012 – 2013 gg."// Analiticheski obzor osnovnykh pokazateley I statisticheskiye materialy (Sector-wise and economic indicators of tuberculosis prevention work in 2012 – 2013//Analytical overview of the key indicators and statistical materials) /FGBU "TsNII OIZ, RF Ministry of Public Health. – [Moscow, 2014]. URL: http://www.mednet.ru/images/stories/files/CMT/otraslevie_pokazateli_2012_2013.pdf (accessed date: 01.05.2015).

¹⁶ "Epidemicheskaya situatsiya po tuberkulyozu v Rossii" (TB Epidemic Situation in Russia)// Federal Centre for Monitoring Tuberculosis Control / FGBU "TsNII OIZ, RF Ministry of Public Health. – [Moscow, 2015]. URL: http://www.mednet.ru/images/stories/files/CMT/tub_epidsituaciya.pdf (accessed date: 01.05.2015).

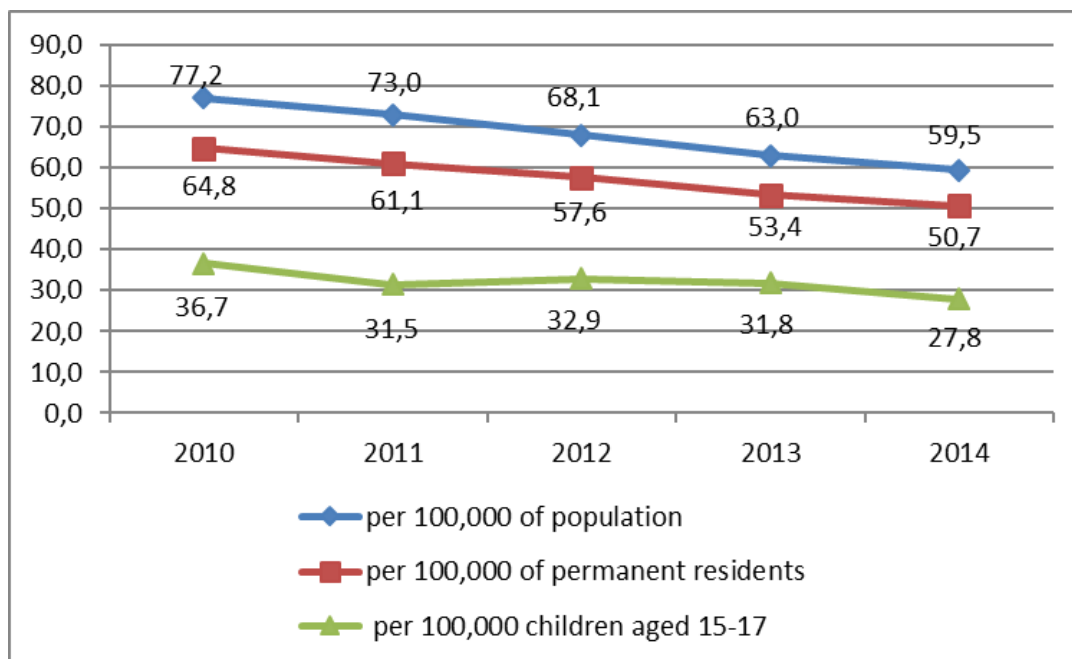


Fig. 4. Tuberculosis incidence in the Russian Federation.

The indicator remained relatively stable for children aged under 17 (for hepatitis C in 2013 – 0.31 per 100,000 children, in 2014 – 0.30 per 100,000 children; for hepatitis B in 2013 – 0.08 per 100,000 children, in 2014– 0.09 per 100,000 children)¹⁷.

3. Syphilis. The number of newly-detected cases as well as the syphilis incidence were steadily declining year-wise (Fig. 5).

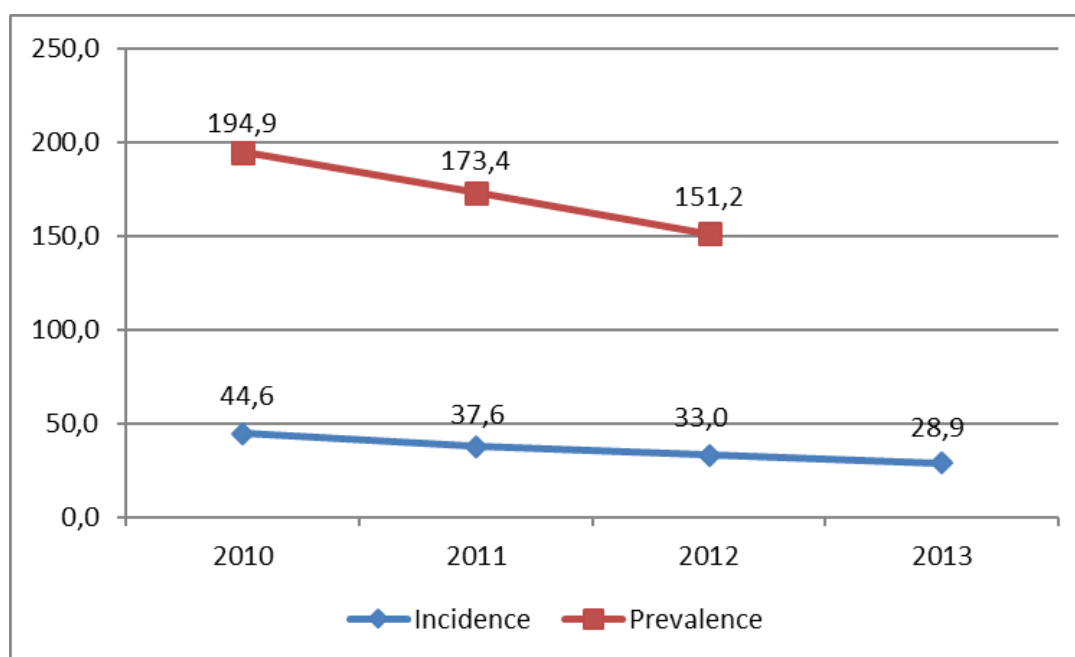


Fig. 5. Syphilis incidence and prevalence per 100,000 of population¹⁸.

¹⁷ "Statistical Yearbook of Russia, 2014"/ Federal State Statistics Service. – [Moscow, 2014]. URL: http://www.gks.ru/wps/wcm/connect/rosstat_main/rosstat/ru/statistics/publications/catalog/doc_1135087342078 (accessed date: 01.02.2015).

¹⁸ "Statistical Yearbook of Russia, 2014"/ Federal State Statistics Service.– [Москва, 2014]. URL: http://www.gks.ru/wps/wcm/connect/rosstat_main/rosstat/ru/statistics/publications/catalog/doc_1135087342078 (accessed date: 01.02.2015).

4. Other AIs. Data on gonococcal infection is available for the Russian Federation. Incidence for it is also declining year-wise (Fig. 6).

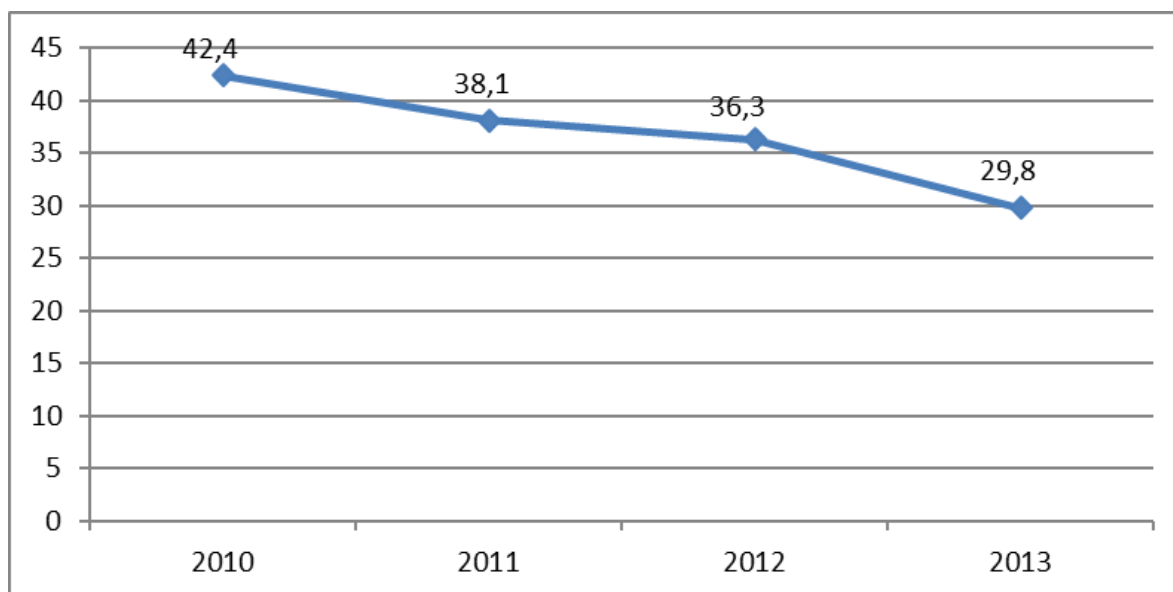


Fig. 6. Gonococcal infection incidence year-wise (per 100,000 of population).

HIV infection in the Northwest Federal District. The Northwest Federal District constantly reports high prevalence of HIV among the population. As of the end of 2013, NWFD had 85,448 cases of PLHA. Even though the prevalence rate relatively stabilized in 2012-2013, it grew significantly from 2010, to wit, in 2010 – 553.4 per 100,000 people, in 2011 – 586.6 per 100,000 people, 2012 – 619.0 per 100,000 people, 2013 – 619.2 per 100,000 people.

The incidence remains relatively stable, to wit: 2010 – 6,225 cases (46.4/100,000 people), 2011 – 6,491 cases (47.3/100,000 people), 2012 – 6,019 cases (43.9/100,000 people), 2013 – 6,119 cases (44.5/100,000 people). During that period, reduction was reported in the number of tested users of injected drugs so as a result the number of detected HIV cases under code 102 was as follows: in 2010 – 843, in 2011 – 720, in 2012 – 606. The number of users tested under code 103 (MSM) remained constantly low, no sufficient information is available.

The number of tested foreign citizens grows year-wise; in 2010, 148,990 blood serums of foreign citizens were tested, with 418 PLHIV cases detected (280,6/100,000); in 2011, 231,024 serums were tested, with 395 PLHIV cases detected (171,0/100,000), in 2012, 299,224 serums were tested, with 508 PLHIV cases detected (169,8/100,000), in 2013, 373,382 serums were tested, with 615 PLHIV cases detected (164,7/100,000).

HIV infection in St. Petersburg. St. Petersburg is one of the worst HIV-affected cities in NWFD. This indicator is only worse in the Leningrad Oblast surrounding St. Petersburg. As of the end of 2013, the number of PLHA in St. Petersburg was 48,303. Prevalence rate between 2010 and 2013 changed as follows: in 2010 – 959.6/100,000; in 2011 – 950.8/100,000; in 2012 – 988.5/100,000; in 2013 – 941.2/100,000. Incidence in St. Petersburg tends to decline: in 2010 – 63.9/100,000; in 2011 – 60.6/100,000; in 2012 – 53.5/100,000; in 2013 – 52.1/100,000. During the period, reduction was reported in the number of tested users of injected drugs so as a result the number of detected HIV cases under code 102 was as follows: in 2010 – 502, in 2011 – 378, in 2012 – 347, in 2011 – 251. According to the data of the Northwest AIDS Centre, the percentage of infections contracted through homosexual intercourse between males is constantly growing, and was 3.8% in 2013 (in 2010 – 1.3%, in 2011 – 2.4%, in 2012 – 3.7%).

The number of tested foreign citizens grows year-wise, with the highest proportion of persons tested in NWFD accounting for St. Petersburg. In 2010, 105,060 blood serums of foreign citizens were

tested, with 352 PLHIV cases detected (335.0/100,000); in 2011, 185,523 serums were tested, with 325 PLHIV cases detected (175.2/100,000); in 2012, 242,535 serums were tested, with 426 PLHIV cases detected (175.6/100,000); in 2013, 317,499 serums were tested, with 506 PLHIV cases detected (159.4/100,000).

HIV and associated infections in Kaliningrad. According to the data of the Kaliningrad AIDS Centre, HIV prevalence per 100,000 of population grew from 2010 to 2013 (521.2 per 100,000 of population; 541.5 per 100,000 of population, 570.0 per 100,000 of population, and 590.8 per 100,000 of population respectively). However, it is typical of the Kaliningrad Oblast to have a reduction in the total proportion of patients infected with HIV due to the use of non-sterile injection equipment (from 30.4% to 20.0%), and an increase in the proportion of patients infected through heterosexual transmission route (from 67.1% in 2010 to 75.3% in 2013, with reduction down to 65.8% in 2011, and down to 66.9% in 2012). An increase in the proportion of patients infected with HIV through homosexual intercourse was also reported – from 0.8% to 2.08%. The data on the overall HIV incidence in the group aged 15-24 were not available to the research team. However, the statistics on new HIV infection cases is not that unambiguous. The number of newly detected HIV cases remained relatively stable between 2010 and 2013 (2010 – 43.0; 2011 – 46.0; 2012 – 46.8; 2013 – 44.6). For the newly detected cases for groups aged 15-19 and 20-29, the data is available for the period of 2011–2013. The highest number of detected infections out of the total number accounts for the group aged 20-29. In 2011, the group aged 15-19 reported 1.86 cases per 100,000 of population, and the group aged 20-29 – 35.73 cases per 100,000 of population; in 2012 – 2.1/100,000 and 34.0/100,000; in 2013 – 0.7/100,000 and 30.5/100,000 respectively.

The number of tested foreign citizens grows year-wise, the number of foreign citizens tested for HIV in Kaliningrad is the second largest in NWFD. In 2010, 12,587 blood serums of foreign citizens were tested, with 16 PLHIV cases detected (127.1/100,000); in 2011, 12,686 serums were tested, with 13 PLHIV cases detected (102.5/100,000); in 2012, 16,969 serums were tested, with 22 PLHIV cases detected (129.6/100,000); in 2013, 18,084 serums were tested, with 28 HIV cases detected (154.8/100,000).

Tuberculosis prevalence among the population is declining from 175.3 in 2010 down to 126.2 in 2013¹⁹. The number of newly detected TB cases per 100,000 of population was as follows: in 2010 – 93.6, in 2011 – 79.6²⁰; in 2012 – 70.8; in 2013 – 64.5²¹. The data for the group aged 15-24 were not available for the research team.

The data for the incidence rate of hepatitis C, hepatitis B and syphilis were not available for the research team. The number of newly detected hepatitis C cases per 100,000 of population was as follows: in 2010 – 56.4; in 2011 – 55.2²²; in 2012 – 64.0; in 2013 – 59.46²³. The number of newly detected hepatitis B cases per 100,000 of population was as follows: in 2010 – 11.4; in 2011 – 16.2²⁴; in 2012 – 14.36; in 2013 – 11.62²⁵. The data for the group aged 15-24 were not available for the research team.

The number of newly detected syphilis cases per 100,000 of population was as follows: in 2010 – 51.4; in 2011 – 50.4²⁶; in 2012 – 42.3; in 2013 – 33.06²⁷. The 2010 data for the group aged 15-24 are not available but in 2011 for the group aged 15-17 there were 27.1 cases detected per 100,000 people; for

¹⁹ State report "On the state sanitary and epidemiological welfare of the population in the Kaliningrad region in 2013".

²⁰ Health Kaliningrad region in figures in 2010 – 2011.

²¹ State report "On the state sanitary and epidemiological welfare of the population in the Kaliningrad region in 2013".

²² Health Kaliningrad region in figures in 2010 – 2011.

²³ State report "On the state sanitary and epidemiological welfare of the population in the Kaliningrad region in 2013".

²⁴ Health Kaliningrad region in figures in 2010 – 2011.

²⁵ State report "On the state sanitary and epidemiological welfare of the population in the Kaliningrad region in 2013".

²⁶ Health Kaliningrad region in figures in 2010 – 2011.

²⁷ State report "On the state sanitary and epidemiological welfare of the population in the Kaliningrad region in 2013".

the group aged 18-29 – 107.2/100,000; in 2012 – 40.0 and 70.7; and in 2013 – 15.4 and 66.2 respectively²⁸.

Out of other associated infections, data on chlamydia were available to the research team. The number of cases recorded in 2010 was 57.8/100,000²⁹; in 2011 – 67.9/100,000; in 2012 – 55.2/100,000; and in 2013 – 49.7/100,000³⁰. The data for the group aged 15-24 were not available.

HIV and associated infections in Latvia. 1. HIV infection. According to the data of the Centre for Disease Prevention and Control of Latvia, the cumulative number of newly diagnosed HIV cases is growing year-wise³¹. Thus, in 2010, 247 HIV cases were diagnosed, in 2011 – 299, in 2012 – 339, in 2013 – 340, in 2014 – 347. The cumulative number of patients reached 6,214 people by the end of 2014.

2. Tuberculosis. It is currently difficult to draw a conclusion regarding any time trend related to tuberculosis incidence among the population but it may be noted that in 2012 the largest number of patients over the period was reported – 880 (Fig. 7).

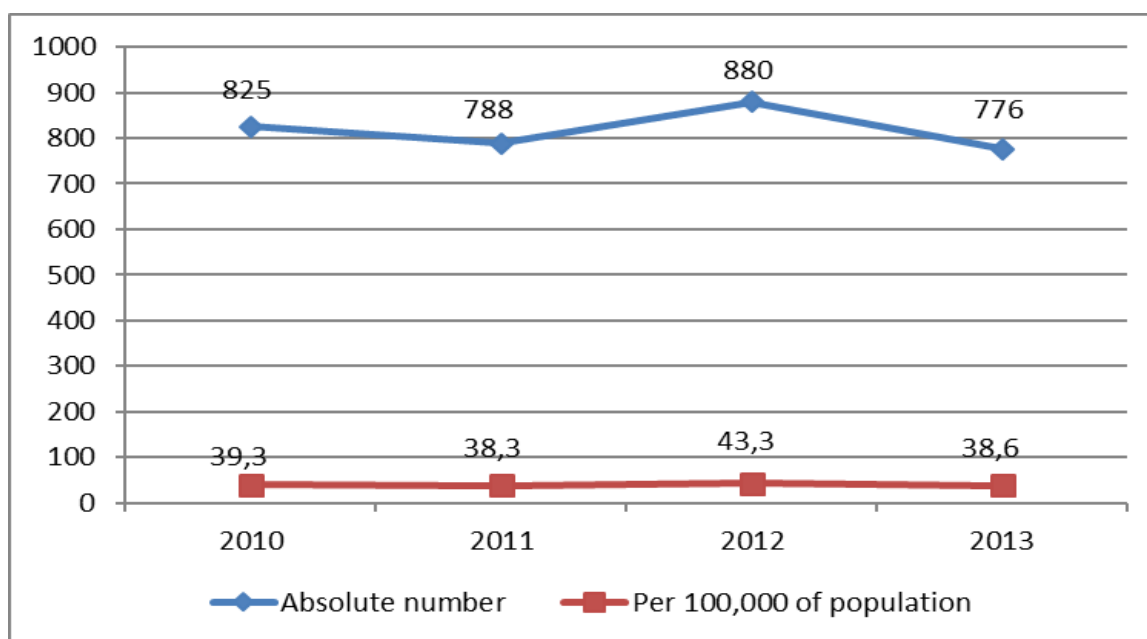


Fig. 7. Tuberculosis incidence in Latvia (all forms).

3. Viral hepatitis B and C. The situation with viral hepatitis in Latvia is unstable but could be considered as stable growth (Fig. 8).

4. Syphilis and other AIs. The incidence of syphilis and gonococcal infection remained relatively stable over years but, in contrast, the incidence of AI such as chlamydia is swiftly growing (Fig. 9).

HIV and associated infections in Poland. 1. HIV infection. According to the data of the National Institute of Public Health, and the National Institute of Hygiene, the number of HIV cases is growing in Poland. By the end of 2010, the total number of HIV epidemic cases detected was 13,917, by the end of 2013, the number was already 17,565 cases. Out of all reported HIV cases, 41.1% of infection cases were due to injection transmission, in 2011 – 38.7%, in 2012 – 36.5%, in 2013 – 34.3%. The sexually transmitted structure was as follows: heterosexual transmission – 2010 – 5.7%, 2011 – 6.6%, 2012 – 6.7%, 2013 – 7.0%; homosexual transmission – 2010 – 6.5%, 2011 – 8.4%, 2012 – 9.8%, 2013 – 11.2%. No general HIV statistics are available for the group aged 15-24.

The number of newly detected cases year-wise is also growing in Poland: in 2010 – 765, in 2011 – 1,193, in 2012 – 1,135, in 2013 – 1,258. However, in most cases the infection route was not identified but the proportion of cases due to injection use out of the total number of new cases in 2010 was 4.7%, in

²⁸ State report "On the state sanitary and epidemiological welfare of the population in the Kaliningrad region in 2013".

²⁹ www.epinorth.org

³⁰ State report "On the state sanitary and epidemiological welfare of the population in the Kaliningrad region in 2013".

³¹ "Statistics, January 1, 2015"// HIV/AIDS in the Baltic States/ BaltHIV. – [2015]. URL: <http://balthiv.com/hiv/aids/statistics-january-1-2015> (accessed date: 01.08.2015).

2011 – 4.9%, in 2012 – 3.5%, in 2013 – 3.5%, for heterosexual transmission: in 2010 – 11.8%, in 2011 – 6.6%, in 2012 – 8.1%, in 2013 – 7.5%. In 2010, the group aged 15-19 accounted for 1.4% of cases, group aged 20-29 – 45.6%; in 2011, the group aged 15-19 accounted for 1.0%, group aged 20-29 – 35.7%; in 2012, the group aged 15-19 accounted for 1.4%, group aged 20-29 – 29.3%; in 2013, the group aged 15-19 accounted for 1.0%; group aged 20-29 – 35.0%.

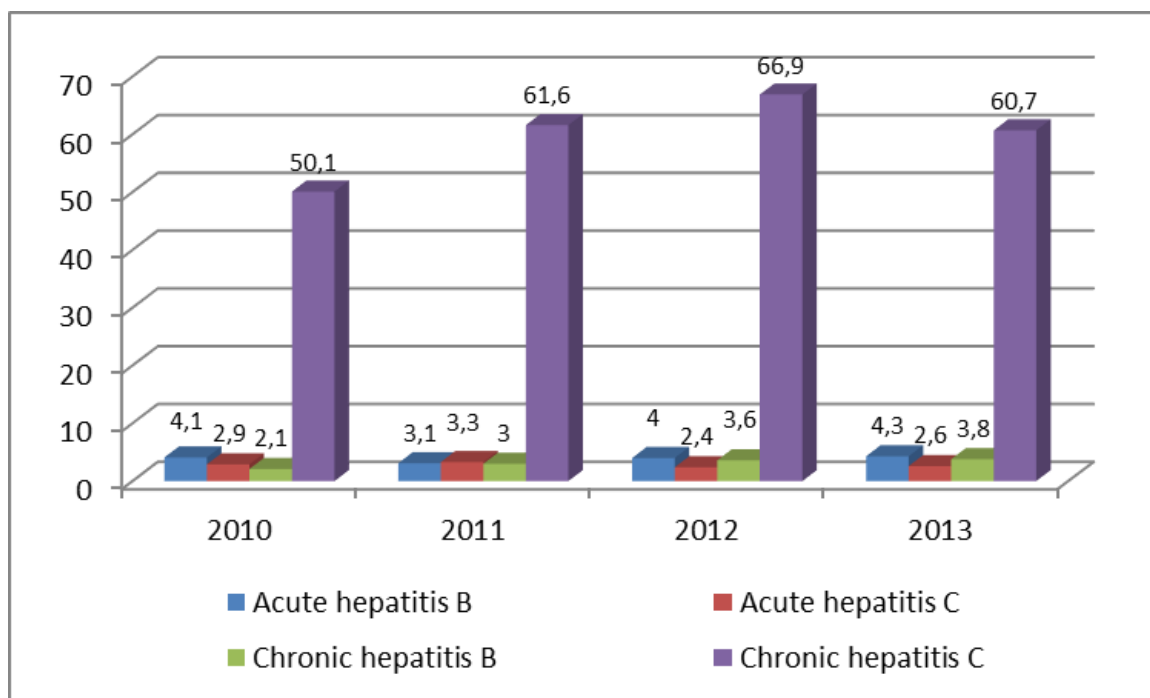


Fig. 8. Viral hepatitis incidence (per 100,000 of population).

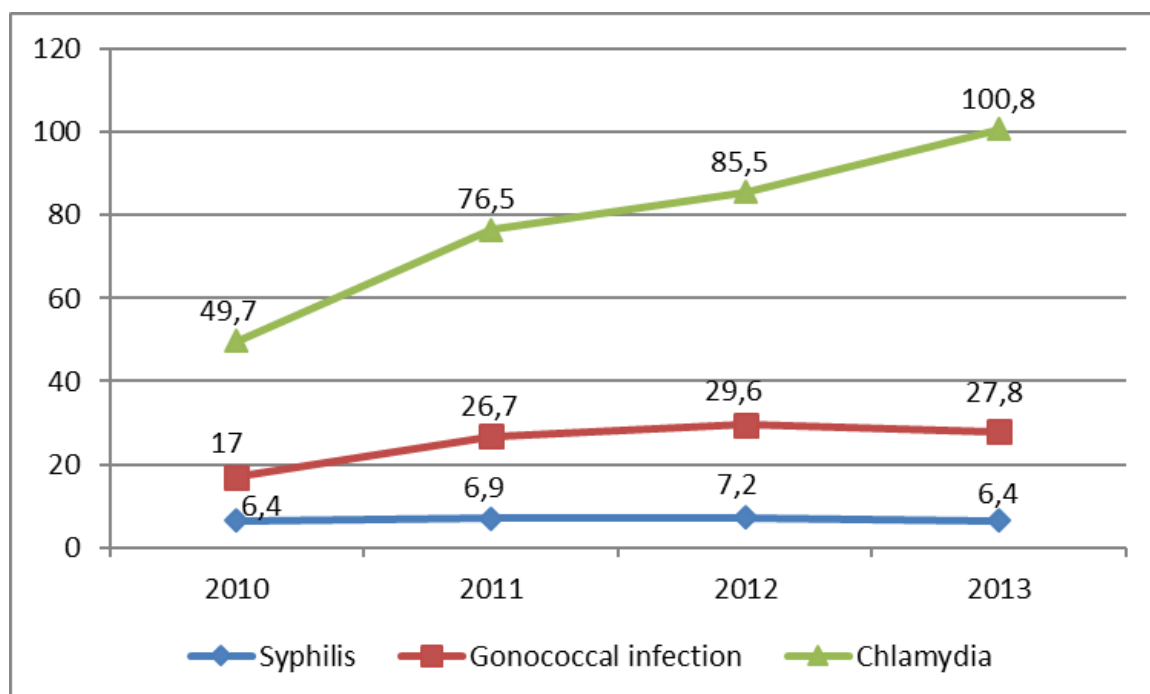


Fig. 9. Syphilis and other AIs incidence in Latvia (per 100,000 of population).

2. Tuberculosis. Since 1950, around 512,000 cases of tuberculosis have been reported in Poland. No data are available for the group aged 15-24. In 2010, 7,509 new cases were recorded, in 2011 – 8,478 case, in 2012 – 7,542 cases. No data are available for the group aged 15-24.

3. Viral hepatitis. From 1997 up to the end of 2013, 751,209 cases of hepatitis C were detected in Poland, and 324,706 cases of hepatitis B. No data on the total number of hepatitis cases are available for the group aged 15-24. From 2010 to 2013, there was a significant growth in the number of newly recorded cases of hepatitis C, from 1,986 cases in 2010 to 2,642 cases in 2013 but the above trend does not prevail in the youth group: 2010 – 207 cases, 2011 – 215 cases, 2012 – 196 cases, 2013 – no account. There is a reduction in the number of newly detected cases of hepatitis B year-wise: 2010 – 1,633, 2011 – 1,583, 2012 – 1,583, 2013 – 1,540. The same trend is reported for young people: 412 in 2010, 367 in 2011, 309 in 2012, 2013 – no account.

4. Syphilis and other AIs. Since 2004, Poland recorded 5,875 cases of syphilis. No data are available for the group aged 15-24. The number of newly detected cases of syphilis year-wise is growing: in 2010 – 914 cases, in 2011 – 941 cases, in 2012 – 961 cases, in 2013 – 1,274 cases. No data are available for the group aged 15-24.

No data on the total number of recorded cases of other AIs are available but in 2010, 2,776 new cases of chlamydia were detected, in 2011 – 2,226 cases, in 2012 – 2,431 cases, in 2013 – 759. No data are available for the group aged 15-24.

Migration in Russia. Steady growth of all migration indicators of foreign citizens has been reported, with a swift growth in the number of issued patents. Accordingly, an increasing number of foreign citizens get employed through companies recruiting workers from abroad in a centralized manner^{32,33,34}.

As of August 2015, foreign citizens predominating in the foreign population within the Russian Federation included: citizens of Ukraine (2,631,638 including those under 17 – 387,054, those aged 18-29 – 712,197); citizens of Uzbekistan (2,125,193 including those under 17 – 141,742, those aged 18-29 – 990,385); citizens of Kazakhstan (701,133 including those under 17 – 115,216, those aged 18-29 – 177,570); citizens of Belarus (592,451 including those under 17 – 73,460, those aged 18-29 – 190,762), citizens of Azerbaijan (554,346 including those under 17 – 76,015, those aged 18-29 – 167,976), citizens of Moldova (535,163 including those under 17 – 46,265, those aged 18-29 – 196,991), citizens of Armenia (535,135 including those under 17 – 63,083, those aged 18-29 – 160,114), citizens of Kirgizia (518,993 including those under 17 – 92,769, those aged 18-29 – 241,160)³⁵.

Migration in NWFD and St. Petersburg. A significant portion of residential permits issued to foreign citizens accounts for NWFD. A majority of such permits is issued in St. Petersburg (Fig. 11)^{36,37}. A general trend of migration flow growth year-wise has been reported across NWFD.

Migration in Kaliningrad. According to the analytical reports on the work of the Kaliningrad Oblast Department of the RF Migration Service, the number of registered immigrants, and also the number of issued work permits and temporary residential permits as well as RF citizenship licenses, differ greatly year-wise. For instance, in 2011, the total number of registered immigrants was 43,865 including 3,647 people under voluntary relocation program "Fellow Countrymen", the number of issued work permits was 6,018 (and 937 study permits). 2,679 people were granted temporary residential permits, and 5,060 persons obtained RF citizenship. In 2012, the total number of registered immigrants was 35,546

³² "Data on migration situation in the Russian Federation for 12 months of 2012"// Key performance indicators of the RF Federal Migration Service/ RF Federal Migration Service. – [Moscow, 2013]. URL: <http://www.fms.gov.ru/about/statistics/data/details/53595/> (accessed date: 05.03.2015).

