# HIV Prevention among Most-at-Risk Adolescents:

## Implementation Results of the Targeted Models

Kyiv 2011

Український інститут соціальних досліджень імені Олександра Яременка
Громадська організація

unicef

УДК 303.442.23:[616.98:578.828ВЫЛ-084-053.6](477)

ББК 60.5В(4Укр)+55.148(4Укр)

П 84

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Approved for publication by the Academic Board of the Ukrainian Institute for Social Research after Olexander Yaremenko (protocol #5 of 29 November 2010)

This report is prepared and published with support provided by the

United Nations Children's Fund (UNICEF) in Ukraine as part of the international project 'HIV Prevention among Most-at-Risk Adolescents in Ukraine and South-Eastern Europe'

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HIV Prevention among Most-At-Risk Adolescents: Implementation Results of the Targeted Models / UNICEF, UISR after O. Yaremenko. – К.: Версо 04, 2010. – 88 с.

П 84 ISBN 978-966-8869-42-6

УДК 303.442.23:[616.98:578.828ВЫЛ-084-053.6](477)

ББК 60.5В(4Укр)+55.148(4Укр)

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ISBN 978-966-8869-42-6

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# Acknowledgements

This report was prepared by the team of authors as a part of the international UNICEF project 'HIV Prevention among Most-at-Risk Adolescents in Ukraine and South-Eastern Europe' (UNICEF MARA project). The project is supported by the Government of Ireland and managed by the UNICEF Regional office for Central and Eastern Europe and the Commonwealth of Independent States. The London School of Hygiene and Tropical Medicine (LSHTM), the international partner in the project, provided significant input into and support for this document.

At the national level the main governmental partners of the project are the Ministry of Family, Youth and Sport of Ukraine and the State Social Services for Family, Children and Youth (SSSFCY).

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Special thanks to the entire team of the Kyiv City Centre of Social Services for Family, Children and Youth; the Donetsk Oblast and City Centres of Social Services for Family, Children and Youth; the NGO "Faith. Hope. Love" (Odesa); "The Way Home" Odesa Charitable Foundation for Rehabilitation and Social Adaptation of Homeless People; and all other partners that assisted during this project.

The Project team would also like to thank the vast number of experts from NGOs in Ukraine who supported and participated in the project's meetings, consultations, training sessions and seminars. Gove services in the frameworks of models of implementation of the interventions on HIV-intection prevention among MARA.

The Project team extends special thanks to Natalia Lukyanova, Director of the SSSFCY, Irina Dubinina, Deputy Director of the SSSFCY and Lubov Shnerenko, Head of the Public Relations and Communication Department of the SSSFCY for their many important insights and contributions to the research and the project in general.

Clients – most-at-risk adolescents – played an active role in the preparation, implementation and evaluation of the models. The Project team would like to thank all respondents for their trust. This report is dedicated to all of these clients.

# List of Acronyms and Abbreviations

| | |
|---|---|
| AIDS | Acquired immune deficiency syndrome |
| BDI-model | Logical model of intervention implementation 'Behaviour – Determinants – Interventions' |
| CF | Charitable Fund |
| CSSFCY | Centre for Social Services for Family, Children and Youth |
| CWG | Cross-sectoral working group |
| D.I.P | NGO "Development, Initiative, Partnership" |
| DOAAH+ | Donetsk Oblast Association to Assist HIV-positive people |
| FCSW | Female commercial sex workers |
| GFATM | Global Fund to Fight AIDS, Tuberculosis and Malaria |
| HIV | Human -immunodeficiency virus |
| IDU | Injecting drug user |
| LSHTM | London School of Hygiene and Tropical Medicine |
| M&E | Monitoring and evaluation |
| MARA | Most-at-risk adolescents |
| MCF UNITUS | Mykolaiv Charitable Foundation UNITUS |
| MDT | Multidisciplinary team |
| MoE&S | Ministry of Education and Science of Ukraine |
| MoH | Ministry of Health of Ukraine |
| MoIA | Ministry of Internal Affairs of Ukraine |
| MSM | Men who have sex with men |
| NGO | Non-governmental organization |
| OCF | Odesa Charitable Foundation |
| OC | Oblast Council on Tuberculosis, HIV/AIDS |
| PAS | Psychoactive substances |
| PLWH | People living with HIV |
| RAC | Regional Advisory Council on HIV Prevention |
| RAG | Regional cross-sectoral and interagency advisory group |
| RG | Risk groups |
| OSVD | Oblast Skin and Venerological Dispensary |
| SEC | Syringe Exchange Centre |
| SMP | Substitution maintenance therapy |
| SSSFCY | State Social Service for Family, Children and Youth |
| STI | Sexually transmitted infections |
| TB | Tuberculosis |
| TR | Trust room |
| UISR after O. Yaremenko | Ukrainian Institute for Social Research after Olexander Yaremenko |
| UN | United Nations Organization |
| UNAIDS | Joint United Nations Programme in HIV/AIDS |
| UNICEF | United Nations Children's Fund |
| VCT | Voluntary counselling and testing for HIV |
| VS | Vocational Schools |
| VTC | Vocational training school |
| WHO | World Health Organization |

# Introduction

The pilot project on introduction of service delivery models for MARA in four cities of Ukraine was implemented within the framework of the UNICEF project 'Prevention of HIV among Most-at-risk Adolescents in Ukraine and South-Eastern Europe'. In Ukraine this project has been implemented since 2007 and has included the following components.

**Table 1**

| Tasks | Activities | Key results |
|---|---|---|
| - To identify the regulatory and legal framework for service delivery to most-at-risk adolescents<br>- To analyse the current situation with service delivery to most-at-risk adolescents and to study already-conducted studies in this field and their results and achievements<br>- To collect new data on risk behaviour and HIV infection among MARA in order to obtain an evidence base for strengthening the response to HIV<br>- To identify ethical principles of service delivery to most-at-risk adolescents<br>- To conduct training for social sector specialists to prepare them for service delivery to MARA within pilot models. | • Desk research of the currently available data on MARA, their behavioural determinants, existing knowledge gaps; review of key achievements, strengths and weaknesses of the national HIV/AIDS response to the needs of these population groups<br>• Analysis of the potential key stakeholders and a capacity needs assessment of selected service providers<br>• Targeted situation analysis of gender-specific issues relating to MARA boys and girls<br>• Qualitative and quantitative surveys (semi-structured interviews and focus groups) of MARA[1]<br>• Secondary analysis of data on MARA IDUs, FSWs and MSM from 2007, 2008 and 2009 behaviour surveillance studies[2]<br>• Workshop to develop a strategic plan of action on HIV prevention among most-at-risk adolescents and young people;<br>• Training on 'Gender-specific work with most-at-risk adolescents'<br>• Training on 'Legal norms and ethical principles of work with most-at-risk adolescents in providing services to prevent HIV infection and STI'<br>• Training seminar on 'Development of plans for monitoring and evaluation to study the impact of projects on health and behaviour of most-at-risk adolescents' | • Analytical review of policy and legislation on medical and social services for children and adolescents most-at-risk of HIV infection[3]<br>• Ethical principles for social research among children in Ukraine[4]<br>• Analytical report 'Most-at-risk adolescents: the evidence base for strengthening the HIV response in Ukraine'[5]<br>• 7 booklets containing the materials of the conducted studies:<br>- 'Legal status of children and young people aged from 10 to 18 years in the context of their access to HIV services';<br>- 'Access barriers to HIV prevention services for girls and boys most at risk of HIV';<br>- 'Risks of HIV infection among adolescents living and/or working on the streets';<br>- 'Risk of HIV infection among adolescents injecting drug users';<br>- 'Gender-specific work with most-at-risk adolescents - building consensus on the importance of gender issues in HIV prevention among most-at-risk adolescents';<br>- 'Risks of HIV infection of adolescent girls involved in commercial sex services or as a result of exploitation'<br>- 'Risks of HIV infection for adolescent boys having sex with men'<br>• Booklet 'Data analysis from monitoring the behaviour of IDUs, CSWs, MSM among adolescents' |

[1] The results of the research can be found in 'Most-at-Risk Adolescents: the Evidence Base for Strengthening the HIV Response in Ukraine': Analytical report/UNICEF, UISR after O. Yaremenko. – K. : K.I.S., 2008.-192p.

[2] Secondary data analysis was conducted on the data taken from the behaviour studies conducted at the request of ICF International HIV/AIDS Alliance in Ukraine within the programme 'Overcoming the HIV/AIDS epidemic in Ukraine funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria.

[3] Buromenskyi M.V. The current situation concerning policy and legislation on medical and social services for children and adolescents most at risk of HIV: Analytical Review / M.V.Buromenskiy, V.M.Steshenko. – K. : UISR, 2008. Available: http://www.unicef.org/ukraine/ukr/media_10621.html

[4] Ethical principles for social work with children in Ukraine. – Approved by the Board of the Sociological Association of Ukraine (protocol #7 of 10 December 2008).

[5] The results of the research can be found in 'Most-at-Risk Adolescents: the Evidence Base for Strengthening the HIV Response in Ukraine': Analytical Report/ UNICEF, UISR after O. Yaremenko. – K. : K.I.S., 2008.-192p.

The results obtained became the evidence base for HIV risk behaviour among adolescents in Ukraine:

- Results from a secondary analysis of most-at-risk adolescents indicated that:
  - 30 per cent of IDUs used shared injecting equipment;
  - 22 per cent of IDUs gave or sold their syringes to others after injecting with them;
  - 58 per cent of IDUs injected drugs with a pre-filled syringe (they did not know how it was pre-filled)
  - 52 per cent of FCSWs always used a condom with a client within the past 30 days (48 per cent were at risk)
- Results from the study of the evidence base for adolescents living or working on the streets:
  - 10 per cent of boys living and working on the streets have had penetrative anal sex with men (52 per cent of them for remuneration);
  - 15.5 per cent of adolescents have tried injecting drugs; 45 per cent of these adolescents tried injecting drugs for the first time when under the age of 15. By the time they reach the age of 18 this indicator is 98 per cent.
  - 61 per cent used shared injecting equipment during the past month;
  - More than two thirds (69 per cent) of the adolescents in this target group get equipment from IDU friends. More than half (55 per cent) of the respondents buy it at a pharmacy.
  - Injecting drug use occurs in all public institutions in which these adolescents are placed. It is most common in juvenile colonies and other penitentiary facilities in which adolescents reported staying at some point in their lifetimes (30 per cent and 46 per cent of the respondents who stayed in such institutions, respectively).

The results from the qualitative research study outline the reasons for the low level of medical, social, informational and other service delivery to adolescents[6]:

- Health is not a value for MARA;
- MARA address medical services only when there is an exceptional need or danger to life;
- The level of MARA awareness about existing services is low;
- There are no targeted services to meet the needs of most-at-risk adolescents;
- MARA are afraid of police detention or referral to shelters, and that is why they choose a strategy of self-help when problems arise;
- MARA do not seek assistance, expecting a hostile attitude from service providers; some MARA experienced such attitudes or their confidentiality was violated;
- MARA's own experiences or the experience of their friends in paying for medical services create a barrier towards MARA addressing services;
- The requirement to present identification documents to obtain services is also a barrier towards MARA addressing medical and social services;
- Lack of experience among MARA (and their friends or acquaintances) in addressing and receiving services.

The long term goal of the project 'Prevention of HIV Among Most-at-risk Adolescents in Ukraine and South-Eastern Europe' is to prevent new cases of HIV among most-at-risk adolescent boys and girls in Ukraine by providing adapted HIV prevention services to MARA by governmental and non-governmental institutions, and developing their cooperation.

The results of the conducted studies helped to define the main characteristics of MARA, identify the main approaches to service delivery that could affect the factors of behavioural change, identify some problems that MARA face and identify existing barriers that prevent them from accessing social, medical, informational, legal and other services. These findings were discussed during workshops for strategic planning at the regional and national levels, where cross-sectoral teams of specialists helped

[6] Analytical report 'Existence and Availability of HIV Prevention Services for Most-at-risk Adolescents' (based on the results of the qualitative research that was held in four regions of Ukraine: Kyiv, Dnipropetrovsk, Donetsk, Mykolaiv, Ochakiv and Voznesensk, Mykolaiv oblast) / O.M. Balakireva, PhD in Sociology, T.V. Bondar. – K: 2008. – 63pp.

to identify key target groups among MARA for models of prevention interventions and the basic needs of different groups of adolescents. Based on these results, five models of service delivery to MARA were developed and piloted in four cities of Ukraine:

- Model 'Provision of maximum access to integrated health services, social services, HIV/AIDS/STI prevention programmes for adolescent girls-commercial sex workers' – Mykolaiv city[7]';
- Model 'Street HIV-prevention work with most-at-risk adolescents according to the multidisciplinary team approach' – Kyiv city;
- Model ''Friendly' HIV-prevention interventions through establishment of informal leaders in the environment of most-at-risk adolescent injecting drug users' – Donetsk city
- Model 'HIV/STI prevention, support services delivery, development and adjustment of work methodology on rehabilitation of underage girls-victims of violence, including sexual violence, or involved in commercial sex' – Odesa city
- Model 'HIV/STI prevention and development of social rehabilitation services for adolescent drug users' – Odesa city

This Report presents the key results of HIV service delivery models implementation and lessons learned in 2009-2010. The projects' assessment includes a consideration of their relevance, description of design, implementation process and results achieved.

[7] Adolescents – female commercial sex workers in Ukraine: evaluation of the process and results of the targeted intervention model: analytical report / UNICEF, Ukrainian Institute for Social Research after O. Yaremenko. – K., 2010. – 100 p.

# Methodology used for the study and analysis

Pilot models were implemented in 2009 and 2010 in four cities (Kyiv, Mykolaiv, Donetsk, Odesa) with a high HIV-infection rate. The implementation process had a strong component of external and internal monitoring. Monitoring and evaluation was conducted by the Ukrainian Institute for Social Research after O. Yaremenko together with the State Social Service for Children, Family and Youth. The process of internal monitoring involved members from each team that implemented the models. All teams were trained to conduct the monitoring and analysis of interim results (intermediate evaluation) during a special training seminar that preceded the implementation of the pilot models.

In order to conduct monitoring and evaluation of each of the models, the research team developed a protocol for monitoring and evaluation of the implementation process of the models to reduce the risk of HIV/AIDS spread among most-at-risk adolescents (see the appendix).

The main purpose and objectives of the external monitoring and evaluation was to review the factors that impede and/or facilitate the implementation of the model and develop recommendations for successful project implementation. The logic of the external M&E included three phases of project development (input, process and output) and relied on different sources of data. Throughout the process of model implementation the project partner, the Ukrainian Institute for Social Research after O. Yaremenko, conducted external M&E by conducting monitoring field visits and by defining the level of staff and client satisfaction.

Structure of components for the external M&E:

1. Input: resources (financial, logistical, human) – readiness of the project as a whole, availability of equipment, materials, facilities, necessary mechanisms and framework for the model implementation; system of client database management (according to the socio-demographic characteristics and the services provided); staff recruitment and training; funding sources; understanding of the characteristics of the potential target group of clients.
2. Process: number of clients and their socio-demographic profile (collecting and analysing data according to age), number of different services delivered to clients, evaluation of the quality of the services provided.
3. Output: client satisfaction with services received, staff satisfaction with: a) role in the project, b) compliance with planned objectives and implementation of these objectives; clients' awareness about HIV transmission and prevention methods; motivation and skills of safe behaviour; clients' awareness about the services offered.

All components of activities within projects, target indicators and suggested monitoring indicators were taken into account during the preparation of instruments for each model and were controlled for during the monitoring visits. During the first monitoring visits more attention was paid to the input indicators, while during the following monitoring visits more attention was paid to process and outcome indicators according to the stages of model implementation. The comprehensive structure of sources of information depending on project components and the M&E logical framework is presented in Table 2. All the project participants were guaranteed confidentiality of information received.

**Table 2**

**Sources of information for external monitoring and evaluation**

| Project components | Components of the logical scheme for monitoring and evaluation | | |
|---|---|---|---|
| | Input | Process | Output |
| Resources | - Project plan<br>- Monitoring forms: material infrastructure, supplies (informational materials and HIV/AIDS prevention products) | - Data from the monitoring forms on resources for a certain period of time and comparison of the collected data with the data obtained in the beginning of the project (input). | |
| Staff | - Project plan<br>- Monitoring forms: preparation, system of supervision and management | - Data from the monitoring forms on staff for a certain period of time and comparison of the collected data with the data obtained in the beginning of the project (input);<br>- Primary documentation on staff (registers, staff diaries, plans and protocols of supervisions, work plans, etc.);<br>- Analysis of the documentation related to the training sessions (programme, list of participants, forms (entry and final) filled in by participants, etc.);<br>- Interviews with staff members. | - Focus group with staff members to evaluate the level of staff satisfaction;<br>- Individual in-depth interviews with staff members to evaluate the level of staff satisfaction. |
| Target group | - Project plan<br>- Monitoring forms | - Data on clients of the project from the database;<br>- Data from the monitoring forms on the involvement of the target group in the planning, implementation, and evaluation of the project;<br>- Interviews with staff members. | - Mini-interviews with the clients about the level of their satisfaction (including adherence to principles of friendliness) with the received services and about their motivation to participate in the project.<br>- Data from the 'exit' forms for clients (level of knowledge about HIV prevention, awareness about the available services, knowledge of how to use these services) |
| Services | - Project plan<br>- Monitoring forms | - Data on the clients from the database<br>- Data from the monitoring forms on service delivery to the clients<br>- Protocols on principles of service delivery<br>- Interviews with staff members | |
| Data management | - Project plan<br>- Monitoring forms: scheme of internal M&E | - Databases (on clients and services) | - Database |
| Referral system | - Project plan<br>- Monitoring forms: scheme of the referral system | - Data on referrals from the database<br>- Data from the monitoring forms: evaluation of the referral system by the staff | |
| Advocacy, coordination | - Project plan<br>- Monitoring forms | - Data from the monitoring forms on advocacy and coordination<br>- Plans, protocols, decisions made during advocacy and coordination activities. | - Decisions of the local executive authorities about the institutionalisation of the corresponding coordinating structures<br>- Plan of advocacy activities |
| Project sustainability | - Project plan<br>- Monitoring forms | - Data from the monitoring forms on fundraising<br>- Fundraising plan | - Fundraising plan |

A survey of the involved staff and clients was conducted at the beginning and at the end of each model. This allowed obtaining information on the quality of services provided and to define the level of client satisfaction with the services received.

The intermediate results of the monitoring were discussed primarily with the staff and coordinators of the pilot models. As a result of these discussions the group identified further steps for improvement that could relate to the recruitment of potential clients, to the structure and quality of services, to the involvement of new partners, to the interaction between team members, to management of databases on clients, etc.

The overall results of the monitoring process enabled the teams to evaluate the effectiveness of each model; analyse factors of success, existing barriers and how to overcome them; and learn some lessons during implementation of projects on HIV prevention among MARA. The data obtained through monitoring and evaluation and the general conclusions could be useful for the development of current and new projects, expansion of the range of services for HIV prevention among adolescents of different target groups and assurance of their availability for MARA.

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# Model 'Street HIV-prevention work with most-at-risk adolescents according to the multidisciplinary team approach' – Kyiv city

# Relevance of the model

Adolescents aged 10-19 years are one of the most vulnerable groups in terms of HIV infection in Ukraine, especially most-at-risk adolescents who are not covered by systemic prevention services, treatment and social and medical support. It was found out that there is no emphasis on the inclusion of homeless, neglected adolescents, adolescents-injecting drug users, commercial sex workers or persons who practice risky sexual behaviour in the system for prevention work. In fact, the current range of services in primary, secondary and tertiary prevention does not target adolescents. Another problem is the lack of access to services based on the principles of anonymity, confidentiality and friendliness. This causes distrust among adolescents about the activities of institutions and organizations-service providers and leads to the spread of HIV infection among risk groups.

The quantitative behavioural study of adolescents living and working on the streets aged from 10 to 19 years conducted in Kyiv in December 2007–February 2008 showed the following results: 97.5 per cent of girl and boy respondents in Kyiv use alcohol; 85.1 per cent have experience with substance abuse; 76 per cent have experience with sexual relations; 19 per cent of young men have purchased sexual services; 69 per cent of girls have sold sexual services; 10 per cent of young men have had anal sex with men; 18 per cent of girls were pregnant; 15.5 per cent out of the 201 adolescents surveyed had experience with injecting drug use; 61 per cent of them had shared the syringe with others during their last injection. This shows that the behaviour of adolescents living and working on the streets in Kyiv carries a very high risk of HIV infection and of other parenterally and sexually transmitted diseases.

The quantitative and qualitative indicators of the project implementation confirmed the relevance of these existing problems.

# Model description

## Design of the implemented model

Implementation of the pilot model 'Street HIV-prevention work with most-at-risk adolescents (MARA) according to the multidisciplinary team approach' started in February 2009 at the initiative of the Kyiv Centre of Social Services for Family, Children and Youth in partnership with governmental and non-governmental partner organizations supported by UNICEF.

**Project objectives:**

- To contribute to reduction of the risk of HIV infection and of sexually transmitted diseases among adolescents practising risky behaviour aged from 14 to 19 years by providing systematic information on the streets, counselling and voluntary HIV testing using mobile multidisciplinary street teams;
- To ensure the provision of social support to adolescents with HIV-positive results and referral to specialised centres, primarily to the municipal organizations the Kyiv City Right Bank Centre for HIV-infected Children and Youth and the Kyiv City Left Bank Centre for HIV-infected Children and Youth.

**Target group:**

The project is designed for adolescents aged from 14 to 19 years:

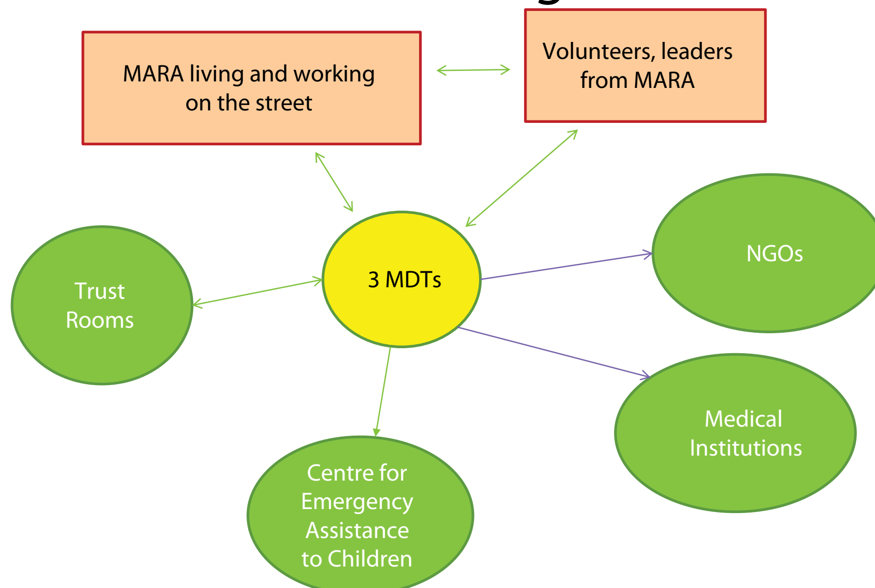
1) living and working on the streets;
2) having unprotected sex;
3) living with HIV/AIDS;
4) who are chemically dependent, first of all, injecting drug users and their sexual partners;
5) girl commercial sex workers;

6) boy commercial sex workers;
7) boys who have sex with men;
8) from disadvantaged (crisis) families spending most of their time on the streets.

A multidisciplinary approach was chosen to implement the model due to the complex needs of the target group, such as:

- lack of information about the possibility of receiving HIV prevention services;
- lack of positive experiences in receiving services;
- the need to obtain information about services directly in the places where they congregate;
- the need for information services from several experts at the same time: social workers, psychologists, outreach workers, etc.;
- the need to be referred to health facilities, namely 'trust rooms', for testing and to other organizations; the need for members of the multidisciplinary team to give clients direct guidance to these organizations.

