BORDER|NET work

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External evaluation

BORDERNET Work Package 3

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Highly active prevention: scale up HIV/AIDS/STI prevention, diagnostic and therapy across sectors and borders in CEE and SEE

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Report

External Evaluation in brief:

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External Evaluation in detail:

The external evaluation focused on the expected outputs and outcomes of the project BORDENETwork and asked whether they have been achieved. Documents, semi-structured interviews, and a standardized online-questionnaire were used and analyzed by qualitative and quantitative methods. An external evaluation implies that the deliverables were available and implemented before evaluation of outputs and outcomes can start. Not all work packages of BORDENETwork fulfilled these conditions. The external evaluation started in May 2011 and ended End of September 2012. In accordance with the activity plans of the work packages, four of the seven for the evaluation relevant outputs were available during this period. The other three outputs (Handbook with recommendations for referral and management of HIV and co-infections, manual for community-based participatory approaches, and the online evaluation tool for quality assessment in youth prevention programs) were scheduled for October 2012. But parts of these deliverables were available and we included them as far as possible in our analysis. However, the external evaluation is limited to the deliverables available during the evaluation.

While evaluation the project's outputs and outcomes, also the political, social and economic context of the countries have to be considered. The project BORDERNETwork is limited by the different laws in the participating countries, the financial situation depending on the economic crises and the budget cuts within the field of HIV/STI prevention. There are also limitations due to the local and national structures. For example, the Eastern and Central European countries are historically organized as centralistic states. These structures may affect the stability of the political system. Due to these difficulties and challenges in the different participating countries, the project was very complex and solutions to achieve the outputs and outcomes varied by country.

Overall, the results of the evaluation showed that most of the expected outputs and outcomes of the project BORDERNETwork have been achieved. The project especially maintained the balance between HIV/STI prevention, diagnostic and therapy. Civil society resources were mobilized by the involvement of target groups into prevention. Different public health stakeholders were integrated and supported the project. For sustainability of the project BORDERNETwork, it is very important that public health policy makers commit to the outputs and outcomes of the project and provide further financial resources.

Introduction

The Project BORDERNETwork

BORDERNETwork is based on a multi-sectorial commitment in the field of HIV/STI expanding upon two former projects BORDERNET (EU-funded, 2005-2007) and BORDERNETwork (financially supported in 2008 and 2009 by the German Ministry of Health). The network partnership aims at producing new practice-relevant models and their transfer to affected regions in Central, Eastern and South Eastern Europe. 8 EU Member States (6 CEE countries) and 4 ENP countries (Ukraine, Moldova, Serbia, Bosnia and Herzegovina) act as associated and collaborating partners, divided in 5 model cross-border regions. The coordinator of the networking project BORDERNETwork is SPI Forschung gGmbH, Berlin. The project is co-funded from the European Commission (the Public Health Programme) and the German Health Ministry (BMG) for the period 2010-2012. The project has started on 1st January 2010 and will be finished on 31st December 2012. Important components of the project are an internal and external evaluation (SPI Forschung gGmbH Berlin 2011).

Objectives and aims

The project's general objective is to improve the nexus between prevention, diagnostic and treatment of HIV/AIDS (incl. co-infections) and STI through bridging of gaps in practice, policies and cross-country cooperations and enhancing capacity in interdisciplinary response. To achieve this general objective, 6 fields of activities and 9 work packages with 6 relevant deliverables (outputs) and expected outcomes have been defined. The basis therefore is the evaluation of the logic model shown in Figure 1.

Whereas the internal evaluation focuses on the process, the capacity and quality of network partnership (implementation), the external evaluation will focus on the most relevant outputs and outcomes. Therefore the objective of the external evaluation is to analyze, if the project BORDERNETwork achieves its expected outputs and outcomes in terms of:

- maintenance of balance between HIV/STI prevention, diagnostic and therapy,
- scale up of combined prevention, reflecting the particularities of local contexts and target groups,
- mobilization of civil society resources
- involvement of a diverse mix of public health stakeholders.