³³ "Data on migration situation in the Russian Federation for 12 months of 2013"// Key performance indicators of the RF Federal Migration Service / RF Federal Migration Service. – [Moscow, 2014]. URL: <http://www.fms.gov.ru/about/statistics/data/details/81106/> (accessed date: 05.03.2015).

³⁴ "Data on migration situation in the Russian Federation for 12 months of 2014"// Key performance indicators of the RF Federal Migration Service / RF Federal Migration Service. – [Moscow, 2015]. URL: <http://www.fms.gov.ru/about/statistics/data/details/110975/> (accessed date: 05.03.2015).

³⁵ "Data on foreign citizens staying within the Russian Federation, gender and age breakdown (by citizenship countries)"// Key performance indicators of the RF Federal Migration Service / RF Federal Migration Service. – [Moscow, 2015]. URL: <http://www.fms.gov.ru/about/statistics/data/details/54892/> (accessed date: 06.08.2015).

³⁶ "Demographic Yearbook of Russia for 2012"/ Federal State Statistics Service. – [Moscow, 2013]. URL: http://www.gks.ru/bgd/regl/B12_16/Main.htm (accessed date: 01.03.2015).

³⁷ "Demographic Yearbook of Russia for 2013"/ Federal State Statistics Service. – [Москва, 2014]. URL: http://www.gks.ru/bgd/regl/B13_16/Main.htm (accessed date: 01.03.2015).

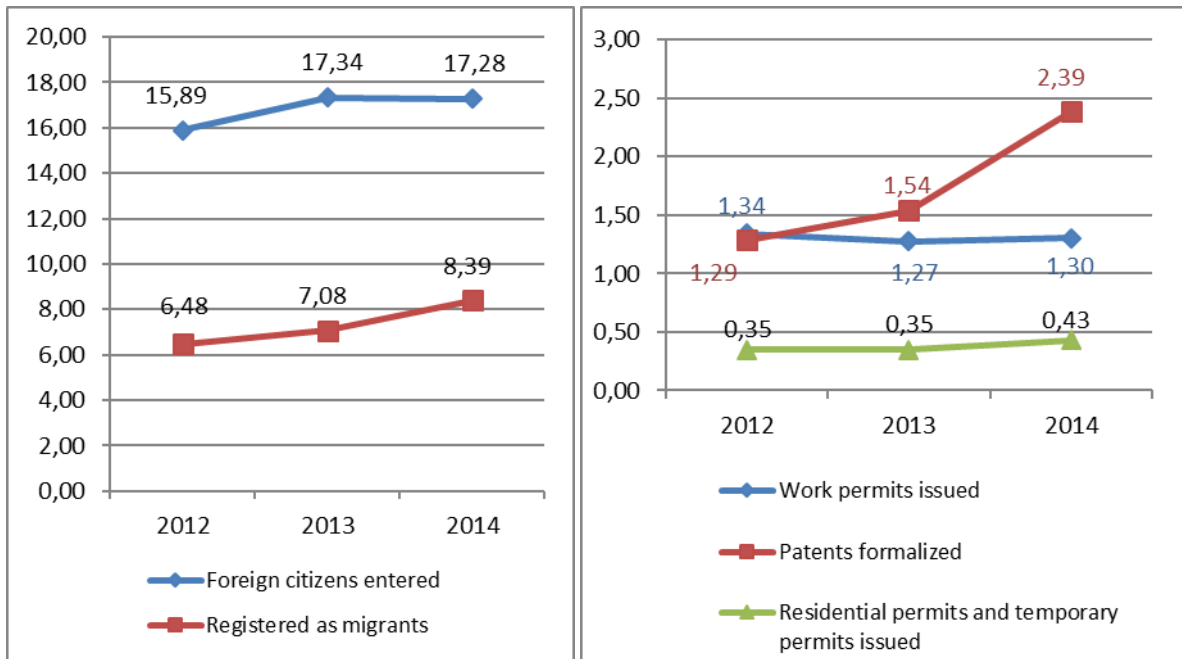


Fig. 10. Immigration to the Russian Federation, 2012 – 2014 (millions, absolute numbers).

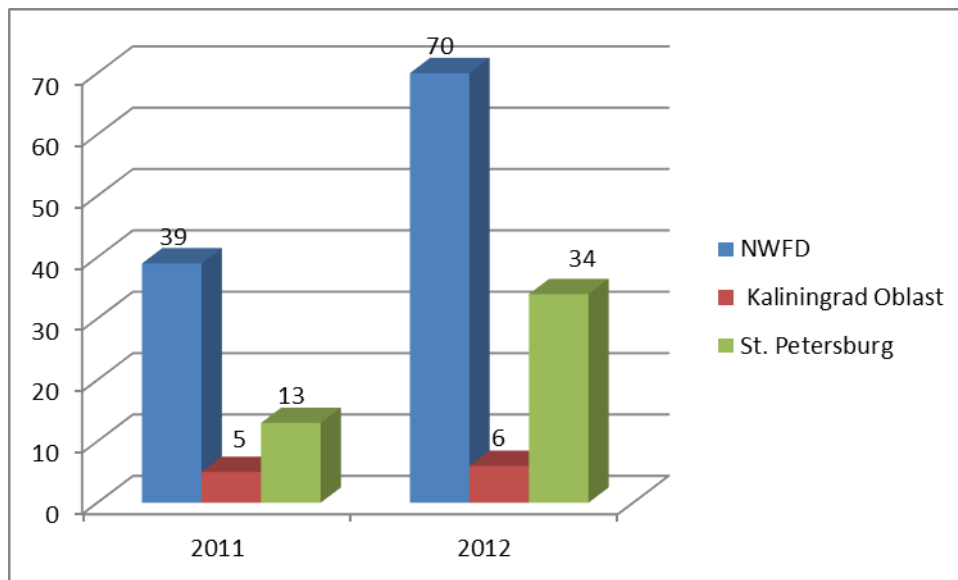


Fig. 11. Number of residential permits and temporary permits, 2011 – 2012 (thousands, absolute numbers).

including 5,536 people under voluntary relocation program “Fellow Countrymen,” the number of issued work permits was 8,025 (and 1,438 study permits), patent work permits were issued to 7,831 people, 5,582 people were granted temporary residential permits, and 3,859 persons obtained RF citizenship. The largest number of immigrants came from Kazakhstan, Kyrgyzstan, Uzbekistan, Ukraine, and Armenia. In 2013, the total number of registered immigrants was 48,152 including 5,536 people under voluntary relocation program “Fellow Countrymen,” the number of issued work permits was 8,573 (and 2,138 study permits), patent work permits were issued to 9,938 people, 7,132 people were granted temporary residential permits, and 6,746 persons obtained RF citizenship. The largest number of immigrants came from Kazakhstan, Kyrgyzstan, Uzbekistan, Ukraine, and Armenia.

Migration in Latvia. As of 1 January 2013, there were 352,046 (immigrants) in Latvia including those granted permission to reside in the country and those with a temporary permit, refugee status, or an alternative status. 4% or 15,517 persons out of the total number were aged 15 to 24. Most of the

immigrants aged 15-24 came from Russia, Ukraine, Belarus, Azerbaijan, Georgia. During the period of 2011-2014, the year 2012 featured the peak of migration activity. That year, 13,303 persons (30.5% of the were Russian citizens) entered the country for a long-term stay.

Migration in Poland. In 2010 and 2011, according to the data of the Central Statistical Office of Poland, 40,097 and 57,500 respectively entered the country. According to the data of the Ministry of Labour and Social Policy, in 2010, the number of immigrants who entered Poland in search of work was 36,622 people, in 2011 – 42,268 people, in 2012 – 39,144, in 2013 – 39,078 people (the number is declining). The number of those arriving for the purpose of studies is growing: in 2010 – 17,000, in 2011 – 20,934, in 2012 – 24,253, in 2013 – 29,172. In addition, according to the data of the Foreign Citizens' Office there is a significant number of refugees – 6,534 in 2010 (including 4,795 people from Chechnya), 6,887 in 2011 (4,305 from Chechnya), 10,753 in 2012 (6,084 from Chechnya), 14,996 in 2013 (12,666 from Chechnya). The key countries of departure for Poland have been Bulgaria, the Russian Federation (Chechnya, Dagestan, Ingushetia), Ukraine, Belarus. No data on young migrants are available. However, the country was left by 2,000,000 people in 2010; 2,060,000 people – in 2011; 2,130,000 people – in 2012; and 3,600,000 people – in 2013. Most of the Polish citizens were leaving for the USA, the UK, Germany, Norway.

Alcohol and drug abuse in Russia. 1. Use of alcohol. The number of newly-detected citizens with alcoholism and alcohol-related psychoses has been declining year-wise (Fig. 12)³⁸.

2. Drug addiction. The number of newly detected individuals diagnosed as drug addicts. In addition, there is a reduction in the number of patients suffering from drug addiction registered for regular check-ups (Fig. 13)³⁹.

In 2010-2012, there was a reduction in incident in the group aged 15-17 but the indicator started growing again in 2013 (Fig. 14)⁴⁰.

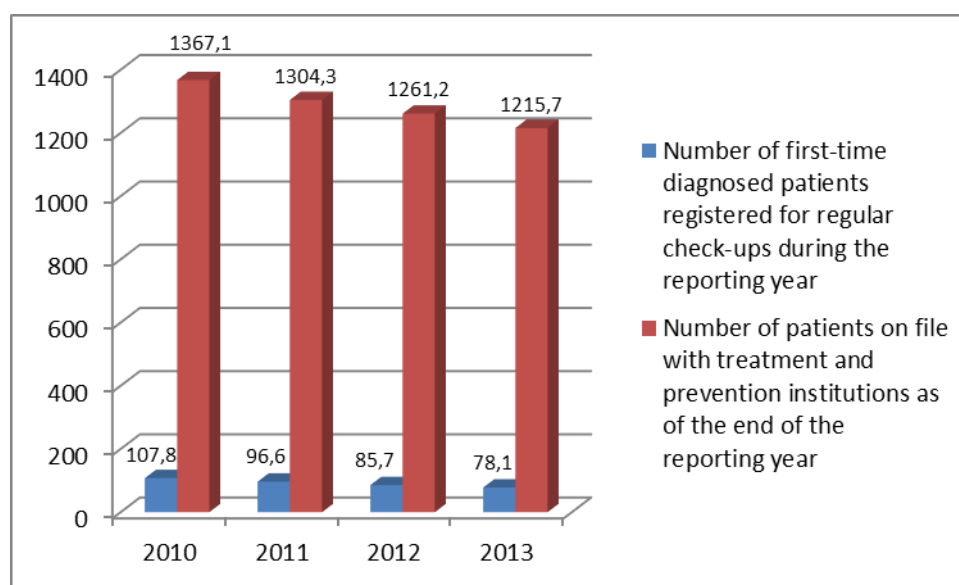


Fig. 12. Alcoholism and alcohol-related psychoses in Russia (per 100,000).

³⁸ "Incidence of alcoholism and alcohol-related psychoses among the population (data of the RF Ministry of Public Health, calculations by the Federal State Statistics Service)"/ Federal State Statistics Service. – [Moscow, 2014]. URL: http://www.gks.ru/wps/wcm/connect/rosstat_main/rosstat/ru/statistics/population/healthcare/# (accessed date: 01.02.2015).

³⁹ "Incidence of alcoholism and alcohol-related psychoses among the population (data of the RF Ministry of Public Health, calculations by the Federal State Statistics Service)"/ Federal State Statistics Service. – [Moscow, 2014]. URL: http://www.gks.ru/wps/wcm/connect/rosstat_main/rosstat/ru/statistics/population/healthcare/# (accessed date: 01.02.2015).

⁴⁰ "Statistical Yearbook of Russia, 2014"/ Federal State Statistics Service. – [Moscow, 2014]. URL: http://www.gks.ru/wps/wcm/connect/rosstat_main/rosstat/ru/statistics/publications/catalog/doc_1135087342078 (accessed date: 01.02.2015).

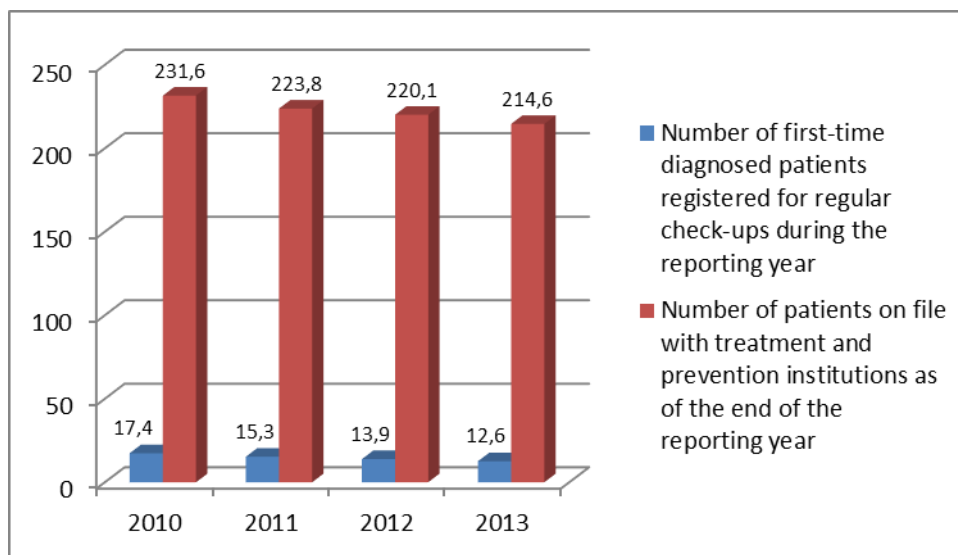


Fig. 13. Drug addiction in Russia (per 100,000).

Alcohol and drug abuse in St. Petersburg. In 2013, the overall incidence rate of drug disease diagnosed as “Narcotic drugs use with harmful consequences” and registered by public drug rehabilitation institutions among the population of St. Petersburg was 14.0 per 100,000 of population (in 2012 – 12.68 per 100,000 of population). 686 patients with the above diagnosis were subject to regular medical check-ups (580 patients – in 2012), including 184 children under the legal age (148 in 2012)⁴¹. Hence, St. Petersburg tends to have an increase in drug disease indicators.

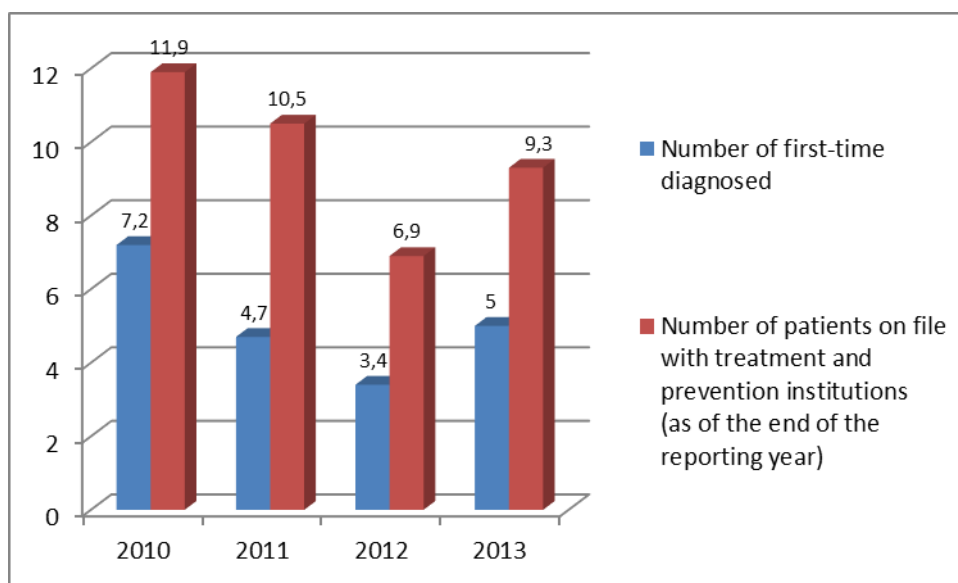


Fig. 14. Drug addiction in Russia, group aged 15 – 17 (per 100,000).

Alcohol and drug abuse in Kaliningrad. 1. Alcohol use. The prevalence of alcohol use was also declining from 2010 to 2012: from 1,225.2 to 1,142.1 persons per 100,000 of population. However, in 2012, a drug abuse upsurge was recorded among the group aged 18-19, to wit, 309.9 cases per 100,000 (in 2010 – 126.9, in 2011 – 94.9). Yet for the group aged 15-17 the number remained fairly stable (2010 – 40.7; 2011 – 38.3; 2012 – 25.5).

2. Drug addiction. According to the data of the State Service for Consumer Rights (available for 2010-2012), drug abuse prevalence per 100,000 of population was declining year-wise from 183.7 to

⁴¹ “The status of children and families with children in St. Petersburg”// Analytical materials on the status of children and families with children in St. Petersburg / St. Petersburg State Budget Institution “City Information and Methodology Centre “The Family.” – [St. Petersburg, 2013]. URL: <http://www.homekid.ru/analiticheskie-materialyi-o-polozhenii-detey-i-semej-v-sankt-peterburge.html> (accessed date: 01.08.2015).

167.7 persons. However, the proportion of injected use remained stable – 98.7-98,0%, with an insignificant share of non-injected use of 1.3%-2.0%. No data is available for the incidence among the group aged 15-24. There was also a reduction in the number of newly detected cases of drug abuse (2010 – 9.5 per 100,000 of population, 2011 – 5.3 per 100,000 of population, 2012 – 3.7 per 100,000 of population). For the group aged 15-17, the number of newly detected cases of drug abuse was: in 2010 – 3.4/100,000, in 2011 – 0.0/100,000, in 2012 – 3.6/100,000, and for the group aged 18-19 the number of newly detected cases was: in 2010 – 7.5/100,000, in 2011 – 7.0/100,000, in 2012 – 9.0/100,000.

Alcohol and drug abuse in Latvia. By the number of newly detected cases of alcoholism and drug abuse the situation in Latvia is relatively stable (Fig. 15). With respect to newly diagnosed alcoholism by age group taking into account gender differences, it should be noted that in 2013, in the group aged 0-19 incidence among men was 4.5 per 100,000 members of the group concerned, for women – 0.0, in the group aged 20-29 the numbers were 88.3 and 20.7 respectively⁴².

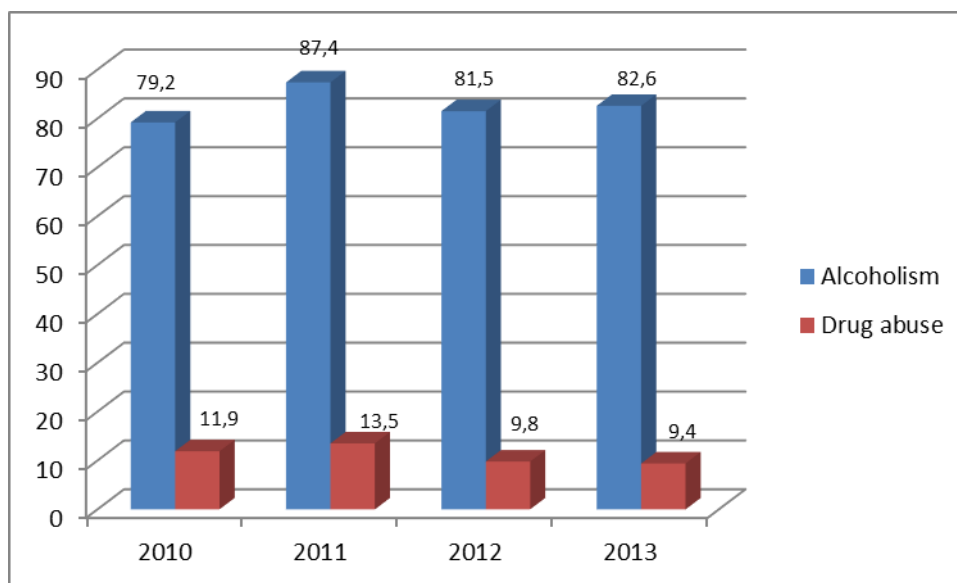


Fig. 15. Incidence of alcoholism and drug abuse in Latvia (per 100,000 of population).

Alcohol and drug abuse in Poland. 1. Alcohol use. According to the data of a research conducted among young people by the National Office for Drug Control, 49% in the group aged 15-16 had had alcohol overdose at least once in their life. More detailed statistics on alcohol are not available.

2. Drug abuse. According to the estimates of the National Office for Drug Control the number of drug addiction cases in Poland is from 57,000 to 103,000, with 20,000 to 27,000 cases accounting for injected use.

According to research data, in 2011, 29.1% of the group aged 15-24 had experience in cannabinoids use. In 2011, the most popular drugs were cannabinoids: among those aged 15-16 – 24.3 %, among those aged 17-18 – 37.3%; amphetamines: among those aged 15-16 – 4,6% , among those aged 17-18 – 8.3 %; and also legal substances ("dopalacze"): among those aged 15-16 – 10.5%, among those aged 17-18 – 15.8%. In 2012, during the last 12 months 88% of the group used cannabinoids, and 10% used amphetamines.

Commercial sexual exploitation of children in Russia. According to the official statistics, during 2010-2013 the number of sexual crimes against children varied as follows: 9,524 crimes in 2010; 10,624 crimes in 2011; 8,825 crimes in 2012; 8,490 crimes in 2013⁴³.

⁴² "The Statistical Yearbook of Health Care in Latvia, 15th Edition"/ Centre for Disease Prevention and Control of Latvia. – [Riga, 2014]. URL: <http://www.spkc.gov.lv/statistics/> (accessed date: 01.12.2014).

⁴³ "Basic statistical data on the protection of the rights and interests of the child"/ Commissioner of the President of Russia on the Rights of the Child. – [Moscow, 2014]. URL: <http://www.rfdeti.ru/files/StatData-2014-aug.pdf> (accessed date: 01.08.2015).

Commercial sexual exploitation in St. Petersburg. The Main Department of the RF Ministry of the Interior for St. Petersburg and Leningrad Oblast reported that in 2013 the number of registered crimes committed against children and adolescents in St. Petersburg and Leningrad Oblast was 1,167 (-71), with more than 75% of them being of violent nature. The list of crimes included crimes against sexual freedom and sexual integrity of children (articles 131, 132, 134 and 135 of the Criminal Code of the Russian Federation – 218; +43). Quite often violence was committed in the child's family by people who were very close to the child even though not necessarily his/her relatives. There is a trend towards growth of violent crimes of sexual nature year-wise. (Fig.16)⁴⁴:

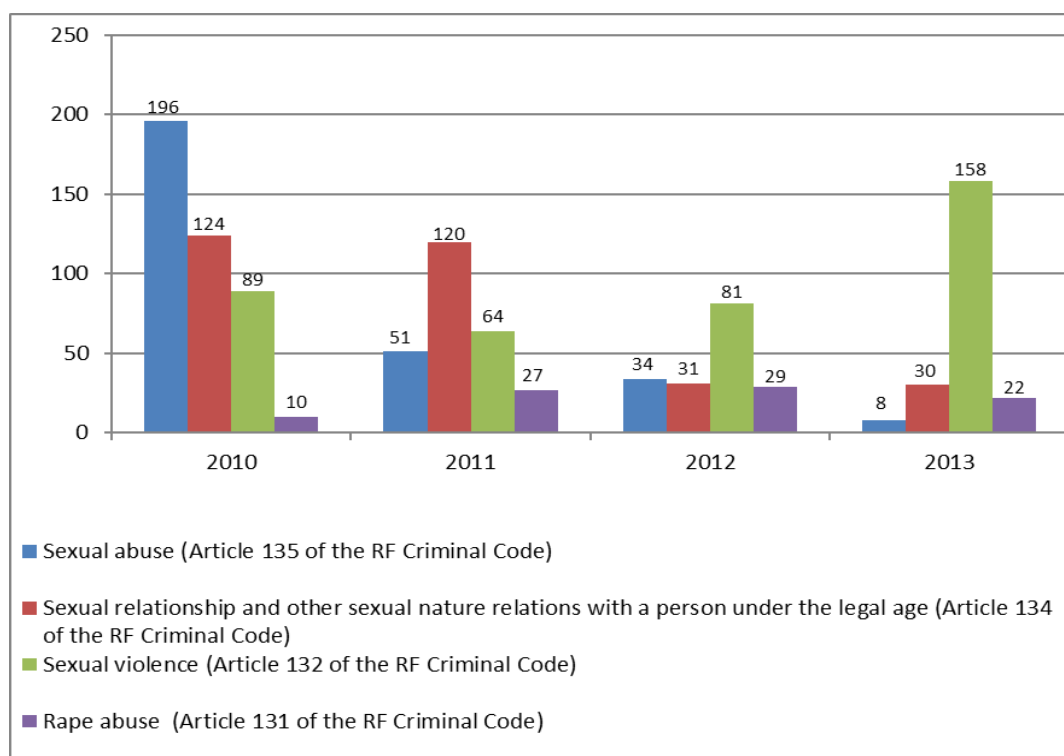


Fig. 16. Crimes against children under the legal age, St. Petersburg, 2010 – 2013 (absolute numbers).

Commercial sexual exploitation of children in Kaliningrad. Unfortunately, most of the data directly or indirectly related to the CSEC issue are non-available (data such as the number of sexual crimes against children, number of cases of children's involvement into pornography and prostitution, traffic, existing estimates of the number of individuals involved in CSEC, CSEC research data).

Commercial sexual exploitation of children in Latvia. In Latvia, data were available for crimes committed against children under the legal age such as rape abuse. In 2010, the number of rapes was 19, in 2011 – 20, in 2012 – 23, in 2013 – 16.

Commercial sexual exploitation of children in Poland. According to the estimates of the Central Trafficking Control Unit of Police Department's Criminal Bureau, in 2010, there were 24 children among trafficking victims, in 2011 – 17 children, and in 2012 – 16 children⁴⁵.

Conclusions from the statistics overview. 1. HIV infection and AI. The HIV epidemic is steadily growing in Russia, the main transmission channels being injection and heterosexual intercourse. But transmission pathways have not been identified for a considerable proportion of cases. Even though the percentage of young PLHA is declining, it still remains significant. Consequently, it is most important to carry out HIV

⁴⁴ "The status of children and families with children in St. Petersburg"// Analytical materials on the status of children and families with children in St. Petersburg / St. Petersburg State Budget Institution "City Information and Methodology Centre "The Family." – [St. Petersburg, 2013]. URL: <http://www.homekid.ru/analiticheskie-materialyi-o-polozhenii-detej-i-semej-v-sankt-peterburge.html> (accessed date: 01.08.2015).

⁴⁵ "Statistics"/ Handelludzmi. – [29.07.2013]. URL: http://www.handelludzmi.eu/hle/database/statistics/6181_Statistics.html (accessed date: 01.08.2015).

preventive activities including their components aimed at combatting drug addiction and risky sexual practices.

The number of cases of tuberculosis is declining but the epidemiological situation including the group aged 15-17, remains unfavorable. Also coming under notice is a significant number of forms of HIV-related tuberculosis. Therefore, an important area of prevention outreach is raising awareness of TB transmission routes and promotion of annual X-ray examinations. It is noticeable that there is a reduction in the number of officially registered cases of other AIs: hepatitis, syphilis and gonococcal infection.

The number of new HIV cases is also increasing in Latvia. In addition, the growth in an AI such as chlamydia stresses the need for preventing HIV transmission through intercourse.

The number of HIV cases is also growing in Poland while the AI incidence there is slightly down. Hence, HIV prevention programs still remain quite relevant.

2. Migration. With respect to migration, there are significant differences between the countries. For instance, an increasing number of foreign citizens arrive in Russia every year in search of work, and the number of issued temporary residential permits is also growing. CIS citizens predominate among the migrants, and there is a significant proportion of young people. In Latvia, migration flows are not so significant. The proportion of young migrants is fairly low. Poland is distinguished for a reduced number of labour migrants, and an increase in the number of young people coming to the country to get education. Hence, HIV prevention programs are mostly relevant for Russia and Poland but due to differences in the composition of migration flows, they should feature different focuses and content.

3. Alcohol and drug abuse. Despite a general reduction in the number of registered cases of drug addiction and alcoholism, comes under notice the growth of drug addiction cases registered in St. Petersburg as well as an increase in this indicator in the group aged 15-17 across the Russian Federation. The above indicators do not tend to grow in Latvia but a significant difference between male and female groups is quite conspicuous. The data available for Poland is insufficient.

4. Commercial sexual exploitation of children. All of the surveyed countries do not register an adequate number of indicators that could provide direct or indirect indications regarding the incidence of CSEC. However, Russia tends to have fewer children kept in orphanages. In St. Petersburg there is a pronounced trend toward an increase in the number of sexual crimes against children under the legal age. The data on Latvia and Poland is insufficient.

Survey results for adolescents and young people aged 15 to 24

In Russia and Latvia, the respondents were recruited from basic and secondary vocational education institutions. The students of such institutions typically come from the most socially vulnerable groups of population. In Poland, respondents were recruited from special centers providing service to young people with behavior and social problems, addiction treatment clinics, family and youth centers located in deprived areas. Before adopting the decision to include an institution in the survey, the research team consulted at least three experts from the region. The total sampling included 1,596 people. The number of respondents in each location is shown in Table 1.

Table 1. Data gathering sites and number of respondents.

Region	Respondents	Number of institutions	Number of respondents	Average and median age	Gender, men, %
Kaliningrad, Russia	College students aged 15-24	5	365	M=16.8 Me=17	74.8%
St. Petersburg, Russia	Vocational school students aged 15-24	5	431	M=17.6 Me=17	62.4%
Riga, Latvia	Vocational school students aged 18-24	6	400	M=18.8 Me=19	56.8%
Warsaw, Poland	Young people with behavior and social problems aged 15-24	8	400	M=18.4 Me=18	56.5%
Total number of respondents			1,596		

Sociodemographic profiles. Data processing using chi-square test revealed that there are statistically significant gender and age differences between the countries (cities) where the data were gathered. Survey respondents from Russia were younger ($p \leq 0.001$), with a higher percentage of male respondents ($p \leq 0.001$) compared to respondents from Latvia and Poland (Table 2). Even though they belonged to relatively disadvantaged groups, according to the self-assessment of 87% to 95% of all the respondents on all of the data gathering sites, they considered their well-being as medium- or upper-medium level ($p \leq 0.001$). In all the countries, the respondents were members of the dominant (titular) nation of the country (least of all in Latvia – 83.5%, most of all in Poland – 98.5%).

Table 2. Sociodemographic profiles.