This approach was also chosen to promote trustful relationships with the target group and to improve the process of recruitment and encourage representatives of the target group who are not clients of either medical or social institutions to become clients of the project.




**Picture 1. Street Prevention Work with MARA aged 14-19 years**

The three multidisciplinary teams of specialists included a coordinator, social workers, social pedagogues, psychologists and outreach workers. Each team was established taking into account gender specifics. Multidisciplinary teams for prevention work worked at least three times a week during evening hours in defined locations where the target groups gather (based on the results of focus groups). An algorithm of work of the multidisciplinary teams corresponded to the ethical principles of work with adolescents and included the following components: services delivered by MDTs in trust rooms, referral to the partner organizations and service delivery there.

**Functions of the organizations – model participants**

| Activities of the multidisciplinary team |
|---|
| - Establishing contact with an adolescent (group of adolescents) on the street (outreach workers, recruiters from MARA);<br>- Informing an adolescent about the possibility of becoming a participant in a prevention programme and about his/her rights and the observance of these rights by the team members;<br>- Conducting a questionnaire with an adolescent (social workers) to collect primary data about the clients and assigning a code to each client to ensure compliance with the principles of anonymity and confidentiality;<br>- Informing an adolescent about the possibilities for receiving medical and social services and providing him/her with informational materials (social workers);<br>- Performing pre-test counselling of an adolescent in a mobile transport vehicle (street consultant);<br>- Giving an adolescent, with his/her consent, a participant card for a city prevention programme and personal protection products (condoms)[8];<br>- Referring an adolescent to organizations-project participants;<br>- Accompanying an adolescent to medical institutions, the trust room, NGOs in order that he/she receives the necessary services (social workers);<br>- Motivating an adolescent to participate in social education activities in school of volunteers in the role of leaders informants or recruiters;<br>- Recruitment of leaders, informants, recruiters to participate in outreach work. |
| **Service delivery in the trust rooms:** |
| - Testing for HIV and receiving post-test counselling;<br>- Motivating a client to participate in the project by giving him/her a food package after the VCT. Adolescents were informed about this package by the multidisciplinary team and it represented one of the incentives for taking an HIV test;<br>- In case of a positive result, conducting a second test and motivating the adolescent to inform one of his/her parents (if he/she has parents) about his/her positive status (psychologist). |
| **Kyiv City Centre of Social Services for Family, Children and Youth** |
| - Accompanying an adolescent (family) to the Kyiv City Centre for AIDS Prevention for registration in the database (psychologist, social workers) and to the Centre of Emergency Assistance to Children to receive informational, psychological, pedagogical and other services (26 Novodarnytska Street). Eight HIV-positive adolescents were registered in the Kyiv City Centre for AIDS Prevention during project implementation;<br>- Ensuring referral of an adolescent with positive status to the following institutions: the Kyiv Left Bank Centre for HIV-positive Children and Youth and the Kyiv Right Bank Centre for HIV-positive Children and Youth (social workers). In these centres clients can receive informational services, counselling and diagnostic services;<br>- Organizing social and medical support for HIV-positive adolescents. |
| **Referral of clients to NGOs and centres for children to receive additional services:** |
| - Low-threshold services (dwelling in social apartments, provision of clothes, food, etc);<br>- Social and psychological services;<br>- Social and pedagogical services;<br>- Motivational social and psychological services for HIV-positive adolescents, including counselling on lifestyle after determination of HIV status and on the need for safe behaviour (Kyiv City Right and Left Bank Centre for HIV-positive Children and Youth) |
| **Referral of clients to health facilities to receive additional services** |
| - Medical examination and treatment;<br>- Registration of HIV-positive adolescents (AIDS Centre). |

[8] Contribution of NGOs involved in the project.

To optimize the work of all partners and the relationship between different components of the project, the key coordinator of the project (KCCSSFCY) was assigned supervisory functions and responsibilities for advocacy and for finding additional resources to improve service delivery within the model.

In the framework of the model, therefore, the clients were provided with the following basic package of services:

- informational services with distribution of information materials, adapted for adolescents, about places of service delivery and features of safe behaviour in the context of HIV and sexually transmitted infections;
- individual and family (if requested by an adolescent) counselling (social-psychological, social-educational, social-medical and social-legal);
- pre-and post-test counselling in the context of HIV;
- social and medical services (testing for HIV in the trust rooms of the Kyiv City Centre for HIV/AIDS Prevention and Control, distribution of personal hygiene products, assistance in the diagnosis of sexually transmitted diseases, cooperation with medical institutions for medical and socio-medical support of MARA);
- social and educational services (involvement of most-at-risk adolescents in volunteer jobs, their participation in the organization and implementation of prevention activities among adolescents and young people).

## Process of the model implementation

**Preparation**

| | |
|---|---|
| 1. Institutional aspects | Cooperation agreements were signed between the Kyiv City Centre for Social Services for Family, Children and Youth and the Kyiv City Centre for HIV/AIDS Prevention and Control; with non-governmental organizations such as the Kyiv City Branch of the All-Ukrainian Charitable Organization People Living with HIV/AIDS, Time for Life+ and World and Wellbeing to ensure their cooperation when working with MARA. |
| 2. Resources | It was important for the project's implementation that it was not only supported by UNICEF, but also supported financially by the partners. The key partner in the project, the Kyiv City AIDS Centre, provided free of charge a number of 'trust rooms'. Partner organizations provided assistance with humanitarian aid, printing materials, etc.<br>Specially developed and adapted informational materials about the location of free medical and social service delivery for adolescents at risk and materials about safe behaviour are still being disseminated among most at-risk adolescents and in their social environment. |
| 3. Staff recruitment | The key issue was to ensure the multidisciplinarity of the teams, which included highly qualified and experienced social workers, medical workers, psychologists and representatives of governmental and non-governmental organizations. |
| 4. Staff training | A three-day training session was conducted for the members of the street mobile multidisciplinary teams, which included a consultant-psychologist from the Kyiv City Centre for HIV/AIDS Prevention and Control (one person per team); a street consultant (one person per team); social workers (two persons per team); and outreach workers (two persons per team).<br>The trainers were recommended by the partner organizations. Some opportunities were used to train the project staff during other training sessions conducted by the partner organizations (the East-West fund) |
| 5. Recruitment of the target group and registration of clients | To detect clients, plans were to conduct a questionnaire among MARA to define the level of their knowledge about HIV/AIDS and safe behaviour; to give them participant cards for the city prevention programme; to provide them with a specially published information kit on locations where services are delivered.<br>The client coverage strategy envisaged development and improvement of schedules and routes to define when and where to conduct street prevention activities in the locations where the target groups gather and in their social environment. A mapping exercise was done with MARA in order to locate those places (June). |

## Implementation Process

1. Material resource base

The main difficulty with the informational materials was a delay in the printing of a 'service guide book'; plans were for it to be published in the beginning of the project. Project staff members expressed their concern that the absence of this guidebook decreased the effectiveness of their work. This book could have better assisted in providing information about available services.

2. Target group coverage

A total of **1,131** persons received participant cards upon their decision. These cards indicated their participation in the city prevention programme ANTIHIV after pre-test counselling in the mobile centre.

**Table 3**

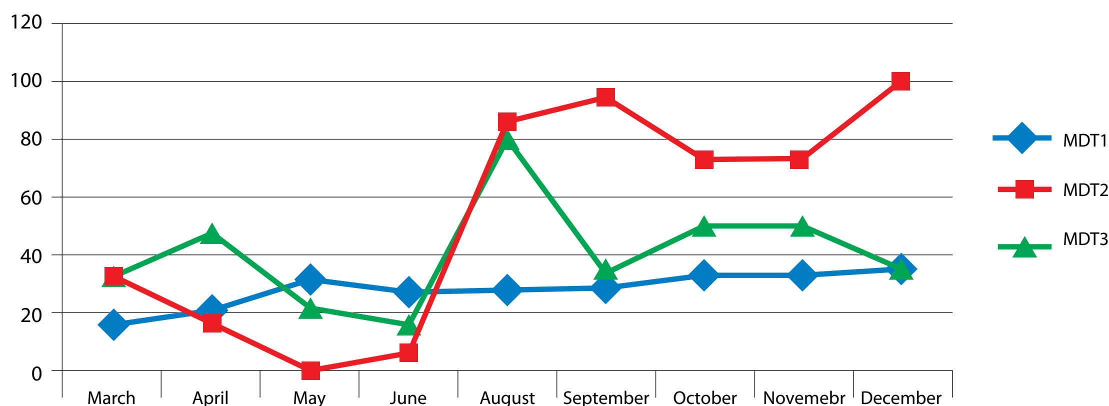
**Coverage of clients by the project**

| Month | Number of clients |
|---|---|
| March | 83 |
| April | 88 |
| May | 58 |
| June | 50 |
| August | 196 |
| September | 169 |
| October | 157 |
| November | 158 |
| December | 172 |
| **Gender** | |
| Boys | 660 |
| Girls | 470 |
| **Age** | |
| 14 years | 33 |
| 15–17 years | 497 |
| 18–19 years | 598 |
| **Total** | **1,131** |

These dynamics of inclusion of adolescents in the project shows the improvement in specialists' performance in establishing contacts on the street. This was to a certain extent due to effective contact establishment with street leaders.

The goal of achieving wide client coverage led to a decreased opportunity to conduct in-depth work with clients. This means that quantity prevented, to a certain extent, quality. The experience shows that very high indicators of target group coverage were established at the beginning.

- By the end of the project 1,131 adolescents had become the clients of the project, although the planned figure was 2,000 adolescents.
- 685 clients were tested (eight HIV clients were registered at the AIDS Centre). The planned indicator for testing coverage was more than 1,000 adolescents.




**Picture 2. Dynamics of client coverage by the multidisciplinary teams,** *persons*

The work of all MDTs had significant features depending on the assigned regions. The main client group for team #1 was adolescents living and working on the streets and chemically dependent adolescents, primarily injecting drug users. Some **344** adolescents were motivated to take a test for HIV and receive services, while **256** adolescents found out their HIV status.

The experience with model implementation on the level of separate city rayons and microrayons showed the needs to introduce a flexible approach to organization of prevention work depending on the charateristics of the target group of clients.

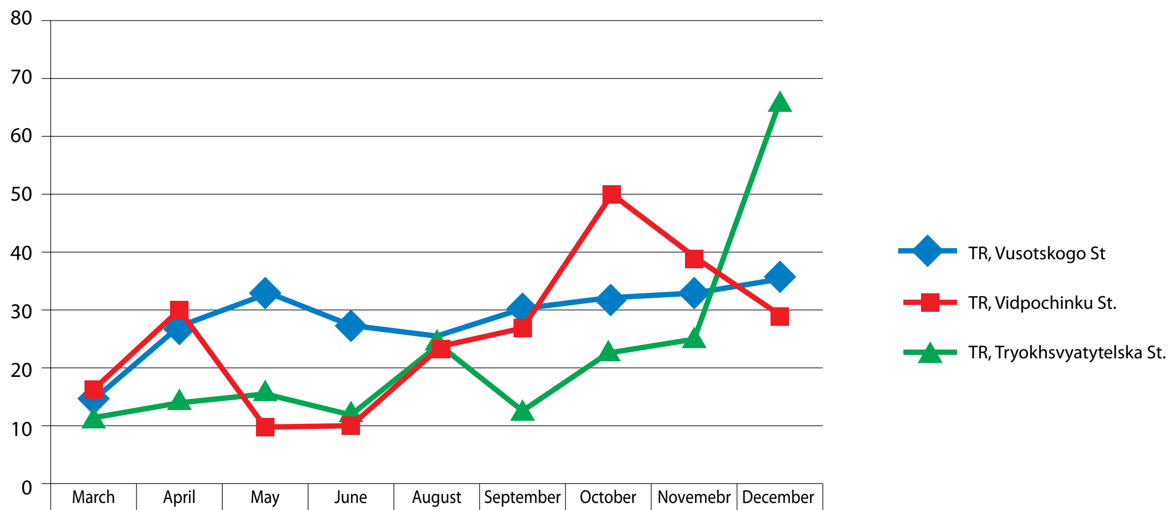
Besides the coverge of clients by MDTs, clients were also recruited in the 'trust rooms'. This gave a chance to hold onto those boys and girls who had been brought for testing by their friends-clients of the projects. During the whole duration of the project, **685** persons in total were tested (table 4). As a result of tests for HIV, eight adolescents found out about their HIV-positive status and were registered with the AIDS Centre. KCCSSFCY is providing social support to these adolescents. These adolescents also receive social-psychological and low-threshold services from specialists at the Kyiv Right and Left Bank Centres for HIV-infected Children and Youth (counselling on lifestyle after establishment of HIV-positive status, counselling for discordant couples, counselling on safe behaviour; clients also get shelter, food, clothing, etc.). Support for HIV-positive children is a big achievement of the model, because in Ukraine 'there are no procedures for receiving access to diagnostics and treatment for 'street children' and most-at-risk children without the consent of a parent or guardian (in general practice this means failure to provide services without a parent or caregiver)[9]'.

**Table 4**

**Number of clients receiving services from the MDTs**

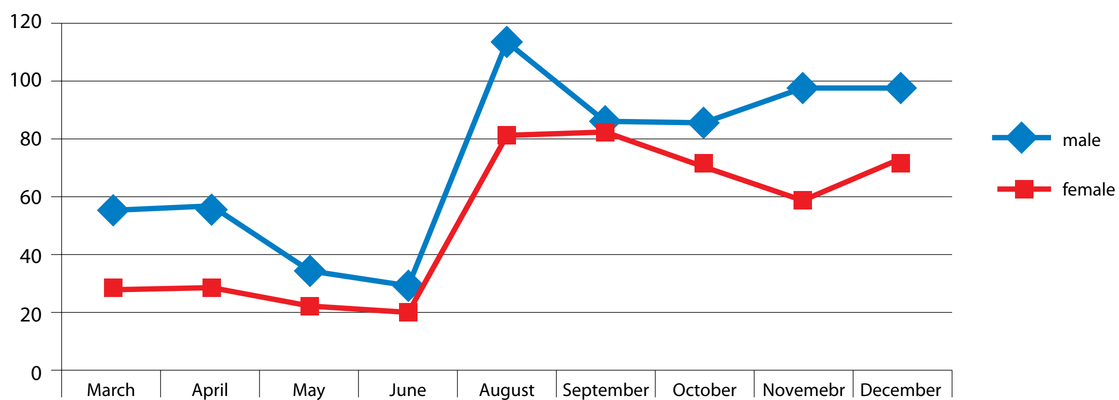
| Trust rooms | Number of clients |
|---|---|
| TR, Vusotskogo St. | 256 |
| TR, Vidpochynku St. | 225 |
| TR, Tryokhsvyatytelska St. | 204 |
| **Total** | 685 |

[9] 'National strategic plan for HIV prevention among children and adolescents at risk of and vulnerable to HIV, care and support for children and youth affected by HIV/AIDS', adopted by the National Council on Counteracting TB and HIV / AIDS of 26 May 2010.



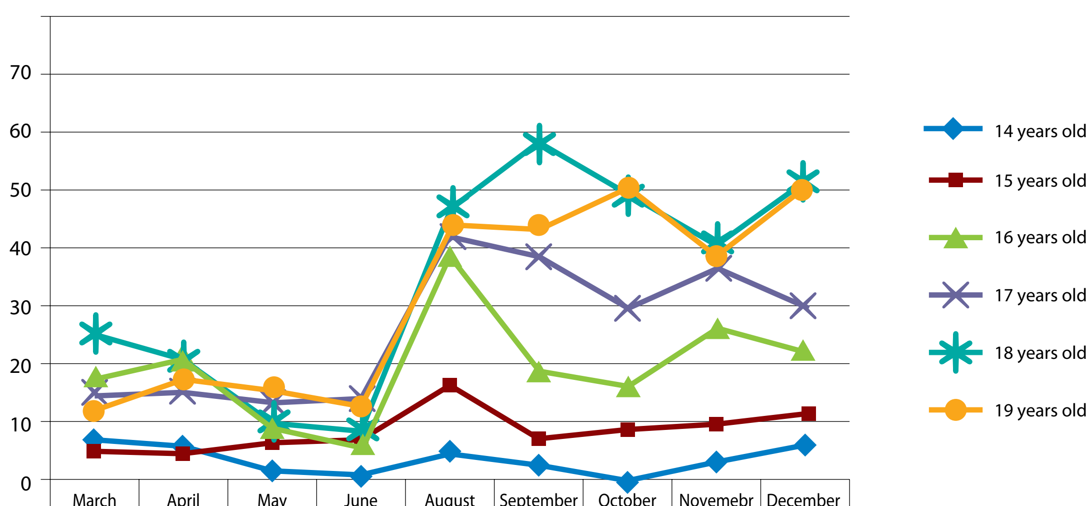

**Picture 3. Dynamics of client testing for HIV/AIDS in the trust rooms,** *persons*

The work productivity of a 'trust room' directly depended on client coverage by the multidisciplinary teams and their success in motivating clients to be tested, which contributed to the relative increase of the target indicator for HIV testing coverage.




**Picture 4. Dynamics of client coverage based on gender,** *persons*

During all the months of the project the team managed to reach more boys than girls. According to the staff, such dynamics of client coverage can be explained by the greater number of males among the target groups of the model and the greater ease of establishing contact with them due to their level of trust. Only in September was the number of boys and girls covered by the project equal. The biggest difference in client coverge based on gender was in November.




**Picture 5. Dynamics of client coverage based on age,** *persons*

During all the months of the project the least represented group among clients were the lower age groups, especially 14-year-olds. According to the model team, this can be partially explained by the fact that representatives of this target group tend to overstate their age and pretend to be older than they really are. One reason for this overestimation is their fear of being referred to a shelter for minors. The dynamics of coverage of all age groups was the same: from the starting point in March, the lines go down until June, and in August (after the vacation month) there is a sharp increase (except for 14–15-year-olds, where the coverage remains very low compared to other groups). There is then a relative decline. In general, there are increases and declines (within the range of 10 persons per month). After August there is a sharp decline in the coverage of 16-year-olds, in September.

## Cooperation with clients and services

In general the planned algorythm of cooperation with adolescents turned out to be proper and given to generating results. Some lessons learned should be discussed. One of these concerns has to do with the features of cooperation with clients.

Involvement of MARA in the discussion about and adjustment of the work of mobile multidisciplinary teams (June) allowed for defining new potential sites for street prevention work for the summer period. Also discused were the needs of adolescents to find jobs and problems of cooperation for different multidisciplinary teams when working with adolescents-migrants. The second meeting (October) with adolescents addressed the need to conduct additional testing for chemically dependent adolescents who had further risks of infection.

In many cases adolescents who did not agree at first to become the clients of the project and undergo testing did so later after the positive experience of their friends.

It was easiest to establish contact with adolescents who had been living and working on the street for more than three to five years. These adolescents, who were adjusted to street conditions, knew best about the institutions and organizations that delivered services.

MDTs always provided social support to the clients when taking them to the trust rooms. However, social support and escorting to other service providers (for example, to the AIDS Centre, the Centre of Emergency Assistance to Children, etc.) remained problematic due to the limited number of staffers and resources. Each team has had examples of 'case management', but these were isolated cases. Cases of 'client loss' (for example, when an HIV-positive client did not reach the AIDS Centre) prove that referral, escort and social support were not implemented completely.

The project staff established that most of the adolescents living and working on the street did not want to go back to their biological families or their regions, but wanted to stay on the street in the future. Such components of the planned service package as work with parents and searching for official jobs therefore found no success. However, such services as family counselling for unregistered street families, including discordant couples, were delivered when there was a need. It was also difficult to motivate children who lived with their families but spent a lot of time on the street to inform their parents about potential problems related to risk behaviour or about their need for familial support. This problem was related primarily to the reluctance of most clients that social workers establish contact with their parents. Because confidentiality was one of the principles of service delivery, this client request was respected by the project staff.

It was also difficult to interact with the clients after their testing for HIV so that they could receive their results in due time. Social workers found it challenging to work with adolescents after they received an HIV-positive result (there was migration, breaking of agreement to come to meetings, lack of desire to go for a second test).

Clients motivated to cooperate with the MDTs – MARA volunteers – did not show any interest in systematically continuing their education in the existing schools for volunteers. This was due to their negative attitudes to any school, the absence of any positive experience with systematic education on their part and their need to provide some means of living. Non-systematic classes were thus conducted for these adolescents at Golosiivskiy RCSSFCY (5 Bubnova St.) and in the 'social apartments' of the youth non-governmental organizations Life for 100% and the Caritas Charitable Fund (Mykytenka St.). One of the classes, on 'How to search for a job and what you need to know', was conducted at the Kyiv City Youth Centre for Employment. After this, four adolescents managed to find a job. In the implemented model, MARA-volunteers performed the functions of recruiters and informants. They could easily establish contact with the target group, talk about the advantages of the model and motivate them to participate as clients. MARA-volunteers also informed the model team about any behavioural changes among the target group, about changes of the places where they gathered, etc.

Involving MARA in sport and recreational activities, watching them participate in football games, was a very positive experience. However, mostly boys were involved in these activities.

There was a clear scheme for social support and referrals from the MDTs to the trust rooms, but the system did not function well in other areas (for referrals to the AIDS Centre, for example) due to limited human and financial resources (lack of funds for a vehicle).

### Preparation and supervision of the staff

More preparatory work should be done with the MDT members. The members of the MDTs, the composition of which completely changed, remained without any preparation or training. According to the members, the training sessions that were conducted in November should have been conducted in the beginning of the project. Analysis of the satisfaction level with preparation as well as the results of the monitoring visits showed that one training session in the beginning of the project that combined thematic and administrative issues was not sufficient. The main training sessions should have been conducted in the beginning or in the middle of the project, because the staff members, as they said themselves, needed the knowledge that they actually received at the end of the pilot phase of the project. It is important to note that the project staff developed a strategy for self-education: MDTs coordinators played the roles of supervisors for their social and outreach workers during the self-training process. This influenced the quality of staff preparation positively.

One barrier to an integrated system of staff preparation was an absence of a training and re-training system for specialists who deliver services to MARA at the national and regional levels.

The work of staff on each MDT was well organized and all staff members were interchangeable. An MDT coordinator was the key person who made decisions about a team's routes and tasks for a team and about division of labour. A change in the composition of one of the teams, and some changes in the compositions of other teams, were cited as negative experiences.

During the project implementation there was regular supervision of the MDTs and 'trust rooms' by a person responsible for project implementation, including joint trips to the field. However, taking into account the limited time and heavy workload of the staff, coordinating meetings of all the project staff with partner organizations were held rarely. As a result there were some gaps in the knowledge that one MDT had about the work of other MDTs.

During project implementation there were controversial moments related to the routes of the MDTs. This requires closer supervision and coordination of the project components, namely an agreement among key staff members about the current and future MDT plans and strong analysis and monitoring of MDT activities.

External monitoring revealed a need for a separate specialist in the project who would coordinate the work of MDTs (unfortunately the project coordinator who was supposed to undertake this role changed during the project implementation process, which caused some difficulties in coordination).

### Cooperation with interested parties, advocacy

One of the specific results of the cooperation between the international organizations and the state institutes in Ukraine was order of the Ministry of Family, Youth and Sport of Ukraine of 29 December 2009 #4568 'About approval of the exemplary provision "On multidisciplinary social work on the streets with risk groups among children and youth"'.

In this context, one of the possible solutions to the issue of risky sexual behaviour is the adoption at the regional level of a joint order by the State Administration of Health and Medical Services, the State Administration of Education and Science, the Kyiv City Centre for Social Services for Families, Children and Youth and Services for Children on the following: 'About the establishment of a single open window to ensure diagnostics, treatment and medical and social support to MARA in the context of HIV-infection and sexually transmitted diseases (STIs)'.

During the project an agreement was reached with the Department of Infectious Diseases for Children (32 Bogatyrska St.) that can deliver services to diagnose STIs for underage clients without any documents and free of charge, as long as they have a note from the Kyiv City Centre for Social Services for Family, Children and Youth or from any other organization that takes responsibility for the client. However, in practice, Ukrainian health facilities do not all provide free of charge treatment, due to the costs of the medications used in treatment. Therefore, the issue of treatment after a positive diagnosis of a disease remains unresolved.

The implementation of an innovative model in the limited time period turned up some 'weak spots' in the organization of work with MARA, in particular:

- Absence of an infrastructure of 24/7 centres for social support that would deliver basic services to MARA (food, clothing, shelter, hygiene products) and rehabilitation and re-socialisation of most-at-risk adolescents;
- Absence of standards for prevention work with MARA and of standards for social support to HIV-positive adolescents living and working on the street;
- Existence of inter-institutional barriers; ill-defined levels of responsibility during prevention activities with MARA;
- For-pay services for most-at-risk adolescents, especially when it comes to diagnostics and treatment;
- Absence of standard ethical principles for work with MARA and of standards for the referral process.

# Results of the model implementation

## Staff satisfaction

In general the staff remained satisfied with their workloads and salaries, and with their working hours. However, at first the members of MDTs were not warned about a large number of additional non-paid visits during off-hours. In addition, the satisfaction of the MDTs with work hours was determined by how their schedule was coordinated with the work schedules of other components of the project and partner organizations. A lot of staff members mentioned that the testing of clients had to be done on the same day as their recruitment. This could not be done, however, because the 'trust rooms' were open only till 18:00. This was the time at which the MDTs were just starting their outreach work.

## Client satisfaction

The project team succeeded in establishing relationships of trust with its clients. This is proved by the data obtained during the client satisfaction study:

- all clients 'fully trust' the specialists working with them on the street;
- nine out of 10 clients 'fully trust' the psychologist in the 'trust room';
- nine out of 10 clients 'fully trust' the nurse in the 'trust room'.

Clients provided information about the location of other potential clients and were involved in recruitment. However, the clients' motivation to receive other services besides services delivered by a MDT and 'trust rooms' (for example, services from the Youth Employment Centre, the school of volunteers, a summer camp for scouts, etc.) was very low for a number of reasons. Clients were not interested in these services because their basic needs for food and security were not met through them. 'Older' street adolescents did not want their 'dependents' to spend time in other places. 'Home' adolescents who spent most of their time on the streets did not want any services because it meant they had to spend time on them and inform their parents (about their departure to a summer camp, for example). Any active client involvement in the project was difficult because the model was focused on outreach work and wide coverage. This did not allow for work with all the clients continuously.

## Sustainability of the model

- The process of model implementation proved that clear standards are necessary for clear referrals and support provision. Social support and referrals from the MDTs to the trust rooms were well-organized. The clients were also referred to other partner organizations, but without social support many clients did not arrive there (there were cases of losses of clients who received positive test results and did not arrive at the AIDS Centre). The limited human and financial resources of the MDTs became a barrier to delivering continuous social services. Many clients also refused social services (reasons: lack of trust, desire to be independent from anybody).
- The model showed that work with MARA requires confronting their systematic problems, because this is a very vulnerable group. It is impossible to improve their knowledge about HIV/AIDS without satisfying their basic needs (food, security, hygiene). The fact that there is a very limited number of services offered to young people only reinforces the need to expand the list of project services.
- Another important aspect for the sustainability of the model is the regular involvement of all team members in the planning process, in evaluation and monitoring and in advocacy activities. However, during the implementation of the model, this requirement was not been fully met. As a result, there were some problems with the organization of the work process and unreasonable timing for external monitoring and evaluation team visits. Separate staff members were involved in some advocacy activities, which made these activities more persuasive. Moreover, the project

staff gained more experience in working with MARA. A few staff members did not understand the goal and purpose of some components and this influenced the overall vision of the project.

- One of the important arguments concerning the possibilities of cooperating with other specialists had to do with the fact that none of them took part in the street 'raids[10]', and that two teams had specialists who had experience with successful implementation of such projects, based on the principle of a friendly and tolerant attitude to the target group. There were thus difficulties in establishing contacts in new locations that were not parts of previous projects.
- The project proved the need to standardise ethical principles of work with adolescents in general and with most-at-risk adolescents in particular. A religious organization was a partner during the project implementation; its staff members were involved in the MDT work. There was a conflict between the ethical principles informing prevention work with MARA of this organization and the principles of social services providers on the other. The implementer of the project saw no problem, because outreach work with MARA was being implemented, and not only by religious organization representatives, but also by other members of the MDT: representatives of the social services and other NGOs. Even within a team there were unofficial divisions into 'religious' workers and the rest, as representatives of the religious organizations had their own ethical principles and work objectives. In particular, there is no single strategy for distribution of condoms, conversations about sexual behaviour and the like.

## Lessons learned

1. *Preparatory phase.*
   - The project had a lot of target groups with a variety of needs that cannot be satisfied by the staff of a single project and with no organized system of social support and referrals.
   - It is important to sign cooperation agreements between all the partners in order to ensure accountability among all of them during the model implementation, and to improve the quality of their involvement.
   - The involvement of specialists who previously had experience in working with the target group or implementing similar projects is important to the successful implementation of the model. However, all specialists, even those with experience, require additional training before the start of the project so that they can learn the particularities of work for a given model.
2. *Staff stability.*
   It is important to ensure constant staff composition. In cases of changes and involvement of new staff members it is necessary to conduct additional training for them.
3. *Expansion of the range of services.*
   It is possible to meet the needs of most-at-risk adolescent within the model only if there is an immediate improvement and expansion of services for MARA and their families; delivery of basic services (food, clothing, hygiene, shelter), especially for adolescents living or working on the streets; development of algorithms for counselling and social and medical support of adolescents; and adolescent involvement in the work of friendly clinics and other specialised medical facilities.
4. *Recruitment of clients.*
   - Continuous collaboration of team members with the clients, especially with their leaders, helps to identify potential locations for street work; it also helps in tracking of and timely respond to the migration of the target group.
   - Adolescents living and working on the streets for a few years were easier to contact, and more motivated to participate in the project. Adolescents who still had contact with their

[10] The oblast criminal police for minors conducts a weekly comprehensive operational and preventative search of the area, i.e. raids. Its purpose is to reveal facts of drug use among minors and their involvement in criminal activity, to prevent homelessness and begging and to bring children back from the streets.

parents were against informing their parents or relatives about their participation in the project or the services they were delivered.

5. *Referral.*
   - Physical presence and escorting a client to an organization he/she was referred to was an important component in the implementation of the model. If this condition is not fulfilled during the referral it will lead to loss of clients.
   - The project demonstrated the need for well-organized legal support for clients who received HIV-positive results, and for ongoing services.

## Conclusions

This project was the 'first robin' in Kyiv to establish cooperation between interested parties whose activity is related to MARA directly or can potentially include MARA (the AIDS Centre, for example, has not had the opportunity to work directly with MARA, although this group is very vulnerable to HIV infection). Sharing experience could be possible. Decision makers should be involved in the dialogue and there should be advocacy for project interests. This is one of the strategic challenges of the project.

The model in Kyiv designed to provide services to most-at-risk adolescents was more evidence of the immediate need to provide services and the high need for these services on the part of the target group. A multidisciplinary approach is effective in the Ukrainian context and is one of the best methods for establishing contacts with the target group and for effecting successful recruiting.

The project showed the need for legal regulation of the support delivery process to HIV-positive adolescents and adolescents in need of medical services in the absence of parents or guardians. It also showed the need for establishment of 24/7 centres where adolescents can satisfy their basic needs (clothing, food, shelter, etc.). In addition, the project showed the need to develop methodology to regulate the practice of referrals and the generalisation of this experience to develop referral technology. There must be a single registration system for clients and standardisation of the databases of clients of various services in specific residential areas. This will improve the social support and referral system.

The piloted model showed the possibility of delivering service using the method of multidisciplinary teams and sharing this experience with other organizations and agencies in Kyiv and other cities of Ukraine, all while taking into account lessons learned and key factors that impeded the model's successful implementation.

## Contacts for additional information:

**Kyiv City Centre of Social Services for Family, Children and Youth**
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Phone number: 456-82-28
Phone/Fax number: 458-27-67
Website: www.ssm.kiev.ua

# Model 'Implementation of the model of "friendly" HIV- prevention intervention through establishment of informal leaders in the environment of most-at-risk adolescents-injecting drug users' – city of Donetsk

## Relevance of the model

The data obtained during the primary research and secondary analysis of bio-behavioural data (see introduction) on adolescents at risk of HIV showed the need to deliver services for MARA in Donetsk. During the strategic planning done by the regional cross-sectoral and interagency advisory group (RAG), which was established within the UNICEF project 'HIV Prevention among Most-at-risk Adolescents', a group of adolescents-IDUs was selected as a target group for piloting the model in Donetsk.

In 2008 1,757 children inclined to vagrancy, homelessness and begging were detected in Donetsk. Among them, 180 adolescents were using alcohol and 72 were using narcotic or toxic substances. Forty-six crimes were committed by underage children while in states of alcoholic intoxication. The service for children in Donetsk referred 11 children using alcohol to the Regional Medical and Social Rehabilitation Centre.

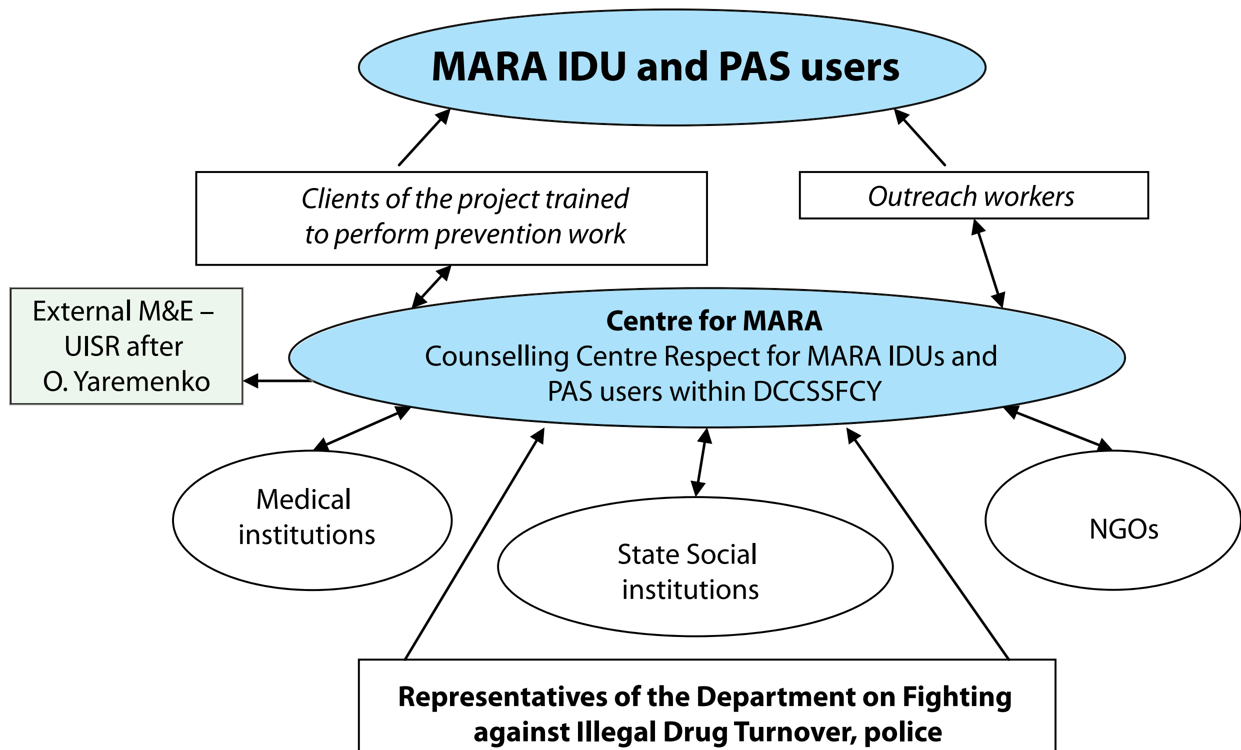
At the Oblast Narcological Dispensary, 22 children (in a dispensary group) and 126 (in a prevention group) were officially registered as drug-addicted children under 18. According to the Donetsk Oblast Centre of Social Services for Children, Family and Youth, specialised treatment care is provided to children in the narcological rooms of central district and city hospitals, at 11 narcological dispensaries and at seven narcological clinics.

In July 2008, during a meeting of the cross-sectoral working group of the Oblast Council on Tuberculosis, HIV/AIDS (CWG), the status of the Regional Advisory Council on HIV Prevention (RAC) among MARA was defined. The RAC would be a subgroup of the CWG, with 61 members from governmental and non-governmental organizations. In August 2008, during a meeting of the Oblast Council for TB and HIV/AIDS Prevention (OC), RAC activities and the project 'HIV Prevention among MARA in Ukraine' (2007-2009) were discussed.

Taking into account the large number of MARA, there was a need to expand access for adolescents to social services and medical assistance based on the principle of a friendly approach that directed at preventing HIV/AIDS and other socially dangerous diseases and improving the system of primary, secondary and tertiary prevention among adolescents in difficult life situations.

## Model description

In December 2008, during the OC meeting, the status of the RAC was defined. It was decided to pilot 'Implementation of the model of "friendly" HIV-prevention interference through establishment of informal leaders in the environment of most-at-risk adolescents-injecting drug users' in the city of Donetsk. The Donetsk Oblast Centre of Social Services for Family, Children and Youth was defined as the responsible party for the implementation of this project. This model was implemented together with the Donetsk City Centre of Social Services for Family, Children and Youth and governmental and non-governmental partner organizations with the support of UNICEF in Ukraine (see picture 6 for the model design). Timeframe of project implementation: September 2009 – May 2010.




**Picture 6. Design of the model 'Implementation of the model of 'friendly' HIV-prevention intervention through establishment of informal leaders in the environment of most-at-risk adolescents-injecting drug users'**

**Goal of the model:**

To reduce the HIV spread among MARA injecting drug users through the implementation of a model of 'friendly' HIV-prevention through establishment of informal leaders in the environment of adolescents-IDUs.

**Target group of the model:**

Adolescents 14 to 19 years old who use injecting drugs and non-injecting psychoactive drugs. (The decision was made to provide services to adolescents using psychoactive substances during the implementation of the model. This was because this group's need for services became clear during the implementation of the project and because this group was defined as containing potential injecting drug users.)

**Project staff**

- Seven outreach workers trained for the street work (two experienced outreach workers (former IDUs) and five clients of the "Your Victory" Oblast Centre for Resocialisation of Drug Addicted Youth who were in the last stage of rehabilitation – four boys and one girl). They provided HIV-prevention services in locations accessible to potential clients (these locations were defined during the preparatory phase of the model, during the working meetings of specialists who work with or have information about the target group. The "Respect" counselling centre was established for the clients of this model. Clients could receive information, social and medical services. When additional services were needed clients were referred to partner organizations:
  1. Syringe Exchange Centre within the NGO "Development, Initiative, Partnership".
  2. Syringe Exchange Centre within the NGO "Donetsk Oblast Association to Provide Assistance to HIV-positive People".
  3. Syringe Exchange Centre within the "Svitanok" club.
  4. Youth-friendly clinic.

5. Donetsk City Narcological Centre.
6. Donetsk Oblast Skin and Venerological Dispensary.
7. "Your Victory" Oblast Centre for Resocialisation of Drug Addicted Youth.
8. Charitable Fund "Mylist".
9. Oblast Foundation "Molod Donbasu".
10. Medical polyclinics (hospitals).

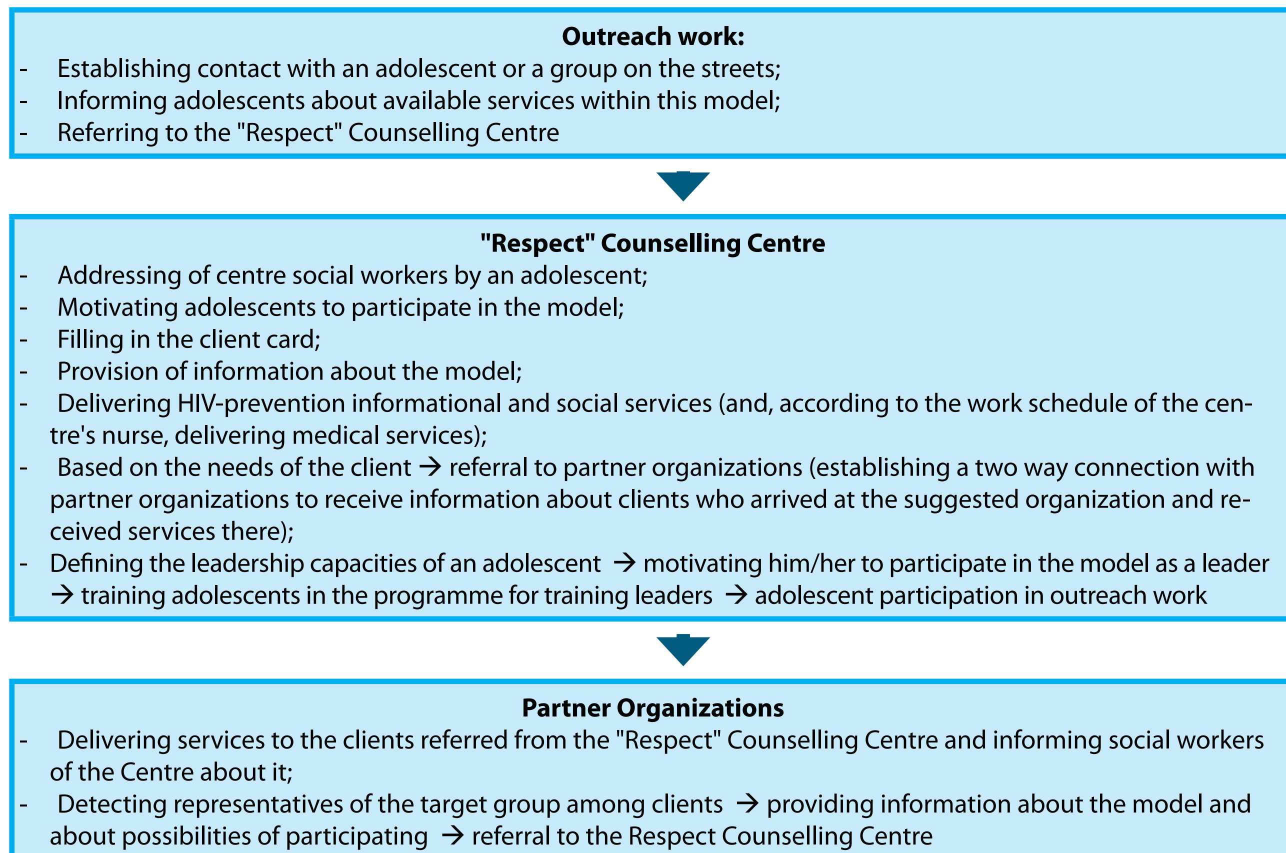
In order to support the implementation of the model, the following additional partners were involved:

1. The Donetsk city criminal police for minors. In cases of detection of adolescent IDUs or PAS users, the police referred them to the Respect counselling centre. They were encouraged to use a tolerant and benevolent attitude towards adolescents from different institutions in Donetsk and involved adolescents in active sport activities.
2. The Donetsk regional representation of the ICF International HIV/AIDS Alliance in Ukraine had an impact on the implementation of the model on the advocacy level, through participation in various meetings at the local and regional level. It encouraged the NGOs that were its to cooperate during the model implementation.

To expand the access to the target group of adolescents-leaders, former IDUs and PAS users were involved in the project activity. After training, these adolescents took part in outreach work. In other words, after changing their unsafe behaviour and additional training, the clients of the project could become a part of the team and, together with outreach workers, perform prevention activities. This increased significantly the motivation of adolescents to participate in the model.

To implement the model successfully, volunteers also participated in project activities. They were involved in primary prevention activities in vocational schools (VS) and summer camps for MARA organized on the basis of secondary schools. The educational institutions where primary prevention was conducted were not chosen randomly. While working on the project, outreach workers found that, among students of vocational schools, there are a certain number of target group representatives and an even greater number of students who are close to becoming a model target group, i.e. they are close to becoming injecting drug users or psychoactive substance users. The MARA summer camp has been functioning for several years in Donetsk. It is based in the secondary school in Kuybashyvskyi district. School and summer camp management initiated primary prevention activities, conducted by the model's HIV team. During the external monitoring of the model, the school management showed high motivation for cooperation within the model. According to the teachers, this had a positive impact on the summer camp's participants.

## The algorithm for work with MARA within this model had the following components:




The basic package of services for clients and their environment included:

- 'outreach' services (delivered in the field in the locations where the target groups gather):
  - Informational and educational materials about HIV and access to services (during friendly prevention initiatives in the MARA environment;
  - Social support (with the agreement of the adolescent) and referral to the Respect Counselling Centre (hereinafter – "Respect");
- Counselling (on HIV issues and motivation for HIV prevention activity);
- Educational work (using the 'peer-to-peer' principle and related to HIV prevention);
- Acquiring skills for HIV prevention work and decision making;
- Intermediary services (receipt of special social services from other subjects of social work: diagnostics, treatment, care and support, supply of condoms and lubricants, etc);
- Services to reduce harm (syringe exchange, overdose prevention, provision of information – as a result of referrals to syringe exchange centres (SEC) and HIV service non-governmental organizations);
- Psychological and social counselling (through 'hotlines' and based on the 'peer-to-peer' method and/or on participation in self-assistance groups and/or on counselling from the specialists (social workers, psychologists); pre- and post-testing counselling;
- Social and financial assistance (assistance in getting access to medical services, provision of humanitarian aid, representation of the client's social interests at health facilities, agencies for social protection, governmental institutions and offices of local authorities).

An important condition for creating a friendly environment and sharing successful experience in providing services to MARA is the presence of advocacy activities. They reduce stigmatisation and discrimination through continuous cooperation with medical institutions and governmental and non-governmental organizations and encourage the staff to maintain a tolerant attitude to project clients and representatives of most-at-risk groups in general.

# Process of the model implementation

**Preparation**

| | |
|---|---|
| *1. Work plan* | • a clear plan-schedule for the implementation process was developed. This plan included a schedule for all activities planned within the project and outlined in the project proposal.<br>• mapping of locations where the target populations gather was done and a schedule for visits by the outreach team for each of the defined locations was developed. |
| *2. Official cooperation within the model framework* | • During the meeting of Oblast Council on Fighting against TB and HIV/AIDS, the Department of Education and Science, the Department of Health within the Oblast State Administration, the Oblast Centre of Social Services for Family, Children and Youth and oblast NGOs received recommendations to support cross-sectoral referrals of MARA and to adopt a friendly approach when providing social and medical services. This decision supported the involvement of a necessary number of partners in the implementation process and the signing with them of official agreements of cooperation. Official agreements of cooperation were signed with medical institutions, NGOs and law enforcement authorities (for the full list of partner organizations see pages 29-30). |
| *3. Additional resources for model implementation* | • The resources used for the model implementation were provided by UNICEF as well as other partners: the premises for the Respect Counselling Centre were provided by the Donetsk City Centre of Social Services for Family, Children and Youth. Consumable materials (condoms, tissues, lubricants) were provided by the Donetsk Association to Provide Assistance to HIV-positive People. The syringe exchange programme was provided by all the project's syringe exchange centres-partners. |
| *4. Staff preparation and training* | • The main criterion for staff selection was experience and knowledge about the behavioural features of the target group.<br>• All outreach workers were trained to perform activities within the model framework:<br>- Training on the main features of work with MARA;<br>- Training on ethical principles of work with MARA;<br>- Training on the main features of outreach work;<br>- Learning individual functions within the project;<br>- Training on safety.<br>• The coordinators of the model implementation (DOCSSFCY and DCCSSFCY) participated during the preparatory phase and took part in the seminar on strategic planning, in the training session on gender specifics and the training session on legal norms and ethical principles of work with most-at-risk adolescents. This helped them to conduct training for other staff members. |
| *5. Coordination of the referral system* | • During a working meeting between the main partners and implementers of the model, a referral system was developed. It included mandatory feedback, meaning that a social worker from Respect had to inform the specialist who the client was referred to in order to receive the necessary services. In his/her turn, the specialist to whom the client was referred had an obligation to provide information about whether the client came for services and what services he/she received. For the convenience of the referral process, a 'referral pass' was developed and agreed upon. It included the name of the institution that referred the client, the name of the institution to where the client was referred, addresses and telephone numbers, the positions and names of the specialists who referred and were referred to and the name or code of the client who was given the pass. This pass was in duplicate: the information was filled in twice. The first part was cut off and remained with the referring specialist. The other part went to the client. If the client requested services, it was given to the specialist to whom the client was referred. This referral system allowed for controlling the number and quality of services received by the clients and for tracking the clients if they did not address "Respect" again. |

## Implementation process

During the model implementation stage the key implementers and partners focused their activity on ensuring such components as coverage of the target group, delivery of a complete package of services, the required material resource base, etc. This activity revealed main advantages that could be useful for other partners and the main disadvantages that should be avoided during the implementation of similar models in the future.