	Kaliningrad	Riga	St. Petersburg	Warsaw	Total	p
<i>Gender</i>						0.001
Female	92	173	160	173	598	
	25.2%	43.3%	37.1%	43.3%	37.5%	
Male	273	227	269	226	995	
	74.8%	56.8%	62.4%	56.5%	62.3%	
<i>Age</i>	M=16.8	M=17.6	M=18.8	M=18.4	M=17.9	0.001
	Me=17	Me=17	Me=19	Me=18	Me=18	
<i>Educational background</i>						0.001
Secondary school	6 (1.6%)	15 (3.8%)	7 (1.6%)	84 (21.0%)	112 (7.0%)	
Basic vocational school	17 (4.7%)	157 (39.3%)	114 (26.5%)	226 (56.5%)	514 (32.2%)	
College	321 (87.9%)	215 (53.8%)	301 (69.8%)	54 (13.5%)	891 (55.8%)	
University	5 (1.4%)	2 (0.5%)	3 (0.7%)	36 (9.0%)	46 (2.9%)	
Other	5 (1.4%)	9 (2.3%)	3 (0.7%)	0 (0.0%)	17 (1.1%)	
Unanswered	11 (3.0%)	2 (0.5%)	3 (0.7%)	0 (0.0%)	16 (1.0%)	
<i>Takes up any paid job</i>	70 (19.2%)	100 (25.0%)	56 (13.0%)	93 (23.3%)	319 (20.0%)	0.001
<i>Migrants (those who did not leave in the region since their birth)</i>	65 (17.8%)	7 (1.8%)	27 (6.3%)	3 (0.8%)	102 (6.4%)	0.001

Use of PAS. 1. Smoking incidence among respondents. Active smokers (40.5%) and ex-smokers (18.0%) accounted for more than a half of respondents. The lowest number of active smokers was in Kaliningrad, the highest number – in St. Petersburg, which suggests that the approach to smoking in these Russian cities should be different (Fig. 17).

2. Use of alcohol by respondents. 81.4% of respondents had used alcohol at some time in the past. Half the respondents used alcohol for the first time before the age of 14. It should be noted that while there were significant differences between the average age of first taking alcohol, the median age was the same throughout the sampling (14 years old). In addition, it may be noted that alcohol use is more widespread among Latvian respondents, and less widespread among those from Kaliningrad. Moreover, the number of respondents with signs of alcohol abuse is the highest for Latvia and Poland (Table 3).

A comparison between the results of self-assessment of alcohol dependence and those based on the CAGE scale shows that young people are evidently non-realistic in their self-assessments. Accordingly, in all of the cities surveyed as well as in the sampling as a whole, young people underestimated their alcohol dependence (Fig. 18).

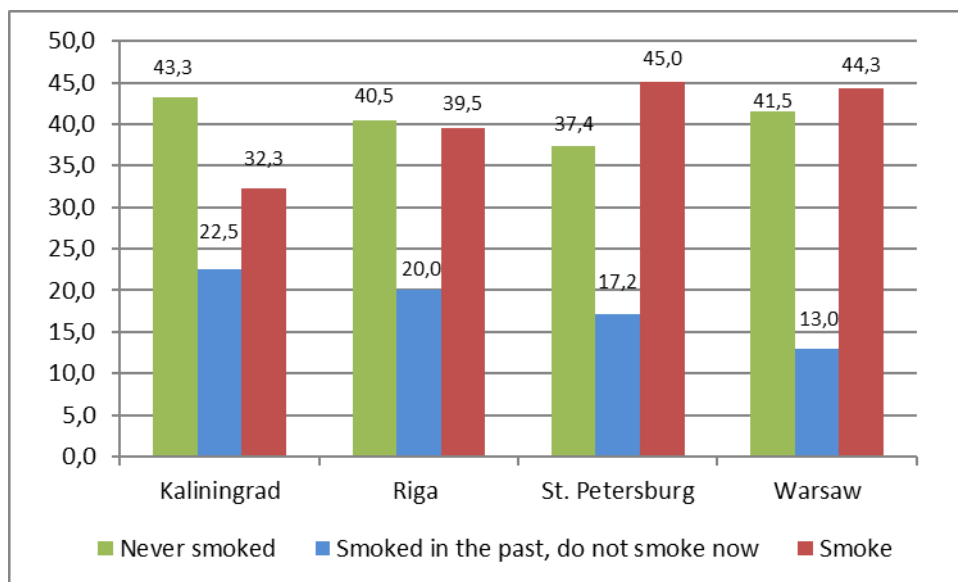


Fig. 17. Smoking (%), $p \leq 0.001$.

Table 3. Use of alcohol.

	Kaliningrad	Riga	St. Petersburg	Warsaw	Total	p
Used alcohol at some time	266 (72.9%)	388(97.0%)	285(66.1%)	360(90.0%)	1299(81.4%)	
Age of first use of alcohol	M=17.8 Me=14	M=15.9 Me=14	M=19.3 Me=14	M=14.9 Me=14	M=16.8 Me=14	0.01
Have been having 5+ shots of alcohol per week over the last 12 months	12 (3.3%)	34 (8.5%)	23 (5.3%)	63 (15.8%)	132 (8.3%)	0.001
Show signs of alcohol dependence based on the CAGE scale	19 (5.2%)	42 (10.5%)	27 (6.3%)	43 (10.8%)	131 (8.2%)	0.01

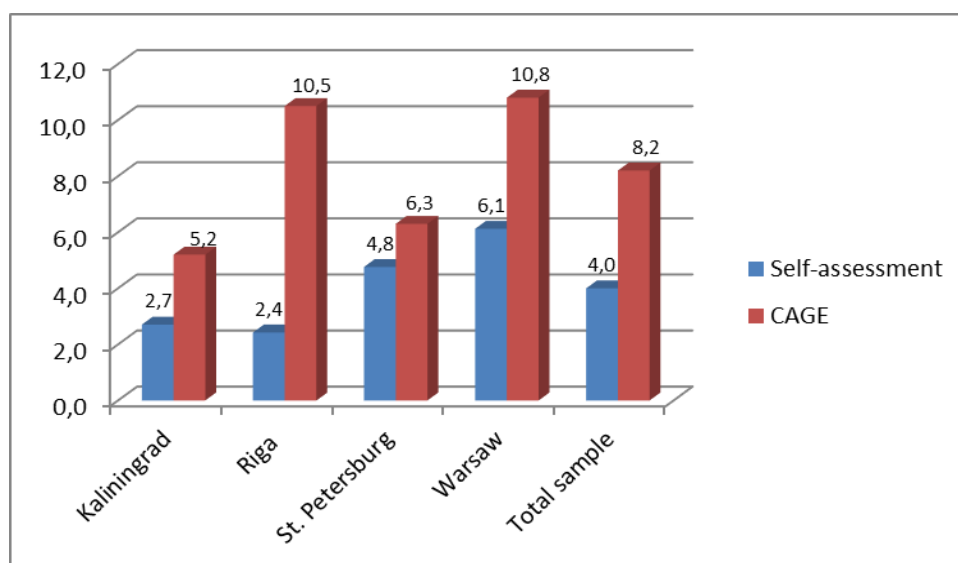


Fig. 18. Results of assessment of alcohol dependence based on the CAGE scale (more than two 'yes' answers) (%), ($p \leq 0.01$) vs. self-assessment results (believe they abuse alcohol) (%), ($p \leq 0.001$).

3. Use of drugs by respondents. 37.7% of respondents had used drugs at some time in the past. There proportion in the cities concerned was as follows: in St. Petersburg – 19.5%, in Kaliningrad – 25.5%, in Riga – 47.3%, in Warsaw – 59.0%. ($p \leq 0.001$). Most of the respondents had tried drugs long before this survey. For instance, the median age of first-time use was 16, slightly varying by cities. A small percentage of respondents had used drugs by injection at some time in the past, with young people from St. Petersburg having had this experience more often than the other respondents (Table 4).

Table 4. Use of drugs.

	Kaliningrad	Riga	St. Petersburg	Warsaw	Total	p
Age of first use of drugs	M=14.9 Me=15.0	M=13.3 Me=16.0	M=15.5 Me=16.0	M=14.9 Me=15.0	M=15.4 Me=16.0	0.01
Used a drug for the first time during the last 12 months	40 (11.0%)	21 (5.3%)	24 (5.6%)	173 (43.3%)	258 (16.2%)	0.001
Had used drugs by injection at some time in the past*	0 (0.0%)	1 (0.5%)	6 (7.1%)	12 (5.1%)	19 (3.2%)	0.001
Used drugs by injection during the last 12 months*	0 (0.0%)	1 (0.5%)	3 (3.6%)	9 (3.8%)	13 (2.2%)	0.001
Used drugs for the first time because others in their close environment use them*	5 (5.4%)	27 (14.3%)	4 (4.8%)	51 (21.6%)	87 (14.5%)	0.001

*(among those using drugs)

4.5% of respondents show signs of drug dependence, the indicator being the highest in Warsaw – 12%, and the lowest in Kaliningrad – 0.8%. Unlike in the case of alcohol dependence, young people from the Russian cities assess their dependence higher than shown on the DAST scale. However, the trend for respondents from Riga and Warsaw is similar to the self-assessment of alcohol dependence (Fig. 19).

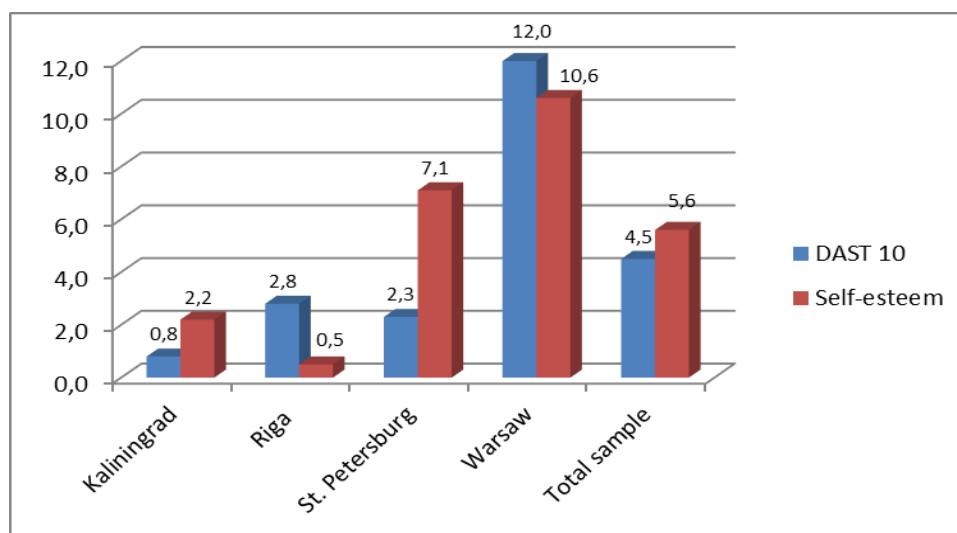


Fig. 19. Results of assessment of drug dependence based on the DAST 10 scale (6+points) (%), ($p \leq 0.001$) vs. self-esteem (%), ($p \leq 0.001$) (among those using drugs).

4. Use of alcohol and drugs by members of the respondents' social environment. Respondents were to answer the question which members of their social environment, in their opinion, were having alcohol problems. In Kaliningrad, one fourth of respondents answered that certain members of their closest environment (15.9% among their relatives); in Riga – more than a half (54.3%) of respondents (39.4% among their relatives); in St. Petersburg – 37.4% of respondents (26.8% among their relatives); in Warsaw – 59.0% of respondents (37.8% among their relatives) ($p \leq 0.001$). For the whole sampling, 44.3% of respondents specified that certain members of their closest environment had alcohol

problems, and for their relatives – 30.3%. The closest social environment includes father ($p \leq 0.001$), mother ($p \leq 0.001$), grandfather (grandmother) ($p \leq 0.001$), close friend ($p \leq 0.001$), hostel/rental property mate ($p \leq 0.001$). There were also significant differences for the respondents who did not have such people in their environment ($p \leq 0.001$).

In addition, in the social environment of respondents there are fairly many friends and students of educational institutions using alcohol three or more times a week (Fig. 20).

Respondents were to answer the question who from their social environment, to the best of their knowledge, had used or was using drugs. In Kaliningrad, 27.7% of respondents had somebody from their closest environment who had used (or were using) drugs (3.4% of respondents had relatives who had used (or were using) drugs; in Riga – 52.3% and 5.9% respectively; in St. Petersburg – one fifth of respondents and 4.8% respectively; in Warsaw – 71.0% and 16.8% respectively ($p \leq 0.001$). For the whole sampling, 42.6% of respondents specified that certain members of their closest environment were using drugs, and for their relatives – 7.8%. The closest social environment includes father ($p \leq 0.001$), mother ($p \leq 0.001$), brother/sister ($p \leq 0.001$), grandfather/grandmother ($p \leq 0.01$), close friend ($p \leq 0.001$), husband/wife ($p \leq 0.01$), permanent partner other than husband or wife, hostel/rental property mate ($p \leq 0.001$). There were also significant differences for the respondents who did not have such people in their environment ($p \leq 0.001$).

In addition, in the social environment of respondents there are fairly many friends and students of educational institutions who had used or were using drugs (Fig. 21).

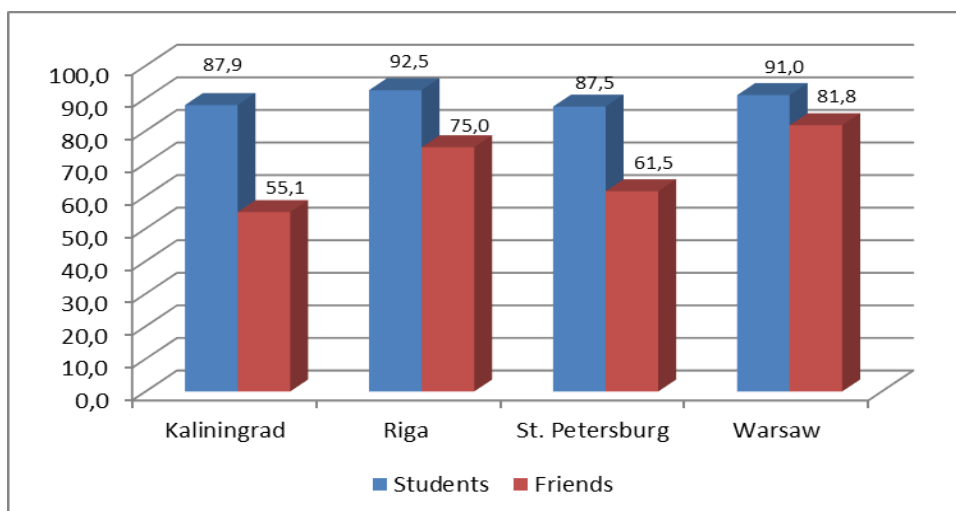


Fig. 20. In the social environment, there are students and/or close friends using alcohol three or more times a week ($\%, p \leq 0.001$).

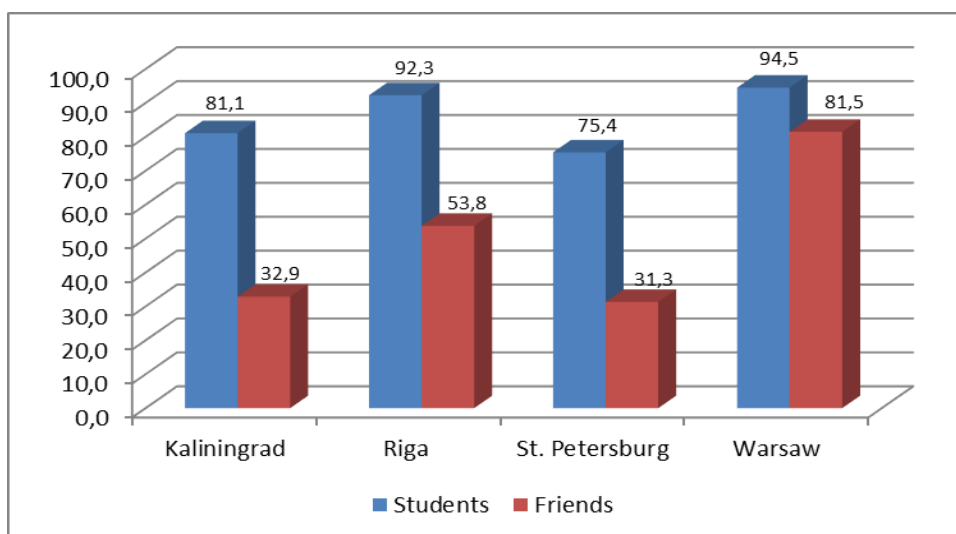


Fig. 21. In the social environment, there are students and/or close friends who had used or were using drugs ($\%, p \leq 0.001$).

Sexual relationship. More than half of both male and female respondents had had sexual relationship at some time in their life (Table 5). Male respondents had their first sexual relationship much earlier than female respondents. More than one fifth of female and male respondents did not use a condom for their first intercourse. There was also a significant proportion of males who had their first intercourse in a state of alcoholic intoxication. That was particularly for respondents from St. Petersburg and Warsaw. 2.8% of males and 4.5% of females had had STIs at some time in the past. It also comes under attention that more than one third of females did not use a condom in their latest sexual intercourse with at least one type of sexual partners.

Table 5. Features of sexual behavior among sexually active young people.

Feature		Kaliningrad	Riga	St. Petersburg	Warsaw	Total	p
Had had sexual intercourse at some time, %	Males	48.0%	52.0%	72.2%	64.2%	58.3%	$p \leq 0.001$
	Females	52.2%	56.9%	85.5%	51.4%	62.9%	$p \leq 0.001$
Age of first sexual intercourse, M	Males	14.5	14.7	16.0	15.4	15.2	$p \leq 0.001$
	Females	16.2	16.2	16.3	16.1	16.2	insignif.
Age of first sexual intercourse, M <15, %	Males	19.4%	22.3%	7.9%	19.5%	17.6%	$p \leq 0.001$
	Females	4.3%	7.5%	9.8%	9.2%	8.2%	insignif.
Did not use a condom in their first sexual intercourse *, %	Males	25.2%	25.4%	13.2%	20.8%	20.7%	$p \leq 0.05$
	Females	29.3%	27.3%	23.8%	15.1%	23.2%	insignif.
Had their first sexual intercourse under the influence of alcohol*, %	Males	15.9%	14.6%	29.4%	32.4%	23.6%	$p \leq 0.001$
	Females	18.2%	15.1%	30.1%	22.5%	23.2%	insignif.
STIs diagnosed at some time in the past*, %	Males	2.3%	2.1%	1.8%	4.8%	2.8%	insignif.
	Females	4.2%	6.6%	4.1%	2.2%	4.3%	insignif.
Feature		Kaliningrad	Riga	St. Petersburg	Warsaw	Total	p
Number of sexual partners over the last 12 months*, M	Males	3.0	3.1	2.1	3.5	2.9	$p \leq 0.05$
	Females	1.6	1.6	1.6	1.9	1.7	$p \leq 0.05$
Did not use a condom in their latest sexual intercourse with at least one type of sexual partners (regular, occasional)*, %	Males	9.1%	19.1%	14.6%	26.9%	17.7%	$p \leq 0.001$
	Females	25.6%	38.9%	33.1%	23.9%	31.5%	insignif.

*Among those who had had sexual intercourse at some time in the past.

HIV/AIDS and AI. Most of the respondents are aware of the existence of a disease such as HIV. But only 20.7% of respondents gave correct answers to all of the five indicator questions. The respondents who were most aware of HIV were from Poland, the least aware respondents were Russian young people (Fig. 22, 23).

Respondents estimate their risk of contracting HIV as very high ($p \leq 0.001$). However, only a very small percentage of respondents who were tested over the last 12 months and know the test result (Fig. 24).

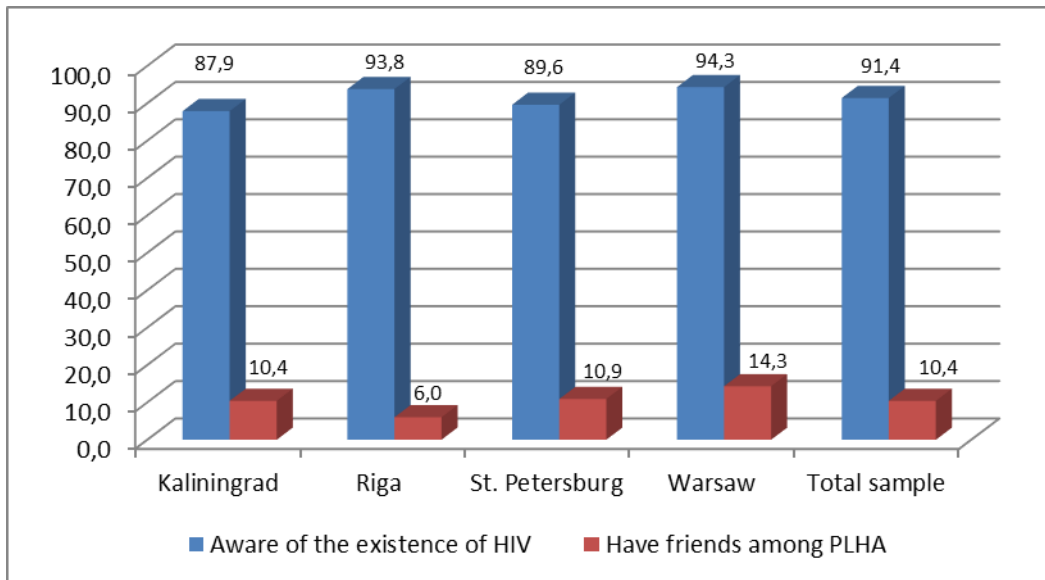


Fig. 22. Respondents' awareness of the existence of HIV (% , $p \leq 0.001$).

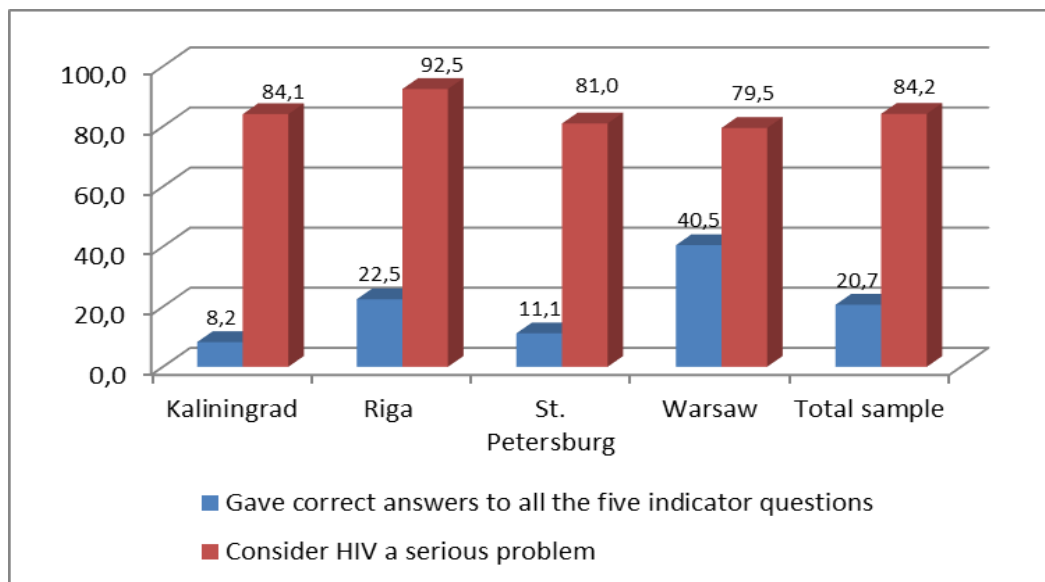


Fig. 23. Index of knowledge about HIV (% , $p \leq 0.001$).

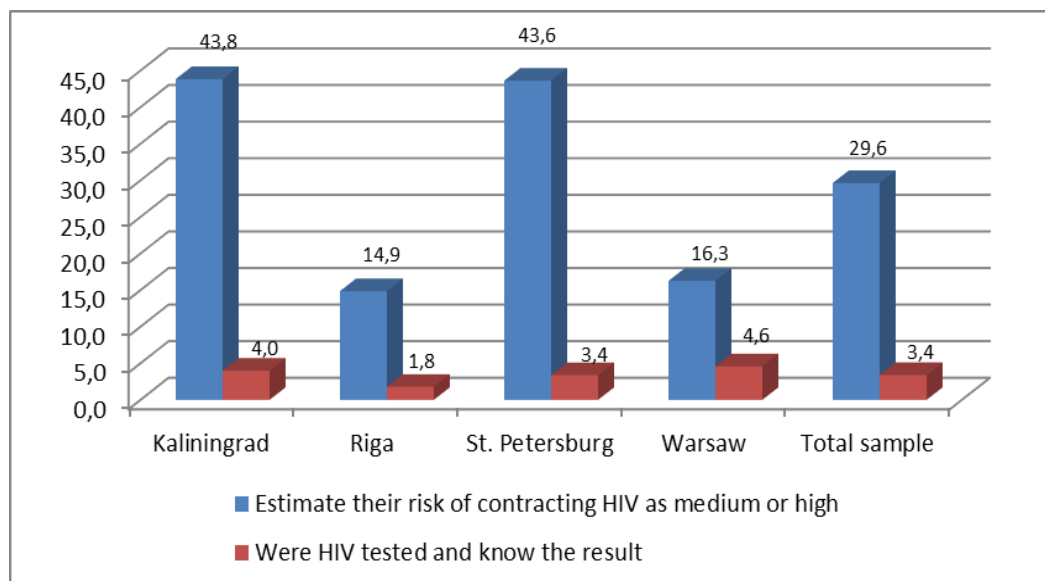


Fig. 24. Estimate their risk of contracting HIV as medium or higher than medium vs. those tested over the last 12 months, %.

Tuberculosis. Fairly few respondents know people who were or are ill with tuberculosis (Table 6). Less than half the respondents agree that TB is airborne-transmitted though it is a correct statement. Just as well, less than half the respondents are aware that medication is available to treat tuberculosis.

Table 6. Knowledge about tuberculosis.

	Kaliningrad	Riga	St. Petersburg	Warsaw	Total	p
Know people who are or were ill with TB	2(0.5%)	0(0.0%)	1(0.2%)	2(0.5%)	5(0.3%)	0.001
TB is transmitted from person to person via air – when speaking, coughing, or sneezing	226 (61.9%)	177 (44.5%)	209 (48.5%)	136 (34.0%)	748 (46.9%)	0.001
Do you think there are medicines capable of curing TB	160 (43.8%)	186 (46.7%)	193 (44.8%)	171 (42.8%)	710 (44.5%)	0.001

Hepatitis. Two thirds of respondents are aware that there are viral hepatitis forms B and C. One tenth of respondents know people living with hepatitis or killed by it. The respondents most informed about hepatitis were Latvia (Fig. 25).

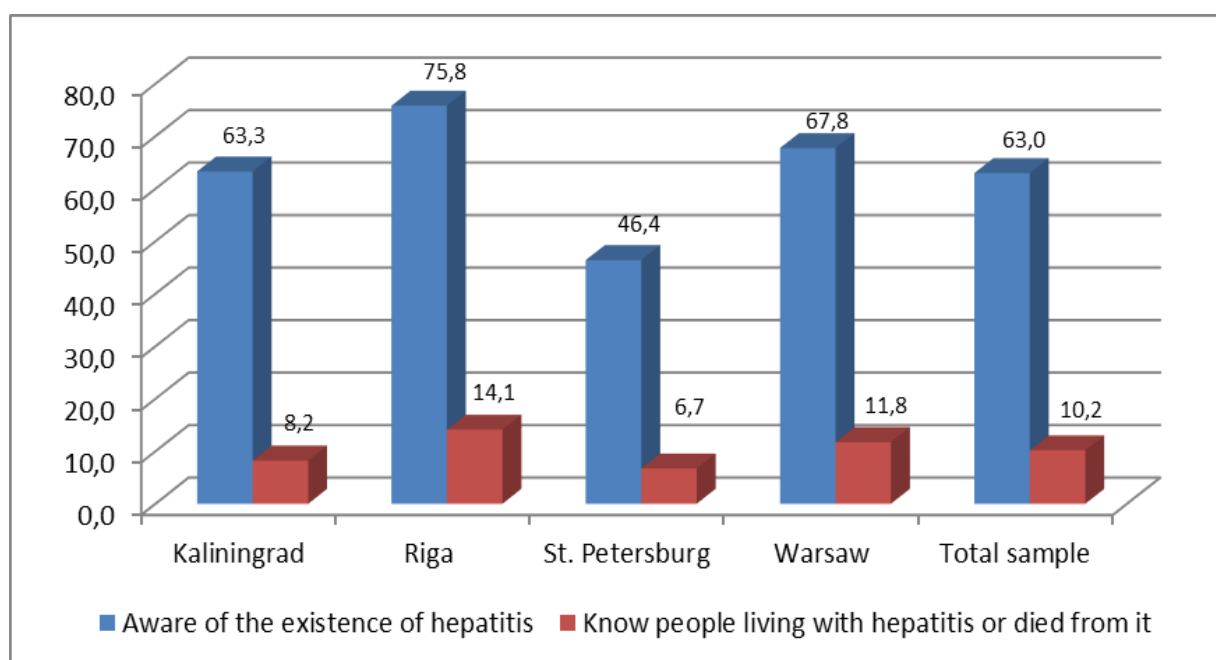


Fig. 25. Awareness of respondents of the existence of viral forms of hepatitis (%; $p \leq 0,001$).

Less than one fifth of respondents are aware of the existence of a vaccine for hepatitis B, Russian respondents being much less aware of it that those from Latvia and Poland (Table 7). A majority of respondents agree to the correct statement about the fact that an externally healthy person may have a viral hepatitis (36.5%).

Table 7. Knowledge of hepatitis.

	Kaliningrad	Riga	St. Petersburg	Warsaw	Total	<i>p</i>
A vaccine is available which helps to prevent hepatitis B	22 (6.0%)	116 (29.1%)	16 (14.2%)	112 (28.0%)	311 (19.5%)	0.001
Hepatitis forms B and C are much more contagious than HIV	42 (11.5%)	90 (22.7%)	52(12.1%)	63 (15.8%)	247 (15.5%)	0.001
An externally healthy person may have hepatitis B or C	115(31.5%)	167 (42.1%)	141(32.7%)	158 (39.5%)	581(36.5%)	0.001

Reach of prevention activities and demand for them. 1. Knowledge of where to apply for help. The respondents as a whole do not highly assess their knowledge of where to apply for help in case of problems with alcohol, drugs, or sexual violence (in all of those cases, it is around one third of respondents, Table 8). Respondents more often positively assess their knowledge of how to protect themselves against STIs but such respondents accounted for only slightly more than a half of the total number of respondents. Just like before, the persons most informed on these issues were young people from Latvia and Poland.