*1. List of available services for clients*

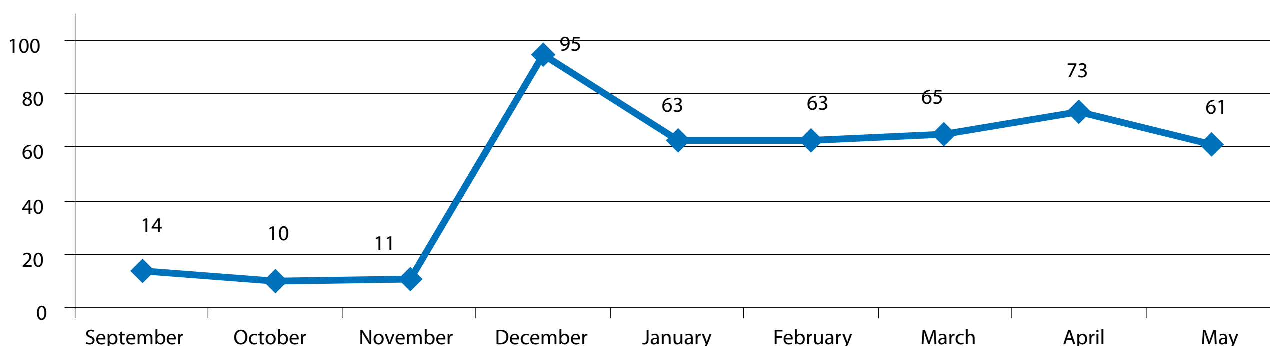
The main problem in terms of the delivery of all services to clients was the absence of low threshold services such as products for personal hygiene, food and clothing. Within the framework of the model clients could have a cup of tea with sweets at the "Respect" Counselling Centre, but other services, such as provision of necessary clothes, food and personal hygiene products, were not provided. The solution to this problem was found at the end of the implementation process, when a cooperation agreement was signed with CF "Caritas". Clients could receive those services at the day centre for adolescents. Cooperation was also possible with the International Youth Centre, which also had day centres as part of its "Sun City" project. The inclusion of the day centre and the 24/7 centre on the list of project partners is very important, because boys and girls with risky behaviour need to have their basic needs, such as for shelter, food and clothing, satisfied. This will help facilitate better communication with them. It will also enable performance of HIV prevention activities and delivery of other services.

*2. Material and resource base*

The main problem for model implementation was the lack of informational materials designed for adolescents. Two types of leaflets were developed and printed during the implementation process. These leaflets contained information about the model, the location of the Respect Counselling Centre and a list of available services in the framework of this model. However, informational booklets designed for HIV prevention, drug abuse and dangerous behaviour were very general and did not account for age and gender. During the model implementation and surveys of clients about their satisfaction with the project, it was revealed that it was necessary to have informational materials that would be easy to understand for adolescents. An important component should therefore have been development of informational and educational materials (IEM) aimed at HIV prevention. Adolescents should have been engaged in the development process to ensure that the information provided in IEM was adapted for the age group and accounted for gender specifics.

*3. Target group coverage*

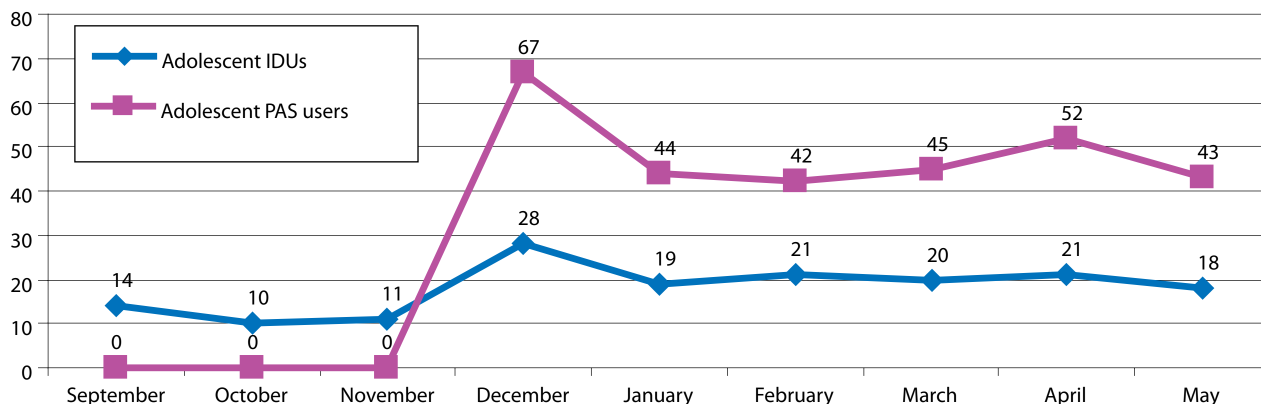
Target group coverage was different during the implementation process. In the beginning of the model implementation (August-November), 35 clients used the services. Starting from December the coverage increased significantly (see picture 7).




**Picture 7. Number of clients of the model according to month of the implementation process**

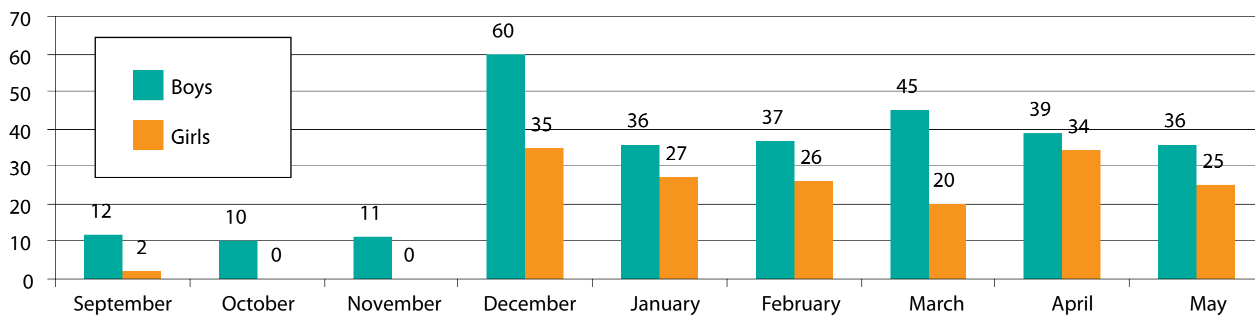
The main reasons for the increase in the number of clients were:

- Expansion of the target group (it was decided to consider adolescents using non-injecting psychoactive substances as clients of the model as well as adolescent IDUs. The former can be inclined to use injecting drugs in the future and to adopt dangerous sexual behaviour.) (see picture 8)
- The work schedule of the "Respect" Counselling Centre was extended (it was switched to a daily work schedule)
- During the first few months outreach work (recruitment) was conducted in all the regions of the city. This caused a lack of strong motivation among adolescents to become "Respect" clients. Starting from December outreach work was conducted in locations where the target groups gather and that are not far from "Respect".
- The first few months were used to establish contact with the target group, to develop trustful relationships and to study the specifics of working with the target group in practice.
- The increase in client coverage can be explained by the improvement in the knowledge and skills of outreach workers, due to their participation in the training session 'Techniques for social support provision to different MARA groups before HIV infection'. (Odesa, Mykolaiv). Besides providing new information, the training sessions gave participants from Kyiv, Mykolaiv and Odesa the opportunity to exchange experience with each other.



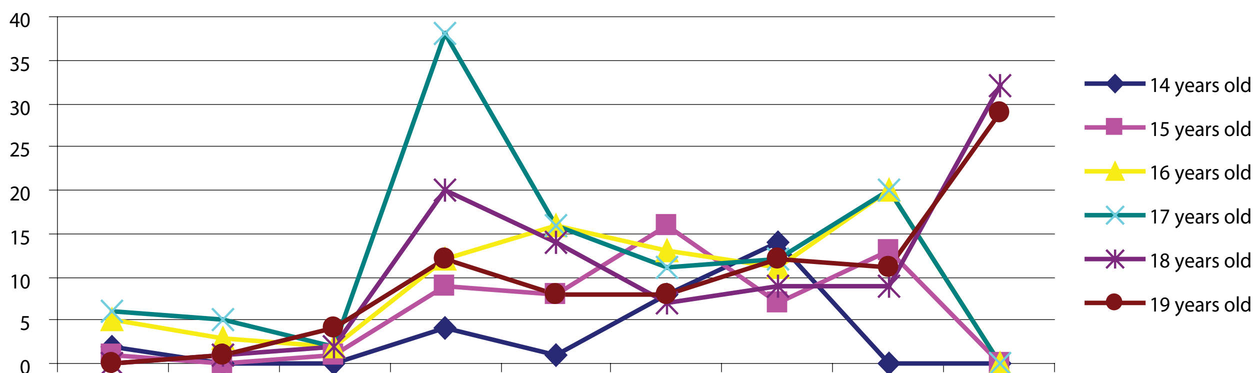

**Picture 8. Number of clients according to method of drug use**

During implementation it became possible to cover more male than female clients (see picture 9). This can be explained by the fact that there are more drug users among boys than girls. A female worker on the outreach team positively influenced the recruitment process. Clients were more trusting when they were approached by the outreach team, especially one with a female representative. According to many girls-clients of the project, they agreed to join the model only after recommendations from a female outreach worker. Some boys also mentioned that it was easier for them to communicate with the female outreach worker. Accounting for gender specifics during the staff recruitment may thus have a great impact on establishing contact with the target group and recruiting clients.




**Picture 9. Number of clients according to the gender,** *persons*

Representatives of all age groups within the target group were reached (see picture 10). The numbers of young people of various age groups break down as follows: 17 years – 110 persons, 18 years – 94 persons, 19 years – 85 persons, 16 years – 82 persons. It was most difficult to deliver services to adolescents aged 14–15 years (14 years – 29 persons, 15 years – 55 persons). According to the outreach team the smaller coverage of that age group was caused by difficulty of access. They are rarely found in the locations where the target groups gather; they are more reserved in communication and rarely trust outreach team members.




**Picture 10. Number of clients according to their age,** *persons*

Project clients usually requested services once or for a short period of time. Only 103 out of 455 clients requested services from the Respect Counselling Centre for a second time. According to the project staff, the key reasons for which clients stopped receiving services were the following:

- Clients had no desire or motivation to request services because they did not consider their health to be valuable;
- There were no low threshold services;
- The inconvenient location of Respect: most of the clients were from other areas of the city, and 35 clients were from different cities;
- No escorts (no transportation for clients).

One more problem was the relatively distant location of partners – service providers. This complicated the referral system (see table 5). Most of the referred clients' requests were registered at the movable syringe exchange centre of the Donetsk Oblast Association to Assist HIV-infected People. This could be explained by the centre's work schedule – every Tuesday this mobile centre was located in front of Respect for a few hours. All clients could receive services. Twelve requests for services were registered at the mobile centre. These people were tested for HIV (all the results were negative).

**Table 5**

**Referrals of clients in the framework of the model**

| Referral: | Number of referred clients | | Number of clients who received services at the suggested organizations | |
|---|---|---|---|---|
| | PAS users | IDU | PAS users | IDU |
| SEC DOAAH+ | 21 | 14 | | 12 |
| Youth-friendly clinic | 18 | 14 | 2 | 14 |
| Psychologist from the Donetsk Centre of Social Services for Family, Children and Youth | 1 | | 1 | |
| Health facilities | | 1 | | 1 |
| SEC "Development, Initiative, Partnership" | | 3 | | 3 |
| SEC "Svitanok" | | 4 | | |

According to the project staff, the low level of referrals to partner organizations was caused by the clients' personal reluctance to seek services and to continue to participate in the model. Another reason was the remote location of partners from "Respect" or from the places of residence of clients: clients did not want to waste their time and money to get to the organization they were referred to. During planning and implementation of a model with the involvement of different partners it is important to account not only for the motivation of a partner or its experience in service delivery and working with MARA, but also or how convenient the organization's location is for project client.

## Preparation of project clients-former IDUs for outreach work

The most active and motivated clients were selected for the leadership programme. In total 26 clients were trained, 10 out of 26 of whom were adolescents-IDUs. For the purpose of the model, the project staff considered these clients as 'leaders'. This title was necessary to motivate the clients to dive deeper into the model and its work, to avoid risk behaviour in a sustained way and to encourage others to give up HIV risk behaviour. Eleven training sessions were conducted to prepare the "leaders". They addressed the following issues:

- Specific approaches to work with MARA;
- Principles of ethical work with MARA;
- Specifics of outreach work;
- Leadership functions within the model framework;
- Safety training.

After completing the training the "leaders" were involved in outreach work. With other outreach workers they recruited new clients in locations where the target group gathers. The negative side of involvement in outreach work was the risk of return to dangerous practices (two "leaders").

Specialists conducting training for selected leaders noted the difficulty of working with former IDUs in terms of keeping them away from using drugs. It was decided that an experienced psychologist should conduct motivating interviews to prepare adolescents for the outreach work.

Two educational seminars were conducted for the leaders. Outreach workers and key specialists from partner organizations participated in the seminars.

### Training of Volunteers

Volunteers were involved in conducting the primary HIV prevention. During the model implementation process 18 volunteers were trained. Most of them were students from vocational training schools and secondary schools; two volunteers were from CF "Mylist". It was important to involve volunteers in the project to conduct prevention work in educational institutions and camps for MARA. Vocational training schools were primarily selected among all other schools, because, during the model implementation, the outreach workers and other project staff found that a significant number of clients recruited in places where the target group gathers are students from vocational schools. This defined the direction of prevention work at some vocational schools in Donetsk. The school summer camp for MARA that was established at the secondary school in Donetsk was open during the summer holidays. The camp was attended not only by MARA, but primarily by students who had problems with schooling or manifested deviant behaviour and were frequently absent from class. The camp pedagogical staff called it 'Camp for MARA', but it certainly did not have such a stigmatizing image as far as children were concerned. They considered it an ordinary summer camp. Given the specifics of the target group in the camp, it was decided to involve volunteers in the educational process. Meetings with the model leaders and outreach workers were organized from time to time.

Training sessions for volunteers were conducted on the "Respect" premises and led by the best specialists working for the project.

### Cooperation and Advocacy

During the implementation process 11 working meetings were conducted with key partners in order to inform them about model implementation progress, receive feedback about the services delivered to clients and resolve any problematic issues.

In cases when problematic issues could not be resolved at specialist level, these issues were discussed during the meetings of Oblast Council on TB and HIV/AIDS Prevention (hereinafter the OC). The results of the implementation were also presented during OC meetings. This promoted the exchange of work experience with MARA.

During the OC meeting in April 2010 it was recommended:

1. To the regional coordinator of the ICF International HV/AIDS Alliance in Ukraine, the director of the Interregional HIV/AIDS Informational and Resource Centre, the NGO Union Amicus' and the regional representative of the All-Ukrainian Network of People Living with HIV/AIDS that NGOs providing HIV services be included in the activity of multidisciplinary street teams for social work with children and youth in the risk groups formed within the city and rayon CSSFCY, and that delivery of friendly services in referral cases be ensured.
2. To the director of the Oblast Centre of Social Services for Family, Children and Youth, the regional coordinator of the ICF International HV/AIDS Alliance in Ukraine and the regional representative of the All-Ukrainian Network of People Living with HIV/AIDS to develop and that a minimum package of services for children in risk groups be provided.

These activities helped to expand the number of partners within the model and enlist their support to continue service delivery to MARA even after the model's termination.

## Results of the model implementation

### Staff Satisfaction

In general, the staff members were highly satisfied with the model. However, there were some remarks on the implementation process. Improvement of some components will help to increase the staff's work effectiveness.

The training of staff before the beginning of the implementation, especially for outreach workers, was not sufficient. All members of the outreach team and other staff members appreciated the positive influence of the on the job training. The training sessions were conducted by UNICEF in November-December 2009.

The staff members were motivated to work with model clients and therefore felt a certain dissatisfaction when, in the beginning of the implementation process, they did not manage to ensure wide coverage.

Some staff members, however, were satisfied by the entire process of implementation and client coverage from the very beginning: "*To be honest, I'm shocked. Because when we planned, when we developed this project here during the seminars, even taking into account the current situation in oblast, we thought that we would have single clients, here and there. Moreover, the statistics showed that we have very few adolescents-users of psychoactive substances officially registered. The service for children asserted that we had already overcome the problems of homelessness and vagrancy of children, that only a small number of children were officially registered as homeless or vagrant. And when the children felt the friendly attitude, the understanding, the attention; when the children felt that they did not have to have a passport or official data, they started to open up. Plus, when they saw and listened to the outreach people who had crossed the barrier themselves and coped with their difficulties - this impressed them and us so much that the children started to open up. And every day they did that more and more, and they even started to discover a lot for themselves.*"

During the implementation process the staff had difficulties due to a heavy workload. The project coordinator and internal M&E specialist were changed in the first months of the implementation process (November).

A heavy workload was mentioned by other staff members as well. However, they pointed out their motivation to implement the model: "*During the implementation the evening hours were difficult.... When we worked twice a week it was a bit easier. But we decided to extend this schedule as an experiment; we are pioneers - ready for everything... Of course, our director tries to be flexible as well. On Tuesdays and Thursday, for example, I start work at 11am here; I shifted my work hours, so to speak.*"

Implementation of the model motivated a lot of staff members to improve their knowledge and skills in MARA work. This improved service delivery: "*I learned a lot during the project, starting from information about drugs to providing good coordination of partners in different rayons of the city. But this happened during the project. Primarily, what I learned has to do with work with adolescents. There was a new group and plenty of new information. There is a lot of new literature. Of course, there is a lot on the Internet, methodological literature, for example, but finally we pulled all that together. We conducted seminars for our specialists where we talked about working with IDUs and PAS. That was the main group. Of course, we would like to name more. Because it's impossible to have too many skills. We always want more.*"

Staff members expressed their concern about the model's sustainability and level of completeness for clients.

*"We have not completed the project. We worked with children and everything was wonderful. Vasya, you are a good boy. We gave you some tea, even provided you with transportation. We resolved that. It looked like we did not have an issue with fuel any more. We took the client home. But we know that he is a drug addict or in a risk group. We need to do something with him. But we left him. He opened up to me. And then what could I do for him? Our rehabilitation centre works only with adults. We came to the conclusion during the seminars and with our volunteers, colleagues and team that we needed a rehabilitation centre for adolescents. Then we can say - you talked to us, we took you home, but look, there is a centre where you can receive the same services regularly."*

This statement also shows that the focus of work is to fight drug addiction among the clients, not to reduce the risk of HIV infection. Withdrawal from drug use is a long-term goal and cannot be achieved within the framework of the pilot model. It should be implemented through rehabilitation centres and other institutions that specialise in this. That the pilot model showed that there is a need to create rehabilitation centres for minors who have drug addictions or other types of dependences is also one of the achievements of the model.

### Satisfaction of clients

The staff of the model managed to create a relationship of trust and cooperation with the clients of the model. The most active clients were involved in the work process. They went through a training programme and participated in outreach work. The study of the client satisfaction also helped to detect some gaps in the preparation phase: "*We went to the street and worked next to the pharmacy. Together with two other outreach workers. I was given special forms. People were approaching... you can always tell whether a person is using drugs by just looking at them. I approached these people and gave them the forms" (girl, 17 years old).* This opinion is evidence of stigmatized assessments of drug users and the possibility of easily detecting them on the street. During preparation for the outreach work or any other activities, therefore, it is necessary to pay special attention to the development of tolerant attitudes towards the target group and to overcome stigma.

Interviews with clients showed a very high level of satisfaction with the model:

- *"Yes, I like it a lot. People treat you nicely. They respect you. When I come here it seems that my inner personality wakes up. My self-esteem increases. I feel like a person here, and the fact that I am trusted, that I can walk in and talk about it... I like this a lot. I feel welcomed here; we drink tea or coffee and talk about anything"* (girl, 18 years old).
- *"People start saving themselves little by little. Young people come to the rehabilitation centre and ask for help. They trust'* (boy, 18 years old).

Model clients mentioned the friendly attitude of the staff:

- *"The friendship is open. There is no room to be reserved. Everyone is equal, no one is superior to you. No. Our conversations are structured like suggestion-suggestion"* (boy, 18 years old).
- *"Yes, I like everything, it's very cosy, a very friendly environment. The staff members are always very polite, they always offer tea or coffee as well as their support and understanding. We talk a lot about problems people have. We discuss where we will go and work a lot. The staff members are wonderful. Yana Vasylivna, for example, always asks about my mood, how I am doing, she always supports me and I like that a lot. It feels like this person really wants to help, to cheer you up, to talk and support you"* (girl, 17 years old).

The clients expressed a lot of interest in the programme for preparation of leaders. They mentioned that they received all necessary information during training:

- *"We have training sessions, we play games. There are some plastic tests, they go in around. We also chose correct answer while playing. We made a portrait of an outreach worker"* (girl, 17 years old).

### Sustainability of the model

During the implementation 14 specialists and seven outreach workers were trained and got experience in working with MARA. Close cooperation was established with non-governmental organizations, medical institutions and rehabilitation centres. After the official completion of the model implementation and the exhaustion of funding, the project staff continued delivering a full set of services to clients according to the developed standards for service delivery and the referral system.

The issues of rehabilitation and re-socialisation of drug addicted young people and their referral to rehabilitation centres until they turn 18 remain unsolved. Currently this cooperation is taking place based on a verbal arrangement, but there are no well-defined standards. There is also a need to establish a 24/7 centre where clients can come for food, shelter, personal hygiene products, clothing, etc.

It is important to involve clients in planning activities, in order to adjust the services delivered within the model to client needs. During the model implementation the project staff regularly discussed the implementation of the model and its components with clients. As a result of these discussions it became possible to equip Respect so that the clients could feel comfortable there, set up the most convenient schedule for outreach work, add some important and necessary services such as 'hotlines' to the range of delivered services and identify if the clients needed low-threshold services such as food, clothing, personal hygiene products, etc. According to the project staff these continuous discussions led to a substantial increase in trust in staff and increased client motivation to participate in the model.

Social workers, psychologists, health workers, outreach workers, leaders from among former IDUs and volunteers who are qualified to continue working in a specified direction, were trained and gained experience in working with most-at-risk adolescents.

The model allowed for combining the efforts of governmental and non-governmental organizations and for providing MARA-friendly services.

The success of the model was a push to expand work with MARA, providing friendly services not only in Donetsk but also in other cities of that oblast. The experience of the counselling centre "Respect" is shared in Mariupol, Shakhtarsk and Kramatorsk. Plans are to share this experience with all regional centres for family, children and youth in Donetsk oblast by 2014.

## Lessons learned

1. *Preparatory phase*. There was no time allocated for the preparatory phase. Therefore, budget and staff salary planning, the signing of cooperation agreements, organization of assistance to clients, the search for additional financial resources and staff training occurred in the first months after the start of the model's implementation. It is important to make these arrangements before the provision of services to the clients.
2. *Staff stability*. The model coordinator, M&E specialist and outreach workers were replaced. To ensure the effectiveness of the model, it is necessary to promote staff loyalty, motivation for participating in the model and system development to reduce the primary employment workload that arises due to participation in the model. If any staff changes occur, there is a need to develop a clear training plan for new staff in a short period of time.
3. *Staff training*: Project staff training organized by UNICEF had a significant impact on improving service delivery. This training included two types of sessions: on VCT and on case management. One of the most positive aspects of these training sessions was the consolidation of the teams from various regions (Kyiv, Donetsk, Odesa, Mykolaiv). This led to an exchange of experiences and improvement of service delivery within the model.
4. *Expansion of the range of services*. The implementation of an innovative model revealed weaknesses in work with most-at-risk adolescents, namely lack of infrastructure for 24/7 centres for social support and for rehabilitation and re-socialisation of most-at-risk adolescents IDUs. However, additional financial resources are needed to implement these plans. The necessity of 24/7 centres for social support and for rehabilitation and re-socialisation was observed by all parties to the models, but project staff and clients.
5. *Training MARA leaders*. Because there was no previous experience in the recruitment of the target group, outreach workers took several months to establish contact with the target group and develop routes for outreach work. Identification of leaders and their training should take far

more time than the model allowed. During the model implementation, therefore, only those MARA were trained who were immediately motivated to cooperate. No assessment of whether they were true leaders in the target group was conducted.

6. *Flexibility and adjustment of the model.* During the implementation process some adjustments were introduced. They focused on expansion of the target group and re-routing of the outreach workers. These changes were not registered in the proposal, but had a positive impact on the coverage of clients. The possibility of adjusting the project proposal should thus be incorporated to improve the model implementation, respond to the recommendations of staff and M&E representatives, respond to any changes in client needs and expand the target group and range of services. This is important especially for under-studied and poorly structured groups of MARA. External and internal monitoring and evaluation is the most effective tool for timely response to the need for change during the model implementation.
7. *Financial resources*. There is a constant need for additional funds to improve the effectiveness of the model.

## Conclusions

The implemented model proved the efficiency and possibility of services delivery to most-at-risk adolescents, such as injecting drug users and psychoactive substances users, through using the approach discussed above. The main advantage of this model was the involvement of former IDUs in outreach work. This helped to establish contact with the target group and recruit clients.

To further implement this approach within other projects it is important to strengthen the referral component – that is, to physically accompany ]clients or to find other effective ways to encourage adolescents to seek services at other institutions. The referral system used during the model implementation was completely based on approaches that had been developed by centres for social services. Its advantage was that there was continuous control of those adolescents who were referred and requested services.

The component of basic service delivery (food, clothing, hygiene products and shelter) also needs to be strengthened. These services were not included during the preparation for model implementation; clients were offered only some tea with sweets, which according to the clients was insufficient. All projects that are designed for most-at-risk adolescents should include the range of basic low-threshold services, increasing the target group's motivation to participate in the model.

## Contacts for additional information:

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# Model 'HIV/STI prevention, development and adjustment of work methodology on rehabilitation of underage girls-victims of violence, including sexual violence, or involved in commercial sex on the method of "one-stop-shop" – Odesa city

## Relevance of the model

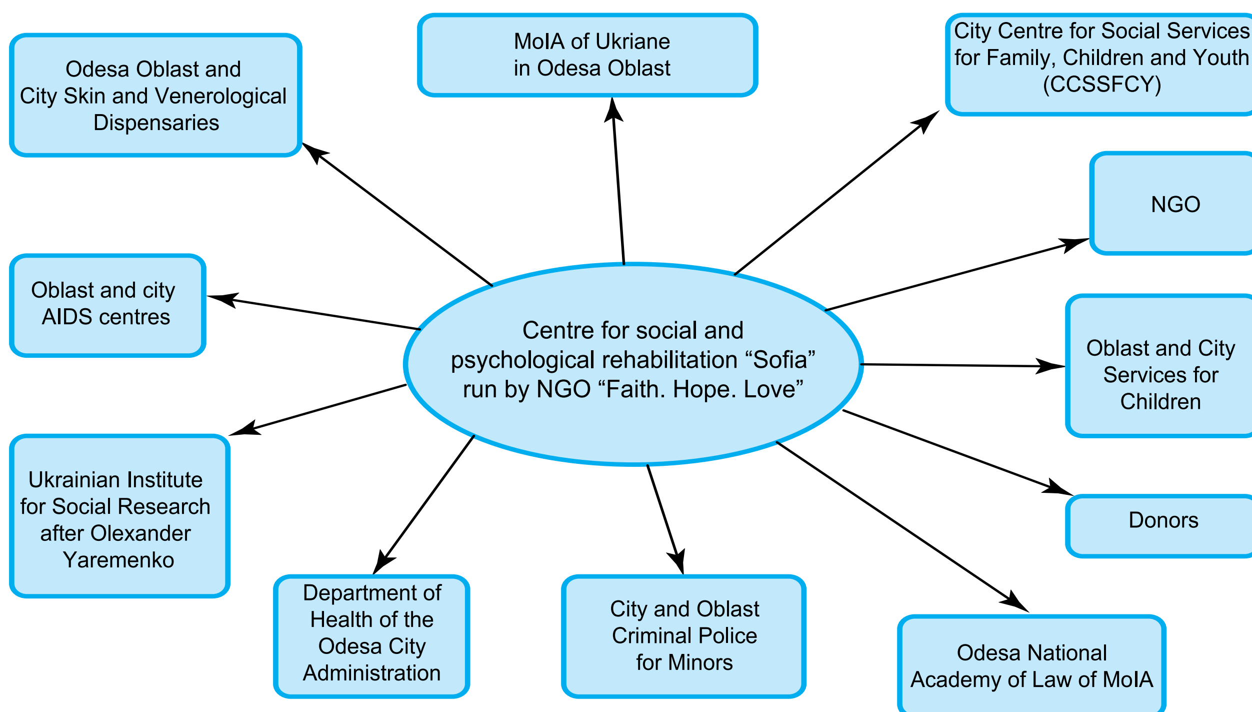
The public movement "Faith. Hope. Love" had previous experience in implementing projects to deliver HIV-prevention and rehabilitation services to female sex workers or those who have suffered sexual abuse and are older than 18. However, the current situation shows that adolescents also require such services. The situation pertaining to adolescents who live in 'crisis' families and often have to take care of themselves is very difficult in Odesa oblast. According to the results of studies conducted by the Odesa Oblast Criminal Police for Minors in 2007:

- Every third adolescent on the streets without any supervision tried using some sort of narcotic substance, including injecting drugs. Half of them mentioned that they did so out of curiosity.
- Three out of four adolescents claimed to be victims of physical violence and half were victims of sexual violence.
- Every fourth child complained about regular problems with nutrition and hunger.

HIV/STI prevention, delivery of support services and rehabilitation are therefore extremely necessary for adolescent groups who practice HIV risk behaviour.

## Model descption

In July 2009 the public movement "Faith. Hope. Love" together with governmental and non-governmental partner organizations supported by UNICEF piloted the model 'HIV/STI prevention, support service delivery, development and adjustment of work methodology on rehabilitation of underage girls-victims of violence, including sexual violence, or involved in commercial sex'. The goal was to test a new approach to work with MARA in Odesa city (see picture 11).




**Picture 11. Scheme of the organizations-partners involved in the implementation of the project Method of the project 'HIV/STI prevention, support services delivery, development and adjustment of work methodology on rehabilitation of underage girls-victims of violence, including sexual violence, or involved in commercial sex' in Odesa city**

**Target group:** underage girls-victims of violence, including sexual abuse, or involved in providing sexual services.

The girls participating in this model were provided with a package of services:

- individual and group psychological training;
- psychotherapeutic training groups;
- legal counselling and assistance in obtaining documents;
- counselling with a narcologist;
- social and medical services (testing for HIV and STIs at the Odesa city AIDS centre, cooperation with medical institutions for medical, social-medical support, treatment and motivation for treatment of diseases diagnosed in partner outpatient health centres, provision with personal hygiene products);
- art therapy;
- group developmental games;
- training for diagnostics and correction of psychological state;
- group viewing and discussions of thematic movies;
- reading and discussions of books;
- training on ethics and aesthetics;
- teaching of socially necessary life skills (preparing food, grocery shopping, housekeeping, personal hygiene skills, safe sexual behaviour);
- general education curriculum (bringing participants to an adequate academic level);
- optional classes based on their interests: basics of life safety, safe sexual behaviour, contraception methods, development of communication skills;
- provision of thematic informational materials adapted for adolescents about HIV/AIDS/STI prevention and drug use;
- professional education with socially required specialisations such as sewing machine operation, hairdressing, and computer use over the course of two months.

The key implementer of the model, "Faith. Hope. Love", performed the following activities to optimise the model and create the conditions for its sustainability:

- Educational and training activities based on the experience of the centre;
- Advocacy to ensure the sustainability of the project and development of services for MARA;
- Development and adaptation of a city 'map' for delivery of social and psychological services, together with local and regional governmental and non-governmental organizations;
- Development of the scientific and methodological basis of the centre, which will facilitate the development of statutory, project and technical documentation for similar institutions, and organization of prevention activities for adolescents-victims of violence, including sexual, in other regions of Ukraine.

## Process of the model implementation

To implement the model PM "Faith. Hope. Love" provided its 'Sofia' centre for social and psychological rehabilitation. It was important that this project was financially supported by UNICEF as well as other partners. The key project partner was 'Geneva Global Philanthropy'. Organizations-partners provided support through delivery of humanitarian help, hand-out materials, etc. The project managed to bring together the interests of many organizations, which ensured its financial sustainability and reduced the cost.

Staff was recruited according to the project task. All staff members (nine persons) had substantial experience in reintegration work with women victims of human trafficking, street children and delinquents. The organization "Faith. Hope. Love" also has experience in development and implementation of innovative work methods with different socially excluded population groups.

Training sessions[11] had a significant impact, especially taking into account the work specifics of the medical institution and the requirements for following safety procedures when working with children. Representatives from the UISR after O. Yaremenko and UNICEF were among the trainers. During the training sessions the implementers of the model could communicate and exchange experience with the implementers of other models (in Kyiv, Mykolaiv, Donetsk).

During the nine months of the model's implementation 36 girls aged 12 to 18 went through the rehabilitation course that "Faith. Hope. Love" held at the 'Sofia' centre.

The 'Sofia' social and psychological rehabilitation centre is located on two floors. All rooms are well furnished and contain all the necessary equipment for the rehabilitation, professional education and accommodation of girls. Material and technical support for the project is very good. There is a need to expand the territory for outside leisure activities; negotiations are in process.

The centre always has a wide variety of informational and educational printed materials that can be taken along.

A sufficient number of transportation vehicles facilitated the process of organizing work (two passenger cars, a Gazel minibus and a mobile out-patient clinic owned by 'Faith. Hope. Love'. Transportation was needed to improve recruitment of girls-participants in the project and refer them to the partner organizations to receive services.

The process of recruitment was positively influenced by the staff's work experience with the target group, different organizations, service providers and medical institutions. The recruitment process of the target group was well set-up. 'Faith. Hope. Love' has multiyear experience in cooperation with the Centres of Social Service for Family, Children and Youth in different rayons of Odesa city and Odesa oblast. This contributed to the recruitment process, which was performed by multiple organizations, such as non-governmental organizations, different service providers, medical institutions and law enforcement agencies (during raids[12]).

### Advocacy and participation of the interested parties

'Faith. Hope. Love' takes an active in meetings of the Coordination Council on AIDS and Drug Dependency Prevention at the Odesa Oblast Administration and the meetings of the Supervisory Council on Adolescent Neglect and Homelessness Prevention within the OSA MoIA of Ukraine in Odesa Oblast (quarterly). The results of the implemented model were presented at the regional and city levels.

## Results of the model implementation

### Staff Satisfaction

The staff survey showed that the staff satisfaction with the training and preparation was relatively high. All nine participants were completely or mostly satisfied with the knowledge and skills they received during the project. However, it is necessary to improve exchange of information and experience among staff members who receive different levels of training and take part in different training sessions and seminars. A well-organised process of exchange of such information will improve the effectiveness of service delivery to the clients.

[11] 'Legal and ethical issues/questions related to work with MARA for delivering HIV/AIDS/STI prevention services' (Mykolaiv city); 'Voluntary counseling and testing for HIV' (Kyiv, Mykolaiv); Techniques for case management with different MARA groups for HIV-prevention' (Kyiv, Mykolaiv)

[12] The oblast criminal police for minors conducts a weekly comprehensive operational and preventative search of the area, i.e. raids. Its purpose is to reveal facts of drug use among minors and their involvement in criminal activity, to prevent homelessness and begging and to bring children back from the streets.

Three out of nine participants consider that they know and understand the general structure of the project, its components, and offered services very well; six participants understand the general structure of the project, but have better knowledge of the set of services they deliver. All project participants understood their roles in the project and carried out their duties.

The project staff did not have any difficulties with record keeping.

There was no negative evaluation of the organization of work: all participants were satisfied with their workload and the work schedule within the project.

Eight out of nine participants were completely or mostly satisfied with the project.

## Client satisfaction

During individual interviews the girls who passed through rehabilitation said that in general they were happy to have the opportunity to spend two months in the centre, where they had the opportunity to attend many different classes. Some of them felt the warmth and cosiness of home for the first time.

– *"I received a lot of new information and learned how to do girls' hair. I learned how to write dictations fast, at first slowly, and then faster and faster. How to read in Russian and Ukrainian. How to clean and cook. It's peaceful here. There are people I can rely on, and if I need anything I can ask. Now I know what HIV, AIDS, drugs, etc. are"* (girl, 12.5 years old, from a single-parent family; her mother is an alcohol addict).

– *"...it is good here, it is warm here, I can eat here, I can wash. What else do you need?"* (Girl, 17 years old).

The study conducted among the project participants also confirmed fears that girls who had been living on the streets for a long time or in other difficult situations would be difficult to immediately establish contact with. The service delivery and involvement in project activities, which were clearly outlined in the schedule, were perceived by most of the girls as hostile or boring:

| Quotes of girls-participants | Staff comments |
|---|---|
| As for the daily routine: *"I don't know, I can go crazy from boredom here; we sit in the room, there's only one TV, we watch movies, I'm sick of them already. We were sitting the whole day yesterday and today is the same thing." "We sit for up to nine hours, watch TV, sometimes we draw. In general we are not talked to, we're just there. They came, sat down at the table and were looking just so we did not leave the room, did not go anywhere."* (girl, 13 years old). | One of the behavioural features of the target group is their unwillingness to live according to clear rules and schedule. Every day the daily schedule is posted on the bulletin board. In order not to overload the girls with conversations, lectures and lessons the staff of the centre purchased a complete set of popular-scientific BBC videos about nature, wildlife, history, geography, culture and art. Videos are alternated with classes. This is confirmed by the girls in their interviews. The rules and living conditions at the centre are thus: girls cannot leave the centre unaccompanied; one two-hour walk in Moscow Park is scheduled for working days and during the weekends there are longer walks around the city, visiting city attractions. Almost none of girls can stay in one place for half an hour; lessons or training sessions create boredom and a sort of protest. Girls also lack the skills to organise their free time themselves. |
| *As for the trust in the staff: "No. Never, they all talk to each other, I never tell them anything, if I have anything I always write it in my notebook; I do not consult with anyone. Yesterday they found my diary and they took it. They gave it to the psychologist and read it. Today the psychologist came to talk to me'* (girl, 15 years old). | It was not a diary; it was a notebook for the Ukrainian language lessons. She wrote that she wanted to die and she felt better only after a talk with the psychologist. Of course, after this she was assigned an additional individual meeting with a psychologist. In fact, such demonstrative behaviour on the part of the girls in this group is understandable. They require more attention, and they want more care and understanding from the staff of the centre. They all get very envious of any manifestation of care by the staff in other girls. |

### Sustainability of the model

The project implementation provided an opportunity for internships at the centre for professionals working in the field of HIV/STI prevention among underage girls-victims of violence, including sexual abuse, or among girls involved in provision of sexual services.

Training about friendly service delivery to vulnerable children (street children, adolescent CSWs, adolescent IDUs, etc.) is to be conducted at the Sofia Centre for Psychosocial Rehabilitation. Training sessions on the methodology of drug use prevention and prostitution and juvenile delinquency prevention are to be conducted at educational institutions (schools, orphanages, vocational schools, universities and childcare facilities).

Currently the project is sustained by PM 'Faith. Hope. Love' with the support of the partner Geneva Global Philanthropy and others. The management of the organization is continuously fundraising.

## Lessons learned

1. *Extension of the time period for service delivery.* Two months for the rehabilitation of girl victims of violence, including sexual violence, or of those who were involved in providing sexual services, are not enough. After the inpatient programme the girls require support with outpatient programmes. The rehabilitation programme should focus on the individual needs of girls and be flexible in term of time.
2. *Recruitment of girls-participants.* During the project implementation the active involvement of girls in the planning and implementation of the project activities and in development of informational and educational materials had a positive impact.
3. *Assessment of the girls' satisfaction.* The study of participant satisfaction with the project demonstrated the complexity of the target group and the difficulty of establishing contact with them. The girls at the centre who have just started their course of rehabilitation perceive their daily schedule at the centre in a rather hostile way. Any requirements of the staff are seen by the majority of the girls as an infringement on their freedom and independence. However, after some time spent at the centre they get used to the routine and develop a more trustful attitude towards the staff. Then their satisfaction with the services provided increases. When working with this target group, therefore, one should consider the sensitivity and vulnerability of these girls, and the need for a more delicate and sensitive approach to working with them.
4. *Advocacy.* To ensure a stable process of service delivery and implementation of activities to improve service delivery to the target group according to their needs, it is necessary to develop an advocacy strategy with the involvement of other stakeholders. Advocacy activities implemented during the project show that a single presentation may not be sufficient to promote the interests of the target group, but will only help to disseminate information about certain successful outcomes; in other words it will be successful advertising. It is important that advocacy activities are carried out at the regional and oblast levels with the involvement of all stakeholders and decision makers.
5. *Financial resources.*
   - It took one year from the time of the writing of the project proposal to the completion of the pilot model. Core inflation in Ukraine was 14.9 per cent in 2009. During budget development for the project proposal it is therefore important to consider average annual or forecasted inflation.
   - Advocacy activities should include elements of fundraising.

## Conclusions

The model in Odesa city was implemented by PM 'Faith. Hope. Love' as one of the components of its activities. The description of the model therefore did not provide a lot of information about material and technical resources or staff training, because this NGO had these resources prior to the beginning of the model's implementation.

Problematic issues for the model remain the short terms that characterize the stays of MARA-girls at 'Sofia' and their further support.

The suggested approach proved the existence of a high demand among the target group for low-threshold services (shelter for two months, clothing, food, etc.). One of the biggest advantages of this approach related to service delivery is that adolescents can receive all necessary services in one place: they can get information and medical, social, psychological, domestic and legal services at the centre.

This service model for most girls represents an intermediary stage of re-socialisation. On the one hand, the short period in at the centre for rehabilitation is extremely important for the target group. On the other, during the next stage of their lives, after leaving the centre, they need professional social support and assistance in solving a wide range of issues related to independent living.

## Contacts for additional information:

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# Model 'HIV/STI prevention and development of social rehabilitation services for adolescent drug users' – Odesa city

## Relevance of the model

Adolescents living and working on the street are in the high risk group for HIV-infection because of social factors and risk behaviour: injecting drug use, provision of commercial sex services, non-use of condoms, etc. When the model implementation started in Odesa city and oblast, there was no monitoring of adolescent drug users, so the number of these adolescents is unknown.

According to the information from a narcologist of the Oblast Narcological Dispensary, in 2009 311 adolescents were registered as drug users, although "this number should be multiplied a few times so that the figure becomes real."

In September 2008, during a working group, the results of the project 'Evaluation of HIV-infection spread among children and youth in Odesa' were summarised. A survey of MARA was conducted within this study. The results showed that 60 per cent of surveyed children and young people and 28 per cent of adults did not have a clue about where they could turn for assistance in case for problems related to drug use.

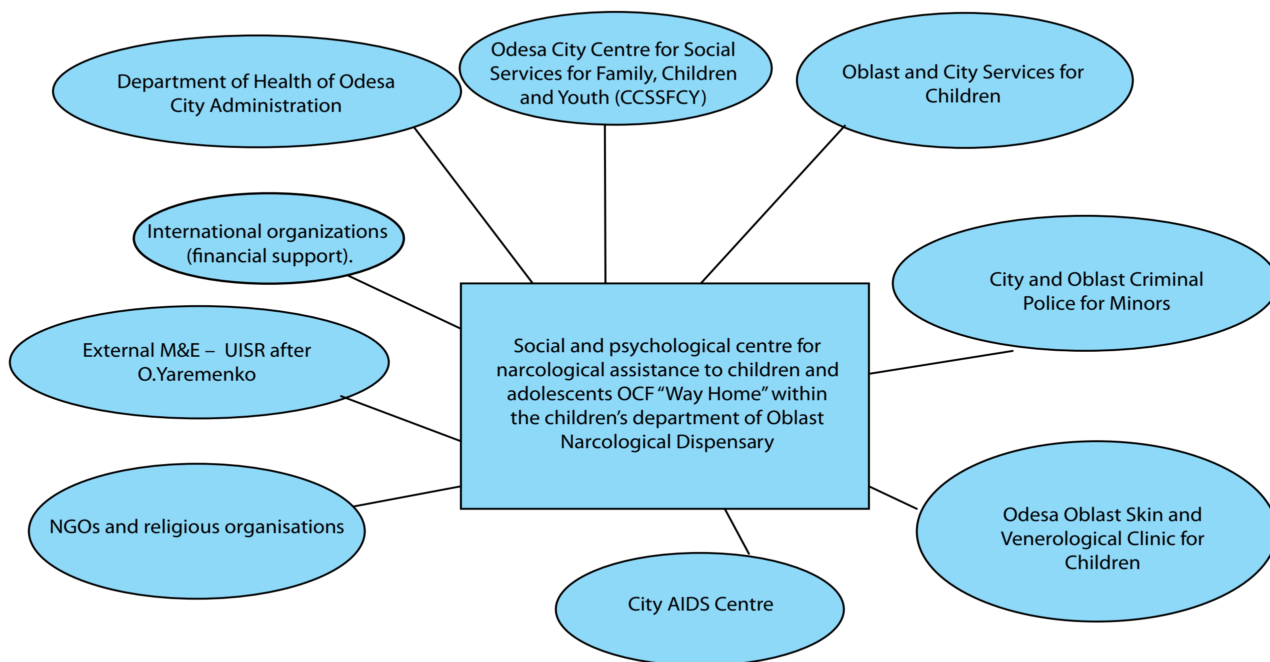
In the beginning of 2009 (before the beginning of the UNICEF project), a social patrol of the OCF 'Way Home' brought children and adolescents to the children's department of the Oblast Narcological Dispensary with further visits and support of the children by a social worker. Analysis of the treatment's effectiveness conducted by 'Way Home' showed that 70 per cent of the children voluntarily leave the centre before completing the treatment or at the beginning stage. The main reasons children do so are these: 1) the programme is boring, there is nothing to do; 2) they are hungry; 3) they decided to go back to their friends; 4) there is no opportunity to take a walk.

It was decided to change the treatment of the target group, which increased effectiveness. 'Way Home' and the Oblast Narcological Dispensary signed a cooperation agreement to unite their efforts and common activities to help adolescents who need drug addiction treatment.

## Model description

'Way Home' and the Odesa Narcological Dispensary, supported by UNICEF, started to implement the model of HIV/STI prevention and development of social rehabilitation services for adolescents-drug users in Odesa city (see picture 12 for the scheme of organizations-partners).

In the framework of the model, a social and psychological centre for narcological assistance to children and adolescents was established within the children's department of the Oblast Narcological Dispensary as an integral system of psychological, educational, recreational, social and legal activities to ensure the personal re-adaptation of patients, their re-socialisation and their reintegration in society under conditions of refusing to use psychoactive substances.