2. Reach of prevention activities. The overall reach of prevention activities under different programs in the sampling over the last 12 months was as follows: for STIs – 14.9%, for hepatitis – 7.0%, for tuberculosis – 8.2%, for drug use – 20.2%, for alcohol use – 20.2%, for smoking – 19.7%, for HIV – 15.7%. The widest reach of programs was among Polish respondents, and the worst reach was among Latvian respondents. It should be noted that, overall, the reach of any particular prevention intervention does not exceed 37.0% in any of the categories (Fig. 26).

Table 8. Self-assessment of knowledge (answer: "Know well enough or very well").

Type of knowledge	Kaliningrad	Riga	St. Petersburg	Warsaw	Total	<i>p</i>
What is alcohol dependence, and how can it be prevented?	179 (49.1%)	320 (80.8%)	214 (49.7%)	285 (71.3%)	998 (62.7%)	0.001
Where could one apply for help in your city if experiencing a problem due to alcohol use?	104 (28.5%)	140 (35.4%)	133 (30.8%)	173 (43.3%)	613 (34.5%)	0.001
What is drug addiction and how can it be prevented?	129 (35.3%)	255 (64.7%)	173 (40.1%)	263 (65.8%)	820 (51.5%)	0.001
Where could one apply for help in your city if experiencing a problem due to drug use?	88 (24.1%)	115 (29.1%)	125 (29.0%)	155 (38.8%)	483 (30.3%)	0.001
How can you protect yourself from sexual violence and abuse?	162 (44.4%)	233 (59.2%)	184 (42.7%)	194 (48.6%)	771 (48.5%)	0.001
Where could one apply for help in your city in case of being forced to have intercourse?	115 (31.5%)	130 (33.0%)	147 (34.1%)	107 (26.8%)	499 (30.4%)	0.001
How do you protect yourself against STIs?	162 (34.4%)	229 (58.0%)	211 (49.1%)	243 (60.8%)	845 (53.1%)	0.001

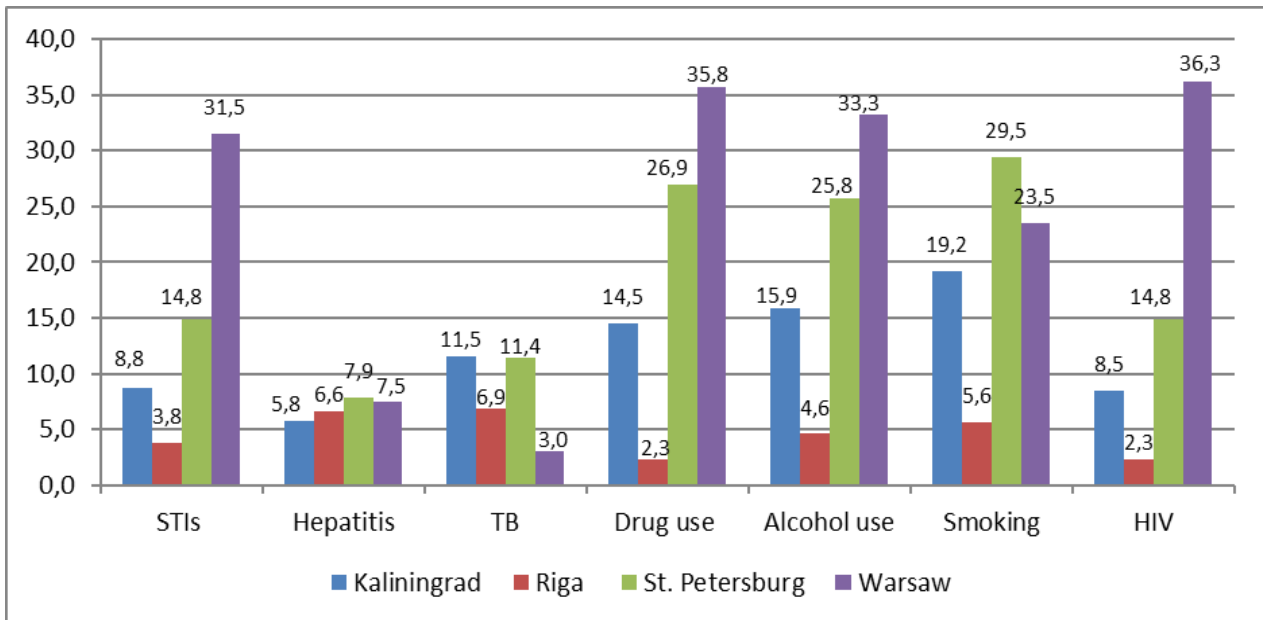


Fig. 26. Reach of prevention activities (% , $p \leq 0.001$).

3. Channels of prevention interventions:

- personal communication: respondents are better disposed to learn prevention information from specialists in the course of personal communication (Fig. 27), only in Riga students place more trust in their age peers. On the whole, respondents have the least trust in their parents (Fig. 27);

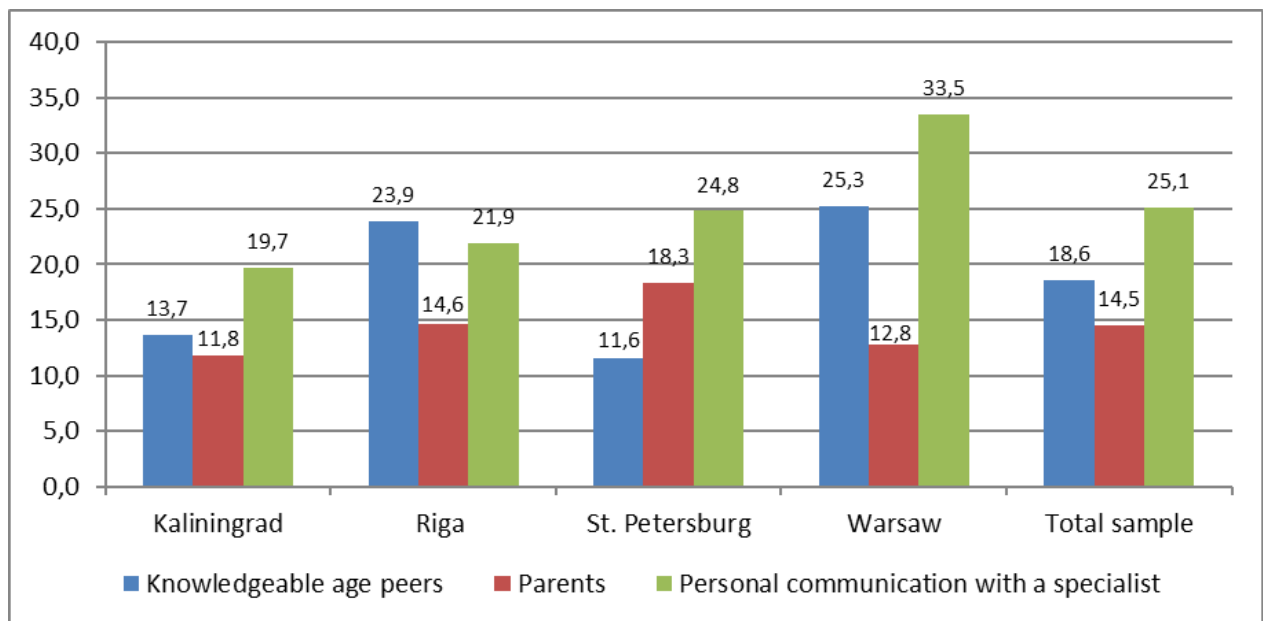


Fig. 27. Preferred channels of HIV prevention interventions – personal communication (% , $p \leq 0.001$).

- public activities: the most preferred public activities are lectures and presentations of real life stories of sick people (Fig. 28). Respondents are least attracted by active forms of participation – topic-based plays and panel discussions;
- unaided search: respondents prefer to learn information on HIV unaided on websites, literature being the least popular source of information. It should be noted that difference between the sources are least pronounced in this category (Fig. 29).

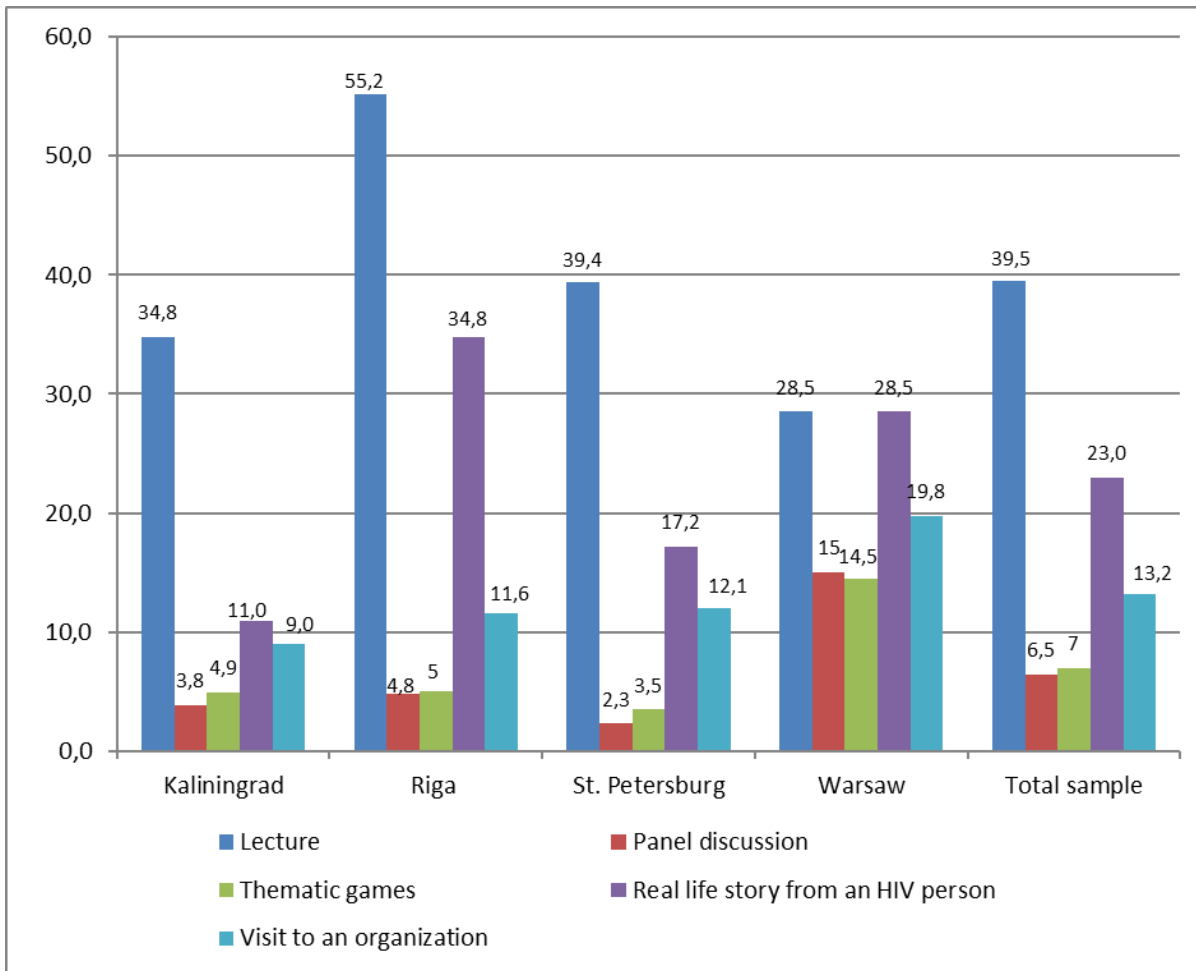


Fig. 28. Preferred channels of HIV prevention interventions – lectures and public discussions (% , $p \leq 0.001$).

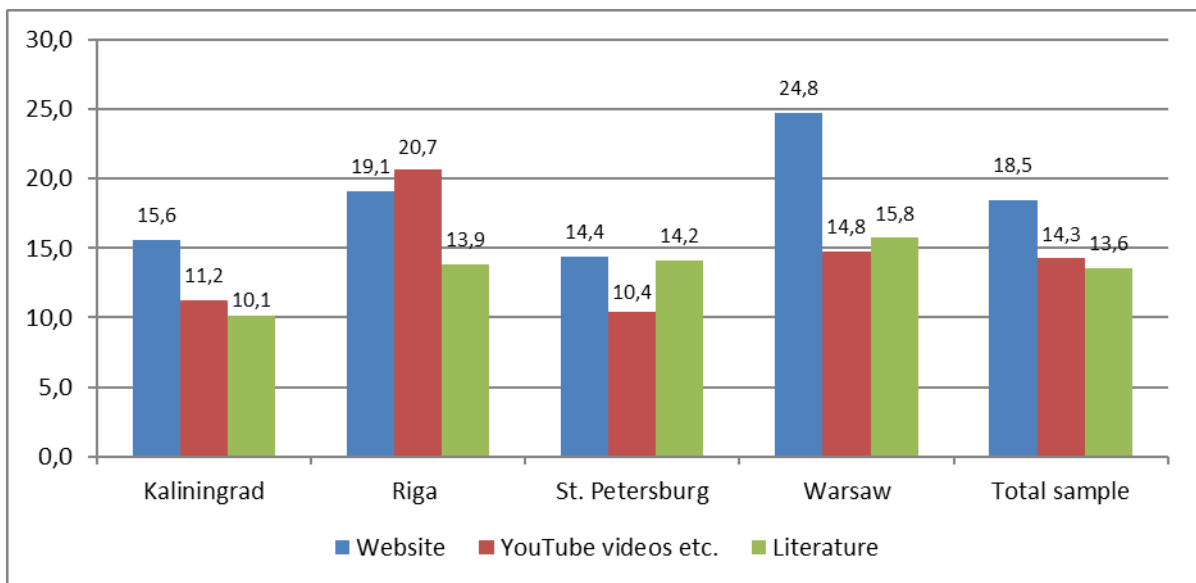


Fig. 29. Preferred channels of HIV prevention interventions – unaided search (% , $p \leq 0.001$).

4. Prospects of using advanced technologies in prevention outreach. Three quarters of respondents use the Internet daily (Fig. 30). More than half the respondents have smartphones, and the proportion of those using tablets is also significant. Respondents from Kaliningrad showed most interest in a health application. Overall, less than one fifth of respondents showed interest in a health application.

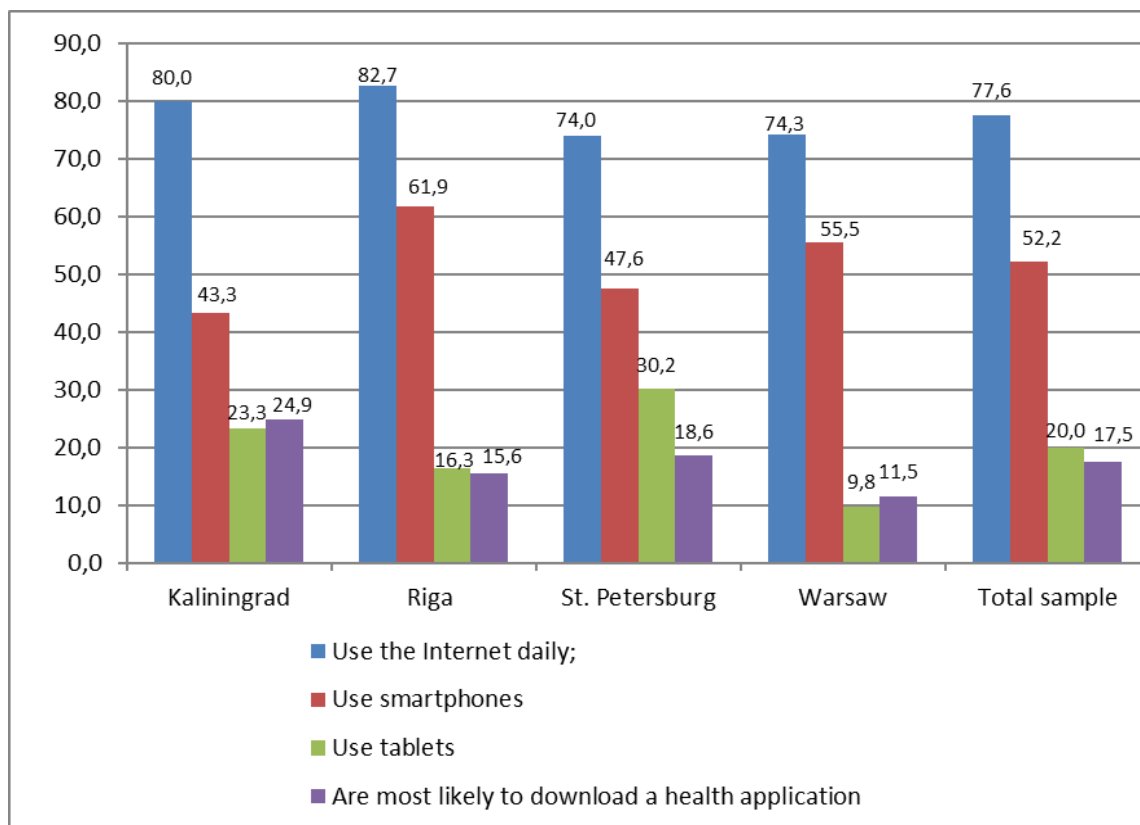


Fig. 30. Prospects of prevention outreach using advanced technologies (% , $p \leq 0.001$).

Conclusions from the behavioral survey. The use of PAS is widespread among the respondents. More than half the respondents smoked before or smoke now, most of the respondents have already used alcohol, and started using it at a fairly young age. In all the cities surveyed, and in general for the sampling, young people underestimated their alcohol dependence. More than one third of respondents used drugs at some time in the past. Young people from Russian cities estimate their dependence higher than shown on the DAST scale. But respondents from Riga and Warsaw tend to estimate their drug dependence similarly to the assessment of alcohol dependence. Hence, it is necessary to include components in HIV prevention programs, which would prevent risky behavior under the influence of PAS, and programs to combat smoking, alcohol use and drug use are still quite relevant.

In addition, the social environment of respondents includes a fair number of relatives, friends and students of educational institutions using alcohol three times a week or more often, and also those who used or are using drugs. So it is necessary to also reach young people's social environment as well as include a component on raising the level of acceptability and response to unfavorable group norms.

Risky sexual behavior is widespread among respondents which shows the relevance of HIV prevention programs.

The lowest level of HIV awareness is reported in the cities with the highest HIV prevalence (St. Petersburg, Kaliningrad). The percentage of young people covered by prevention programs is inadequate. Hepatitis and tuberculosis are not widely discussed.

The most preferred sources of prevention information are the specialists (lectures and personal communication) and real life stories. The high level of Internet and mobile phones use may help to conduct prevention interventions. However, only an insignificant proportion of respondents is willing to use health applications.

Results of focus groups

Focus group with experts on migrants in St. Petersburg. The focus group was held on 4 April 2014.

Composition (9 persons): 2 specialists from orphanages; 1 social worker; 2 specialists from vocational schools (involved with orphan children); 1 child welfare inspector; 1 social work specialist from AIDS Centre; 1 worker of the Herzen State Pedagogical University of Russia; 1 NGO specialist.

According to the specialists, there is an inflow of migrants, both from the group of children under legal age and the group of young people. Specialized orphanages have reported an increase in the

number of children from Uzbekistan and Tajikistan. According to specialists' estimates, one third of migrants from the above countries arrive with their families. This group of migrants is included in the labour migrants category.

Specialists also note that migrants coming to St. Petersburg to get education should be deemed a separate group because currently their number is growing, and they come not only from CIS countries. A separate group is also formed by girls from Africa who come to St. Petersburg for sex work (or get involved in commercial sexual exploitation). Experts also stress that girls from Tajikistan, Uzbekistan also come to St. Petersburg for the same purpose and work at brothels for their fellow countrymen. They may include under-age girls but the specialists have not come across them in their work.

According to the specialists, migrants have high demand for legal services to make arrangements for obtaining documents and refugee's status. Legal services are currently provided to migrants in their ethnic communities. However, according to the specialists, this assistance is only formally free of charge so that migrants may become subject to commercial exploitation.

According to the experts, there are currently no organizations in St. Petersburg specialized in working with migrants from Muslim countries to conduct HIV prevention outreach. The need for it does exist because migrants from such countries quite often do not accept barrier methods of birth control. Moreover, HIV and STI awareness is practically non-existent among them.

As a rule, migrants do not have insurance policies that is why only treatment for urgent acute conditions is available to them as well as TB abacillation before being deported. Experts note that migrants entering the country are predominantly ill with tuberculosis. Tuberculosis is also typical of children entering the country.

In addition, one may not forget about pendulum-like migration when migrants get back to the country of departure, and may spread infections they contracted through not using HIV and STI protection methods. Given the low level of counseling provided during testing as well as the migrants' fear of deportation, St. Petersburg may have a large, hidden population of illegal migrants.

The specialists emphasize that impact could be most effective if implemented through public opinion leaders: elders, religious leaders, influential community members. Another efficacious impact channel is providing stands with HIV prevention brochures in Tajik and Uzbek (the Kyrgyz speak Russian) at the medical Centre (15 Krasnogo Tekstilschika Street), and also in the room where they receive the documents. According to the specialists, prevention channels such as SMS messaging may prove ineffective because migrants often change their phone numbers.

Key conclusions based on the focus group results:

1. Based on the discussion, the following targets can be identified for prevention interventions: migrants and their children; labour migrants and those who came for educational purposes; migrants who are victims of trafficking for sexual and labour exploitation; migrants countries such as Tajikistan, Uzbekistan, China, Vietnam, Ukraine, Moldova, Kyrgyzstan, Belarus, Nigeria, Congo, Syria. It is necessary to work both with illegal and legal migrants.
2. Based on the results of the discussion, the following areas of work with migrants can be identified: HIV and STI prevention, alcohol dependence prevention, improved access to medical care for migrants, legal counseling (labour legislation, legal residence in the country).

Focus group with experts on commercial sexual exploitation in St. Petersburg. The focus group was held on 4 April 2014.

Composition (10 persons): 2 social workers; 1 orphanage worker; 1 specialist from a vocational schools (involved with orphan children); 1 child welfare inspector; 1 social work specialist from AIDS Centre; 3 NGO specialists; 1 member of an ethnic community (editor of information materials for fellow countrymen).

During the discussion, the experts stated that currently in more than half the cases it is children and adolescents from CIS countries who stay in temporary orphanages. The victims of CSEC in St. Petersburg may include girls from CIS countries sold by their families (Ukraine, Moldova). Such girls may be kept in flats which they share with disabled people forced into begging.

Children may get involved in CSEC by deception which is facilitated by the psychological peculiarities of their age as well as their lack of awareness. Children with developmental and mental disorders are also at risk of getting involved in CSEC.

The children who are most likely to be victims of CSEC (and abuse) come from dysfunctional families where both children and their parents may have a low educational level. Such children are quite often driven by economic motives. They could have also been victims of sexual abuse and other forms of violence in their family.

CSEC organizers and assistant organizers may also be children themselves, both boys and girls. But more often it is women they know because women cause fewer suspicions and it is easier for them to win their victims' trust.

Specialists stress a high incidence of STIs and lower HIV and hepatitis incidence at present but this is irrelevant for drug addicts who are currently not too numerous either.

According to the specialists, only a small number of children under legal age are capable of informing the adults that they were involved in CSEC, or abused. Specialists may notice it by indirect psychological and behavioral manifestations.

During the investigation of CSE cases, children under legal age and young people are exposed to psychologically traumatic investigative activities. There are also problems with the reintegration of children (who were involved in CSEC) from other countries because families may refuse to foster such children due to their social and religious mindsets.

In St. Petersburg, assistance to the victims of CSEC and violence is provided by several organizations but there is lack of both competent specialists and financial resources. Programs to combat CSEC and violence should be taught at school as part of subjects such as Health and Wellness. School psychologists should be ready to adequately respond to such challenges. In addition, parents' awareness should be raised. According to the specialists, the effectiveness of specialized programs may also be improved through early detection at health centres and population outreach programs.

Key conclusions based on the focus group results:

1. Based on the discussion, the following targets can be identified for prevention interventions: young people, both male and female; starting from an early age (5-year-old), mainly from low income families and dysfunctional families, with parents who abuse alcohol and drugs, or orphan children; young people with a low level of educational background (less than 9 years at school); adolescents and children with signs of sexualized behavior, developmental delays, and addictions.
2. The following programs are in progress now: HIV and CSEC prevention among street children, children with risky behavior and children from dysfunctional families (low reach programs).
3. Based on the results of the discussion, the following areas of work can be identified to prevent CSEC: incorporate a special component to raise awareness of recruitment (types of recruiters – children, friends), incorporate a component on the prevention of HIV and AI, for PLHIV, prevention and treatment of drug and alcohol use. The programs should be implemented based on healthcare institutions (polyclinics (out-patient health centres), Centre for AIDS and Infectious Disease Prevention and Control), NGOs, social services, orphanages and orphan homes, secondary and vocational schools.

Focus group with experts on migrants in Kaliningrad. Group composition (9 specialists): 3 NGO specialists; 3 physicians (drug therapist, phthisiologist, infectionist); 1 official of the Federal Migration Service (FMS); 1 official of the Federal Service for the Oversight of Consumer Protection and Welfare (Rosпотребнадзор); 1 lawyer.

According to the experts, the authorities concerned only record labour migrants, with one third of those arriving in the Kaliningrad oblast not taken in account. Among the unrecorded migrants may be those who started hiding themselves to avoid deportation after getting positive results of HIV-test or chest photofluorography. The Kaliningrad Oblast is also a participant of the Fellow Countrymen federal program the participants of which have more opportunities to get access to assistance.

In the area of HIV and AI there is a problem related to "patented" workers. Under the existing legislation, those are migrants who work under patents and are not subject to mandatory health check-ups. Only some of the companies, at their own initiative, make arrangements to have their patented workers checked up. The specialists stated that the most reasonable would be to extend mandatory check-ups over this type of migrants.

According to the experts, there is currently a fair number of young people among labour migrants. Quite often, they do not speak Russian which hampers communication. Such migrants typically have "zero" level of knowledge about HIV and AI as well as about many other issues related to health care.

The specialists estimate that tuberculosis and HIV are most widespread among the migrants from Uzbekistan, Tajikistan (tuberculosis), and Kazakhstan.

Effective prevention intervention could be provided through prevention brochures on HIV infection, tuberculosis, viral hepatitis and STI in Uzbek, Tajik and Russian. These brochures could be distributed during testing (AIDS Centre), at the tuberculosis dispensary and venereal diseases clinic.

Quite useful could also be a regional program for the adaptation and integration of migrants and their families. It is also necessary to address the issues related to health insurance since both in the Kaliningrad Oblast and in St. Petersburg migrants only have access to emergency care.

Given the fact that many migrants start avoiding deportation after getting a positive diagnosis, the specialists suggested introducing additional "non-repressive" outreach with migrants to separate medical treatment and deportation.

The specialists stress that migrants contract civil marriages in Russia and also use sex workers' services which may contribute to HIV and AI spreading.

Key conclusions based on the focus group results:

1. Based on the discussion, the following targets can be identified for prevention interventions: migrants and migrants' children, labour migrants and those who came for educational purposes; "patent" workers, participants of the Fellow Countrymen federal program; migrants from countries such as Tajikistan, Uzbekistan, Kazakhstan, Ukraine, Moldova. It is necessary to work both with illegal and legal migrants.
2. Based on the results of the discussion, the following areas of work with migrants can be identified: HIV and STI prevention, alcohol dependence prevention, improved access to medical care for migrants, legal consultancies, consulting and distribution of brochures in the migrants' native language.

Focus group with experts on commercial sexual exploitation in Kaliningrad. Composition (9 specialists): 3 NGO specialists; 4 social workers; 1 worker from the infection disease hospital; 1 psychiatrist.

According to the experts, adolescents and young people may agree to being involved in CSEC being unconscious of what is going with them. It can be children from boarding schools, children with developmental delays, other limited-capacity children. In addition, it can be girls from dysfunctional families who find themselves forced to earn money through prostitution.

Age peers may force children to get involved in CSEC. The main role is played by the economic driver. The experts have also seen parents acting as their children's "sellers."

The specialists have also focused on the pressure from age peers, for instance, in respect of having first intercourse. The specialists attribute the use of alcohol and drugs the desire of young people to relax and run away from problems.

The time-consuming bureaucratic mechanism delays the process of interaction between different departments, and as a result, a child who is at risk may turn into a victim. Assistance is provided to children and young people by: Trust Centers – centers intended for children in need of psychological, pedagogical, medical and social help, Family and Child Centre, Child Welfare Chapter, Juvenile Affairs Commission, post-boarding school adaptation, Kaliningrad regional public foundation "Open World," ANNA foundation. All of the aforesaid centers also take part in combatting CSEC because they engage in the prevention of HIV, deviating behavior, drug addiction and alcoholism. The specialists think very highly of the Ladya (The Boat) program.

It is necessary to introduce additional outreach programs or their components on issues such as the prevention of violence, sexual and psychological abuse. Moreover, for this purpose not only children but also adults should be informed (including specialists and parents).

Key conclusions based on the focus group results:

1. Based on the discussion, the following targets can be identified for prevention interventions: young people, both male and female; starting from an early age (5-year-old), mainly from low income families and dysfunctional families, with parents who abuse alcohol and drugs, or orphan

children; young people with a low level of educational background; adolescents and children with developmental delays. It is necessary to outreach the adults.

2. Based on the results of the discussion, the following areas of work can be identified to prevent CSEC: incorporate a component on the prevention of HIV and AI, for PLHIV, prevention and treatment of drug and alcohol addiction. The programs should be implemented based on NGOs, social services, orphanages and orphan homes, secondary and vocational schools.

Focus group with experts on migrants in Latvia. Group composition (10 specialists): 1 worker of an international organization; 3 workers of a non-profit organization; 2 officials from ministries; 4 officials from migration and border control services.

As of 1 January 2014, the number of immigrants living in Latvia was approximately 66,000. Those are registered, legal foreign citizens. No data on illegal migrants are available but the experts do not consider it an important problem. Latvia has accommodation centers for asylum seekers which typically accommodate the citizens of Georgia, African countries, Syria. According to the experts, many of them are young, single men.

Illegal migrants are the responsibility of the IOM (International Organization for Migration) Office. According to IOM's statistics, 84% of them are males, and 16% are females. They are mainly young people, most often from Georgia. IOM helps them to get back to their native as well as with their reintegration. IOM is also implementing an integration project for women coming from FSU countries. The women are aged mostly between 30 and 50.

The centers mainly provide assistance based on project activities funded by international foundations. The funding applies primarily to health issues because arriving asylum seekers most often did not even had vaccination. There are also drug users among them.

Those obtaining a temporary residential permit are only to be tested for tuberculosis but the specialists believe express HIV tests should be introduced for this group. Express testing is deemed primarily necessary for the people staying in accommodation centers. Asylum seeking migrants may conceal their diseases. In many cases, though aware of their diseases, they do not say that they need treatment.

Key conclusions based on the focus group results:

1. Based on the discussion, the following targets can be identified for prevention interventions: asylum seeking migrants; migrants arriving from Georgia, Africa, and Arab countries; young men, women from FSU countries.
2. Based on the results of the discussion, the following areas of work with migrants can be identified: HIV and STI prevention; testing for infectious diseases; prevention of drug addiction; improved access to health care both for migrants and Centre-based specialists.

Focus group with experts on commercial sexual exploitation in Latvia. Group composition (10 specialists): social services (2); Inspectorate for the Protection of the Rights of the Child (1); youth and children's centers (4); non-profit organizations (2); police (1).

The specialists are quite confident that children get involved in exploitation via the Internet as a widespread type of CSEC in Latvia. In addition, young people can be exploited for the purpose of pornography production.

It is also typical of Latvia to have young women involved in sex work due to their financial ill-being and the need to take care of their children. Street prostitution may also involve children lacking strong social support, parentless children from orphanage institutions as well as adolescents from dysfunctional families, and domestic violence families. The victims of violence may start perceiving violence including sexual abuse as a norm. Such adolescents treat exploitation as a way to earn money. In addition, adolescents may get involved in exploitation through deception, or their own naivety. The specialists stated that young people from Latvia may get involved in exploitation in other European countries.

Such adolescents may use alcohol and drugs to avoid problems, to escape from them. Troubled adolescents often use drugs, mainly Spice.

There are government prevention programs aimed at ensuring children's safety. The experts highly appreciate the Jimba program and believe that if funding could be provided it would be necessary to develop its module for adolescents because prevention outreach is also necessary for this group. There

are also organizations and specialists cooperating with specialists from boarding schools to prevent violence and CSEC.

Latvia also has Marta Centre providing assistance to women involved in prostitution. At the government level, combatting CSEC is included in the development strategy.

Key conclusions based on the focus group results:

1. Based on the discussion, the following targets can be identified for prevention interventions: young people, both male and female; starting from an early age (5-year-old), mainly from low income families and dysfunctional families, with parents abusing alcohol and drugs, or orphan children; young women who are single mothers. It is necessary to get specialists involved in the work.
2. Based on the results of the discussion, the following areas of work can be identified to prevent CSEC: raising awareness of the channels used to get children involved in CSEC and its types; prevention and treatment of drug and alcohol addiction. The programs should be implemented based on orphanages and orphan homes, secondary and vocational schools.

Focus group with experts on migrants in Poland. Group composition (9 specialists): all of them representing non-profit organizations (human rights protection, services for migrants, HIV prevention).

It is rather difficult to obtain information of migration flows in Poland as well as on the situation in groups of migrants. There also little data on the behavioral peculiarities of particular groups. It is necessary to distinguish between forced migrants i.e. refugees, and voluntary migrants i.e. students and all types of labour migrants coming to Poland of their free will. Ukrainians account for most of voluntary migrants. As far as refugees are concerned, then from the 1990s it is Chechens who account for 80% of migrants applying for refugee's status.

Poland features various types of migrants: starting from seasonal workers and asylum seekers and ending by those coming for permanent residence, and foreign students. All of the aforesaid groups need particular methods and channels of prevention information.

HIV prevention programs intended for the public at large may work with migrants but most successful will be programs taking into account the cultural background, migrant's native language, and the place where the person that the specialist is planning to reach out is staying at the moment. For instance, asylum seekers stay at special centres so it is easy to identify them. In contrast, it is much more difficult to identify labour migrants.

A significant proportion of migrants are young people who may find themselves at high risk of infection in a new environment due to behavior change.

No systemic assistance is currently available to migrants in Poland. All services are provided by NGO's using the funds provided by the government to finance projects. However, a specific feature of project-based activities is that they do not ensure continuity and stability of the activities.

Key conclusions based on the focus group results:

1. Based on the discussion, the following targets can be identified for prevention interventions: migrants; young migrants; migrants arriving from countries such as Russia (Chechnya, Dagestan), Georgia; it is necessary to reach out to both illegal and legal migrants.
2. Based on the results of the discussion, the following areas of work with migrants can be identified: HIV and STI prevention; legal counseling; consulting and distribution of brochures in the migrants' native language; providing for stable funding of prevention activities.

Focus group with experts on commercial sexual exploitation in Poland. Group composition (10 specialists): all of them represent non-profit organizations (services, outreach, human rights protection).

Generally speaking, it is rather difficult to assess the incidence of commercial sex work in subgroups aged 15 to 18 because those are illegal practices. The specialists who worked at schools came across only several cases like this among female students. The situation is different for the group aged 18 to 24. Even though quantitative studies on the problem are not currently available, the specialists believe that women mostly provide services in the street and in brothels while men sell sexual services primarily at gay clubs.

It is impossible to identify the level of education typical of those selling sexual services. Commercial sex frequently involves childhood emotional problems and psychological traumas. In addition, a low

financial income of the parents may also cause risky behavior. However, that is typical of street sex workers.

Children from well-to-do families may get involved in CSEC via the Internet, they may also get involved in exploitation forms such as pornography production through deception. The same applies to children from dysfunctional families.

At present, there is a group of specialist in Poland who have relevant experience and are capable of conducting HIV prevention activities. However, for various reasons such as policies, mindsets and financing, their work is limited to project financing, and sometimes is carried out on a voluntary basis. Prevention outreach is mostly conducted in large cities, with NGOs specialized in this type of work. No organizational capabilities and solutions are currently available in Poland to establish prevention systems for young people at secondary schools as well as for street sex workers.

Key conclusions based on the focus group results:

1. Based on the discussion, the following targets can be identified for prevention interventions: young people, both male and female; starting from an early age (5-year-old), mainly from low income families and dysfunctional families, with parents abusing alcohol and drugs, or orphan children.
2. Based on the results of the discussion, the following areas of work can be identified to prevent CSEC: include a special component on raising awareness of the risks of getting children involved in exploitation via the Internet; include a component on HIV and AI prevention; prevention and treatment of drug and alcohol addiction. Organizational and financial capabilities should be ensured to implement the programs.

Analysis of the needs of adolescents and young people at high risk of getting infected with HIV and associated diseases showed that the following aspects should be selected as the main "targets" for prevention programs designed for this group of adolescents and young people:

1. Raising awareness among adolescents and young people at high risk of contracting HIV and associated diseases on the transmission routes and methods of preventing HIV infection, elimination of misconceptions and myths about HIV transmission.
2. Formation among adolescents and young people at high risk of HIV contraction of capability for realistic evaluation of their own risk of contracting HIV.
3. Formation among adolescents and young people at high risk of contracting HIV and associated diseases of capability for positive attitude to the methods of avoiding risky behavior including:
 - to fidelity and avoiding early sexual contacts;
 - to 100% condom use in all sexual encounters;
 - to discussion of HIV and STIs with a sexual partner before starting a sexual contact;
 - to avoiding random sex;
 - to avoiding situations of having sexual contacts while intoxicated;
 - to avoiding situations of having sexual contacts under pressure/coercion;
 - to avoiding trying injection drugs;
 - to an idea of applying medical institution for getting HIV counseling and testing.
4. Formation among adolescents and young people at high risk of contracting HIV and associated diseases of a tolerant attitude to HIV-positive people.
5. Formation among adolescents and young people at high risk of becoming HIV infected of the skills which are necessary for avoiding risky situations (communication skills, refusal skills, skills allowing resisting peer group pressure, etc.).

CHAPTER III. CASE STUDIES OF PROGRAMS AIMED AT THE PREVENTION OF HIV INFECTION AND ASSOCIATED DISEASES AMONG ADOLESCENTS AND YOUNG PEOPLE AT HIGH RISK OF INFECTION

O.I. Kolpakova, V.A. Odinkova, M.M. Rusakova

This chapter presents programs aimed at the prevention of HIV infection and associated diseases among adolescents and young people at high risk of infection being implemented in Russia, Poland, Finland, Germany, and Latvia. The programs were identified by the partners of project "Building capacity in prevention of HIV and associated infections among youth at high risk in the Northern Dimension area."

The prevention programs for publishing in this guide were initially supposed to meet the below key criteria recognized by the international scientific community:

- focus on prevention of HIV infection and associated diseases among young people at high risk of infection;
- prevention interventions are carried out at the individual / group / community level;
- the results of program implementation were published in a scientific peer-reviewed journal, or another peer-reviewed scientific publication;
- the program was implemented in one of the Northern Dimension Countries;
- the program effectiveness was estimated to prove that the program was efficacious.

Unfortunately, in the course of project implementation it became clear that there are actually no programs meeting all of the above criteria in the Northern Dimension Countries. Hence, the project's Working Group took the decision to include in the guide potentially efficacious programs for prevention of HIV infection and associated diseases among adolescents and young people at high risk of infection.

The programs presented in this Guide meet the key criteria as follows:

- the program aims exclusively at the prevention of HIV infection and associated diseases, or addresses a wider scope of health-related problems and includes prevention of HIV infection as one of its components;
- the program targets exclusively adolescents and young people at high risk of getting infected with HIV and associated diseases, or focuses on a wider target group, which inter alia includes adolescents and young people at high risk of infection;
- prevention interventions are carried out at the individual / group / community level;
- the program was implemented in one of the Northern Dimension Countries;
- the program effectiveness was estimated, and the estimation proved that the program was efficacious, or it was found effective by the Working Group of project "Building capacity in prevention of HIV and associated infections among youth at high risk in the Northern Dimension area" based on the available data about the program.

All the programs were described using the following pattern: name, author, target groups, aims, theoretical basis of the program, main results of baseline study, main activities and resources, methods and results of effectiveness estimation, resources where additional information about the program is available, authors' contact details. The key available information is presented in each section.

1. Russian Federation

O.I. Kolpakova, V.A. Odinkova, E.G. Shalagaeva, M.M. Rusakova

The program "St. Petersburg Street Children"

Author of the program: St Petersburg Charitable Social Fund for Medical and Social Programs "Humanitarian Action".

Target group: homeless and neglected children and adolescents as well as their family members.

Aims of the program. The program aims at preventing HIV infection and other socially significant diseases among street children and adolescents, ensuring their access to health services, social, psychological and legal assistance.

Theoretical basis or model of the prevention program. The program is based on a multidisciplinary approach to the provision of assistance to street children, and envisages joint actions of specialists of diverse profiles – health and social workers, psychologists, lawyers, educators, and program volunteers.

Main results of baseline study which have been used in development of the program. In 2004, the Street Children Assistance Centre tested 199 street children for HIV infection, syphilis, viral hepatitis B and C. The test results were as follows: HIV infection was detected in 5.9% of tested children, syphilis – 5.9%, antibodies for hepatitis B and C – in 16.8% and 28.6% of children respectively.

Main program activities, resources required to implement the program. The key program components included: outreach work, training, comprehensive medical, psychological and social assistance aimed at changing children's attitude to their health and ensuring behavior change; provision of medications, food and overnight accommodation; voluntary, anonymous and free blood testing for HIV infection, viral hepatitis B and C, syphilis, with pre- and post-test consultancies; distribution of information booklets. Over the 11 years of the implementation of the St. Petersburg Street Children program comprehensive medical and social assistance has been provided to 6,000 children.

Methods and main results of program effectiveness estimation. No information available.

Resources where additional information about the program is available. Additional information about the program is presented in guide "Methodology recommendations on reaching out to street children" (URL: <http://haf-spb.org/biblioteka/spisok-publikatsiy/Metodicheskie-rekomendacii-po-rabote-s-ulichnymi-detmi.pdf>).

Author's contact details: St Petersburg Charitable Social Fund for Medical and Social Programs "Humanitarian Action", Email: office@haf-spb.org.

The program "Assistance to HIV-positive Street Children and Youth"

Author of the program: St. Petersburg Non-Governmental Organization Doctors for Children.

Target group: street adolescents (homeless and neglected children younger than 18 years old).

Aims of the program: ensuring access to different types of assistance for HIV-infected adolescents, and preventing further spreading of HIV infection among street children and adolescents.

Theoretical basis or model of the prevention program: integrated model of successive assistance to street adolescents and young people which includes socio-psychological support and provision of access to health care for HIV-positive adolescents, primary prevention of HIV infection and change of risky behavior among HIV-negative adolescents.

Main results of baseline study which have been used in development of the program. In -2006 Doctors for Children in cooperation with Centers for Disease Control and Prevention (CDC) and St. Petersburg Center for Prevention of and Combating AIDS and Infection Diseases conducted a research of the HIV prevalence among street adolescents and young people aged from 15 to 18 years old in St. Petersburg. The study revealed that 37,4% of street adolescents and young people in St. Petersburg were HIV infected. Many of them were unaware of their status, and had not applied for care. Almost half the respondents had previously used injected drugs, a majority of adolescents practiced various risky forms of sexual conduct.

Main program activities, resources required to implement the program. Main components of the program: 1) health care (express HIV testing using a mobile laboratory, referring and accompanying children to the AIDS Centre and other healthcare institutions, provisions for admission to hospitals, developing commitment to antiretroviral therapy); 2) psychological assistance (crisis consultancies; training in peer-to-peer counseling; addiction counseling; family counseling; vocational guidance counseling); 3) social assistance (providing information about, referring and accompanying adolescents to governmental centres for socio-psychological assistance and other partner organizations, case management jointly with staff of centres for socio-psychological assistance, social and legal counseling, assistance in the preparation of documents, obtaining benefits and financial aid); 4) organization of cooperation between representatives of health care, social protection institutions and NGOs to make sure that target group gets professional assistance.

Methods and main results of program effectiveness estimation. The follow-up study of HIV prevalence among street adolescents was conducted in 2012 and revealed that the number of HIV infected street adolescents decreased.

Resources where additional information about the program is available. Additional information on the program is available in publication "Rukovodstvo po profilaktike VICH-infektsii i pomoschi VICH-polozhitelnym ulichnym podrostkam (Guide on prevention of HIV infection and assistance to HIV-positive street adolescents)/Edited by R.V. Yorik (Р.В. Йорика). 2nd edition. – St. Petersburg: Doctors to Children, 2009. – 134 pp.; and also in section "Assistance to HIV-positive Street Children and Youth" on the official website of the Doctors to Children NGO (URL: http://www.vd-spb.ru/projects/zavershennie_proekty/422/).

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The program "HIV Prevention for Children and Youth in St Petersburg"

Author of the program: St. Petersburg-based Non-Governmental Organization Doctors to Children.

Target group: adolescents and young people aged 14 to 21 in a difficult life situation, with risky forms of behavior in day-to-day life.

Aims of the program: prevention of HIV, risk reduction and development of responsible health behavior among children, adolescents and young people.

Theoretical basis or model of the prevention program. The methodology of the Steps preventive training program is based on a cognitive behavioral approach.

Main results of baseline study which have been used in development of the program. In 2006 – 2009, St. Petersburg Non-Governmental Organization Doctors for Children and the St. Petersburg Center for Prevention of and Combating AIDS and Infection Diseases provided assistance to street adolescents including HIV infected adolescents. In 2006 37,4% of street adolescents at the age from 15 to 18 years old were HIV infected.

Main program activities, resources required to implement the program. Providing assistance to children was based on principles of succession and case study. One of the main components of assistance to non-infected adolescents was HIV prevention. The Steps preventive training program is composed of 10 sessions and includes three components: information, motivation and development of behavioral skills. Participants of the program should be motivated. A stepwise incentive system is used to attract program participants (after each session the participants are given a hot lunch, those who attend five sessions in a row are given an item of clothing with the organization's logo, and those who attend ten sessions receive a Walkman and sneakers). To conduct the Steps training the following resources are required: room for 8 – 15 people, flipchart, snacks for coffee-break.

Methods and main results of program effectiveness estimation. The program effectiveness was estimated by an independent expert. 132 adolescents who took part in the program were attending the Steps program. Methods of program effectiveness estimation: structured interview, focus groups and monitoring of practical skills before and after participation in the training sessions. The effectiveness assessment showed, among other things, that there was a statistically significant increase in the HIV infection awareness of program participants (from the average values of 8.10 up to 10.46 points out of a maximum of 15 points).

Resources where additional information about the program is available. Additional information about the program is available in the following sources:

- section "HIV Prevention for Children and Youth in St. Petersburg" on the official website of the Doctors to Children NGO (URL: <http://www.vd-spb.ru/projects/profilaktika/>);
- "Rukovodstvo po profilaktike VICH-infektsii i pomoschi VICH-polozhitelnym ulichnym podrostkam (Guide on prevention of HIV infection and assistance to HIV-positive street adolescents)/Edited by R.V. Yorik (Р.В. Йорика). 2nd edition. – St. Petersburg: Doctors to Children, 2009. – 134 pp.

- Программа профилактического тренинга для подростков "STUPENI" (STEPS preventive training program for adolescents). Trainer's aid/ Edited by R.V. Yorik (Р.В. Ёорика) and A.V. Shaboltas (А.В.Шаболтас) – St. Petersburg: Doctors to Children, 2009. – 92 pp.

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The program "Supporting Governmental Organizations in Organization of Systemic HIV Prevention among Adolescents and Young People"

Author of the program: team of workers of Regional NGO "Stellit".

Target group. Students of secondary schools, vocational schools and colleges, children who stay at social and rehabilitation centres and orphanages. Staff of the aforesaid institutions.

Aims of the program: providing support to governmental organizations in organization of systemic HIV prevention among adolescents and young people.

Theoretical basis or model of the prevention program: Health Belief Model, PRECEDE-PROCEED model.

Main results of baseline study which have been used in development of the program. The program was piloted at various institutions working with adolescents and young people. Each time a primary survey of the students/pupils and staff of the organizations involved in program piloting was conducted. In all of the cases the survey revealed that different types of behavior related to high risk of getting HIV infected are widespread among adolescents and young people and they do not consider the workers educational institutions to be a reliable source of health information. The students/pupils and workers of organizations are not informed about HIV infection well enough, and are not tolerant enough toward PLHA, organization workers do not have the skills required to conduct prevention outreach.

Main program activities, resources required to implement the program. Main components of the program: 1) baseline study (assessment of institution's organizational capabilities to develop HIV prevention program; assessment of the awareness and attitudes of institution workers towards HIV prevention; assessment of the awareness, attitudes, and behavior of adolescents and young people); 2) preparation of programs for HIV infection prevention (establishment of Health Care Teams, theoretical and methodological training of members of Health Care Teams, planning of prevention activities); 3) implementation of prevention activities; 4) assessment of the effectiveness of prevention activities, refining of the content of prevention programs taking into account effectiveness assessments. The whole cycle lasts for one academic year. Implementing the program at one institution requires the participation of four staff workers and 3 to 4 activist students/pupils, during the academic year the Health Care Team should be supported by an out-of-house psychologist or public health specialist (in our case – a worker of Regional NGO "Stellit").

Methods and main results of program effectiveness estimation. Program effectiveness was estimated using pre/post assessment with control group. Main results of effectiveness estimation: there was a statistically significant change in the awareness of students/pupils with respect to HIV infection, their tolerance toward PLHA grew as well as their trust in the staff workers as agents of prevention intervention. The program did not result in increased incidence of risky behavior. The awareness of staff workers with respect to HIV infection grew statistically significantly as well as their tolerance toward PLHA. After the formal completion of the projects all the organizations continue their work towards preventing HIV infection.

Resources where additional information about the program is available. Additional information on the program is available in "Planirovaniye, osuschestvlenie i otsenka effektivnosti program profilaktiki VICH infitsirovaniya sredi uchashchikhsya uchrezhdeniy sistemy nachalnogo I sredengo professionalnogo obrazovaniya" (Planning, conducting and assessing the effectiveness of programs for the prevention of HIV infection among the students of basic and secondary vocational education institutions). Scientific and Methodological Guide/ Edited by I.N. Gurvich (И.Н. Гурвич) – St. Petersburg: 2008. – 178 pp.

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The program "East-West Project for the Prevention of HIV Infection among Migrants"

Author of the program: Regional Non-Governmental Organization "Look into the Future".

Target group: labour migrants arriving for temporary employment in St. Petersburg from Central Asian states.

Aims of the program: creating conditions to reduce morbidity from socially significant infections among labour migrants arriving for temporary employment in St. Petersburg from Central Asian states.

Theoretical basis or model of the prevention program: peer-to-peer approach.

Main results of baseline study which have been used in development of the program. The workers of Regional NGO "Look into the Future" conducted survey "Labour Migrants from Central Asia: Challenges and Health Risks."

Main program activities, resources required to implement the program. Information and education materials are distributed among labour migrants (in particular, information outlets are provided in the migrants' mass meeting places and at their workplaces). Public opinion leaders selected from among migrants are trained and then get involved in the prevention work with their fellow countrymen. A hot line is available to provide the migrants with additional information on HIV infection and the available services. Specialist service organizations get engaged in the work with the target group so that migrants can be referred to the specialists they need.

Methods and main results of program effectiveness estimation. No information available.

Resources where additional information about the program is available. Additional information about the program is available on the website of Regional NGO "Look into the Future" (URL: <http://www.vvb.spb.ru/projects/current-projects/vostok-zapad>).

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The program "HIV/AIDS Prevention Among Vulnerable Population Groups"

Author of the program: workers of Russian Non-Governmental Organization "Open Health Institute": Mr. A.V. Bobrik, Ms. K.M. Eroshina, and Ms. E.A. Mikhel.

Target group: foreign citizens from CIS and other countries working within the Russian Federation.

Aims of the program: combating the spreading of HIV infection, STIs, and viral hepatitis B and C among labour migrants.

Theoretical basis or model of the prevention program: peer-to-peer principle.

Main results of baseline study which have been used in development of the program. The results of the baseline study of the current situation among migrants conducted by Open Health Institute in 2007 in five cities in the Russian Federation, confirmed the high vulnerability of this target group to HIV infection due to extremely low awareness of foreign workers about its pathways and prevention methods as well as due to widespread risky behavioral practices. E.g. 41% of surveyed labour migrants thought that HIV can be transmitted through mosquito bites, 34% believed that it is possible to contract HIV from sharing dishes. It was also found out that a large number of sexually active respondents did not use condoms over the past 30 days (their proportion varied, depending on the region, between 10% and 36%). Two key avenues for the prevention of HIV infection among labour migrants in Russia – raising HIV/AIDS awareness and promoting the use of condoms as a reliable means of preventing HIV and STIs.

Main program activities, resources required to implement the program. The program includes the following main components: 1) disseminating reliable information on health protection and reducing the risk of infection among migrants; 2) distributing means of preventing HIV and STIs; 3) training volunteers and getting them involved in conducting peer-to-peer counseling; 4) conducting outreach work; 5) providing pre- and post-counseling for HIV testing; 6) facilitating access to health care for diagnosing and treating sexually transmitted infections and tuberculosis; 7) facilitating access to social, psychological and legal assistance for labour migrants; 8) monitoring and assessing the project. Tentative organization structure of a typical project: project leader, two employees trained in

intercultural communication, volunteers and various consultants from among trained and motivated members of the target group, consultants (psychologist, lawyer, STD and skin specialist), bookkeeper.

Methods and main results of program effectiveness estimation. The assessment of program effectiveness aimed, in particular, at assessing the level of migrants' knowledge about HIV transmission pathways and prevention, assessing the rate of incidence of risky behavior among migrants. The results of effectiveness estimation are not available.

Resources where additional information about the program is available. Additional information about the program is available in publication "Organizatsiya kompleksnoy profilaktiki VICH infektsii, IPPP I virusnykh gepatitov sredi trudovykh migrantov" (Implementing comprehensive prevention of HIV infection, STI and viral hepatitis among labour migrants." – Moscow, 2009. – 32 pp.

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The program "Social Integration of Labour Migrants and their Family Members in St. Petersburg"

Author of the program: St. Petersburg-based Non-Governmental Organization Doctors to Children (with the support from the Committee on Social Policy of St. Petersburg).

Target group: members of migrant families living in St. Petersburg (mainly from Middle Asian countries).

Aims of the program: raising tolerance towards labour migrants and members of their families in St. Petersburg, providing labour migrants with information on Russian legislation in the field of official registration of migrants, receiving work permission etc., development of the program of social integration of family members of labour migrants. One of the program components is aimed at preventing HIV infection and tuberculosis among migrants living in St. Petersburg.

Theoretical basis or model of the prevention program: development of prevention materials, organization of consultations for labour migrants and their family members. Providing training for migrants so that they could provide consultations and spread information materials among their compatriots. Raising tolerance towards migrants by means of providing training to mass media representatives on how to cover issues related to migrants in an objective way.

Main results of baseline study which have been used in development of the program. At the commission of the UN Women organization, the Centre for Migration Studies conducted research "Potential and Challenges of Social Integration of Labour Migrants from Central Asian Countries in Russia". The research revealed that the level of knowledge of labour migrants and their family members on HIV/AIDS and tuberculosis is very low. Labour migrants and their family members used to live in very bad conditions which increase their risk to become infected by different diseases including tuberculosis.

Main program activities, resources required to implement the program. A number of leaflets and information materials on health issues, on rules of getting work permissions, on official registration were developed in Uzbek, Tajik and Kyrgyz languages. The leaflets and materials were approved by Federal Migration Service of Russian Federation in St. Petersburg and Leningrad Region and Committee on Law, Order and Safety of St. Petersburg Government. Leaflets were spread in Central Bureau for Registration of Migrants, at the airport and other places popular among migrants. The program component on the prevention of HIV infection and tuberculosis includes reaching out to ethnic community members, training volunteers from among the migrants (including college student volunteers), and getting them involved in health and social counseling in the ethnic communities; distribution of information brochures in native languages; health counselling and referral of migrants' family members.

Methods and main results of program effectiveness estimation. In 2012 – 2013 14 migrant volunteers were trained in the "School for Volunteers" to further spread the information in their national communities; 19000 labour migrants and their family members got consultations and information materials on legislation related to migration issues and HIV prevention; 53 stakeholders from St. Petersburg social protection institutions raised their qualification on the issue of providing social assistance to families where one or more members are foreign nationals (the program was developed by St. Petersburg-based Non-Governmental Organization "Doctors for Children" in cooperation with Governmental Training Resource Centre "Sem'ya" (Family). Since January 2014 300 foreign nationals

got assistance in special services of Centers for Social Assistance in Pushkinskiy and Kalininskiy districts of St. Petersburg.

Resources where additional information about the program is available. Additional information about the program is available on the website of Doctors to Children NGO (URL: http://www.vd-spb.ru/projects/sotsialnaya_integratsiya_trudovyh_migrantov_v_sank/).

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The program on prevention of high risk behavior "ProHealthy Choice – Program"

Author of the program: Regional Non-Governmental Organization "Look into the Future".

Target group: adolescents and young people aged 15 to 17, adults' audience.

Aims of the program: prevention of HIV/AIDS, drug addiction, sexually transmitted infections, alcoholism, unwanted pregnancy, tobacco smoking, violence. In addition, the program is related to various issues of conflict resolution, sexual anatomy and physiology, general psychology, and community work.

Theoretical basis or model of the prevention program. The program is based on a comprehensive approach both the terms of problem studies and the implementation of preventive work methods. The foundation for the ProHealthy Choice program is provided by the I Know – I Can – I Want – I Will behavior change model, and the whole methodology is based on play-like, interactive, associative approach, and the peer-to-peer principle.

Main results of baseline study which have been used in development of the program. No information available.

Main program activities, resources required to implement the program. The program provides for dealing with issues as follows: organization of the body; HIV/AIDS; sexually transmitted infections; reproductive health; risky behavior and its consequences; causes and consequences of smoking, use of alcohol and drugs; stigmatization, discrimination, tolerance; behavior in crisis and conflict situations; control of emotion; prevention of violence. The authors developed over 300 interactive techniques for the discussion of the aforesaid issues with adolescents, which can be used for work in small groups and for holding mass-scale events. To be able to carry out the program the specialists should undergo a 40-hour training course to get the necessary skills and commentaries to the skills provided in methodological aids, and thereafter they should undergo practical training in a youth or special group. Based on the results of the training course and practical training, the decision is taken to issue a certificate for the right to use the program.

Methods and main results of program effectiveness estimation. No information available.

Resources where additional information about the program is available. Additional information about the program is available on the website of Look into the Future NGO (<http://www.vvb.spb.ru/products/uchebnik-po-profilaktike>). A detailed description of the program is available in three methodological aids: "Sistema PRO" (PRO System), "PROvedeniye" (Basics of PRO), and "PROpaganda" (PROpaganda).

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2. Poland

O.I. Kolpakova, V.A. Odinkova, T. Malkuszewski, P. Silakowski, A. Skonieczna

The program "STREETOPCJA – streetworking project aimed at adolescents and young people who spend time or live in the streets"

Author of the program: Program STACJA Association.

Target group(s). Adolescents and young people at the age between 15 and 26 years old spending time or living in the streets including youth in crisis life situations, without family or other kind of support, in unstable house situation, unemployed and not educated young people who are beyond the institutional care, young people with problematic drinking, victims of violence or perpetrators, young people involved into prostitutions.

Aims of the program. The program is aimed at providing support and assistance to young people in crisis life situations including increasing their access to counseling, education, available services, reducing their risk of getting HIV and associated infections, motivating them to change their behavior from risky to safer practices.

Theoretical basis of the program. Harm reduction.

Main results of baseline study which have been used in development of the program. Baseline study was not conducted. The program was developed based on theoretical knowledge and experience of project workers.

Main program activities, resources required to implement the program. There are two main directions of work within the program: 1) outreach and 2) organization of joint activities when program volunteers and young people in crisis life situation could spend time together. Outreach work is conducted in the streets (in regular surroundings of the clients). It includes provision of education and information depending on client's needs, distribution of condoms and prevention leaflets, provision of reliable and evidence-based information about risky behaviors and available services/offer, motivation of clients to change their behavior from risky to safer practices. Joint activities are free for young people taking part in the program. Clients can go together with program volunteers to play billiard, bowling or to the cinema, cook something tasty, etc. During such activities program volunteers share their knowledge about sexual health, HIV/AIDS, provide free of charge prevention leaflets and other prevention materials as well as condoms/ The project is implemented by 4 street workers working as volunteers, and covers 10 hours of outreach work per week. Street workers are qualified outreach workers, specialists in HIV/drug use prevention and harm reduction. Often young pedagogues or students of pedagogy are involved into street work as well.

Methods and results of effectiveness estimation. No research to estimate the effectiveness of the program was conducted. Nevertheless, the program staff could see that clients acquire social, psychological, practical skills and knowledge to be used in a long-term perspective.