**Picture 12. Scheme of the organizations-partners involved in the implementation of the project 'HIV/STI prevention and development of social rehabilitation services for adolescent drug users' – Odesa city**

**Goal:** reduction of HIV/STI spread among drug addicted adolescents who undergo medical rehabilitation by provision of informational and educational services and social and psychological support within the social and psychological centre for assistance to children and adolescents within the Oblast Narcological Dispensary.

**Target group:** underage young people who are inpatients at the Oblast Narcological Dispensary.

**Main directions:**

- Development of social and psychological components in rehabilitation of adolescents and encouragement of the formation of social skills for MARA;
- Formation of safe behaviour related to HIV and STI for MARA;
- Exchange of experience gained during work with the target group in Ukraine;
- Support of the dialogue between governmental and non-governmental organizations working with the target group as well as with state centres for services for children and MARA and the department of health and the city council;
- Advocacy activity to develop medical and social and HIV-prevention services for MARA and integration of this work into the practice of governmental and non-governmental organizations.

**Main stages of pilot model implementation:**

- Cross-disciplinary case management by a team of psychologists, social workers and medical workers. Development of individual programmes and implementation of rehabilitation activities (social and psychological; social and living, social and environment, social and leisure).
- Delivery of informational and educational services for the target group related to HIV/AIDS/STI, drug addiction and other negative factors;
- Provision of social and psychological support for children in socially dangerous situations after going through a treatment;
- Development/reinforcement of preparation of staff, volunteers and specialists involved in the model;

- Organization of round tables, meetings with governmental and non-governmental organizations, mass media to discuss the conditions for the model sustainability;
- Support for continuous analysis of model implementation, introduction of necessary changes, documentation of experience.

## Process of model implementation

### Preparatory process

The preparation stage of the model was necessary in order to establish a good platform for introduction of innovations in service delivery to drug-addicted adolescents going through medical rehabilitation.

1) *Involvement of partners in model implementation*

To implement the model, OCF 'Way Home' (hereinafter – the organization-implementer) and the Oblast Narcological Dispensary signed a cooperation agreement to combine efforts and take joint action in assisting adolescents who need drug addiction treatment. The model included a comprehensive package of services that contained counseling sessions with a psychologist, lawyer and social worker and classes with teachers and mentors in order to readapt the patients and help them re-socialise and reintegrate into society if case of their quitting psychoactive substances.

Other partners involved in model implementation:

- Department of Health of the Odesa City Administration – counseling and assistance to deliver medical and prevention services to improve the health of project clients
- Oblast and City Services for Children – counseling on protection of the rights of the child; the service regularly carries out raids in locations with street children.
- City and Oblast Criminal Police for Minors – bringing home children after raids, 'taking them back from the streets'.
- Odesa City Centre for Social Services for Family, Children and Youth – social support of adolescents after the completion of the course of rehabilitation, work with crisis families.
- City AIDS Centre – once a week a doctor, along with the mobile clinic of Way Home, visits defined locations (two to three locations per day) and conducts voluntary testing for HIV/STIs.
- Oblast Skin and Venerological Clinic for Children – the clinic provides qualified medical assistance and food for children. The 'Way Home' medical and social centre was established at the clinic. Its goal: to provide access to integrated social and psychological support for homeless children coming to the clinic; to make arrangements for children in socially dangerous situations after their treatment; to reduce the number of children leaving the clinic when they need hospital treatment and hospitalization; to reduce the spread of sexually transmitted diseases and dermatological infections.
- Religious organization (convent) – daily provision of warm food.

Partners agreed on a referral system and support for clients. These were coordinated by 'Way Home' (and implemented by social workers).

2) *Financial and technical arrangements*

The main funding for the model implementation was provided by UNICEF. The organization-implementer was doing additional fundraising and provided resources from other projects. This ensured the financial and technical sustainability of the centre according the needs of the target group.

3) *Staff training*

The project staff had previous work experience with representatives of the target group and gained additional knowledge and skills during training sessions related to the work specifics of the medical institution and to compliance with safety regulations when working with children. During the

training sessions the participants could exchange their experience with the implementers of other models in Kyiv, Mykolaiv and Donetsk. Training was also conducted during team working meetings during implementation.

During the model implementation a few learning and training sessions were conducted for the project volunteers as part of the training for 'peer-to-peer' counsellors.

4) *Plan for model implementation*

The project staff developed a detailed plan-schedule for model implementation which helped to structure the work, organize the process of service delivery according to all deadlines and establish a sequence for all activities.

5) *Recruitment of the target group and delivered services*

Recruitment of the clients was done in three different ways: 1) social patrol (outreach work); 2) referral of adolescents by project partners; 3) self-arrival (adolescents learn about the centre from their friends, acquaintances, relatives).

Within the framework of the model the clients could receive a comprehensive package of services which included:

- Cross-disciplinary case management by a team of psychologists, social workers and medical workers. Development of individual programmes and implementation of rehabilitation activities (social and psychological; social and living; social and environment; social and leisure);
- Delivery of informational and educational services for the target group related to HIV/AIDS/STIs, drug addiction and other negative factors;
- A system of social support and referral to governmental and non-governmental organizations as well as to the partner organizations;
- Provision of social and psychological support for children in socially dangerous situations after going through treatment;
- Supply of consumable materials.

OCF 'Way Home' has considerable experience in the development of medical and social assistance to most-at-risk adolescents. It has been working for more than 12 years with marginalised groups of the population, including homeless adults, injecting drug users, women and 'street children'. The following centres have been established on 'Way Home's' basis:

- An education and health centre for street children;
- A centre for registration and work with poor families and families with many children;
- A community centre and syringe exchange centre;
- A medical and social centre at the Oblast Skin-Venerological Clinic for Children.

'Way Home' helps street children, drug users, ex-prisoners and homeless adults return to normal life. Its specialists have also developed and implemented unique programmes for prevention of child homelessness, HIV/AIDS and drug addiction in Odesa and the Odesa region. 'Way Home' provides legal assistance such as establishment of identity, obtaining and renewal of documents, searches for family members (relatives), assistance in deprivation of parental rights, solutions for children in conflict with the law (usually for storage and distribution of drugs), etc. Children can participate in the rehabilitation programmes at the Education and Health Centre for Street Children. Specialists help them to restore their physical and psychological health, rid themselves of addiction and return to normal life. Occupational therapy is one of the important elements of the rehabilitation programme.

6) *Logistical arrangements*

The following institutions were involved in the model implementation:

- the social and psychological centre for narcological assistance to children and adolescents within the children's department of the Oblast Narcological Dispensary; the administration provided one room, and later another room, for individual classes with a psychologist;
- 'Way Home' central office,
- organizations within 'Way Home': centre for children, medical and social centre, community centre and syringe exchange centre, centre for registration and work with families with many children and low income families,
- medical institutions: infection disease doctor at the City Centre for HIV Prevention, Oblast Skin and Venerological Clinic for Children.

All premises were equipped with furniture and necessary equipment, corresponded to the principle of friendliness and were comfortable for clients. Material and technical supplies were in accordance with planned standards.

7) *Consumable and informational materials*

Consumable materials included informational and educational materials (pencils, notebooks, playdough, painting supplies, pens were funded by UNICEF), personal hygiene products (obtained as charity items from local pharmacies), clothes (from the campaign Help, from the convent and from charitable campaigns to collect clothes from local people; other clothes were purchased with funds from other projects).

The following informational materials were developed and printed:

1) Booklet 'Enjoy Your Life Without Drugs';
2) Booklet 'Learn About Yourself';
3) Scientific-methodological manual 'Methods and Forms of Work with Drug-Addicted Adolescents' (now being prepared for publication).

All informational materials were developed taking into account the gender and age specifics of the clients of the model. They filled gaps in providing information to children in the target group outlining the consequences of using narcotic substances, as well as drug abuse prevention and healthy lifestyle promotion. The methodological manual helped share experience and the achievements of the model with specialists working on this issue, especially with those who work distantly from Odesa region and lack access to new methods of working with MARA.

8*) Project staff: motivation, preparation, management and supervision*

Staff members (11 persons) were recruited according to the tasks of the model. All staff members had work experience in the social area, including with most-at-risk groups in particular. The model coordinator supervised the implementation process. Every staff member understood the model's strategy and tasks.

Staff involved in the model implementation:

- A project coordinator was responsible for attaining the model's goals of the model and managed the implementation process (one person);
- A lawyer provided consultation to MARA and their parents on social and legal issues (one person);
- A teacher organized the general educational process (one person);
- A psychologist defined the needs of adolescents, developed psychological rehabilitation programmes, evaluated implementation results and conducted group sessions for self-help and mini-training sessions for the target group (one person);
- Mentors ensured comfortable conditions for every child, the formation of personal hygiene habits and self-service skills and conducted activities pertaining to social-environment orientation (three persons);

- An accountant ensured that all the payments were made according to the work plan and the project budget, prepared financial reports and received approval from the project coordinator (one person);
- A social worker provided social support to adolescents (one person);
- A narcologist for adolescents performed the following key functions: organization, diagnostics, counseling, treatment and prevention (one person).
- An art therapist worked with children to develop their creative skills and switch their focus from socially negative models to art (one person);
- 'Peer-to-peer' counsellors (two persons).

9) *Informational and educational activity within the framework of the model*

On 29-30 October 2009 (in the urban-type village Kodyma, Odesa oblast) a practical seminar on 'Specifics of work with most-at-risk drug addicted children' was conducted for representatives of oblast and city shelters, centres for social services for youth and the city rehabilitation centre (30 participants). The topic of the seminar attracted the interest of the participants, especially psychologists and educators working with drug-addicted adolescents in shelters.

All the specialists received information about the work of the social and psychological centre within the narcological dispensary and on services delivered to drug-addicted adolescents. During the seminar it was identified that there was a need for practical knowledge in this area.

A set of primary documentation was developed specially for the model, in order to support programmatic activity and monitoring: staff documentation (contracts, technical tasks, etc.); a work schedule for staff involved in the project; cards/questionnaires for project participants; report forms for social workers, doctors, psychologists and other specialists; accounting records for project activities (a list of participants, agenda/programmes of activities, protocols); write-off certificates for consumable materials, etc.

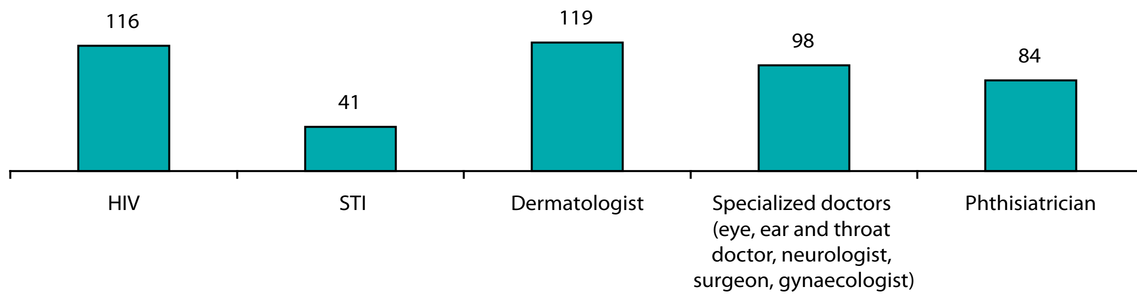
## Activites during model implementation

*Coverage of the clients*

During the model implementation:

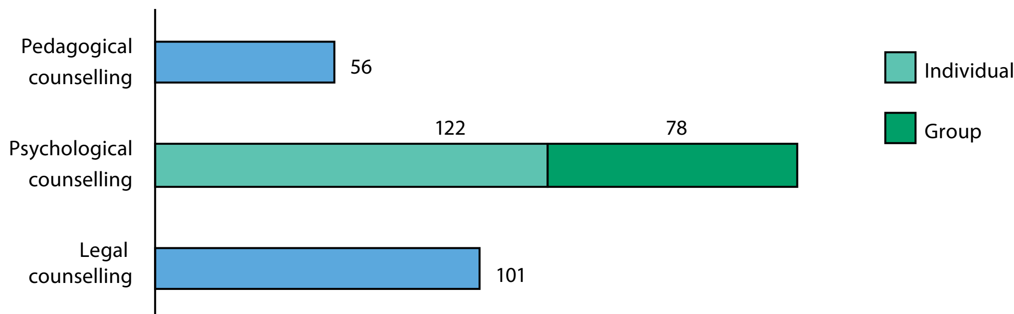
- **152** adolescents aged 12 to 18 went through counselling with a psychologist; **63** out of **152** were referred for in-patient treatment;
- **56** adolescents went through a complete course of medical, social and psychological rehabilitation. They received legal assistance (establishment of identity, obtaining or renewal of documents, search for relatives, assistance in deprivation of parent rights, solutions to certain legal problems (mostly for storage and distribution of narcotic substances, etc) and also informational and educational services.
- **7** adolescents out of those who were referred for in-patient treatment did not complete the course of treatment due to:
  - Disturbance of the regime – they left and returned to the centre a few times (four adolescents);
  - Leaving the centre and never coming back (three adolescent, one of whom has since died).

Within the framework of the model the clients could have themselves examined and tested for HIV, STIs and other diseases (see picture 13):



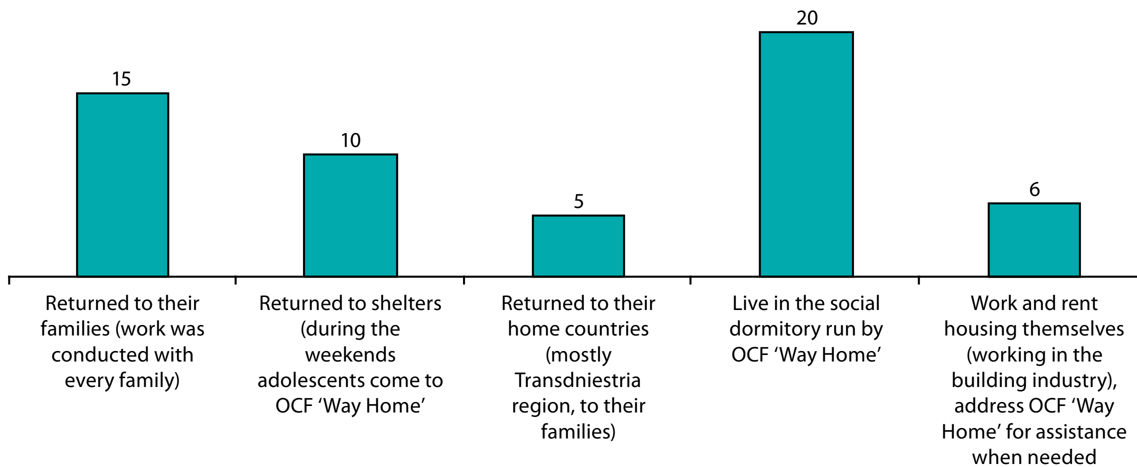

**Picture 13. Number of examinations of clients,** *number of examinations*

Specialists conducted continuous counseling sessions with the clients of the model to ensure the delivery of psychological, legal, pedagogical and other services (see picture 14).




**Picture 14. Number of counselling sessions conducted by the staff,** *number of counselling sessions*

After treatment and rehabilitation, none of the 56 adolescents went back to the streets (see picture 15).




**Picture 15. Location of the clients of the model after the course of treatment and rehabilitation (N=56)**

The project narcologist and psychologist counselled parents whose children have drug addiction problems (currently five families in Odesa city).

The decision was made for the specialists from the social and psychological centre to participate in the seminars conducted by the Service for Children for workers at the regional shelters.

Over seven months of project implementation the project team worked coherently. The recruited staff had significant experience in working with the target group. This had a positive influence on implementation.

### Advocacy and participation of interested parties

Advocacy activity was mostly related to participation in meetings of the Oblast coordination council's health division. Verbal agreements were made with the service for children, the criminal police for minors, the city AIDS centre, the oblast skin and venerological clinic for children, the city centre for social services for family, children and youth and the health and education departments of the city administration in order to carry out round tables and press-conferences.

Specialists from the city administration of social protection, the health and education departments and the mass media were actively involved in the project to ensure further sustainability of the Social and Psychological Centre's programme. An advocacy plan was implemented in accordance with the project proposal.

The following round tables were conducted within the model:

- 'About the concept of integrated prevention and rehabilitation of MARA developed by the working group' for the representatives of education, health and social protection departments and school psychologists (6 August 2009, Social and Psychological Centre for Assistance to Children and Adolescents within the Oblast Narcological Dispensary);
- 'Quality improvement of social and psychological services for patients of the in-patient department for children at the narcological dispensary' for representatives of the education, health, and social protection departments and for psychologists and the mass media (22 December 2009, Social and Psychological Centre for Assistance to Children and Adolescents within the Oblast Narcological Dispensary).

## Results of model implementation

### Staff satisfaction

The staff survey showed a high level of satisfaction with the preparation for the project: staff members of the organization delivering services were completely or mostly satisfied with the obtained knowledge and skills during the project.

- 8 out of 11 participants consider that they know and understand very well the general structure of the project, its components and offered services;
- 2 participants understand the general structure of the project, but have better knowledge about services they personally deliver;

The project staff did not have any difficulties with record keeping. Feedback from the project staff and clients about consumable and informational materials was very positive.

Management and staff supervision: working meetings of the project team were conducted every Friday.

The project staff had a very strong non-financial motivation, which was based on active engagement with socially important issues and the desire to develop individually and professionally.

*"We approach each client not as a drug addict, but as an adolescent who needs psychological rehabilitation, because most of them are from difficult families. At first we help to resolve the internal problems of an adolescent, the problems that pushed him into that"* – a project staff member.

It should be mentioned that there was no negative evaluation of work process organization: all participants were satisfied with their workload and work schedule within the project.

Salaries caused partial dissatisfaction for 3 out of 11 workers. The project staffers often had to spend their own money to buy small presents for children undergoing rehabilitation.

## Client satisfaction

Adolescents who are currently in the in the in-patient department give very positive feedback about the organization of the project. They did not have to wait long to receive services. They were very satisfied with the delivered services and none of the interviewed adolescents had to face disrespectful, humiliating attitudes from the project staff.

Adolescents had a very high level of trust towards the project staff that delivered services. To the question '**how do you show your trust?**' an adolescent replied:

*"Arina (the project psychologist) always helps somehow. If I have any problems she will always listen and help. It's never happened that she said something bad or hurt me, she always makes things better."*

Everyone who received services from the specialists trusted them completely. This proves that project work with adolescents-patients of the Oblast Narcological Dispensary was well-organized.

The clients themselves also emphasise the positive changes in their lives after their participation in the project. Usually these changes concern a higher level of education, more motivation to care for their own health, increases in self-esteem and in the extent to which they value their lives, formation of new social networks, new goals and improved relationships with parents.

*- "When I lived on the street, before I got here, I did not think that there were people like these are here; people who can make you interested in something else than in a 'booty bump'[13]. When I got here people treated me well. I have new interests. We do art therapy, work with computers, on the Internet. I wish there were more teachers and children so they could come more often. I want to learn how to work with Photoshop. I want to become a designer, I can do a bit already, I was given some video lessons on Photoshop. I wish we had a teacher, because video classes don't explain too well how things should be done. I quit using drugs, I have no interest in drugs any more, I have a new life now, I've begun to study. I want to find a job, have a family. I want this project to continue because we do not want to go back to the street. We don't have anywhere to go. We want to be given a chance so that we can study and go on with our lives." (Boy, 18 years old, from a single parent family; he has been living on the street for 10 years and has used injecting drugs - 'booty bump').*

*- "When I came here a lot changed in my life. I even want to quit smoking a bit. I don't drink beer now, I don't use drugs, nothing. They treat me well here. Everyone. Normal friends. I don't sniff glue anymore. As I said before, I don't even drink anything. And all our mentors treat us well. All of them. When we need anything, we address Sergiy Oleksandrovych (a narcologist at the Oblast Narcological Dispensary). I don't want to leave this place. I want to have teachers here; for example, how do you say it....a trainer, a sports trainer' (Boy, 14 years old, from a difficult family; he lived on the street for more than six years and used inhalants; he saw his mother for the last time two years ago).*

*- 'I quit smoking, I don't drink, I do some sports - together with one of the guys, with Vanya, we go outside and train. I don't want to smoke or drink. I want to change my life, to what it was before. I will go home and see my mother, everything will change. I will get a passport, will get a job, everything will change in my life. But of course I'll be coming back here, to visit...'.[14] (Boy, 18 years old, from a difficult family; he lived on the street for five years and used inhalants).*

[13] Cathinone ('booty bump') – drugs made from medicines containing phenylpropanolamine, with the addition of manganese.

[14] Assessment of participation in the model shows positive results, but this is not an indicator of the model's impact on the lives of clients. The model was implemented during a relatively short period of time, so it is impossible to speak with confidence about the lives of the clients in the future, and thus to evaluate the model's impact.

### Model sustainability and main risks

The model is currently sustained by the OCF 'Way Home'. 'Way Home' is continuously fundraising. Project staff members, however, have doubts about the future of the model, which causes staff dissatisfaction because the seven-month timeframe does not give an opportunity for seeing the results of work, especially in terms of its psycho-corrective and social components.

The project staff managed to establish a friendly environment and adopt a tolerant attitude towards clients. They therefore find it difficult to refer their clients to other organizations, because not all specialists delivering medical-social services are trained for work with adolescents who need a special friendly approach and to work with people who understand their psychological features.

## Lessons learned

1. *Staff training.* Key points to consider when organizing staff training: the initial level of education and qualification of the staff; training should precede the beginning of project activity and should have a special focus on adolescent psychology (especially motivation and counselling) and on work ethics; training activities should consolidate various stakeholders for further networking; it can be useful to supplement training with exchange of work experience between close prevention models (project substructures should be visited, as was done during the UNICEF training).
2. *Recruitment of clients.* At all stages of the project it is important to involve clients in evaluation of informational materials, in escorting other adolescents to doctors, in assisting during preparation of events, etc.
3. *Obtaining information about clients.* When contacted for the first time by staff, clients are often embarrassed to provide true information about themselves because they do not trust the specialists and fear that the information will not be confidential. The information recorded in the primary assessment form, therefore, is often not completely true. During the process of rehabilitation, as an adolescent becomes more open and shows more trust in the specialist working with him/her, the information should be confirmed via a questionnaire for clients.
4. *Flexibility of the project proposal.* It should be foreseen that during the implementation process the project proposal can be adjusted or slightly changed based on the needs and recommendations of clients and staff recruited during the implementation process. Specification of goals, target groups, project components and M&E indicators should be performed taking into account the ideas of the recruited work team in the first quarter of the project.
5. *Financial resources.* There is a constant need for additional funds to improve the model's effectiveness, given the changing needs of clients.

## Conclusions

The new model indicates the possibility of effective work taking place at the Department for Children at the Narcological Dispensary. There is an acute need for adolescent IDUs to undergo rehabilitation services. Surveys of the staff and clients showed a high level of satisfaction with the services the model offered. An important component of rehabilitation for adolescents is the social one. Therefore, social workers, psychologists and pedagogues should be involved in service delivery to adolescents. During project planning it is necessary to take into account that the delivery of such services increases project costs.

Lack of financial stability to ensure the existence of the department after exhaustion of the funding provided within the model indicates that there is a problem for the Odesa region and Ukraine in general when it comes to establishing a specialised department for children in a narcological dispensary. The approach to service delivery for young IDUs is therefore effective and ready for implementation, but the activities require financial resources and support from decision makers in order for the project's work to continue and for such activities to take place at other institutions and organizations.

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# Model 'Provision of access to integrated health services, social services, HIV/AIDS/STI prevention programmes for adolescent girls-commercial sex workers' – Mykolaiv city

This innovative model was designed to ensure maximum access to integrated health services, social services and HIV/AIDS/STI prevention programmes for adolescent girls-commercial sex workers. It was the first model designed for work with adolescent clients in Ukraine. Its development was based on the data indicating a high level of risk behaviour among adolescents-FCSW, data that was obtained via UNICEF studies. In particular the following phenomena were defined: non-use of condoms during sexual contact with clients, injecting drugs use and a low level of knowledge about HIV/AIDS transmission compared to adult FCSWs. The model was implemented in Mykolaiv city due to the high prevalence of HIV/AIDS in the target group there. ICF UNITUS was the key implementer due to its extensive experience in the implementation of interventions for FCSWs.