Resources where additional information about the program is available. E. Bielecka, M. Siuchta, Ulica i co dalej? Praktyka oddziaływań profilaktyczno-resocjalizacyjnych w środowisku otwartym// Probacja i resocjalizacja instytucjonalna – wybrane problemy teorii i praktyki, Red. H. Kupiec, Wyd. Uniwersytet Szczeciński, Szczecin, 2010.

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The program "Networking – project that uses erotic and social chat rooms as an educational and preventive method"

Author of the program: Program STACJA Association.

Target group(s). Adolescents and young people at the age between 15 and 26 years old who use erotic and social chat rooms and are exposed to different risks (young people with problematic drinking and other addictions, young people involved into prostitution, victims of violence or perpetrators, young people taking risky behaviors).

Aims of the program. The program is aimed at providing support and assistance to young people in crisis life situations including increasing their access to counseling, education, available services, reducing their risk of getting HIV and associated infections, motivating them to change their behavior from risky to safer practices.

Theoretical basis of the program. Harm reduction.

Main results of baseline study which have been used in development of the program. No baseline study was not conducted. The program was developed based on theoretical knowledge and experience of project workers.

Main program activities, resources required to implement the program. During conversations in chat rooms networkers provide reliable evidence-based information about risky behaviors, answer users' questions, provide clarifications, and give advices. The project is implemented by 7 networkers, the work in chat rooms takes from 4 to 12 hours weekly.

Methods and results of effectiveness estimation. No research to estimate the effectiveness of the program was conducted. It was difficult to get data on changes in clients' behavior because of confidential nature of contacts.

Resources where additional information about the program is available. K. Rżanek, M. Grotecka, Networking jako forma edukacji i profilaktyki w cyberprzestrzeni – Ej, a dlaczego masz taki dziwny znaczek przy nicku? [w:] Zagrożona młodość. Innowacyjne formy interwencji społecznej, Red. E. Bielecka, Pedagogika Społeczna 2/2010, Pedagogium.

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The program "Streetworking aimed at sexworkers working in the streets"

Author of the program: Program STACJA Association.

Target group(s). Sexworkers or people at risk of prostitution, working in the streets, exposed to risky situations and behaviours (including people with problematic drinking, victims of violence or perpetrators); people outside of the institutional care at risk of social exclusion.

Aims of the program. The program is aimed at providing support and assistance to people in crisis life situations including increasing their access to counseling, education, available services, reducing their risk of getting HIV and associated infections, motivating them to change their behavior from risky to safer practices.

Theoretical basis of the program. Harm reduction.

Main results of baseline study which have been used in development of the program. Baseline study was not conducted. The program was developed based on theoretical knowledge and experience of project workers.

Main program activities, resources required to implement the program. Street workers distribute condoms and prevention leaflets among target group; provide them with reliable evidence-based information about risky behaviors, adjusting the level of conversation to client's needs. The project is implemented by 8 street workers working as volunteers; covers 6 hours of outreach work weekly; 300 condoms are distributed per week. Street workers are qualified outreach workers, specialists in HIV or drug use prevention and harm reduction. Often young pedagogues, or students of pedagogy are involved into street work as well.

Methods and results of effectiveness estimation. No research to estimate the effectiveness of the program was conducted. It was difficult to get data on changes in clients' behavior because of confidential nature of contacts.

Resources where additional information about the program is available. E. Bielecka, Galerianki – badania i refleksje [w:] Zagrożona młodość. Innowacyjne formy interwencji społecznej, Red. E. Bielecka, Pedagogika Społeczna 2/2010.

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The program "Mobile Schools"

Author of the program. The program "Mobile Schools" is implemented in Poland by GPAS Praga: Grupa Pedagogiki i Animacji Społecznej Praga Polnoc. Author of the program is Mr. Andrzej Orłowski.

Target group(s). Street children at the age from 8 to 18 years old, spending most of their day on the street, including those who ran away from their homes and schools, or have been kicked out from youth clubs because they cannot handle the behavioral rules established in such places (no smoking, no swearing etc.).

Aims of the program. The program is aimed at turning children back from streets to educational and sport activities, raising their self-esteem, increasing their knowledge on hygiene, health, on negative aspects of drug and alcohol addiction, on HIV/AIDS, prevention of their involvement into committing crimes.

Theoretical basis of the program. Pedagogic of play and creative therapy.

Main results of baseline study which have been used in development of the program. The baseline study was conducted but the results are not available.

Main program activities, resources required to implement the program. Outreach workers and volunteers provide education and prevention through games and play on the street where the clients spend their time. All the activities are conducted in non-invasive and informal way.

Methods and results of effectiveness estimation. No research to estimate the effectiveness of the program was conducted. Nevertheless, according to the feedback from the program staff, the number of children using the program has been raised; children have been referred to specialists and organizations to get assistance they required.

Resources where additional information about the program is available. More information about the program is available at the following websites: <http://www.gpaspraga.org.pl/english.php> and <http://www.mobileschool.org/en> More information about the baseline study is available at: <http://www.mobileschool.org/en/results/facts-figures>

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The program "SKASTREET"

Authors of the program: Mr. Tomasz Małkuszewski, Ms. Izabela Pazdan, Mr. Cezary Fidor and Mr. Artur Lutarewicz.

Target group(s). Young people at the age from 18 to 30 years old involved into prostitution including young gay men selling sex; young people at high risk of being involved into prostitution including homeless young people, migrants, young people who spend a lot of time in the street and those who are looking for "sponsor" or "client"; young gay men undertaking behavior related to high risk of getting HIV and sexually transmitted diseases.

Aims of the program. The program is aimed at HIV and sexually transmitted diseases prevention among young people, at offering them alternative to spending time on the street, increasing their access to medical and other services they need.

Theoretical basis of the program. Harm reduction.

Main results of baseline study which have been used in development of the program. The baseline study was not conducted.

Main program activities, resources required to implement the program. Within the program outreach work is conducted: 2 persons as part of gender mixed teams visit places where sex is sold (streets, escort agencies), get in contact with young clients, provide them with information on HIV and sexually transmitted diseases prevention, on available health services and other forms of assistance/support, offer them alternatives to spending time in the street. Resources required: qualified outreach workers (HIV-educators experienced in work with youth), condoms, leaflets, drop-in area.

Methods and results of effectiveness estimation. No research to estimate the effectiveness of the program was conducted. One of the reasons which makes effectiveness estimation difficult is that all services provided within the program are anonymous. One of the indicators confirming that the program is acknowledged by the community is that SKA's employees often get phone requests from escort agencies or girls selling sex with an invitation to visit them in their working places, in some cases representatives of escort agencies and girls involved into prostitution visit SKA office by themselves to get condoms and other prevention materials.

Resources where additional information about the program is available. More detailed information about the program is available at the following websites: <http://www.skaid.org> and <http://www.skaid.org/pl/ska-street>

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The program "Baw się bezpieczniejsz ("Party safely") – party working project aimed at harm reduction among occasional drug users

Author of the program: Program STACJA Association.

Target group(s). Young people spending time at night clubs and practicing risky sexual behavior, abusing alcohol or/and other psychoactive substances.

Aims of the program. The program is aimed at raising young people' awareness on negative consequences for health of using alcohol, drugs and risky sexual behavior (including risks of getting HIV and sexually transmitted diseases), at reducing prevalence of risky behavior related to drug and alcohol abuse among young people.

Theoretical basis of the program. Harm reduction.

Main results of baseline study which have been used in development of the program. Baseline study was not conducted. The program was developed based on theoretical knowledge and experience of project workers.

Main program activities, resources required to implement the program. During the program party workers visit night clubs and distribute among clients condoms and prevention leaflets, provide them with reliable factual information about risky behaviors, adjusting the level of conversation to client's needs. The project is implemented by 8 party workers, takes 12 hours of work at the clubs per week, on average 300 condoms per week are distributed in the clubs.

Methods and results of effectiveness estimation. No research to estimate the effectiveness of the program was conducted. It was difficult to get data on changes in clients' behavior because of confidential nature of contacts.

Resources where additional information about the program is available. K. Rżanek, M. Grotecka, Partyworking w doświadczeniach Programu STACJA [w:] Zagrożona młodość. Innowacyjne formy interwencji społecznej, Red. E. Bielecka, Pedagogika Społeczna 2/2010, Pedagogium.

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The program "Ulica"

Author of the program: Mr. Andrzej Skorupski.

Target group(s). Young men and women with criminal background or from dysfunctional families, lacking adult care, from marginalized, stigmatized or socially excluded populations. Quite significant part of them is excluded from the educational system due to difficulties at school, intellectual limitations, parental negligence etc. Some live below the poverty line. The age groups are from 12 to 15 years old and from 16 to 20 years old.

Aims of the program. The program is aimed at raising young people awareness on risky behaviors related to HIV/STIs and use of psychoactive substances; enabling their access to institutions providing social support; demonstrating alternative forms of entertainment for young people; whenever possible providing them with assistance in getting back to formal education system or finding a job.

Theoretical basis of the program. Harm reduction.

Main results of baseline study which have been used in development of the program. Before the project, environmental analysis was conducted, followed by the assessment of needs of most vulnerable youth and their families.

Main program activities, resources required to implement the program. Within the program outreach activities in locations where representatives of target groups meet are conducted on a regular basis. Regularity is very important in order to build trust relations with young people. Outreach workers assess needs of each client, provide them with support/advise, refer them to the network of social institutions according to the needs of each client. Young positive leaders are involved into the program to promote positive values and organize groups of young people around safe and healthy activities. Main principles of the program are clients' confidentiality, respect to their rights and boundaries. Working time of the program staff is adjusted to habits of their service recipients.

Methods and results of effectiveness estimation. No study was conducted to estimate the effectiveness of the program. According to observations of the program staff, many clients successfully

returned to the system of formal education or found a job, quitted drug dealing, avoided conflicts with law, increased their knowledge on HIV and drug-use-related risks.

Resources where additional information about the program is available. Gdańskie Centrum Profilaktyki Uzależnień (<http://www.gcpu.pl>).

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3. Germany

O.I. Kolpakova, V.A. Odinkova, S. Vaittinen

The program "PÄNZ UP!" (bringing up children, protection of children's rights)

Author of the program: Looks e.V. Köln.

Target group(s). Boys in the age of 12 – 18 years old living in difficult social circumstances including those who have experienced sexual harassment, and those with migrant background. Adults working with young people including school teachers and social workers. Parents.

Aims of the program. The program is aimed at providing sexual education, prevention of sexual abuse including developing skills on how to recognize signs of sexual harassment and to resist it, empowerment of boys and young men and protection of their rights. The program includes information about HIV/AIDS and other health topics which is provided as the need arises.

Theoretical basis of the program. Intervention model derived from the baseline study carried out by Sven Brandes, Institute for Prevention and Psychological Health Research (IPG, Freie Universität Berlin).

Main results of baseline study which have been used in development of the program. The program is based on the results of the baseline study of sexual harassment against boys in public and semi-public spaces which was carried out in 2004 by IPG Berlin. The main result was that nearly every 4th – 6th young men have experienced sexual harassment. Many boys involved into prostitution had pedosexual experiences in their childhood and youth. This was the main reason to mobilize the PÄNZ UP! program by LOOKS e.V. Köln.

Main program activities, resources required to implement the program. The program is implemented by social worker in cooperation with school staff. Individual approach for each child is used. The program includes the following activities targeted at children: individual work, anonymous counseling, workshops, outreach prevention activities at schools, youth centers, bars and other places where children spend a lot of time, web based counseling via "Colja" tool (character/symbol with whom children could identify themselves). There is no specific component in the program on HIV/AIDS prevention but information on that and other health related issues is provided in case the need arises. For about 250 children are covered by the program per year. Besides that workshops for school staff (social workers, teachers), staff of sport clubs and church organizations are provided, information is spread among parents. For about 50 stakeholders are covered by the program per year. Resources required for program implementation: one trained social worker (50% of working time: workshops and other educational activities take for about 8 – 12 hours per week, maximum 60 hours per month), comfortable office premises.

Methods and results of effectiveness estimation. In order to guarantee good quality of the program, evaluation of workshops and other educational events have been done continuously. The main success factor of the program is its capacity to raise awareness on topics related to sexual exploitation.

Resources where additional information about the program is available. Information brochure on the project content (in German) is available at http://www.paenzup.de/data/paenzup_broschuere.pdf, information flyer with tips on how to recognize signs and signals of sexual harassment (in German) is available at <http://www.paenzup.de/data/schwimmbad.pdf>, report including description of the PÄNZ UP! – concept (in German) is available at <http://www.paenzup.de/>, web based tool «Colja» (in German) is available at http://www.paenzup.de/co_zone.html.

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The program "Subway"

Author of the program: HILFE-FÜR-JUNGS e.V.

Target group(s). Male sex workers including clients of the drop-in centre (mainly boys and young men under 28 years old including boys younger 18 years old) and clients in the streets (both young men and older sex workers and transsexuals).

Aims of the program. The program is aimed at raising awareness of target group representatives on how to stay healthy and at offering them alternatives in case they would like to quit prostitution.

Theoretical basis of the program. The program is based on the model developed by HILFE-FÜR-JUNGS e.V. in cooperation with 7 other organisations-members of the Working Group of German Speaking Social Organizations for Mail Street Sex Workers (AKSD). In the early 90th many young male sex workers were in the streets of the bigger cities in Germany. Many of them took drugs and needed the money for that; others used sex work as a (difficult and dangerous) way to come out with their homosexuality. There was a big need to provide them with information on safer sex and STIs. Outreach work had to be done to meet them and shelters had to be founded to provide those young men their daily needs (food, shower, washing etc.).

Main results of baseline study which have been used in development of the program. No baseline study was conducted, experience gained since 1994 by Lutz Volkwein and Wolfgang Werner (social pedagogues of the Subway HILFE-FÜR-JUNGS e.V.) during outreach work (they started this work by helping boys and young men in the streets) was used to develop the program.

Main program activities, resources required to implement the program. Approximately 2000 boys and young men are covered by the program per year. The program includes several main components: drop-in centre where clients receive different services (e.g. clothes, medical doctor once a week, shower, food etc.), outreach work in the streets, in bars and other locations, organization of recreation activities for the target group representatives, anonymous individual counseling (including counseling via e-mails and chat), referrals and individual support with visits to other stakeholders (according to the needs of the client), distribution of information leaflets, condoms and lubricants. The following resources are required to implement the program: 5 trained social, 2 trainees helping with day-to-day activities of the project, doctor providing medical help, comfortable premises on two floors (office, kitchen, recreation room, Internet, room with beds for sleeping, shower, washing machine, food, clothes etc.). Services at drop-in centre are available 4 days (16 hours) per week, doctor is available at the drop-in center 4 hours per week, room with beds for sleeping are available at the drop-in centre in the daytime 28 hours per week. Outreach work takes 12 hours per week, mobile medical services are available 3 hours per week, recreation activities are organized every two weeks.

Methods and results of effectiveness estimation. No study was conducted to estimate the effectiveness of the program. One of the indicators showing that the program is valued by target group representatives is that many former clients are still in contact with the personnel of the centre and provide valuable insight into their present alternative lifestyle. According to the former clients' feedback, many of them gained most of their knowledge about HIV and AI through this program because the program staff are the only people with whom they can talk about their issues freely.

Resources where additional information about the program is available. Description of the model of the AKSD Working Group (in German) is available at <http://www.aksd.eu/start.html>, more information about the program is available at Fink K., Werner W. Stricher: Ein sozialpädagogisches Handbuch zur mann-männlichen Prostitution. Lengerich, Pabst. 2005 (URL: http://www.aksd.eu/download/AKSD-Handbuch_2013_1_Version.pdf).

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The program "Prävention mit Jugendlichen und jungen. Erwachsenen. Fünf-Säulen-Konzept" (Prevention work with adolescents and young people. Youth work. The Five pillars concept)

Author of the program: Berliner aids-Hilfe e.V.

Target group(s). Different groups of young people at the age from 14 to 26 years old including general population (mainly young people at schools), young people placed in youth detention centres (the age varies between 16-21 years old), young refugees and migrants, MSM. Adults working with young people including school personnel.

Aims of the program. The program is aimed at motivation and empowerment of young people, raising their self-esteem, making them sensitive for diverse lifestyles, supporting them in overcoming social stereotypes, forming the climate of solidarity, encouragement to take responsibility for their own

actions and sexual life, challenging and changing their current behaviors and attitudes to safer, prevention of HIV, sexually transmitted diseases and associated infections.

Theoretical basis of the program. Structural Prevention Model based on the WHO Ottawa Charter 1986. Peer-education and peer-involvement approach.

Main results of baseline study which have been used in development of the program. The German Federal Centre for Health Education (BZgA) every 2 – 3 years carries out representative studies such as "Jugendsexualität" among 14 – 17 years old adolescents and "Aids im öffentlichen Bewusstsein" among 18 – 20 years old young people. In addition to that, the Deutsche AIDS-Hilfe in cooperation with other organizations has conducted surveys young people among young MSM, migrants and other vulnerable groups and survey among youth in detention centers. Results of the studies (e.g. information that young people have lack of knowledge concerning STDs) are used in conceptualizing workshops. An important part of every basic workshop is devoted to STDs. The epidemiological data, e.g. data on the increase in HIV and Syphilis infections among MSM, are used to implement the outreach prevention in gay clubs. So the statistics and results of the studies are used by the staff of organization to set the focus of work and to build up new projects.

Main program activities, resources required to implement the program. The program is based on the Five pillars concept developed by the Berliner Aids-Hilfe. The five pillars concept is split up in schoolwork and youthwork. A central element of the concept is the prevention work based on latest scientific results as well as on own publications of the staff of organization in the field of HIV and STDs prevention. Projects and outreach prevention is often realized in cooperation with other stakeholders. Pillar I: workshops for school classes, for youth in detention centers; for young MSM, refugees and migrants. Pillar II: events and action days (e.g. youth film days, World AIDS Day, gay pride, youth fairs); outreach prevention work in places popular among young people. Pillar III: peer-education for young volunteers and youth journalists. Pillar IV: school personnel training and education events for diverse adult facilitators. Pillar V: Sex in the City! Geocaching for school youth and other groups of young people. Human resources: one full-time social worker responsible for training activities and coordination of the whole program. One part-time social worker assisting the coordinator and coordination of events. Group of about 20 extensively trained volunteers. Financial resources: project grants from various donor organizations, e.g. MAC cosmetics. Deutsche Klasslotterie Berlin. Federal Ministry of Education and Research. Private donors.

Methods and results of effectiveness estimation. Methods and effectiveness indicators depend on what needs to be found out and on the stage of the project development. Participant enquiry after interventions is done occasionally, e.g. after workshops with school classes. Level of pupils' satisfaction, knowledge and participation rate is measured. Skills of workshop leaders' and methods of training are evaluated. According to the results of participant enquiry before and after interventions in Pillar I of the program, level of knowledge of participants had improved. Results of enquiry after Geocaching (Pillar V) showed a wide acceptance of the program. Evaluation after events (Pillar II) showed that in some youth settings besides HIV information booths also mobile info-teams should be used. Recent enquiry carried out among teachers (Pillar IV) showed that nearly all the respondents were satisfied with the workshops, most were interested in learning methods (and having materials for free) for their later teachings.

Resources where additional information about the program is available. More information about the results of the studies which were used to develop the intervention could be found at the following resources:

- baseline study results could be found at BZgA. (URL: <http://www.bzga.de/home/>);
- results of surveys among young MSM, migrants and other vulnerable groups could be found at Bochow M., Lenuweit St., Sekuler T., Schmidt A.J. Schwule Männer und HIV/AIDS: Lebensstile, Sex, Schutz- und Risikoverhalten. 2011. (URL: www.aidshilfe.de);
- results of survey among youth in detention centers are available at: Man gewöhnt sich an alles (URL: http://www.aidshilfe.de/sites/default/files/berliner_jugendarreststudie_2012_0.pdf).

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4. Finland

O.I. Kolpakova, V.A. Odinkova, O. Karvonen

The program of work with girls who have suffered sexual violence

Author of the program: Girls' House.

Target group(s). Girls and women in the age of 13 – 28 years old who have suffered sexual violence (including unwanted touching, rape, harassment, offering money or goods or intoxicants for sex, coercion, sexually harassing messages or videos in the Internet).

Aims of the program. The program is aimed at prevention of social exclusion of girls who have suffered sexual violence, at their empowerment, raising their self-esteem, development of skills needed in everyday life, prevention of repeated trauma, of mental disorders, decreasing of substance abuse, supporting them in finding their own limits in sexual and other contacts.

Theoretical basis of the program. The program is based on PLISSIT model (abbreviation from P: Permission; LI: Limited information; SS: Specific suggestions; IT: Intensive therapy).

Main results of baseline study which have been used in development of the program. The baseline study was not conducted.

Main program activities, resources required to implement the program. Individual approach is used in work with every girl. The program includes the following components: individual discussions with an employee of the Girls' House (these discussions include information about HIV and STI, testing, treatment etc., and they have therapeutic aim), peer group discussions facilitated by two professionals of the Girls' House, networking with a lawyer, police, healthcare institutions, social protection, parents, teachers. Resources required for the program implementation are the following: one trained employee for individual discussions; two employees trained in group discussions; comfortable premises; one employee who attends court as a support person for the client.

Methods and results of effectiveness estimation. Client survey for all clients of Girls' House is conducted annually. In 2012, 91% of respondents in the client survey agreed with the statement: "I have received support in some of the following issues: self-confidence, self-esteem, social relations, family relations, parenthood, emotions, studies and work, life skills, new views, hopes for future, sexuality, experience of sexual violence, own limits, girlhood, womanhood". According to the results of the client interviews, young women who had experienced sexual violence and had received support at the Girls' House minimum half-a-year, felt that the quality of their life had improved. Difficulties were met in becoming independent from the support, especially if the support was reduced without a careful preparation phase.

Resources where additional information about the program is available. More information about the program is available at the publication Vornanen M. Nuorten naisten kokemuksia Tyttöjen Talon seksuaaliväkivallan tuesta. Haastattelutkimus. Aino&Ilmari-hanke. 2013 (this report includes description of activities with girls and women who have suffered sexual violence and analysis of interviews with five young women – clients), at Annual Report 2012 of Kalliola Youth Association (in Finnish) (URL: <http://www.kalliola.fi/vuosikertomukset/>). More detailed description of the PLISSIT model is available at Annon J.S. The PLISSIT Model: A proposed Conceptual Scheme for the Behavioral Treatment of Sexual Problems// Journal of Sex Education and Therapy. 1976. Vol. 2. Issue 1. Pp. 1–15; Taylor B., Davis S. Using the Extended PLISSIT model to address sexual healthcare needs. Nursing standard. 21(11) (2006). Pp. 35–40.

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Health Education as a part of National Core Curriculum for Basic Education

Author of the program. The program is coordinated by Finnish National Board of Education.

Target group(s). Pupils in compulsory education, 7 – 9 grades (age groups 13 – 16 years).

Aims of the program. The intent of the program is to develop the pupils' competence regarding health, well-being, and safety, including knowledge about prevention of sexually transmitted infections and HIV. The task is to develop the pupils' cognitive, social, functioning and ethical capabilities, and their capabilities for regulating emotions.

Theoretical basis of the program. Holistic approach. WHO recommendations.

Main results of baseline study which have been used in development of the program. No baseline study is conducted as a routine. Sexual education in Finland has been studied and followed up through two national surveys – in 1996 and 2006 – directed at biology and health education teachers. Adolescents' sexual knowledge has twice been measured in national sexual health knowledge quizzes, in 2000 and 2006. Sexual health knowledge increased from 2000 to 2006. Even though the knowledge about STIs and AIDS also increased, it was still a theme which needed improving more than other themes of sex education. Also it came clear that boys have much worse sexual knowledge than girls, and that sex education should pay more attention to sexual issues in which boys are especially interested.

Main program activities, resources required to implement the program. The program includes the following components: school lessons (conducted using interactive methods including watching and discussion of prevention videos), distribution of leaflets and condoms. The themes in sexual health include e.g.: human relations, sexuality, behavior, and the related values and norms; the most common infectious diseases, recognition of symptoms, seeking for care, main health-care and welfare services, rights of children and young people. The schoolbooks include most common STIs and HIV – ways of transmission, symptoms, prevalence in Finland, possible harmful consequences and treatment. The following resources are required to implement the program: health education teachers who have university degree in health education, school health nurses who are prepared to discuss sexuality issues with youth. Sexuality education for 7 – 9 graders takes minimum 3 hours per year.

Methods and results of effectiveness estimation. School health promotion study carried out every second year for 14 – 20 years old adolescents. It covers approximately 180,000 respondents: 8th – 9th graders from secondary school, 1st – 2nd graders from upper secondary school, 1st – 2nd graders from vocational schools. The latest survey was done in 2013. The results of the survey among 8th – 9th graders from secondary school shown that comparing to 2010 the number of young people who didn't use contraception during latest intercourse decreased by 2%, the number of young people who used condom and hormonal contraception during latest intercourse increased by 1%, the number of young people who have had sexual intercourse increased by 0,3%. In 2013 the number of young people who have experienced sexual violence once or repeatedly was 14,2%. In the end of 1990-ies the number of teenage pregnancies and abortions increased in Finland and in 2002 it decreased. The results of the teachers' survey show that the mean hours allocated to sex education almost doubled from 1996 to 2006, from 9.3 hours to 17.3 hours per school year. Comparing the results of 2006 with 1996, the themes of sexual intercourse, contraception, STIs and AIDS, and the social dimensions of sexuality had been moved from the 9th grade to the 8th grade and the issues related to reproduction from the 9th grade to the 7th grade. In the 8th grade the following themes got increased attention: sexual harassment, sex in the media, sexual minorities, intercourse and childhood sexuality.

Resources where additional information about the program is available. More information about the program is available at the section Basic education at the Finish National Board of Education (URL: http://www.oph.fi/english/curricula_and_qualifications/basic_education), at Mitä pojat todella haluavat tietää seksistä/ Ed. by O. Kontula. Väestöliitto. Helsinki, 2012, at Kontula O. The evolution of sex education and students' sexual knowledge in Finland in the 2000s// The Population Research Institute, The Family Federation of Finland. Sex education. Vol.10. No 4. November 2010. Pp. 373 – 386. (URL: <http://www.vaestoliitto.fi/@Bin/1351199/Sex+Education+2010.pdf>). Statistics on adolescents' sexual health is available at Raskaudenkeskeytykset 2012. Aborter 2012. Induced abortions 2012 (URL: http://www.julkari.fi/bitstream/handle/10024/110210/Tr18_13.pdf?sequence=5).

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Health Education as a part of National Core Curriculum for Upper Secondary Schools

Author of the program. The program is coordinated by Finnish National Board of Education.

Target group(s). Pupils of the upper secondary education, 1 – 3 grades (age groups 17 – 19 years).

Aims of the program. Health education is a subject that relies on a multidisciplinary foundation and aims to develop pupils' competence regarding health, safety and well-being. The objective of the

sexuality education is also to increase knowledge about prevention of sexually transmitted infections and HIV.

Theoretical basis of the program. Holistic approach, WHO recommendations.

Main results of baseline study which have been used in development of the program. No baseline study was conducted among this target group.

Main program activities, resources required to implement the program. Within the program school lessons are conducted (it is recommended to use interactive methods to conduct them). The compulsory course covers themes like sexual health, the couple relationship, most common communicable diseases, including relevant risk and protective factors and measures to influence these, methods to acquire health information and critical interpretation of health-related communication, advertising and marketing, use of healthcare and social welfare services. The voluntary courses include more detailed information on sexual health and its promotion as well as basic research principles. The main resource required to conduct health education is teachers who have university degree in health education. Obligatory health education course for 1 – 3 graders of upper secondary schools is 38 hours, from this minimum 3 hours should be spent for sexuality education. Besides that pupils might choose two more courses on health education (voluntary, 38 hours each, in each course at least 1 hour is allocated to sexual education).

Methods and results of effectiveness estimation. School health promotion study carried out every second year for 14 – 20 years old adolescents. It covers approximately 180,000 respondents: 8th – 9th graders from secondary school, 1st – 2nd graders from upper secondary school, 1st – 2nd graders from vocational schools. The latest survey was done in 2013. Results of the research among 1st – 2nd graders of upper secondary school shown that comparing to 2010 the number of young people who didn't use contraception during latest intercourse reduced by 0,5 %, number of young people who used condom and hormonal contraception during latest intercourse increased by 0,4 %, number of young people who have had sexual intercourse decreased by 0,1%. The number of young people who have experienced sexual violence once or repeatedly was 15,7%.

Resources where additional information about the program is available. More information about the program is available at the section General upper secondary education at Finish National Board of Education (URL: http://www.oph.fi/english/curricula_and_qualifications/general_upper_secondary_education) and at Kontula O. The evolution of sex education and students' sexual knowledge in Finland in the 2000s// The Population Research Institute, The Family Federation of Finland. Sex education. Vol.10. No 4. November 2010. Pp. 373 – 386. (URL: <http://www.vaestoliitto.fi/@Bin/1351199/Sex+Education+2010.pdf>).

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5. Latvia

A. Kivite, O.I. Kolpakova, V.A. Odinokova

The program "Health Promotion for Young Prisoners"

Authors of the program. The program was developed within the project supported by the European Commission by a group of organizations. The leading project partner was Scientific Institute of the Medical Association of German Doctors (WIAD). In Latvia the project was coordinated by NGO "Papardes zieds".

Target group(s). The target group of the project was prison staff, the final beneficiaries were adolescents and young people at the age from 14 to 24 years old.

Aims of the program. The project was aimed at the improvement of health promotion among vulnerable young people in prison settings. Specifically the project was aimed at the development of a toolkit for prison staff on health promotion among imprisoned young people. The toolkit covered the following issues: infectious diseases, sexual health, mental health as well as the prevention and treatment of drug use.

Theoretical basis of the program. Participatory approach: the toolkit on health promotion was based on the views and needs of vulnerable young people in prison (quantitative research using standardized

questionnaires; focus group discussions) as well as of prison staff and representatives of NGOs (in-depth interviews) as possible deliverers of health promotion in custodial settings. In total in all project countries 571 imprisoned young people from 38 prisons participated at the survey; of these 223 took part in 24 focus groups. In addition, 228 prison staff and NGO representatives were interviewed face-to-face using open questions.

Main results of baseline study which have been used in development of the program. The program is based on the results of two studies. One of them shown that young people in prisons are at higher risk to become HIV or AI infected than the general population of young people. Another research confirmed that topics related to sexuality and drug use (and related issues like HIV and AI) should be covered by prevention activities implemented in prisons. The necessity of using interactive approach in implementation of these activities was underlined. Based on the results of these studies a Toolkit was developed. In the Toolkit there a description of interactive activities on health related topics (including HIV and AI prevention) was included as well as information leaflets and worksheets which might be used by trainer during interactive lessons with young people.

Main program activities, resources required to implement the program. Main activities included the following: 1) needs assessment research; 2) development of a toolkit; 3) piloting of a toolkit, implementation of the training for trainers; 4) dissemination of the toolkit. Toolkit contains practical materials for individual work, work in pairs, group work, role plays etc. on different health issues (including HIV). Program was implemented in all 12 prisons of Latvia. Training for trainers was held in Riga centrally for all prisons, toolkit was spread in all Latvian prisons (at least 2 copies for each prison) and in other key institutions and organizations in Latvia. The trained prison staff implemented prevention activities targeted at imprisoned young people. Resources required to implement these activities depended on the type of the interactive methods of prevention work chosen by the trainer and might include paper, markers, post-it papers, equipment for playing music etc.

Methods and results of effectiveness estimation. Changes in the level of knowledge, behaviour or attitudes of the target group (prison staff) and final beneficiaries (prisoners) were not evaluated. Only results of the training for trainers were briefly measured: interactive methods were used to get information on the feelings of participants related to the training, to collect positive and negative feedback about the training.

Resources where additional information about the program is available. Results of the baseline studies are available at:

- Sebre S., et al. Atkarību izraisīto vielu lietošanas problemātika specifiskās bērnu grupās, 2008 (Addictive substance use problems among specific groups of children);
- Karnite A. National Research Report. Latvia. HPYP, 2011;
- Toolkit developed within the project: Rokasgrāmata. Veselības veicināšana jauniešiem ieslodzījumu vietās. Nodarbību materiāli ieslodzījumu vietu darbiniekiem (Health Promotion for Young Prisoners. Toolkit).

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The program "Training for Criminal Justice Professionals in Harm Reduction Services"

Authors of the program. The training was developed by the group of experts within the project supported by the European Commission: Ms. Caren Wiegand, Ms. Caren Weilandt, Ms. Morag MacDonald, Mr. Ivan Popov, Ms. Baiba Purvice, Ms. Linda Pavlovska, Mr. Emanuel Parausanu, Mr. Sorin Dobrota.

Target group(s). The direct target group of the project was prison staff; final beneficiaries of the project were imprisoned peoples of all ages (including young prisoners).

Aims of the program. The project was aimed at the promotion of harm reduction approach in Latvian prisons (including harm reduction among young prisoners) by development and improvement of the training for professionals working in the criminal justice system (including work with young prisoners) and providing them with an extensive knowledge about drugs, problem drug use and harm related to

drug use including getting HIV and AI so that they could implement prevention activities targeted at imprisoned people.

Theoretical basis of the program. Participatory approach: development of the training manual was based on the views and needs of vulnerable people in prison (focus group discussions) as well as of prison staff and representatives of non-governmental organizations (in-depth interviews) as possible deliverers of harm reduction measures (including HIV prevention) in custodial settings. A total of 18 prisoners from 2 prisons participated at the survey in Latvia. In addition, 12 prison staff and NGO representatives were interviewed face-to-face.

Main results of baseline study which have been used in development of the program. Results of 4 researches were used to develop the program, out of which 3 were conducted by the project team and one was carried out before the project by other team. One of the studies has shown that young people in prisons are at higher risk of getting HIV and AI than the general population of young people. The results of 3 other studies shown that that the level of knowledge and skills of police and prison employees on drugs and harm reduction (including such harms as HIV and AI) should be improved nationally so that they can provide the information further to offenders (including young ones) they are working with. Thus the training manual includes description of concrete interactive activities on drug related topics (including HIV and AI).

Main program activities, resources required to implement the program. To develop/improve the training desk review and needs assessment was conducted, interactive toolkit for professionals working in prisons and training for trainers was developed. Training for trainers was organized. Prison staff and other professionals motivated to work in prisons (public health specialists, psychologists, social workers etc.) were trained. After that they implemented harm reduction activities targeted at imprisoned people. The resources needed to implement harm reduction activities depended on the type of interactive methods chosen by the trainer and might include paper, markers, post-it papers etc.

Methods and results of effectiveness estimation. Changes in the level of knowledge, behaviour or attitudes of the target group (prison staff) or final beneficiaries (prisoners) were not evaluated. Only results of the training for trainers were briefly estimated: interactive methods were used to get the feedback from training participants on the content of the training and their feelings related to the training.

Resources where additional information about the program is available. More information about results of the baseline researches is available at:

- Karnite A. Literature review. Latvia. TCJP, 2009;
- Karnite A. In-depth interviews. Latvia. TCJP, 2009;
- Karnite A. Focus group discussions. Latvia. TCJP, 2009;
- Sebre S., et al. Atkarību izraisīto vielu lietošanas problemātika specifiskās bērnu grupās, 2008 (Addictive substance use problems among specific groups of children).

Toolkit developed within the project: Wiegand C., Weilandt C., MacDonald M., Popov I., Purvlice B., Pavlovska L., Parausanu E., Dobrota S. Prison staff and harm reduction. A training manual (URL: [http://www.drugsandalcohol.ie/14160/1/Training manual.pdf](http://www.drugsandalcohol.ie/14160/1/Training%20manual.pdf)).

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The program "Peer education on HIV/AIDS and reproductive health"

Authors: Ms. Gita Gange, Ms. Edite Kanepaja-Vanaga, Mr. Reinis Upenieks.

Target group(s). Basically program is targeted at young people who study at secondary school or first 2 schooling years at vocational school (16 – 18 years old); sometimes program also covers schoolchildren who study at older classes of primary school (14 – 15 years old).

Aims of the program. To increase knowledge and awareness of young people regarding healthy relationships, human sexuality as a natural and essential component of personality, on the responsibility

of initiating sexual relations, safe sex (preventing unwanted pregnancy, HIV and other sexually transmitted infections), to develop life skills of young people in a relevant, interesting and attractive way.

Theoretical basis of the program. Peer education approach; main principle is that educational activities targeted at young people should be provided not by adults/ school teachers but by specially trained peers with whom youngsters feel more open to discuss discrete issues like sexuality, drug use and related questions (like HIV and AI).

Main results of baseline study which have been used in development of the program. The baseline study confirmed that students of vocational schools, students of countryside schools are at higher risk to become HIV or AI infected than the general population of students.

Main program activities, resources required to implement the program. Main components of the program: 1) providing training to peer educators (active young people motivated to conduct prevention activities among their peers), 2) implementation by trained young people of prevention activities targeted at their peers. To train young people and to support them in implementation of prevention activities the manual "Rokasgrāmata vienaudžu izglītotājiem. HIV/AIDS un reproduktīvā veselība" (Train the trainer, peer-to-peer approach) is used. It was developed in Latvia in 2003 with the financial and methodological support from UNDP and until now is used in prevention work nationwide. The manual contains the description of the theory on HIV and related issues as well as different interactive techniques and methods which could be used in prevention work with young people on the issues of reproductive health, HIV and AI prevention etc.

Methods and results of effectiveness estimation. Some short evaluation on the satisfaction of target group representatives by implemented prevention activities is carried out (usually the program is highly evaluated). No validated instrument exists. Each NGO implementing the program develops a short questionnaire provided to students after the lesson. Basically the questionnaire contains the questions on the lesson (not checking the knowledge or attitudes of the students). E.g. following questions were asked to students in 2013: evaluate the topicality of the lesson (scale from 1 to 10); was the way how the information was provided understandable and interesting (scale from 1 to 10); what should be changed in similar lessons (free answer).

Resources where additional information about the program is available. More information about peer-education approach could be found at: http://www.unaids.org/sites/default/files/media_asset/jc291-peereduc_en_0.pdf

More information about results of baseline study could be found at: UNDP, Jauniešiem draudzīgi veselības pakalpojumi – pieejamība un vērtējums (Youth-friendly health services – access and rating), 2002.

Manual in Russian: Г. Ганьге, Э. Канепян-Ванага, Р.Упениекс. Справочник для тренеров по системе обучения равный-равному. ВИЧ/СПИД и репродуктивное здоровье. Латвия, 2003 г. – 224с.

Information on HIV and AI prevention activities implemented in Latvia using peer-to-peer approach is published on the regular basis at the following websites: www.spkc.gov.lv; www.papardeszieds.lv; www.redcross.lv, www.ljsk.lv.

Author's contact details. Centre for Disease Prevention and Control of Latvia, e-mail: info@spkc.gov.lv, website: <http://www.spkc.gov.lv/about-SPKC/>; Latvian NGO "Papardes zieds", e-mail: info@papardeszieds.lv, website: <http://papardeszieds.lv/en/index.php>; Latvian Red Cross: e-mail: secretariat@redcross.lv, website: <http://www.redcross.lv/en/about-us/secretariat/>

CHAPTER IV. EXAMPLES OF TOOLS WHICH CAN BE USED FOR THE PREVENTION OF HIV INFECTION AND ASSOCIATED DISEASES

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Analysis of the needs of adolescents and young people at high risk of getting infected with HIV and associated diseases showed that the following aspects should be selected as the main "targets" for prevention programs designed for this group of adolescents and young people:

1. Raising awareness among adolescents and young people at high risk of contracting HIV and associated diseases on the transmission routes and methods of preventing HIV infection, elimination of misconceptions and myths about HIV transmission.
2. Formation among adolescents and young people at high risk of HIV contraction of capability for realistic evaluation of their own risk of contracting HIV.
3. Formation among adolescents and young people at high risk of contracting HIV and associated diseases of capability for positive attitude to the methods of avoiding risky behavior including:
 - to fidelity and avoiding early sexual contacts;
 - to 100% condom use in all sexual encounters;
 - to discussion of HIV and STIs with a sexual partner before starting a sexual contact;
 - to avoiding random sex;
 - to avoiding situations of having sexual contacts while intoxicated;
 - to avoiding situations of having sexual contacts under pressure/coercion;
 - to avoiding trying injection drugs;
 - to an idea of applying medical institution for getting HIV counseling and testing.
4. Formation among adolescents and young people at high risk of contracting HIV and associated diseases of a tolerant attitude to HIV-positive people.
5. Formation among adolescents and young people at high risk of becoming HIV infected of the skills which are necessary for avoiding risky situations (communication skills, refusal skills, skills allowing resisting peer group pressure, etc.).

This section gives examples of prophylactic exercises for each of the identified "targets" for the work on prevention of HIV infection among adolescents and young people at high risk of infection.

A number of these exercises also used to be applied previously by the staff of the state and public organizations in the context of HIV prevention among adolescents. However, these exercises were used for adolescents and young people engaged in risky behavior not in hundred percent of cases. They were adjusted to the needs of this target group under the project called "Strengthening prevention of HIV infection and the associated diseases among the young people at high risk of contracting HIV in the "Northern Dimension" region.

All the exercises presented in this manual have been tested at three state organizations dealing with adolescents and young people engaged in risky behaviour:

- dormitories of State-Financed Autonomous Institution of the Kaliningrad Region "College of Entrepreneurship" (city of Gurjevsk, Kaliningrad Region, Russia);
- State-Financed Vocational Educational Institution St. Petersburg "Lyceum of Services and Industrial Technologies" (St. Petersburg, Russia);
- State-Financed Vocational Educational Institution St. Petersburg "College of Sectoral Technologies "Krasnoderevets" (St. Petersburg, Russia).

In Kaliningrad Region, the adjustment and approval of the exercises were carried out by psychologists of the Centre for Psychological and Educational Assistance called "Doverie" under methodological guidance of the Public organization called "YLA". In St. Petersburg, same was done by the staff of the "Lyceum of Services and Industrial Technologies" and the "College of Sectoral Technologies "Krasnoderevets" under the methodological guidance of the Regional NGO "Stellit". All the experts involved in approval of the exercises had been previously trained in area of organization and implementation of HIV and associated diseases prevention among adolescents and young people at high

risk of contracting the infection. The adaptation and approval of the exercises in both Kaliningrad Region and St. Petersburg were carried out between November, 2014 and June, 2015.

Experts, who participated in the approval, evaluated the effectiveness of each exercise. With this end in view, they filled in an evaluation form, in which, in particular, they specified the level of motivation and activity of the participants, the extent to which the exercise made it possible to achieve each of the goals of preventive work, gave detailed comments on how the exercise was conducted (whether it was necessary to modify the content, how comfortable and confident they felt when carrying out the exercise, what they liked most or least of all in the course of the exercise, have they acquired new skills relating to HIV prevention among the young people of the "risk" group as a result of this exercise), and whether they were interested in using this exercise in the future work. The experts were also asked to describe in what way they would like to change the exercise to increase its effectiveness, and what they could recommend their colleagues, who would use the exercise.

The manual includes the exercises that meet the following basic criteria:

- the exercise allows, to a large extent, to approach achievement of at least one of the goals of HIV prevention among adolescents and young people of high-risk behaviour should be targeted;
- when conducting the exercise the expert feel easy and is comfortable;
- in the course of the exercise the adolescents and young people are involved and interested in what is happening;
- the adolescents and young people have a chance to effect the content and performance of the exercise;
- the expert plans to use the exercise in future in his/her preventive work.

1. Raising awareness of HIV transmission routes and methods of prevention, elimination of misconceptions and myths about HIV transmission

"Questionnaire survey"

Description. The moderator invites the participants to fill in questionnaires designed to identify the level of their awareness with regard to HIV/AIDS. Upon that, the questions put forward by the participants are to be discussed under any free format. The moderator particularizes the main routes of HIV transmission and the means of protection (with emphasis on the priority of sexual abstinence). The relationship between the concepts of "health", "happiness", "success", and "achievements in life" is to be discussed. At the end of the session, the moderator concludes: "It is unlikely that people who are HIV infected thought that it would happen to them. Why did it happen? There is no unambiguous answer to this question. One thing is obvious: each individual can do a lot to protect him/herself against contracting HIV".

Examples of questions that could be included in the questionnaire:

1. Choose the correct answer:
 - a) AIDS is the beginning of HIV infection.
 - b) AIDS is the result of HIV infection developing in human body.
 - c) HIV infection and AIDS are the same things.
2. A person infected with HIV, ...
 - a) ... starts feeling it immediately.
 - b) ... might not know for a long time that he (she) is infected.
3. Life expectancy of a person from the time of contracting HIV (provided he /she takes care of his /her health) can run up to:
 - a) 2 years.
 - b) 5 years.
 - c) 20-25 years.
4. HIV infection is transmitted through:
 - a) blood.
 - b) semen and vaginal secretions.
 - c) breast milk - mother to baby transmission.

- d) all answers are correct.
5. Choose the answers which indicate possible routes of HIV transmission:
- use of non-sterile syringes and needles.
 - insect bites.
 - sharing tableware with an HIV infected person.
 - to use the same toilet as an HIV infected person uses.
 - a handshake or a hug with an HIV infected person.
 - unprotected sex with an infected partner.
 - all answers are correct.
6. The period of the "window", i.e. the time from the day of contracting HIV to the day when it can be identified by tests, is:
- 2 - 3 days.
 - 2 - 3 months.
 - 2 - 3 years.
7. Human immunodeficiency virus could be killed by ... (several correct answers are possible):
- ... boiling.
 - ... freezing.
 - ... ethanol treatment.
 - all the answers are correct.
8. HIV infection today:
- is completely curable.
 - its development can be slowed down by therapy.
 - it does not respond to any medical intervention.

Correct answers: 1b; 2b; 3c; 4d (a,b,c); 5a,f; 6b; 7a,c; 8b.

Requirements as to participants. Recommended number of participants: from 9 to 15 persons. Age: not younger than 16.

Qualification criteria as to the moderator. The moderator should have a basic level of knowledge on HIV contraction and skills in moderating group discussions. The exercise can be moderated by a trained volunteer, a qualified psychologist, a teacher, a social worker, an expert from the Centre for Prevention and Control of AIDS and Infectious Diseases.

Supplies and equipment. Number of copies of the Questionnaire is to correspond to the number of the participants, pens or pencils are distributed according to the number of the participants as well. Information about HIV transmission routes could be provided by means of a Power Point presentation (in such a case, a computer or a notebook, a projector, and a screen will be required).

Duration: 20 minutes.

Recommendations on how to conduct the exercise:

- The exercise allows the moderator to assess the level of HIV awareness among participants, the level to which they are interested in this problem, to highlight the topics that are most relevant to the participants. It is recommended to give the exercise at the beginning of the programme and use the information obtained to adjust the content of the prevention programme.
- After the questionnaire survey it is necessary to discuss its results with the participants of the program, to give the participants the correct answers to each question of the questionnaire. Discussion of the results of the survey can turn into a short lecture on the problem of HIV infection; therefore, the moderator should be ready to give a detailed explanation for each question of the questionnaire.
- It is important to make sure that all the programme participants understand the questions of the questionnaire. If anyone of the participants does not understand the question, it is important to come up to him/her and explain the meaning of the question.
- All the program participants are supposed to have enough time to complete the questionnaire (some of them may need more time than others).

Primary source the exercise is borrowed from. The exercise is part of HIV/AIDS and risky behavior primary prevention program designed for children in early adulthood. The program is called "Lad'Ya - In harmony with oneself". The program was developed by N.A. Sirota, T.V. Vorobieva, A.V. Yaltonskaya, E.E. Rydalevskaya, S.M. Yatsyshin, A.V. Miklyaeva, N.V. Kudryavtseva.

"Kaleidoscope"

Description. The participants sit in a circle. Moderator puts three A4 papers with the statements "I agree", "I disagree" and "I doubt" (one statement on each paper) in front of the participants, inside the circle. The moderator gives to participants small sheets of paper with printed statements on the problem of HIV infection (each participant gets 2 – 3 statements). The participants take turns and read out the statements they have been provided with, say whether they agree with each of these statements (the options: "I agree", "I disagree", "I doubt") and put it below the A4 sheet of paper with the relevant statement. The participants are welcome, if they wish, to give reasons to their choices. Group discussion is considered acceptable, provided it is facilitated by the moderator. If the participant gives a wrong answer, and the other adolescents are in agreement with him/ her, the moderator should give the correct answer to the question and provide arguments to reason the standpoint.

Examples of statements that can be used in the course of the exercise:

1. HIV and AIDS are the same sort of thing.
2. Only drug users and people of promiscuous sexual lifestyle are at risk of HIV contraction.
3. There are methods providing 100% protection against HIV infection.
4. One can be infected with HIV not knowing about it.
5. HIV infected people are to blame themselves.
6. One can have AIDS and look healthy.
7. An HIV infected mother can give birth to a healthy baby.
8. A woman infected with HIV should be prohibited to have children.
9. HIV is transmitted by insects.
10. There is a risk of contracting HIV at a nail care salon.
11. AIDS in humans decreases resistance to infections.
12. Intimate relationship with a drug user dramatically increases the risk of contracting HIV.
13. HIV is transmitted through blood.
14. The problem of HIV/AIDS is not relevant for the residents of our city.
15. Mandatory testing for HIV is the only way to contain the spread of the infection.
16. People having no HIV symptoms of the disease can be a source of HIV contraction.
17. HIV quickly dies outside the body.
18. There is a highly efficient HIV/AIDS therapy available.
19. Women are infected with HIV more often than men.
20. Just one unprotected sexual transaction with a virus carrier is enough to contract HIV.
21. Only adults can have HIV.
22. I know what the "window" period is about".
23. Contacts with a person having HIV should be avoided.
24. If a person knows that he/she has HIV and infects another person, it means that he/she commits a crime and should be punished by imprisonment.
25. AIDS can be cured if treatment starts at an early stage.
26. There are pills that protect against HIV.
27. The results of HIV testing (diagnosis) is doctor-patient confidentiality.
28. It is possible to live to old age being HIV infected.
29. I'm not the kind of person to contract HIV.

Requirements as to participants. Recommended number of participants: 9 to 15 persons. Age: not younger than 16 years old.

Qualification criteria as to the moderator. The moderator should have a basic level of knowledge on HIV contraction and skills in moderating group discussions. The exercise can be moderated by a trained

volunteer, a qualified psychologist, a teacher, a social worker, an expert from the Centre for Prevention and Control of AIDS and Infectious Diseases.

Supplies and equipment. Sheets of paper with printed or written statements on the problem of HIV infection (each participant should get 2 - 3 statements), sheets of A4 format with inscriptions: "I agree", "I disagree", "I doubt".

Duration: 20 – 30 minutes.

Recommendations on how to conduct the exercise:

1. The exercise allows the moderator to assess the level of HIV awareness among participants, the level to which they are interested in this problem, to highlight the topics that are most relevant to the participants. It is recommended to give the exercise at the beginning of the program and use the information obtained to adjust the content of the prevention program.
2. The exercise gives the participants a chance to communicate with other participants, to voice out their opinions and stand up for their standpoints in the course of a discussion. Some participants may face difficulties when putting forward arguments for their standpoint – in such a case they can just say whether they agree or do not agree with the statement. This allows involving all the participants.
3. In the course of the exercise the moderator should keep track of time. It is important that the discussion of certain statements is not lasted way to long.
4. Prior to the exercise, it is important to repeat with the participants the rules of group work ("Do not interrupt other participants", "Do not disapprove other participants", "Speak in turn", "Refuse participating in exercise in case participant doesn't like it for some reasons" etc.).
5. Sheets of A4 paper with statements "I agree", "I disagree" and "I doubt" could be put not inside the circle but on the board with magnets. Then participants might be given small stickers with statements on the problem of HIV infection and put them on the board as well below the relevant sheet of A4 paper.
6. Sheets of A4 papers with statements "I agree", "I disagree" and "I doubt" could be placed not inside the circle but in different corners of the room. In that case moderator could read the statements on the problem of HIV one by one and after each statement ask all participants to go to relevant corners of the room depending on if they agree, disagree with the statement or doubt. After that moderator asks several participants from each corner to give reasons to their choices.

Primary source the exercise is borrowed from . The exercise is part of HIV/AIDS and risky behavior primary prevention program designed for children in early adulthood. The program is called "Lad'Ya - In harmony with oneself". The program was developed by N.A. Sirota, T.V. Vorobieva, A.V. Yaltonskaya, E.E. Rydalevskaya, S.M. Yatsyshin, A.V. Miklyaeva, N.V. Kudryavtseva.

"A short lecture on HIV/AIDS"

Description. The moderator asks the participants to write down on the sheets of paper the questions on the problem of HIV/AIDS, which they would like to clarify for themselves. Each question is written on a separate sheet of paper. The moderator collects the sheets of paper with the questions, puts them in a box, mixes, and then pulls out one by one, and answers each question. Even if participants have no questions, the moderator, choosing an understandable popular form of presentation, tells them about HIV/AIDS covering the following aspects: what HIV and AIDS are about, what are the main stages of the disease, how HIV is transmitted and how is not transmitted, what population groups are at the highest risk of being infected, how the diagnostics is carried out, and what is the "window period" about, what is an antiretroviral therapy, what are the methods of protection against HIV.

Requirements as to participants. Recommended number of participants: up to 25 persons. Age: not younger than 15 years old.

Qualification criteria as to the moderator. The moderator should have basic knowledge on HIV infection and public speaking skills. The exercise can be moderated by a qualified psychologist, a trained teacher or a social worker, by an expert from the Centre for Prevention and Control of AIDS and Infectious Diseases.

Supplies and equipment. Paper, pens (according to the number of the participants), a box for putting in pieces of paper with questions. Information can be given in a Power Point presentation (in this case, a computer or a notebook, a projector, and a screen will be required).

Duration: 30 – 40 minutes.

Recommendations on how to conduct the exercise the exercise:

1. It is important for the moderator to observe anonymity and not to disclose who of the participants has asked the question which the moderator is answering. It is especially important to observe this rule in a group where the participants are not well acquainted with each other.
2. The moderator is recommended to clearly present the information, to observe the time limits, to be in constant contact with the group, to maintain interest to the problem under discussion.
3. To make perception of the information easier for the participants, in addition to the slides, the moderator is recommended to use pictures, diagrams (for example, on the epidemiological situation in the world, country, region, and city), schemes, short video clips. The participants can also be interested in discussing the current research results on the spread of HIV infection among adolescents and young people.
4. It is recommended to solidify the information provided for the participants during the lecture in the course of other preventive exercises.
5. It is necessary to involve the participants into discussion of the problem. For this, it is possible to use "brainstorming".

Primary source the exercise is borrowed from. The exercise is part of HIV/AIDS and risky behavior primary prevention program designed for children in early adulthood. The program is called "Lad'Ya - In harmony with oneself". The program was developed by N.A. Sirota, T.V. Vorobieva, A.V. Yaltonskaya, E.E. Rydalevskaya, S.M. Yatsyshin, A.V. Miklyaeva, N.V. Kudryavtseva.

Lecture on "Measures of protection against sexually transmitted infections"

Description. The moderator asks the participants to write down on the sheets of paper the questions on the sexually transmitted infections, which they would like to clarify for themselves. Each question is written on a separate piece of paper. The moderator collects the sheets of paper with the questions, puts them in a box, mixes, and then pulls out the sheets with the questions one by one, and answers each question.

Then, the moderator asks the participants to enumerate all the sexually transmitted infections that they have heard of: those which have been discussed while the group was answering the questions and those which have not yet been named. All diseases are written on a Whatman paper. If the list is incomplete, the moderator supplements it in such a way, that, at least, the following infections are mentioned there: trichomoniasis, ureaplasmosis, chlamydiosis, herpes, syphilis, hepatitis B and C, HIV infection. Then, the moderator briefly tells the participants about each infection according to the following scheme: the source, transmission routes, populations are at the highest risk of contracting the infection, diagnostics, premises where one can get assistance, prevention, measures of protection (it is important not to repeat the information, which has already been given in the answers to the questions).

Requirements as to participants. Recommended number of participants: 9 to 20 people. Age: not younger than 16 years old.

Qualification criteria as to the moderator. The moderator should have basic knowledge of sexually transmitted diseases and have public speaking skills, should be able to work with the adolescents. It is better if the lecture is delivered by a gynecologist or an expert from the Centre for Prevention and Control of AIDS and Infectious Diseases.

Supplies and equipment. Paper, pens (according to the number of the participants), a box to put in pieces of paper with questions, Whatman paper, a marker. A computer or a notebook, a projector, a screen could be required (if the information on sexually transmitted infections is given as a Power Point presentation).

Duration: 40 – 60 minutes.

Recommendations on how to conduct the exercise:

1. The moderator is recommended to clearly present the information; as far as it's possible, to avoid using complicated terminology, to observe the time limits, to be in constant contact with the group, to maintain interest to the problem under discussion, to use the "question – answer" format.
2. To facilitate for the participants the perception of the information, the moderator is recommended to use presentations, pictures, diagrams (for example, on the epidemiological situation in the world, country, region, and city), schemes, short videos. The participants could also be interested in discussing the current research results on the spread of sexually transmitted diseases among adolescents and young people.
3. It is recommended to solidify the information provided to the participants during the lecture in the course of other preventive exercises.
4. It is necessary to take into account the fact that the adolescents can be embarrassed when discussing this problem. It is recommended to conduct classes in groups comprised adolescence of the same gender.
5. It is important for the moderator to observe the anonymity and not to tell the group who of the participants has asked the question, which the moderator is answering now. It is especially important to observe this rule in a group where the participants are not well acquainted with each other.
6. After classes, it is recommended to distribute among the participants information brochures about sexually transmitted infections.

Primary source the exercise is borrowed from. Ya khochu provesti trening: posobie dlya nachinayushchego trenera, rabotayushchego v oblasti profilaktiki VICH/SPID, narkozavisimosti i IPPP (I want to conduct a training: A guide for a novice trainer working in the field of prevention of HIV/AIDS, drug abuse and STI)/ Novosibirsk: "Gumanitarny project", 2000. M.: "Medicina dlya vas", 2003 – 206 s.

2. Building up a realistic assessment of one's own risk of contracting HIV

"Why are we talking about HIV infection?"

Description. The moderator invites the participants to split into small groups (of 3-4 persons each) and gives the task to come up with as many reasons as possible explaining why people today should know and talk about HIV/AIDS. Each group writes down a list of reasons on a large sheet of paper and presents the results of their work. Then, the moderator organizes a group discussion. The aim of the discussion is to bring the participants to the understanding of the importance of the problem under discussion.

Requirements as to participants. Recommended number of participants: from 12 to 20 persons. Age: not younger than 15.

Qualification criteria as to the moderator. The moderator should have a basic knowledge about the problem of contracting HIV infection and the skills of moderating a group discussion. The exercise can be moderated by a trained volunteer, a qualified psychologist, a teacher, a social worker, an expert from the Centre for Prevention and Control of AIDS and Infectious Diseases.

Supplies and equipment. A separate room, a notepad for the flipchart or large sheets of paper, markers, tables (according to the number of the small groups, so that it would be convenient to draw up a list of reasons on a large sheet of paper).

Duration: 30 – 35 minutes.

Recommendations on how to conduct the exercise:

1. The exercise can be used to monitor how the attitude of the participant to the problem of HIV infection is changing (the exercise can be given in the middle of the prevention programme).
2. The exercise gives most x successful results in a group where the participants trust each other.
3. When conducting the exercise the moderator is recommended to monitor the work of each group and help formulating the reasons.

Primary source the exercise is borrowed from: Gange G., Kanepaja-Vanaga E., Upenieks R. VICH/SPID i reproduktivnoe zdorovje: Spravochnik dlya trenerov po sisteme obucheniya "ravny – ravnomu" (HIV/AIDS and reproductive health: A Handbook for trainers on the "peer - to peer" training system.

Ministry of Education and Science of Latvian Republic). Ministerstvo Obrazovaniya I Nauki Latvijas Republikas, 2003.

"Risk thermometer (ranking cards based on the risk degree of becoming HIV infected)"

Description. The participants sit in a circle. The moderator puts sheets of paper in the centre of the circle; each sheet of paper presents one situation that is or is not associated with the risk of contracting HIV infection. The participants are invited to jointly discuss the situations presented on the sheets of paper and arrange all the sheets of paper in one line. The sheets presenting the situations associated with no risk of becoming HIV infected should be concentrated at one end of the line; the other end of the line is for the sheets presenting situations associated with 100% risk of HIV infection; and between the poles of the line there would be sheets with situations of high or low risk of HIV contraction. Along with this, the sheets specifying situations of high risk of HIV contraction are to be placed closer to the pole of the line, which corresponds to 100% probability of contracting the infection; and the sheets specifying situations of low risk of HIV contraction are to be placed closer to the pole, which corresponds to the absence of risk of becoming HIV infected. After that, the moderator discusses the results of the exercise with the participants and, if necessary, corrects their mistakes relocating the sheets that identify the situations.