The model was implemented in 2009. During this time period 117 adolescents-FCSWs were recruited as clients. Specialists from the Ukrainian Institute for Social Research after Olexander Yaremenko and representatives from SCCFYS and UNICEF and international consultants made monitoring visits once every two months to study the model implementation process and evaluate its results. To better understand the effectiveness of the model, a number of additional studies were carried out: cost evaluation, a study of client and staff satisfaction and a study of mobile communication with clients as a part of intervention.

The model for HIV prevention among adolescent FCSWs that was established on the basis of existing programmes for adult FSCWs includes delivery of various HIV/AIDS prevention services, treatment and advocacy. At the community centre for adolescent FCSWs girls are offered group and individual counselling by social workers, a psychologist and a lawyer. Medical services, including diagnostics and treatment of STIs and HIV, are delivered by project partners: the oblast skin and venerological dispensary, the AIDS centre and the clinic for women. The outreach team, the mobile gynaecological clinic and trained 'peer-to-peer' counsellors from the target group ensure the involvement of adolescent FCSWs in the project. A system of referrals has been developed and includes services delivered by governmental social services, health care institutions, NGOs, etc. The project team is actively cooperating with the department for juvenile delinquents, as well as educational institutions that refer adolescent FCSWs to ICF UNITUS. A low level of client loss during referrals is ensured by the physical escort of each adolescent by a social worker.

The demand for delivered services far exceeded any expectations. The ICF UNITUS project team planned to recruit 100 adolescent FCSWs over 11 months of the project, but this number was exceeded in five months. A study of client satisfaction showed an increase in knowledge about HIV/AIDS as well as motivation to search for services. All (N = 69) surveyed clients said they would recommend the project to their peers. One of the main difficulties of this model is the restricted capacities of the community centre to meet high demand and the need to develop a mechanism of client rotation.

More detailed information about this HIV/AIDS/STI prevention model for girls-FCSWs and its results can be found in a separate analytical report (see 'Adolescents-female commercial sex workers in Ukraine: results of the targeted intervention model': analytical report/UNICEF, Ukrainian Institute for Social Research after O. Yaremenko. – K., 2010. – 100pp./http://www.unicef.org/ukraine/ukr/)

# General conclusions

The experience gained during the implementation of the project 'HIV prevention among most-at-risk adolescents' in certain cities of Ukraine proves that the success of prevention programmes is based on an accurate and reliable evidence base. Comprehensive review of the legal framework and implementation of state policies on HIV infection among vulnerable adolescents and most-at-risk adolescents, collection and analysis of data on the characteristics and structure of the target groups of adolescents and the features of their behaviour, qualitative research on the availability and accessibility of health and social services and assessment of potential key partners and non-governmental HIV-service organizations – all of this provided a sound informational base on which to determine the needs of the target group of adolescents and the barriers to HIV prevention in their environment. The knowledge obtained helped to unite governmental and non-governmental organizations working with most-at-risk adolescents. Strategic information helped in selecting the models for prevention and in developing regional action plans to reduce the risk of HIV infection among MARA. Available information helped in deciding on the selection of target groups in each city, on prevention models and partner on organizations for implementing the selected HIV prevention models among a selected target groups of adolescents.

Piloting or testing of specific HIV prevention models among MARA was intended to summarise the results and lessons learned during implementation at the individual model level and to lead to generalized recommendations and sharing of experience.

With technical assistance from UNICEF five pilot models were implemented in four cities of Ukraine. Each of the models included innovative approaches for Ukraine in terms of service delivery to MARA. The experience gained from the pilot models can be shared with other organizations and institutions to deliver services to MARA, taking into account the advantages of the models, the resource requirements, the availability of partners and the lessons learned.

The piloted models became the first comprehensive approaches to delivery of MARA-friendly services for HIV prevention and involved the largest number of required partners. During implementation 1,795 most-at-risk adolescents became the clients of the model in four Ukrainian cities (Kyiv, Donetsk, Odesa and Mykolaiv).

A few generalisations about the factors influencing the effective implementation of the model can be made. The success of the projects depends on *political support* at the regional and city levels and on implementation of *advocacy activities* that help to form the *project and a MARA-friendly environment* and to attract *additional resources*. A *multidisciplinary team* should be formed to deliver services and meet the needs of MARA. The current structure of organizations providing HIV services requires *inter-sectoral* coordination, combining the efforts of governmental institutions that provide services for children and youth and non-governmental organizations. Difficulties with gaining access to MARA groups require the *involvement of adolescents themselves* to disseminate information about the project and services and to recruit clients.

The limited time period for the model's implementation (the duration did not exceed 12 months) prevents assessing the number of HIV cases that were prevented among most-at-risk adolescents. However, the delivered HIV-prevention services provided access to health and social services for MARA, established an adolescent-friendly environment and generated positive experience in terms of meeting the needs of adolescents. All of this will undoubtedly reduce the number of new HIV cases among most-at-risk adolescents in the long run.

The results of the piloted models prove the necessity, appropriateness, relevance and feasibility of: (a) inclusion of most-at-risk adolescents in the target groups of HIV-service organizations, (b) integration of HIV prevention services into the existing service packages for adolescents offered by the Social Services for Families, Children and Youth, (c) integration of health services for adolescents into specialised medical institutions.

To enhance the response to HIV in the adolescent environment it is important to share experience, consider lessons learned and mistakes to be avoided and eliminate existing barriers. Performance indicators and results are quite often used to evaluate different projects. It is, however, equally important to study and analyze the implementation process, so as to allow for learning from mistakes and foreseeing and preventing possible complications. The conducted studies, as a part of a system of continuous monitoring (of both internal and external components), analysis and evaluation of the model implementation and of discussion of the results by the implementing teams, would allow for generalising the lessons learned. This would be useful to those who plan to prepare and implement projects aimed at different groups of adolescents, and particularly at most-at-risk adolescents.

### Lesson 1

The **first conclusion and lesson** therefore concerns the phase preparatory to the implementation of interventions.

Before planning activities for HIV prevention among MARA one should analyse the available information and if necessary conduct studies to collect an evidence base and identify potential partners. This will guard against making errors in planning and will allow for meeting the needs of the target groups.

Development and implementation of the pilot models were based on data from sociological surveys among most-at-risk adolescents and official statistics available to the organizations that implemented the models. These data were used to identify the major risk behavioural practices typical for MARA and the basic needs of different groups of adolescents to be considered during the service delivery. Approaches to the service delivery were developed by the same specialists who later were involved in the implementation of the models.

### Lesson 2

The **second lesson concerns the initial phase** that precedes the core service delivery activities.

The initial phase is that period of time during which the main activity has not yet started and when the staff is being trained (especially in cases when the target group is a MARA group with special needs and social and psychological particularities), the project team is being formed, a clear project plan and schedule of services is being agreed upon, a strategy for recruitment of clients is being developed and other issues are being discussed. Sometimes such a phrase is not foreseen. This creates the risk that any activities that have started may require substantial adjustment and will have to be designed 'on the fly' or redesigned. They could develop in the absence of a strategic vision.

Conclusion: the initial stage should be planned to take place during the first month of the project. This time should be used to sign cooperation agreements with partners, conduct necessary training and do mapping for the efficient recruitment of target groups. For coordinated activities it is important to have a clear project implementation plan, with a complete list of all events and activities foreseen and the defined responsibilities of partner organizations and the functions of each specialist and project team member. Internal monitoring and interim project implementation evaluation activities should be planned. A record keeping system for clients and services, exchange of information and a referral system should be agreed upon between the partners. Another challenge at this stage is to ensure political support for the project. The existing coordination structure (interagency coordinating councils, working groups, etc.) can be used for this.

The lessons related to the various aspects of the implementation are also important.

## Lesson 3

**Work with the staff** takes place during the entire project period and provides for training, development of teamwork, motivation and assurance of staff stability.

*Staff training.* Key points to consider when organizing the training: the initial level of education and qualification of the staff; the training should precede the beginning of project activities and the central focus should be on adolescent psychology (especially motivating, counselling) and the ethics of working with children and adolescents and most-at-risk groups; training activities should unite various stakeholders for the sake of further cooperation; it may beneficial to combine training with exchange of experience between teams working with related prevention models (project substructures can be visited, as was done during the training that UNICEF organized). The training that UNICEF organized included two kinds of training on VCT and case management, and had a significant impact on improving the service delivery. One of the most positive aspects was the consolidation of teams from various regions (Kyiv, Donetsk, Odessa, Mykolaiv) during this training. This promoted exchange of experience and improvement of service delivery within the models.

Regular (monthly) staff meetings were extremely important. Their absence leads to misunderstanding of individual model components and of the responsibilities of other team members. Meetings foster a comprehensive approach to service delivery to adolescents and increase the effectiveness of referrals. All team members must completely understand the approach to service delivery and there must be a common work system; otherwise the target group receives conflicting messages.

*Staff stability.* It is necessary to ensure a permanent staff composition. If staff members change and new specialists join the team it is important to develop a clear plan for training them fast. To implement the model effectively it is necessary to ensure staff stability, motivate staffers to participate in the model and develop a system for adjusting their workloads at their main places of employment due to their participation in the project.

## Lesson 4

**Recruitment of potential clients** should be not only planned carefully, but also conducted on a regular basis during the whole period of service delivery.

Continuous collaboration of team members with clients, especially with their leaders, provides an opportunity to identify locations for street work and to track and respond to the migration of the target group. Adolescents in difficult situations (e.g., who have been living for several years are on the street) were easier to get in contact with and more motivated to participate in the project. Successful recruitment and retention of adolescents depend on adherence to ethical principles and adequate responses to the interests and needs of each adolescent. Adolescents who have negative relationships with their parents are against informing their parents or relatives about their risk practices, their participation in the project or services they receive. If they have no previous experience in recruitment of the target group, outreach workers will need time to establish contact with it and develop routes for outreach work. This process can be speeded up through close cooperation with those organizations and with individuals who can 'enter' the target groups and are trusted within them. Identifying leaders among MARA and training and motivating them create a bridge to MARA and allows recruitment of potential clients at all times.

### Lesson 5

**Referral system**. The experience of model implementation showed that the adolescent group requires a stronger process of referrals to ensure the physical escort of clients to other organizations/ institutions to receive services. This requires additional human and financial resources, but will help in retaining clients and ensuring that the maximum number of services is delivered. A necessary component in the implementation of the model is thus physical escort of the client by a staff member to the organization to which he/she was referred. Non-taking into account this condition during the referral leads to the loss of clients.

### Lesson 6

**MARA needs significantly exceed the package of HIV prevention services.** Service delivery within the model should satisfy client needs to the greatest extent possible.

*The features of each group of adolescents indicate that there may be a need to expand the list of services and allow more time for service delivery.* For example, two months are insufficient for the rehabilitation of girls-victims of violence, including sexual violence, or of girls who were involved in providing sexual services (in terms of the project in Odesa). After an inpatient programme, the girls need to be supported through outpatient programmes. A rehabilitation programme should focus on the individual needs of girls and be flexible in terms of time. The models implemented in Kyiv and Donetsk lacked low-threshold services that could meet the basic needs of the target group (food, clothing, shelter, etc.). The models also lacked free of charge health services, services for rehabilitation from drug and other dependencies and legal support for HIV-positive adolescents or their parents or guardians from other cities.

### Lesson 7

**Flexibility in the project activities**. The pilot models were adjusted during implementation: the target group was expanded, outreach workers were re-routed. These changes were not registered in the proposal, but had a positive impact on coverage of clients. The possibility of adjusting the project proposal should thus be incorporated in order to improve model implementation, respond to staff recommendations and the conclusions of monitoring studies, respond to any changes in client needs and expand the target group and the range of services. This is especially important for under-studied and poorly structured groups of MARA. External and internal monitoring and evaluation is the most effective tool for timely response to the need for change during model implementation. Specification of the objective, target group and components of the model and M&E indicators should be performed with regard to the accumulated experience of the team during the first quarter.

*Expansion of the range of services*. The needs of most-at-risk adolescents can only be met on condition of immediate and continuous improvement and expansion of the range of services for MARA and their families; of delivery of basic services (food, clothing, hygiene products, shelter), especially to adolescents living or working on the streets; and of development of algorithms for counselling and for the social and medical support of adolescents. Adolescents also have to be involved in the work of friendly clinics and of other specialised health facilities.

### Lesson 8

**Funding and logistical resources**. It is necessary to search for additional resources in order to improve and expand activities within the model. During implementation additional resources were used to provide the necessary premises for services delivery, handout of informational materials, mobile connection, transport, etc. Additional funds are important to improve model activities given the changing needs of clients and the wide range of needs of MARA.

During budget development for a project proposal it is important to consider average annual or forecasted inflation.

### Lesson 9

**Involvement of representatives of the MARA target group.** To meet client needs it is essential to involve adolescents in the assessment of services and in planning activities. At various stages the involvement of the clients in planning and implementation of project activities, development of informational and educational materials, escorting other adolescents to partner organizations and assistance in preparation of events had a positive impact.

### Lesson 10

**Legal support.** Recent experience has showed the need for streamlined legal support of clients, especially those who have received a positive rapid HIV test result, in order to confirm their HIV status and ensure delivery further services. In the long term plans are to develop appropriate approaches to service delivery to most-at-risk adolescents aged from 10 to 14 years because this group is the most difficult to access and the least covered by prevention services. This group also requires legal regulation of service delivery, with application of the principles of anonymity and confidentiality.

### Lesson 11

**Advocacy.** To ensure stable service delivery it is necessary to develop an advocacy strategy with the involvement of other stakeholders. Advocacy activities implemented during the project show that a single presentation may not be sufficient to promote the interests of the target group; it will only help disseminate information about certain successful outcomes. In other words, it will be a successful advertising. It is important that advocacy activities be conducted regularly and be focused (that is, they should take into account the goal in work with specific target audiences). They should involve stakeholders, including decision makers and MARA representatives, if this does not violate ethical work principles. These activities should also include some elements of fundraising.

### Lesson 12

**Monitoring and optimisation of monitoring methodology.** Planning and conducting internal monitoring of project implementation is an important tool for effective model implementation, timely adjustment of activities and improvement of services.

*Client and service database management* helps to monitor the recruitment process and the use of services and provides information about the characteristics, structure and needs of clients. Such a database could also include contact information, the access to which should be limited. Adolescents often agree to provide a mobile phone number, which is useful for making quick contact. However, such numbers occasionally need to be changed.

*Obtaining information about clients.* When contacted for the first time by the staff clients are often embarrassed to provide true information about themselves because they do not trust the specialists and are afraid that the information will not be kept confidential. The information recorded in a primary assessment form is often not completely true. During rehabilitation, as an adolescent becomes more open and shows more trust in the specialist working with him/her, information about him/her must be verified and entered in the database.

*Assessment of client satisfaction.* Assessment of client (project participant) satisfaction indicated the complexity of the target group and helped in establishing contact with them. For example, an important result was obtained during the first survey conducted to determine the level of satisfaction with the project in Odesa. Girls at the centre who had just started a course of rehabilitation perceived

the precise schedule in a rather unfriendly manner. A majority of the girls saw the staff's requirements as infringements on their freedom and independence. This was taken into consideration during individual and group sessions with them.

*Assessment of staff satisfaction*. This component of monitoring is also important in order to consider the capacities and needs of the specialists involved in the project and provide timely assistance or additional training.

To *optimise the monitoring and evaluation* of the models it is important to consider the following factors:

- The importance of staff cooperation with the external M&E coordinators. Studies among clients who are not located in one place and require a friendly attitude depend on the willingness of the staff to negotiate with them and arrange interviews, as well as motivate them to provide information. It is also important to maintain bilateral cooperation and coordination between the staff and those who conduct the external monitoring, or the interviewers;
- The experience with the client surveys within the individual projects (especially surveys of girls involved in commercial sex) proved that it is possible to use mobile phones to conduct individual interviews. The project staff should receive the consent of adolescents that their mobile phone numbers should be given to interviewers to conduct the survey;
- It is important to take an individual approach to project staff members in assessing their satisfaction. This means priority should be given to individual in-depth interviews over focus groups;
- External monitoring visits should be limited, well-planned and coordinated with the plans of the project, so that they do not distract the staff from work or violate the usual mode of operation of the project.

* * *

Synthesis and structuring of lessons learned as a result of the implementation of five pilot models for HIV prevention and service delivery to most-at-risk adolescents can certainly be augmented with a list of problems and barriers.

The most acute are political instability; stigmatisation of and discrimination against the groups most at risk of HIV infection (IDUs, FSWs, MSM); violation of human rights (which is even more serious when it affects minors and underage children); lack of a government tradition of contracting out service delivery to non-governmental organizations, which leads to a lack of financial support and of complex long-term planning; the unpreparedness of health care specialists to provide services to children, and especially most-at-risk children; an undeveloped network of services for MARA, including rehabilitation centres, day-care centres and social dormitories; and a lack of focus on adolescent risk groups (IDUs, FSWs and MSM) in the response to the HIV epidemic.

But as practice shows, awareness of the importance of working with MARA, the desire of specific organizations and the availability of necessary resources (financial, technical and human) help in the implementation of services for most-at-risk adolescents.

The authors wish success to those involved in the development and expansion of the projects aimed most-at-risk adolescents. They are willing to provide their technical and methodological support to all interested parties.

# Appendix

## Protocol for monitoring and evaluation of model implementation to reduce the risk of HIV/AIDS among most-at-risk adolescents

### Relevance of the study

Most-at-risk adolescents[15] (MARA) are more vulnerable to HIV than are most-at-risk adults. MARA are less informed about safe behaviour and organizations that provide medical and social services. They have limited access to health and social services, including for HIV prevention. MARA start practicing risk behaviour before they reach 15 years. The most common among MARA behavioural practices associated with the risk of HIV transmission are unsafe sex and injecting drug use. The secondary analysis showed that 25 per cent of girl IDUs reported practicing commercial sex, and 19 per cent of girl FSWs use injecting drugs. Among boys, 14 per cent of MSM reported practicing commercial sex during the last six months; 25 per cent did not use a condom during their last incidence of sexual intercourse with a commercial partner. The results of the studies show a low level of condom use among both girls and boys (including MSM contacts) with all types of sexual partners (regular, casual or commercial) and regardless of the type of sexual intercourse (vaginal, oral, anal). Only 12 per cent of all adolescents surveyed during the base study reported always using condoms with a regular partner during the last year. Only 15 per cent reported always using one with a casual partner and only 10 per cent reported always using one with a commercial partner. Their level of knowledge about HIV/AIDS prevention services and the use of these services is significantly lower than among most-at-risk adults, indicating serious barriers to access, especially for MARA living and working on the streets. Only 9 per cent of adolescents living or working on the streets answered correctly all the questions about HIV/AIDS. Moreover, among those 'street children' who had symptoms of sexually transmitted infections, 47 per cent did not ask for professional help, but rather performed self-treatment.

Coverage of the target group with prevention programmes is very low (especially given that there are hardly any counselling programmes for MARA that are implemented according to a 'peer-to-peer' approach). The level of sexual and reproductive health of MARA is alarming. There is a need to focus attention on underage mothers with children (according to the baseline study, 2 per cent have children). MARA have to face many obstacles in order to start practicing safe behaviour, so they need special attention and prevention, as much as their partners (commercial, non-commercial), who thus far have remained outside any prevention programme.

Currently the following data is available from studies conducted within the UNICEF project 'HIV prevention among most-at-risk adolescents (MARA) in Ukraine and South-Eastern Europe':

- A comprehensive desk research on MARA in Ukraine and an analysis of social services available to them.
- Policy and legislation review with regard to barriers to access services.

[15] Most-at-risk adolescents are boys and girls (aged 10-19 years) who are most at risk of HIV infection as a result of their behaviour, in particular: 1) Male and female injecting drug users who use non-sterile injecting equipment; 2) Males who have unprotected anal sex with males; 3) Females and males who sell unprotected sex, including those who are trafficked for the purpose of sexual exploitation and have unprotected (often exploitative) transactional sex; 4) Males who have unprotected sex with female sex workers. The age group of adolescents corresponds to the WHO definition and reflects the situation in Ukraine, where adolescents are defined as young people aged 18 years or a little older and where there are often groups of children living or working on the streets and that have a significant impact on younger members of the groups, especially in terms of their risk behaviour. (See: AFEW/UNICEF (2006): Children and Young People Living or Working on the Streets: The Missing Face of the HIV Epidemic in Ukraine, UNICEF in Ukraine, Kyiv). This definition differs from the definition used by UNICEF in programmes for MARA, which includes children from 10 to 18 years according to the Convention on the Rights of the Child.

- Analysis of gender specifics.
- Secondary data analysis of 259 adolescents-IDUs, 281 adolescents-FSWs and 212 adolescents-MSM based on bio-behavioural studies carried out in 2007.
- A baseline study of adolescents living or working on the streets in Kyiv, Mykolaiv, Dnipropetrovsk and Donetsk (in total 805 adolescents were interviewed, including 565 boys and 240 girls). In addition, 129 in-depth interviews with MARA were conducted in the research areas to discuss the preliminary results.
- Analysis of stakeholders working with MARA as the basis for development of an appropriate plan for strengthening human resources in each city and for monitoring and evaluation of the effectiveness of the plan. Such analysis and evaluation were carried out in Kyiv, Donetsk, Dnipropetrovsk and Mykolaiv.

As a result of the completed studies:

- regional models were developed to ensure maximum access of MARA target groups to HIV/AIDS prevention programmes (taking into account gender and age specifics, and adhering to friendly principles for service delivery);
- a regional coordinating council was established;
- a process of model implementation was started for MARA target groups and HIV/AIDS prevention programmes included in the regional plan.

**Objective of the study.** To collect standardised data that reflect the inputs, process and outputs of the implementation of the models.

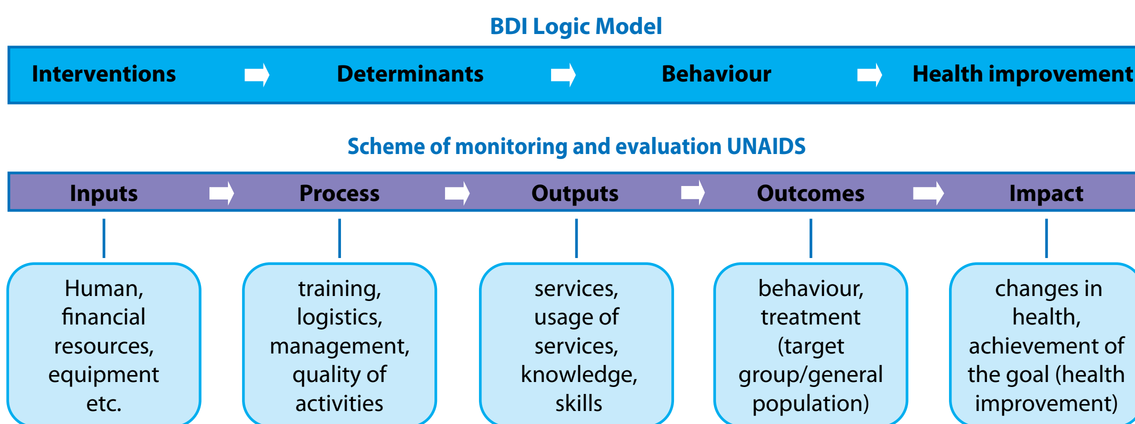
In this study, monitoring and evaluation will be programmatic because the project concentrates on the inputs, process and outputs of model implementation (see picture 1).

**Research objectives**

1. Collect data on basic indicators: coverage of clients, number of services, client satisfaction, staff satisfaction, etc.

2. Assess whether the planned indicators were reached.

3. Analyse the 'lessons learned': factors that prevented and contributed to the model's implementation; internal and external problems encountered and their solutions.




**Picture 1. Conceptual model for monitoring and evaluation of the model implementation**[16]

[16] At this stage of monitoring and evaluation, within the model framework, the following parts are analysed: 'Inputs', 'Process', and 'Outputs'.