Examples of the situations that can be referred to in the course of the exercise:

1. A kiss on the cheek.
2. An injection at a medical institution.
3. Sexual life within marriage.
4. Blood transfusion.
5. Using someone else's toothbrush.
6. Swimming in the pool.
7. Penetrating kiss.
8. Taking care of a patient with AIDS.
9. A mosquito bite.
10. Multiple sexual relations.
11. Ear piercing.
12. Being accommodated in the same room with an HIV infected person.
13. Tattooing.
14. Hugging with a patient that has AIDS.
15. Using a public toilet.
16. A bite of a bedbug.

Requirements as to participants. Recommended number of participants: 9 to 15 people. Age: not younger than 16 years old.

Qualification criteria as to the moderator. The moderator should have a basic level of knowledge on HIV infection and skills in moderating group discussions. The exercise could be moderated by a trained volunteer, a qualified psychologist, a teacher, a social worker, an expert from the Centre for Prevention and Control of AIDS and Infectious Diseases.

Supplies and equipment. A specially allocated room, sheets of paper with situations of high or low risk of HIV contraction written on them in advance. A computer or a notebook, a projector, and a screen may be required (if at the time of summing up the results of the exercise the moderator shows a Power Point presentation on how HIV infection is transmitted and is not transmitted).

Recommendations on how to conduct the exercise:

1. It is important to give clear instructions for the participants before starting the exercise.
2. Summarizing the results of the exercise the moderator could use a short Power Point presentation on how HIV infection is transmitted and is not transmitted.
3. Commonly, a group discussion of the degree of risk of HIV contraction associated with each of the above situations involves several participants speaking up readily, while other members of the group often prefer just to watch in silence. To involve all the participants in the discussion in a more interactive way, the moderator might not put the sheets of paper in the centre of the

circle, but distribute them among the participants, and offer each of them to take turns and place their sheets of paper at a particular place on the "risk thermometer" to and explain their choices.

Primary source the exercise is borrowed from. The exercise is part of HIV/AIDS and risky behavior primary prevention program designed for children in early adulthood. The program is called "Lad'Ya - In harmony with oneself". The program was developed by N.A. Sirota, T.V. Vorobieva, A.V. Yaltonskaya, E.E. Rydalevskaya, S.M. Yatsyshin, A.V. Miklyaeva, N.V. Kudryavtseva.

"Discussion of the data of a study on the HIV dissemination among adolescents and young people"

Description. The moderator invites the participants to answer whether they consider the problem of HIV/AIDS dissemination to be a serious one, whether it is relevant for their city, and whether it requires intervention. Then the moderator briefly presents statistical data on the prevalence of HIV/AIDS among adolescents and young people in the locality, where the program is being implemented. Upon that, the moderator presents the results of a current study carried out among adolescents and young people in the locality the program is being implemented. It should be mentioned that not hundred percent of adolescents and young people aged 16 to 24 years, according to the study, have a sexual experience. For those who have a sexual experience, the risks of contracting HIV infection can be associated with the fact that no condom is used in the sexual intercourse, that one or both partners are intoxicated with alcohol or drugs, that one of the partners is coerced to have sex. Twenty five percent of adolescents and young people in the group of those with sexual experience had random sex partners in the past 12 months. Adolescents and young people are poorly informed about HIV transmission routes. As the next step, the moderator asks the participants to voice out their attitude to the results of the study and answer whether they subsume themselves into a group at risk, and if there were situations in their life, when they risked to contract HIV infection. In the course of the discussion, the moderator answers the questions about HIV/AIDS raised by the participants.

Requirements as to participants. Recommended number of participants: 8 - 12 persons. Age: 16 – 24 years old.

Qualification criteria as to the moderator. A qualified teacher or a psychologist possessing the required knowledge on "risky" behavior prevention. While preparing the exercise, it is necessary to get acquainted with the latest statistical or research data.

Supplies and equipment. To conduct the exercise it is required to have a brochure or a presentation that demonstrate the core results of the study in a format that could be easily perceived visually (diagrams or infographics) (in case a presentation is shown, a computer or a notebook, a projector, and a screen are needed).

Duration: 60 minutes.

Recommendations on how to conduct the exercise:

1. It is important that when preparing for the exercise the moderator could find the most currently important results of the studies conducted among adolescents and young people, whose demographic profile (gender, age, place of training and education, place of residence, etc.) are maximally close to the participants of the preventive programme.
2. When conducting the exercise, it is important to avoid difficult terminology and to present the results of research in an illegible format.
3. It is important to give each participant a chance to express his (her) opinion and identify his /her standpoint regarding HIV/AIDS.
4. It is recommended to conduct the exercise in a group, where the participants trust each other.

Primary source the exercise is borrowed from: The exercise was designed by Regional NGO "Stellit" in collaboration with the State-Financed Vocational Educational Institution St. Petersburg "College of Sectoral Technologies "Krasnoderevets" in 2015 as part of the project called "Building capacity in prevention of HIV and associated infections among youth at high risk in the Northern Dimension area".

3. Building up a positive attitude to the methods of avoiding risky behaviour

Discussion, brainstorming on "Friendship, heartthrob (to be enamored), love"

Description. The moderator organizes a group discussion and invites the participants to answer the following questions:

- What is friendship about?
- What does it mean to be enamored?
- What is love about?
- How to be sure that one person loves another person?
- What is fidelity?
- How are love and responsibility are connected?
- What is the role of sexual relations in love?

The moderator writes statements on a whiteboard or a flipchart, highlighting the common features and differences in concepts. The results of the discussion should make the participants understand that love cannot be confined to the sex or enjoyable time. Love is, first of all, responsibility, fidelity and ability not to betray yourself.

Requirements as to participants. Recommended number of participants: 9 to 15 people. Age: 16 – 19 years old.

Qualification criteria as to the moderator. The moderator should have skills of conducting group discussions. The exercise can be conducted by a trained volunteer, a qualified psychologist, a teacher, a social worker.

Supplies and equipment. A flipchart or a whiteboard, markers.

Duration: 20 – 30 minutes.

Recommendations on how to conduct the exercise:

1. The exercise can be conducted in 2 stages. The second stage could include role plays – performing short sketches covering critical topics (for example, "How to refuse a friend, if he asks to try a soft drug together with him"). The topics could be offered by the participants themselves – the main thing is that the topics should incorporate three conditions: friendship, being enamored, love.
2. While preparing for the exercise, the moderator can choose scenes and plots from literature themes or fragments from feature films that elucidate the concepts of "love", "being enamored", "friendship".
3. It is recommended to conduct the exercise in groups of the same gender.

Primary source the exercise is borrowed from. The exercise is a modification of the exercise presented in the programme of HIV/AIDS and risky behavior primary prevention among children in their early adulthood called "Lad'Ya - In harmony with oneself". The program was developed by N.A. Sirota, T.V. Vorobieva, A.V. Yaltonskaya, E.E. Rydalevskaya, S.M. Yatsyshin, A.V. Miklyaeva, N.V. Kudryavtseva.

"A perfect date"

Description. The group is divided into two subgroups: one comprises young men; the other one comprises girls. Each group should prepare a sketch on the subject of "A perfect date". Participants are asked to think of a script, select performers, and the author for providing off-screen voice. The sketches are to be performed. The moderator organizes a general group discussion. Questions for the discussion:

- What is the difference between the scripts prepared by the girls and by the young men? Is there a "masculine" and a "feminine" approach to gender relations and to a "perfect date"? What does a young man and what does a girl want at the first date?
- Is it possible to have sex at the first date? How can you refuse a young man if he insists on an intimate relationship?
- How can things develop if the girl agrees to intimate relations/refuses having them? What risks can be involved in this situation?

During the discussion the moderator focuses on the problems of sexual coercion and on the situations associated with a high risk of contracting HIV infection.

Requirements as to the participants. Recommended number of participants: 10 to 16 people; the number of young men and girls in the group should be approximately the same. Age: 16 - 19 years.

Qualification criteria as to the moderator. The moderator should have the skills of conducting group discussions. The exercise can be conducted by a qualified psychologist, an expert from the Centre for Prevention and Control of AIDS and Infectious Diseases.

Supplies and equipment. Sheets of paper for writing on them, pens, felt pens.

Duration: 40 minutes.

Recommendations on how to conduct the exercise:

1. It is recommended that the exercise is conducted by two moderators – a man and a woman.
2. It is better to conduct the exercise in a group of participants who are well banded and trust each other.
3. The moderators should help the participants to develop the scripts (scenarios) of a "Perfect date".

Primary source the exercise is borrowed from. This exercise is a modification of exercises presented in the following publications:

- Gange G., Kanepaja-Vanaga E, Upenieks R. VICH/SPID i reproductivnoe zdorovie: Spravochnik dlya trenerov po sisteme obucheniya "ravny – ravnomu" (HIV/AIDS and reproductive health: A Handbook for trainers on the "peer to peer" training system; Ministry of Education and Science of the Latvian Republic). Ministerstvo Obrazovaniya i Nauki Latvijas Respubliki, 2003.
- Ya khochu provesti trening: posobie dlya nachinayushchego trenera, rabotayushchego v oblasti profilaktiki VICH/SPID, narkozavisimosti i IPPP (I want to conduct a training: A guide for a novice trainer working in the field of prevention of HIV/AIDS, drug abuse and STI)/ Novosibirsk: "Gumanitarny project", 2000. M.: "Medicina dlya vas", 2003 – 206 s.

"Advantages and disadvantages"

Description. The moderator breaks up the participants into 4 subgroups. Each group gets paper and a felt pens. Each group gets one question. After 10 minutes, the group should give as many answers to the question as possible. The questions are as follows:

- What are the advantages of being a kid?
- What are the disadvantages of being a kid?
- What are the advantages of being an adult?
- What are the disadvantages of being an adult?

Each subgroup presents the results of its work to other participants. Each list is discussed with the rest of the group and could be completed. The moderator launches a group discussion, which allows discussing the following questions:

- Is it easy to be an adult?
- What does a person lose and gain when becoming an adult?
- What makes an adolescent different from a child and an adult?
- How do young people express their wish to become adults?
- Can sexual experience, alcohol and drug use indicate that a person has become an adult?

Requirements as to the participants. Recommended number of participants: 12 to 20 people. Age: 16 – 19 years old.

Qualification criteria as to the moderator. The moderator should have skills of moderating group discussions. The exercise could be conducted by a trained volunteer, a qualified psychologist, a teacher, a social worker, an expert of the Centre for Prevention and Control of AIDS and Infectious Diseases.

Supplies and equipment. Large sheets of paper, felt pens or markers, tables or flipcharts (according to the number of the subgroups - for taking notes on large sheets of paper).

Duration: 40 minutes.

Recommendations on how to conduct the exercise: The exercise allows bringing the participants more closely together; therefore, it can be conducted at the beginning of the prevention programme.

Primary source the exercise is borrowed from: Gange G., Kanepaja-Vanaga E, Upenieks R. VICH/SPID i reproductivnoe zdorovie: Spravochnik dlya trenerov po sisteme obucheniya "ravny – ravnomu" (HIV/AIDS and reproductive health: A Handbook for trainers in the "peer to peer" training system; Ministry of Education and Science of the Latvian Republic). Ministerstvo Obrazovaniya i Nauki Latvijas Respubliki, 2003.

"Why do people become engaged in sexual relations?"

Description. The moderator invites the group to think about and name as many reasons as possible for people to become engaged in sexual relations. All the reasons named by the participants are written down by the moderator on a notepad for the flipchart or a whiteboard. Then, the group under the leadership of the moderator analyses each of these reasons in terms of social acceptability, moral values, potential health hazards and personal priorities of each individual. After this, the moderator asks the participants, whether the reasons for adolescents to become engaged in sexual relations differ from those discussed in the first part of the exercise. It is important that as a result of this discussion the participants start realizing that one should not rush to start sexual relations, that the best motivation for starting sexual relations is love, not curiosity, that it is always important to remember about the safety rules.

Requirements as to the participants. Recommended number of participants: 9 to 20 people. Age: 15 years and older.

Qualification criteria as to the moderator. The moderator should have skills of conducting group discussions. The exercise can be conducted by a qualified psychologist, an expert of the Centre for Prevention and Control of AIDS and Infectious Diseases.

Supplies and equipment. A flipchart, a notepad for flipchart or a whiteboard; markers.

Duration: 30 minutes.

Recommendations on how to conduct the exercise:

1. It is better to conduct the exercise among participants of the same gender.
2. The moderator should be prepared to get different reactions that may arise in the course of the discussion (from rejection to a keen interest). It is important to understand that such reactions may be related to the specificities of education and life experience of an adolescent and adequately respond to them.
3. When conducting the exercise, it is important to focus on the specific features of the group. If the group is having difficulties while discussing sexual relations, the following method can be used. The moderator hands out the sheets for making notes, asks each of the participant to write on his/ her sheet of paper the reasons for people to become engaged in sexual relations, collects the sheets, voices out the reasons given by the participants and organizes a discussion of the reasons.
4. It is recommended to introduce this exercise after the members of the group have got used to each other, have begun trusting each other. The exercise should not be conducted earlier than the participants have got basic information on HIV/AIDS.

Primary source the exercise is borrowed from. The exercise is developed on the basis of exercises, which are presented in the following sources:

- publication by Gange G., Kanepaja-Vanaga E, Upenieks R. VICH/SPID i reproductivnoe zdorovie: Spravochnik dlya trenerov po sisteme obucheniya "ravny – ravnomu" (HIV/AIDS and reproductive health: A Handbook for trainers on the "peer to peer" training system; Ministry of Education and Science of the Latvian Republic). Ministerstvo Obrazovaniya i Nauki Latvijas Respubliki, 2003;
- programme for primary prevention of HIV/AIDS and risky behaviour among children in their early adulthood called "Lad'Ya - In harmony with oneself". The program was developed by N.A. Sirota, T.V. Vorobieva, A.V. Yaltonskaya, E.E. Rydalevskaya, S.M. Yatsyshin, A.V. Miklyaeva, N.V. Kudryavtseva.

"4 corners"

Description. The moderator prepares in advance 4 sheets of paper (A4 format); one of the following statements is written on each of the sheets: "I totally agree", "I'd rather agree", "I'd rather disagree", "I strongly disagree". The moderator places the sheets in 4 corners of the room (one for each corner). Then the moderator reads the statements about alcohol and drugs and on how the use of the substances is associated with the risk of contracting HIV infection. After each statement, the moderator asks the participants to define their attitude regarding a particular statement and go to the corresponding corner of the room. The moderator comes up to each group and asks several members of the group to explain their choice. In the course of the discussion, the participants can change their standpoints and move to another corner of the room. After the representatives of all four groups have commented on their choices, the moderator explains his/her standpoint with regard to a given statement. Then, a next statement is read out.

Examples of statements that can be used for the exercise:

- In order to enjoy good health it is important to avoid drinking alcohol;
- In order to enjoy good health it is important to avoid drugs;
- Alcohol and drug use can increase the risk of contracting HIV infection.

Requirements as to the participants. Recommended number of participants: 10 to 20 people. Age: 16 to 21 years old.

Qualification criteria as to the moderator. The moderator should have a basic knowledge about the negative effects of alcohol and drug use for one's health, and how alcohol and drug use increases the risk of contracting HIV infection; it is also important to have skills of moderating a group work. The exercise can be carried out by a qualified psychologist, a teacher, a social worker.

Supplies and equipment. A4 sheets of paper with the statements written on them: "I totally agree", "I rather agree", "I tend to disagree", "I strongly disagree" written on them.

Duration: 30 minutes.

Recommendations on how to conduct the exercise:

1. It is important that the moderator organizes the discussion of the statements in such a way that the participants could recognize the negative effects of alcohol and drug use on their health and the connection between alcohol and drug use and an increased risk of contracting HIV infection.
2. The moderator is recommended to think over his/ her arguments on each statement beforehand.
3. It is important to give the maximum number of participants a chance to voice out their opinion.
4. It is recommended to conduct the exercise after the participants have been provided with basic information on HIV transmission routes.

Primary source the exercise is borrowed from. The exercise was presented at the training conducted under the project called "Building capacity in prevention of HIV and associated infections among youth at high risk in the Northern Dimension area".

4. Development of a tolerant attitude towards HIV-positive people

"Watching and discussing the movie 'Above the Sky'"

Description. The moderator organizes a show of the "Above the Sky" movie (2012, Belarus, the script written by Andrei Kureichik, the film was shot by Andrei Kureichik and Dmitry Marinin under the order of the UN). The film presents a story of a 20-year-old young man, he lives and studies in Minsk. He is a musician, a composer, playing in a trendy Minsk band. Once, something happened that turns his life upside down: he found out that he was HIV infected. After watching the film, a free format discussion is launched.

Examples of questions which could be discussed after watching the film:

- routes of HIV transmission;
- risks related to using drugs;
- making decision about first sexual intercourse;
- risks related to sex with casual partners;
- maintain of trust relations with parents;

- getting tested on HIV;
- attitudes towards people living with HIV/AIDS;
- etc.

Requirements as to the participants. Recommended number of participants: 12 to 20 persons. Age: 16 years and older.

Qualification criteria as to the moderator. The moderator be tolerant to people living with HIV/AIDS, and have skills of moderating group work. The exercise can be conducted by a qualified psychologist, a teacher, a social worker.

Supplies and equipment. A notebook, a projector, a screen, acoustic system (loudspeakers).

Duration: about 3 hours (Duration of the movie is 133 minutes, duration of discussion –30 to 45 minutes).

Recommendations on how to conduct the exercise:

1. To reduce the time of discussion, the moderator could select a few of the most impressive episodes and discuss each of them with the participants. It is also possible to divide film into several parts and to watch each part on the separate meeting.
2. It is possible to ask the participants to watch the movie in advance on their own and then discuss it in class. In such a case, the moderator should know the content of the film perfectly; at the beginning of the classes the moderator should briefly bring the content to recollection and show the most significant fragments. This will allow those who have not been able to watch the movie to properly participate in the discussion.
3. *Primary source the exercise is borrowed from.* The exercise has been developed under the project called "Strengthening of the work on the prevention of HIV infection and the associated diseases among young people at high risk of contracting HIV infection in the region of the "Northern Dimension".

"A hot chair"

Description. The moderator invites the participants to take part in a role play. One of the participants acts the part of a person who has discovered that he was HIV infected. Other participants act the parts of people whose opinion is important for the central character (relatives, friends, acquaintances, teachers, etc.). These roles are decided about by the participant acting the central character together with the moderator. Upon that the participant acting the central part of a person who has recently discovered to have HIV infection sits on a chair in the centre of the room. All other participants acts as if they have just learned about his diagnosis and, taking turns, tell him what the characters they are acting would say (may be the words of support, reproof, expression of their own feelings, etc.). After this, the moderator asks the participant, who has acted the part of an HIV infected, to tell the group about the feelings and thoughts that the words by other participants aroused. A group discussion on the difficulties faced by people living with HIV/AIDS is held; participants also discuss what could be done by those around him. The discussion is supposed to provide for enhancement among the participants tolerance to HIV positive people.

Requirements as to the participants. Recommended number of participants: 6 to 10 people. Age: 16 to 22 years old.

Qualification criteria as to the moderator. The moderator should know basic information about HIV/AIDS, should be tolerant to people living with HIV/AIDS, should have skills of moderating group work. The exercise can be conducted by a qualified psychologist.

Supplies and equipment. None.

Duration: 40 – 90 minutes.

Recommendations on how to conduct the exercise:

1. It is recommended to conduct the exercise in the group of participants who already know each other rather well and trust each other.
2. It is recommended to conduct the exercise after the participants have been provided with basic information on HIV infection transmission routs.

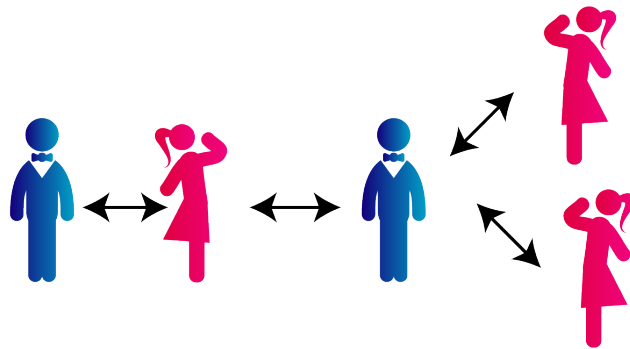
3. At the beginning of the exercise the moderator could ask the participants to name the main routes of HIV transmission and remind them the ways HIV infection is not transmitted through. At the end of this activity it is recommended to conduct a psychological exercise to relieve emotional tension among the participants.
4. It is important to involve all the participants in the exercise - to make sure that everyone has a part to act. If anyone does not want to act the part offered to him/ her, he /she should have a chance to propose a part that would make him/her feel comfortable when acting.
5. If the participants are interested in the exercise, it can be repeated several times to ensure that everyone has a chance to try his/her hand in several parts.

Primary source the exercise is borrowed from. The exercise was developed under the project called "Building capacity in prevention of HIV and associated infections among youth at high risk in the Northern Dimension area"; the exercises presented at the training were used as well.

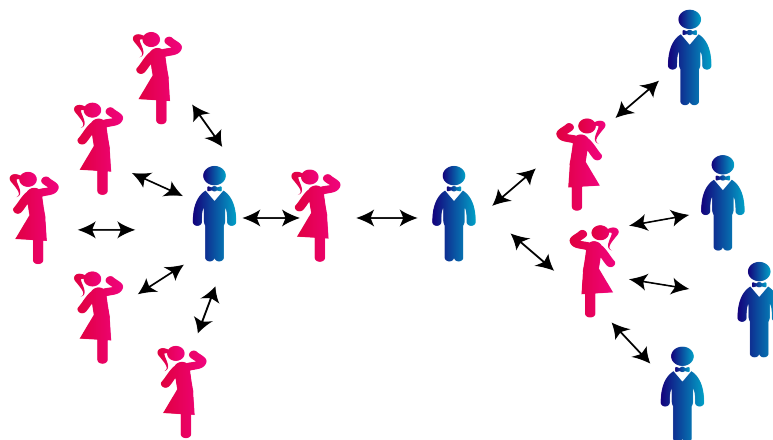
5. Development of skills for avoiding risky situations

"Role play called 'Vasilina and Egor'"

Description. At the first stage of the exercise, the moderator tells and illustrates "in broad strokes" the following story. "Once upon a time, there lived young people; let us name them: Yefrosinya and Anufriy. One day they met each other and fell in love. They had never have such intemperate relations full of trust, such true love. Everything that each of them had experienced in the past was of no importance. These had been random encounters, non-serious relations, and they were not numerous at all. Yefrosinya had has one short summer love affair. And Anufriy previously had has intimate relations with 2 girls.



But the former friend of Yefrosinya had have many girlfriends; he was, in general, a man of straw. And one of the ex-girlfriends of Anufriy was very light-minded, that's why they parted. His second girlfriend simply had moved to another city and left him.



And those, actually alien people, also had have some sexual relations in the past. If we continue expanding the scheme further on we'll realise that our main characters definitely does not even know about the people involved - those we could include into the scheme Yefrosinya and Anufriy, most likely, have never even heard of them.

Why are we referring to them? Because when starting sexual relations, even with a very beloved and close partner, it is necessary to think about what kind of partners he/ she had in the past, whether such sexual relations could lead to contracting HIV and other sexually transmitted infections.

Then, the moderator breaks up the participants into subgroups, so that each of the group would comprise 3 - 5 people, and the total number of the sub-groups would be even. Each subgroup is assigned a number. The moderator reads out the following text: "Vasilina and Egor have already been seeing each other for 6 months. Egor is eager to start intimate relations, but Vasilina wants to postpone these relations till marriage. Each time they meet, Egor "presses" on Vasilina. She is afraid of losing Egor". The participants of even-numbered subgroups are asked to make a list of arguments, which Egor could use to persuade Vasilina to start intimate relations ; they are also ask to cast the parts of Egor and his friends among themselves (all of his friends think that Egor is right). The participants of odd-numbered subgroups are asked to make a list of arguments, which Vasilina could use to explain to Egor, that there is no need to be in a hurry; they are also asked to cast the parts of Vasilina and her friends among themselves (all of them think that Vasilina is right). Then the participants of an even-number subgroup and an odd-numbered subgroup are invited to perform a sketch, in which "Egor" and his "friends" and "Vasilina" and her "friends" discuss whether Vasilina and Egor should start intimate relations or not. The sketch is to be discussed. The moderator tells that each participant has a right to say "no", if he/ she feels that what is happening conflicts his/ her interests, and that it is important to express one's standpoint in a tactful manner, but firmly.

Requirements as to the participants. Recommended number of participants: 9 to 15 persons. Age: 16 to 19 years old.

Qualification criteria as to the moderator. The moderator should have skills of group work, and in conducting role plays. The exercise could be conducted by a qualified psychologist, a teacher trained to conduct this activity or a social worker.

Supplies and equipment. Large sheets of paper for the participants to write down their arguments that substantiate Vasilina's and Egor's attitude, a flipchart and a notepad for the flipchart/a whiteboard, on which the moderator draws a scheme illustrating the experience of Anufriy and Yefrosiniya regarding their relations with other partners. Markers (felt-tip pens).

Duration: 40 minutes.

Recommendations on how to conduct the exercise:

1. It is recommended that at the second stage of the exercise each subgroup include not more than 5 participants.
2. If only young men or only girls take part in the exercise, they can have difficulties in drawing-up the list of the arguments on behalf of the opposite sex character. In this case, the moderator could help them.
3. It is recommended to conduct the exercise after the participants of the group have got used to each other, began to trust each other. The exercise should not be conducted before the participants have got basic information about the problem of HIV/AIDS.

Primary source the exercise is borrowed from. The materials presented in the following sources were used for development of the exercise:

- Ya khochu provesti trening: posobie dlya nachinayushchego trenera, rabotayushchego v oblasti profilaktiki VICH/SPID, narkozavisimosti i IPPP (I want to conduct a training: A guide for a novice trainer working in the field of prevention of HIV/AIDS, drug abuse and STI)/ Novosibirsk: "Gumanitarny project", 2000. M.: "Medicina dlya vas", 2003 – 206 s.;
- A programme of primary prevention of HIV/AIDS and risky behaviour among children in their early adulthood called "Lad'Ya - In harmony with oneself". The program was developed by N.A. Sirota, T.V. Vorobieva, A.V. Yaltonskaya, E.E. Rydalevskaya, S.M. Yatsyshin, A.V. Miklyaeva, N.V. Kudryavtseva.

"Social roles"

Description. The moderator asks the participants to imagine that they are at the birthday party of someone of the same age with them: a variety of alcoholic beverages are being served, it is also possible to get "soft" drugs, to pick up a random partner for "noncommittal" sexual relations. The participants

are asked to name all possible social roles of the young people who are spending time in this company. Each social role named by the participants is to be put down on a separate sheet of paper. If any of the roles is not entirely clear to the group, the moderator clarifies the sense and essence of this role (for example, "a grey cardinal" is someone, who influences the situation in the group, influences decision-making, handle everything, but without appearing to do so). The number of the roles depends on the level of participants involvement and could range from 15 to 25. It is important, that the following social roles are named: "a Leader", "a Grey Cardinal", "a Chicken Shit", "a Cop-Out", "a Sex-bomb", "an Odd Man Out", "an Observer". If the participants fail to name any of these roles, the moderator could help them to this.

Afterwards the moderator hangs out the sheets with the names of the social roles on the walls of the classroom. The participants are invited to choose the role which they play in the group most often or the one they would like to talk about, and to take a seat under the sheet of paper with the name of this role. It is desirable to organize the participants of the group in such a way that they do not concentrate themselves around the same role, but could chose different roles of those presented in the room. If anyone of the participants has difficulties with choosing a role, the moderator could offer him/her to think of another social role, which so far has not been mentioned, put its name on a sheet of paper, hang the sheet of paper out on the wall and take a sit next to it.

After all each of the participants have chosen a role, they are asked to think for five minutes about what benefits a person of such social role could contribute into the group, and what his/ her negative contribution could be. How a typical representative of a particular social role could behave during the birthday party described in the exercise? Would he/ she drink alcohol, use drugs, have sexual relations, would this person invite others to do the same, would he/she create situations, which could be potentially hazardous for his own and other participants' health? Or, on the contrary, whether he/ she would do nothing dangerous for his/ her own health and try to reduce risks for others?

Upon that, the moderator offers each participant to tell the group about the results of their reflections. So all the roles specified on the sheets of paper hanging on the walls are to be analysed.

When summarizing the discussion, the moderator says that, regardless of the role in the group, each person is at risk of being involved in "risky" behaviour, and everyone has a chance to avoid it.

Requirements as to the participants. Recommended number of participants: 10 to 20 people. Age: 17 – 18 years old.

Qualification criteria as to the moderator. A qualified teacher or a psychologist possessing necessary knowledge on prevention of "risky" behaviour.

Supplies and equipment. A4 paper sheets, markers, sticky tape.

Duration: 60 minutes.

Recommendations on how to conduct the exercise:

1. It is recommended to conduct the exercise in the group of already well acquainted participants who trust each other.
2. Thinking about the roles in the group participants often fail to name specific roles, but rather speak about personality (for example, modest, quick-tempered). It is important that the roles, that would be understandable for everyone, rather than personality characteristics, are written down on the sheets of paper.
3. The moderator should make sure that while analysing the roles the participants "should not go into personal". It is important that when discussing a potential contribution by a representative of a certain social role the participants stick to the characteristics of the role, but not to personality characteristics of the participant who has chosen this role in the exercise.

Primary source the exercise is borrowed from. Verbovaya N.V., Osipenko V.E. Trening sotsial'nogo deistviya: Metodicheskoe posobie (Training of social action: Guidance manual). Kaliningrad, 2006. 80 p.

CONCLUSION

M.M. Rusakova, V.A. Odinkova

In this guide, we have discussed the program implementation cycle for the prevention of HIV and AI among adolescents and young people at high risk of getting infected with HIV and AI. The cycle includes a baseline study using statistics analysis, focus groups with specialists, and surveys of adolescents and young people for the purpose of identifying the most widespread behavioral practices involving the risk of contracting HIV and AI, and for selecting and implementing prevention interventions with proven effectiveness.

As stated before, the integral part of the development of prevention programs should be selecting and applying a relevant theory explaining health behavior and helping to change it. The theories allow specialists to determine the components which should be included in the program, and identify the potential indicators for prevention program assessment. All of it helps to improve the quality of prevention programs.

However, the context in which prevention programs are implemented is of major importance. In the course of our project, we discovered that the most common risky situation for adolescents and young people to get infected with HIV is due to unprotected intercourse inter alia under the influence of alcohol and drugs. It was also found that the Northern Dimension Countries have practically no programs focusing on the prevention of HIV and AI among young people at high risk, with proven effectiveness. Therefore, there are ample opportunities for the development, effectiveness estimation, and experience exchange in this area for the specialists and decision-makers in the region.