**Logic framework for internal and external analysis.**

| Organization | | Functions |
|---|---|---|
| **External level** | Ukrainian Institute for Social Research after O. Yaremenko | • Monitoring visits<br>• Survey of the clients at the exit stage<br>• Interviews with the staff |
| | State Social Service for Family, Children and Youth. | • Monitoring visits<br>• Interviews with the staff |
| **Internal level** | Implementer in the region | • Management of the project information<br>• Management of the data about the clients |

Research team:

| | |
|---|---|
| **National level** | International Consultant |
| | Employees of the Ukrainian Institute for Social Research after O. Yaremenko |
| **Regional level**[17] | Project coordinator in the city (oblast) |
| | Regional consultant on monitoring and evaluation |

**Ethical principles:**

Monitoring and evaluation of the model implementation among MARA will be conducted with respect to ethical principles, to protect the right of participants to anonymity and confidentiality.

[17] The regional team has experience in implementing the qualitative and quantitative research components of the project. Before the beginning of the project the team was instructed to follow the methodology and tools for data collection.

**INDICATORS FOR MONITORING AND EVALUATION**[18]

| | INPUTS | PROCESS | OUTPUTS |
|---|---|---|---|
| **Budget** | Availability of:<br>• a signed contract;<br>• forms with cost estimates of all planned activities; contracts for additional logistical support, including fundraising;<br>• office (owned/rented), including facilities for training sessions | | |
| **Informational materials** | • sufficient amount of prepared and tested materials (on different subjects), taking into account gender and age differences;<br>• availability of a plan for distribution of materials | • availability of a sufficient number of copies of materials for distribution;<br>• amount of materials distributed in accordance with the plan (on different subjects), and whether gender and age were taken into account | |
| **Staff (recruitment, preparation, satisfaction)** | • sufficient number of staff to ensure the implementation of all components and all project activities;<br>• qualitative characteristics of staff (experience, professionalism, qualifications, personal qualities) | • number of staff trained (training sessions, seminars) to work with separate groups (including working with the target group);<br>• number of working specialists (in the line of activity) | • turnover/ stability of staff |
| | • availability of procedures and criteria for staff selection for training;<br>• required number of developed programmes for training (including various subjects);<br>• qualitative characteristics of developed training programmes (level of development, author, gender and age components)<br>• assessment of the skills of staff and consultants based on the 'peer-to-peer' principle';<br>• availability of protocols and procedures for staff management (organization of work), supervision, including consultants based on the 'peer-to-peer' principle. | • number and types of training sessions;<br>• in the process of implementation;<br>• management system and supervision of project staff, consultants based on the 'peer-to-peer' principle;<br>• forms for control of staff to follow target group-friendly principles. | • number of staff members satisfied with the services provided;<br>• number of staff members satisfied with their work in the project;<br>• number of staff members satisfied with their preparation (training sessions, seminars) |

[18] Within each project, this list of indicators will be specified in accordance with the services delivered by the participating organizations (within the proposal). Organizations can introduce additional indicators required for their purposes in the internal monitoring. If the organization decides to do so it should inform the project team from MoE&S in order to align them with the general system of indicators.

| | INPUTS | PROCESS | OUTPUTS |
|---|---|---|---|
| **Clients (recruitment, knowledge and motivation, satisfaction)** | **Recruitment**<br>• mapping to identify 'access locations' for the target group (in collaboration with the representatives of the target group)<br>• availability of routes for outreach workers (familiar with the maps of 'access locations') | • number and % of clients (by age and gender)<br>• number and % of new clients<br>• number and % of clients based on the delivered services<br>• number of representatives of the target group involved in the implementation and evaluation of the project, including the number and % of consultants based on the 'peer-to-peer' principle (by age and gender) | **Satisfaction**<br>• % of clients covered by the project (by gender and age)<br>• % of clients satisfied with the received services<br>• % of clients who can/are willing to recommend services to their peers<br>**Knowledge and behaviour**<br>• number of clients who correctly name HIV/STI transmission routes, and prevention methods;<br>• number and % of clients who know that prevention, treatment, care and support are available in their residential area;<br>• number and % of clients who use the services of the project;<br>• number of clients who have been trained according to the 'peer-to-peer' principles;<br>• number and % of clients who in the last 30 days: always used condoms<br>always used sterile injecting equipment |
| **Referral** | • availability of mechanisms and procedures of the referral system;<br>• signed: formal agreements (memoranda, cooperation agreements, etc.) with the organizations and institutions performing referrals (including verbal agreements) | • number of new cases of referrals for services | |
| **Advocacy, coordination, co-operation** | • key stakeholders (including Regional Coordination Council on HIV/AIDS and TB) are informed about the project and facilitate its implementation;<br>• signed agreements/memoranda, etc. on cooperation, interaction;<br>• protocols on MARA-friendly principles are developed and implemented | • meetings with stakeholders are conducted (number of participants, list of participants (including the name of the organization they represent, and their positions), minutes of the meeting);<br>• implemented advocacy activities (number of participants, list of participants (including the name of the organization they represent, and their positions), minutes of the meeting); | |
| **Internal monitoring** | • the system of coding of clients is developed and implemented;<br>• the staff is trained on the coding system of clients | | |
| **Fundraising** | availability of a plan for fundraising and resource mobilisation that will ensure the sustainability of the project after the completion of the pilot phase (financial support provided by UNICEF) | | available funding to support the sustainability of the project for at least one more year (at the end of the project) |
| **Lessons learned** | | | • barriers to access and use the services (problems with the quality of services, stigmatisation, etc.) indicated by the staff/ clients;<br>• positive factors that contribute to the success of the project indicated by the staff/ clients. |

## DATA COLLECTION, TOOLS AND DATA ANALYSIS

| | INPUTS | PROCESS | OUTPUTS | COST |
|---|---|---|---|---|
| **Time period for data collection** | At the beginning of the project (1 quarter) | 1. Internal monitoring is conducted by the implementing organizations in the regions (during the whole duration of the project)<br>2. External monitoring is conducted by the UISR together with CCSSFCY (during the monitoring visits) | 1. August (mini interviews with clients of the project)<br>2. November – December | |
| **Resources** | Plan of the project<br>Filling in form # 1 'Resources' | Observation of the location where services are delivered<br>• Data from form #1 'Resources' for a certain period, comparison of the obtained data with the data collected in the beginning of the project (inputs) | | Financial documentation of the project, forms for the data collection |
| **Staff** | Plan of the project<br>Filling in form # 2 'Staff' | *Analysis of the initial documentation related to the staff + interview with the staff*<br>• Data from form #2 'Staff' for a certain period, and comparison of the obtained data with the data collected in the beginning of the project (inputs)<br>• Initial documentation related to the staff (project data journal, journals of staff, plans and protocols of supervision, work plans, etc.)<br>• Analysis of the documentation related to the training sessions (programmes, list of participants, forms (entry and exit) for participants, etc.) | Monitoring of the staff work + interviews with the staff in order to evaluate the level of staff satisfaction<br>• Staff journals<br>• Protocols of work meetings<br>• Form of staff satisfaction | |
| **Target group** | Form for the new client<br>Form # 3 'Target group' | *Analysis of the data from the primary documentation related to the recruitment of the target group + discussions with staff*<br>• Data from form #3 'Target group' for a certain period, and comparison of the obtained data with the data collected in the beginning of the project (inputs)<br>• Protocols of involvement of the target group in planning, implementation, and evaluation of the project. | *Interviews with clients to assess the level of their satisfaction (including adherence to the friendly principles) with the received services, and also their skills and motivation for safe behaviour.*<br>• In-depth mini-interviews with the clients | |
| **Services** | Plan of the project<br>Form # 4 'Delivered Services' | *Analysis of the data from the primary documentation related to the recruitment of the target group; discussions with the staff in locations of service delivery*<br>• Data from form #4 'Delivered services' for a certain period, and comparison of the obtained data with the data collected in the beginning of the project (inputs)<br>• Project data journals<br>• Diaries of staff<br>• Protocols of the working meetings and training sessions (psycho-correctional, informational-educational, etc.)<br>• Protocols of principles for the service delivery | | |
| **Advocacy, coordination** | Plan of the project<br>Form # 5 – 'Activities for advocacy and coordination' | • Data from form #5 'Advocacy and coordination' for a certain period, and comparison of the obtained data with the data collected in the beginning of the project (inputs)<br>• Plans, protocols of the advocacy and coordination activities. | | |
| **Sustainability** | Plan of the project<br>Form # 6 – 'Fundraising' | • Data from form #6 'Fundraising' for a certain period, and comparison of the obtained data with the data collected in the beginning of the project (inputs)<br>• Plan for fundraising | | |

**External monitoring of the process and outputs – description of special studies**

| Staff satisfaction |
|---|
| **Method of data collection**. Mini-interviews with the staff delivering services directly to the target group. An interview may include discussions of some clusters of issues: problems in the implementation of the project and how they are resolved, factors causing staff dissatisfaction, achievements and success of the project that increase staff satisfaction; staff suggestions and recommendations on how to improve project management , supervision and other components. |
| **Target groups:** Project staff delivering services directly to the target group. |
| **Method for analysis:** Transcript of conversations, analysis of the text is done in the text editor Word, coding. Qualitative data analysis (grouping and analytical data aggregation). |
| **Piloting of tools.** Interview scenario is piloted during two mini-interviews during the second monitoring visit. |
| **Satisfaction, knowledge, and behaviour of the clients** |
| **Method of data collection.** Mini-interviews with the clients after the service delivery in the locations of service provision. |
| **Target groups:** Clients of the project. The questionnaire contains a question-filter which helps to define 'new' clients and clients who already received services. |
| **Tools for data collection.** Questionnaire, mini-interviews. This includes a set of questions related to the satisfaction with services (including assessment of staff friendliness), satisfaction with consultants working based on 'peer-to-peer' principle, and monitoring the barriers to access the services, satisfaction with the involvement in the project, clients' knowledge about HIV/STI transmission routes and prevention, study of the motivation of regular use of prevention methods. |
| **Method for analysis.** Analysis of the database is conducted using the software SPSS 6.0. One-and two-dimensional distributions (in % and absolute numbers of small samples) as well as indicators of client satisfaction and knowledge are calculated. |
| **Training of field workers.** Instructions related to the questionnaire are given to the interviewers during the monitoring visit by the team from the UISR after O. Yaremenko. An emphasis is placed on ethics of conducting the surveys among MARA. Interviewers are representatives of the national network of interviewers of the UISR after O. Yaremenko. |
| **Piloting of the tools.** A questionnaire is piloted with three clients of different age groups (10–14, 15–17 and 18–19 years) |

## Form for the monitoring visit to an organization-participant working to reduce the risk of HIV among most-at-risk adolescents

### Form 1. 'Resources'

| Premises and transportation | Yes | No | Comments |
|---|---|---|---|
| **Availability of office premises for the key implementer of the project**<br>Rent/ personal property<br>*(underline the applicable)*<br>Number of rooms: _____ Area ____ | ☐ | ☐ | |
| **Premises for storage**<br>Rent/ personal property<br>Area ____ | ☐ | ☐ | |
| **Transportation for the project staff** | ☐ | ☐ | |
| **Telephone**<br>Separate phone number | ☐ | ☐ | |
| **Office equipment** | | | |
| Do you have all the necessary equipment? | ☐ | ☐ | |
| *If you lack some equipment, which?* | | | |
| Is the equipment in good working condition? | ☐ | ☐ | |
| **Conclusion:** | | | |

| Availability of consumable materials in storage and their quality | | | | |
|---|---|---|---|---|
| **Name of the consumable material** | **Number available on the day of the monitoring, items.** | **Name (brand, label)** | **Expiration date** | **Comments** |
| 1. Condoms | | | | |
| 2. Sterile syringes | | | | |
| 3. Lubricants | | | | |
| 4. Other, specify: | | | | |

| Storage of consumable materials | Yes | No | Comments |
|---|---|---|---|
| Materials are stored in separate premises | ☐ | ☐ | |
| Materials are carefully organized on the shelves and have labels | ☐ | ☐ | |
| Materials are stored at the required temperature | ☐ | ☐ | |
| Procedures of use of the materials (for example, first in – first out – at first distribute materials that were first delivered to the storage) | ☐ | ☐ | |
| | | | |

| Logistics | Yes | No | Comments |
|---|---|---|---|
| The plan for supply of materials (procurement/ receiving) is developed and followed | ☐ | ☐ | |

| | | | |
|---|---|---|---|
| The plan for distribution of materials is developed and followed | ☐ | ☐ | |
| The plan for storage of materials is developed and followed | ☐ | ☐ | |
| **Conclusion:** | | | |
| **Informational materials** | | | |
| **Informational-educational materials** | | | |
| 1. ____________ | | | ________ items. |
| 2. ____________ | | | ________ items. |
| 3. ____________ | | | ________ items. |
| 4. ____________ | | | ________ items. |
| 5. ____________ | | | ________ items. |
| 6. ____________ | | | ________ items. |
| **Total: ________ items.** | | | |
| | **Yes** | **No** | **Comments** |
| Gender specifics are considered in the informational materials | ☐ | ☐ | |
| Age specifics are considered in the informational materials | ☐ | ☐ | |
| **Informational – advocacy materials (for decision makers)** | | | |
| 1. ____________ | | | ________ items. |
| 2. ____________ | | | ________ items. |
| 3. ____________ | | | ________ items. |
| 4. ____________ | | | ________ items. |
| 5. ____________ | | | ________ items. |
| 6. ____________ | | | ________ items. |
| **Total: ________ items.** | | | |
| Plan for distribution of the informational and advocacy materials is developed and followed | ☐ | ☐ | |
| **Conclusion:** | | | |

## Form 2. 'Staff'

| Recruitment | Yes | No | Comments |
|---|---|---|---|
| Criteria and procedures for staff recruitment are developed and followed | ☐ | ☐ | |
| *Description:* | | | |
| Criteria and procedures for recruitment of consultants from the target group based on the 'peer-to-peer' principle | ☐ | ☐ | |
| *Description:* | | | |
| Available job description for staff members | ☐ | ☐ | |
| Available resumes of staff members | ☐ | ☐ | |
| *Review resumes and check whether the staff members have proper qualifications and experience in:* | | | |
| *Working with the target group* | ☐ | ☐ | |
| *Performing functions that are outlined in the job description* | ☐ | ☐ | |
| **Conclusion:** | | | |

| Supervision | Yes | No | Comments |
|---|---|---|---|
| Regular meetings of the project team _______ number /time period | ☐ | ☐ | |
| Plan for monitoring (supervision) of staff | ☐ | ☐ | |
| Plan for monitoring (supervision) of consultants based on 'peer-to-peer' principle | ☐ | ☐ | |
| Employment agreements | ☐ | ☐ | |
| Work plans | ☐ | ☐ | |
| Work schedules | ☐ | ☐ | |
| Human resources manager (project coordinator) has information about: | | | |
| Staff | ☐ | ☐ | |
| Volunteers | ☐ | ☐ | |
| Consultants based on 'peer-to-peer' principle | ☐ | ☐ | |
| Condition of premises for service delivery | ☐ | ☐ | |
| Availability and condition of equipment | ☐ | ☐ | |
| Necessary facilities to provide services | ☐ | ☐ | |
| Handouts and consumable materials | ☐ | ☐ | |
| Informational materials | ☐ | ☐ | |
| Project finances | ☐ | ☐ | |
| Project logistics | ☐ | ☐ | |
| Project statistics | ☐ | ☐ | |
| **Conclusion:** | | | |

| Staff structure | Yes | No | Comments |
|---|---|---|---|
| Project coordinator ____ person(s).<br>Full time / Part time<br>*(underline the applicable)* | ☐ | ☐ | |
| Project accountant ____ person(s).<br>Full time / Part time<br>*(underline the applicable)* | ☐ | ☐ | |
| Consultant on monitoring and evaluation ____ person(s).<br>Full time / Part time<br>*(underline the applicable)* | ☐ | ☐ | |
| Consultant on legal issues ____ person(s).<br>Full time / Part time<br>*(underline the applicable)* | ☐ | ☐ | |
| Psychologist-consultant ____ person(s).<br>Full time / Part time<br>(underline the applicable) | ☐ | ☐ | |
| Team leader for social workers ____ person(s).<br>Full time / Part time<br>*(underline the applicable)* | ☐ | ☐ | |
| Social worker____ person(s).<br>Full time / Part time<br>*(underline the applicable)* | ☐ | ☐ | |
| Project consultant on social policy development ____ person(s).<br>Full time / Part time<br>*(underline the applicable)* | ☐ | ☐ | |
| Consultant for social-medical support of the project ____ person(s).<br>Full time / Part time<br>*(underline the applicable)* | ☐ | ☐ | |
| Doctor- STI and skin specialist ____ person(s).<br>Full time / Part time<br>*(underline the applicable)* | ☐ | ☐ | |
| Doctor-gynaecologist ____ person(s).<br>Full time / Part time<br>*(underline the applicable)* | ☐ | ☐ | |
| Doctor-infectious disease specialist ____ person(s).<br>Full time / Part time<br>*(underline the applicable)* | ☐ | ☐ | |
| Certified trainers ____ person(s).<br>Full time / Part time<br>*(underline the applicable)* | ☐ | ☐ | |
| Staff member responsible for public relations, mass media ____ person(s).<br>Full time / Part time<br>*(underline the applicable)* | ☐ | ☐ | |
| Staff member responsible for warehouse/storage ____ person(s).<br>Full time / Part time<br>*(underline the applicable)* | ☐ | ☐ | |
| Consultants on 'peer-to-peer' method | ☐ | ☐ | |
| Work plan for consultants on 'peer-to-peer' method is available and followed | ☐ | ☐ | |
| **Conclusion:** | | | |

| Preparation of staff, volunteers | Yes | No | Comments |
|---|---|---|---|
| Assessment of staff needs in training was conducted | ☐ | ☐ | |
| The training programme incorporates staff needs in training/preparation | ☐ | ☐ | |
| Criteria and procedures for staff selection for training are developed<br>*Description:* | ☐ | ☐ | |
| Plan of the training sessions is available | ☐ | ☐ | |
| Evaluation of the training sessions is conducted:<br>*Description:* | ☐ | ☐ | |
| Training session №1 ___________________________________________<br>Number of participants ______ persons.<br><br>*List areas/ sectors represented by the trainees ( see the list of participants):* | ☐ | ☐ | |
| Training session №2 ___________________________________________<br>Number of participants ______ persons.<br><br>*List areas/ sectors represented by the trainees ( see the list of participants):* | ☐ | ☐ | |
| Training session №3 ___________________________________________<br>Number of participants ______ persons.<br><br>*List areas/ sectors represented by the trainees ( see the list of participants):* | ☐ | ☐ | |
| Training session № 4 ___________________________________________<br>Number of participants ______ persons.<br><br>*List areas/ sectors represented by the trainees ( see the list of participants):* | ☐ | ☐ | |
| **Conclusion:** | | | |

## Form 3. 'Target group'

| Recruitment of the target group | Yes | No | Comments |
|---|---|---|---|
| Mapping of 'access points' for the target group is done | ☐ | ☐ | |
| Outreach workers are familiarised with the maps of 'access points' | ☐ | ☐ | |
| Plan for involvement of the target group representatives in the planning, implementation, and evaluation of the projects is developed and followed. | ☐ | ☐ | |
| **Conclusion:** | | | |

| Client data management | Yes | No | Comments |
|---|---|---|---|
| **Database** | | | |
| Electronic | ☐ | ☐ | |
| Paper archive | ☐ | ☐ | |
| *What information about the clients is collected:* | | | |
| *What information is entered in the electronic database:* | | | |
| *What information is not entered in the electronic database:* | | | |
| *Target indicators:*<br>Number and % of new clients ______________________<br>Number of representatives of the target group involved in the planning, implementation and evaluation of the project ________________________<br>Number and % of consultants based on the 'peer-to-peer' principle ___________________________ | | | |
| **Conclusion:** | | | |

## Form 4. 'Delivered Services'

| Protocols, principles for service delivery | | Yes | No | Comments |
|---|---|---|---|---|
| Protocols of MARA-friendly principles are developed implemented new/ old are adapted *(underline the applicable)* | | ☐ | ☐ | |
| | *Gender specifics are considered* | ☐ | ☐ | |
| | *Age specifics are considered* | ☐ | ☐ | |
| Protocols and principles for informational services delivery are devel-oped/implemented new/ old are adapted *(underline the applicable)* | | ☐ | ☐ | |
| | *Gender specifics are considered* | ☐ | ☐ | |
| | *Age specifics are considered* | ☐ | ☐ | |
| Protocols and principles for the delivery of counselling services are devel-oped/implemented new/old are adapted *(underline the applicable)* | | ☐ | ☐ | |
| | *Gender specifics are considered* | ☐ | ☐ | |
| | *Age specifics are considered* | ☐ | ☐ | |
| Protocols and principles for the delivery of medical services are devel-oped/implemented new/old are adapted *(underline the applicable)* | | ☐ | ☐ | |
| | *Gender specifics are considered* | ☐ | ☐ | |
| | *Age specifics are considered* | ☐ | ☐ | |
| Protocols and principles for the delivery of referral services are devel-oped/implemented new/old are adapted *(underline the applicable)* | | ☐ | ☐ | |
| | *Gender specifics are considered* | ☐ | ☐ | |
| | *Age specifics are considered* | ☐ | ☐ | |
| Protocols and principles of safety policy for outreach workers are devel-oped/implemented new/old are adapted *(underline the applicable)* | | ☐ | ☐ | |
| | *Gender specifics are considered* | ☐ | ☐ | |
| | *Age specifics are considered* | ☐ | ☐ | |
| Protocols and principles for child security policy are developed/imple-mented new/old are adapted *(underline the applicable)* | | ☐ | ☐ | |
| | *Gender specifics are considered* | ☐ | ☐ | |
| | *Age specifics are considered* | ☐ | ☐ | |
| **Conclusion:** | | | | |

| Referral system | Yes | No | |
|---|---|---|---|
| Mapping of structures delivering services within the project framework | ☐ | ☐ | |
| Official agreements are signed or confirmed verbally with the organizations and institutions involved in the process of referrals | ☐ | ☐ | |
| A clear plan for coordination and referral for services is available | ☐ | ☐ | |
| **Conclusion:** | | | |

| Services | NUMBER | % |
|---|---|---|
| Number of services - legal counselling | | |
| Number of services - psychological counselling | | |
| Number of medical services | | |
| Number of outreach services | | |
| Number of services delivered by the consultants based on 'peer-to-peer' principle | | |
| Number of new cases of referrals | | |
| TOTAL | | |
| | | |
| Number of VCT | | |
| Number of rapid tests for STIs: | | |
| - rapid test for syphilis | | |
| - rapid test for gonorrhoea | | |
| - rapid test for chlamydia | | |
| TOTAL | | |

## Form 5. 'Coordination and advocacy activities'

| Coordination and involvement of counterparts | Yes | No | Comments |
|---|---|---|---|
| Support provided by the International HIV/AIDS Alliance in Ukraine (consumable materials, 'tests') | ☐ | ☐ | |
| Cooperation agreements are signed with the criminal police for minors | ☐ | ☐ | |
| Cooperation agreements are signed with the organizations delivering services | ☐ | ☐ | |
| Other: | ☐ | ☐ | |
| **Conclusion:** | | | |

| Advocacy | Yes | No | Comments |
|---|---|---|---|
| Plan for advocacy activity is developed and followed | ☐ | ☐ | |
| **Advocacy activities (number of participants, who they represent, topic):**<br><br>**Total:** ____________ **items.** | | | |
| **Conclusion:** | | | |

## Form 6. 'Fundraising'

| Fundraising | Yes | No | Comments |
|---|---|---|---|
| Plan for fundraising is developed and followed | ☐ | ☐ | |
| Available procedures for monitoring the use of resources | ☐ | ☐ | |
| **Specify the events that were organized within the fundraising framework (funding stream, dates, parties providing support)**<br><br>**Total:** ____________ **items.** | | | |
| **Conclusion:** | | | |