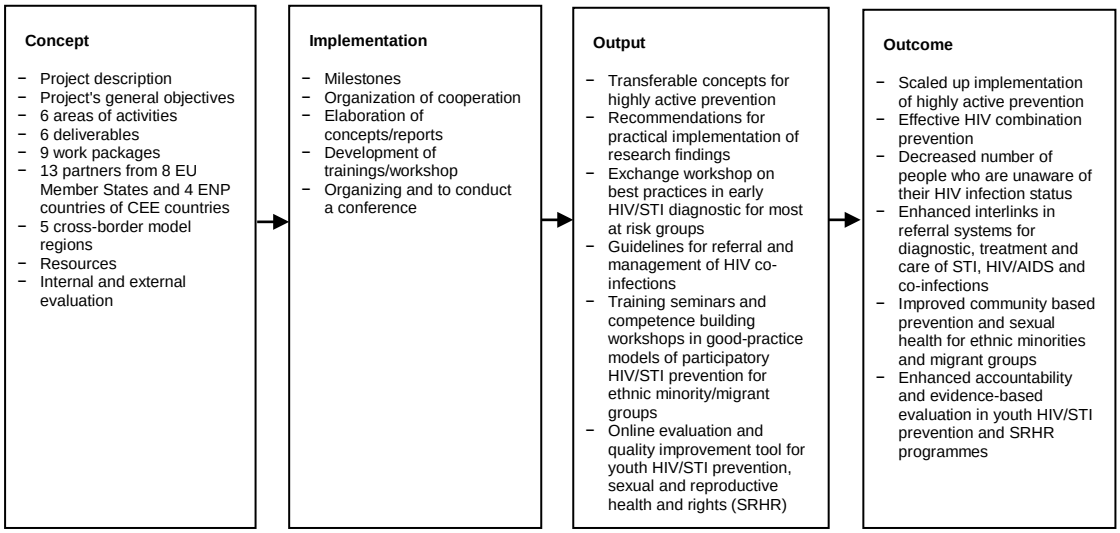

Figure1: Logic model of project evaluation

The external evaluation is designed as a summative evaluation (Scriven 1967). The summative evaluation, in contrast to formative evaluation that focuses on an ongoing activity, is used to assess whether the results of the object being evaluated met the stated goals. Accordingly, the external evaluation will answer the following questions:

- Have the expected outputs and outcomes been achieved? Why, respectively why not?
- How could the outputs and outcomes be enhanced?

Methods

Procedures

The external evaluation was divided into three phases. In the first phase, all the relevant documents available until End of February 2012 on the projects website www.bordernet.eu have been downloaded and assigned to the hermeneutic unit of the program ATLAS.ti 6.2.

The second phase started at the end of March 2012 with the development of the instrument for the in-depth interviews. Deviating from the original project plan, we decided in consultation with SPI Berlin gGmbH to conduct semi-structured face-to-face interviews (Witzel, 1985) instead of the focus-group interviews, mainly with the leaders of the work packages. This method rather provides results appropriate to our research questions than the focus-group interviews.

The semi-structured questionnaire contained issues along the defined output and outcome indicators and tried to bridge the gap between the results of the document analysis and the information we couldn't yet identify in the previous research process. Furthermore the interviews should also verify some of our hypotheses and preliminary results of the document analysis. The interviews started in April 2012 and ended in July 2012.

In the third phase, we conducted the online-survey with a standardized self-administered questionnaire. It was developed on the basis of the results of the desk review and the in-depth interviews and focused on the stated outcome goals of BORDERNETwork. The online-survey was conducted in September 2012. An e-mail with the link to the survey was sent to the WP leaders and the participating partners of each work package. In total, 71 persons were invited to fill in the online-questionnaire.

Participants

Fifteen semi-structured in depth-interviews with 10 persons from 8 organizations were conducted, mainly with WP leaders. Interview partners were Isabell Eibl, Sabine Lex (both Aids-Hilfe Wien), Alexander Leffers (Aids-Hilfe Postdam), Andrea Bentzien, Kathrin Bever (both MAT Rostock), Karin Haar (RKI Berlin), Elfriede Steffan Tzvetina Arsova Netzelmann and Joyce Dreezens-Fuhrke (all SPI Forschung gGmbH Berlin), Sylvia Vasileva (HESED, Sofia), Kristi Rüütel (NHID, Tallinn) and Wolfgang Güthoff (Clinic Ernst von Bergmann, Potsdam). Some of these persons were interviewed twice depending on their participation in other WPs. The interviews took mostly part in the offices of their organizations.

Return rate of the online-survey was about 25%. Twenty-eight persons started answering the questionnaire, but only 18 completed. Mean time to fill in the questionnaire was 9 minutes 42 seconds. Among the participants were 15 women and 3 men between the age 23 to 59. Mean age was 34.3 (SD = 19.3). Fourteen of the 18 participants were from Central and Eastern European Countries, 3 from Germany, and

1 from Austria. For an overview of the distribution of organizations, model regions and work packages see Table 1.

	n	%
Organization		
Robert Koch Institut, Berlin	1	5.5
C.A. Prima, Bratislava	1	5.5
NIHD, Tallinn	3	16.8
AISC, Tallinn	1	5.5
Papardes Zieds, Riga	1	5.5
HESED, Sofia	3	16.8
ARAS, Bucharest	2	11.1
Stadt Wien	1	5.5
UNZG, Zielona Gora	1	5.5
Others	1	5.5
Missing	3	16.8
Model region (multiple answers)		
Model region I: Germany-Poland	1	5.5
Model region II: Germany-Poland	1	5.5
Model region III: Austria-Slovakia	3	16.8
Model region IV: Estonia-Latvia	5	27.8
Model region V: Bulgaria-Romania	6	33.3
Work package (multiple answers)		
WP 4 interdisciplinary networks	7	38.9
WP 5 bridge research to practice	11	61.1
WP 6 early diagnostic	7	38.9
WP 7 referral and treatment systems	5	27.8
WP 8 participatory approches	5	27.8
WP 9 quality assurance in youth prevention	3	16.7

Table 1: Participating organizations, model regions and work packages (N=18)

Measures

To measure the achievement of the outputs and outcomes, the following indicators were used (cf. Table 2):

Work packages	Output indicators	Outcome indicators
WP4: Interdisciplinary networks	2 concepts for highly active prevention approved by the regional committees against the background of the common health objectives are available In elaboration of these concepts different public health stakeholders were involved Behavioral, structural and biomedical prevention strategies are provided in the concepts in equal parts Particularities of local contexts and target groups and especially gender-related aspects are considered The concepts contain HIV and STI as well as sexual and reproductive health issues The concepts combine prevention, diagnostic and treatment The concepts follow ethical principles	Concepts combining behavioral, biomedical and structural prevention are planned to be introduced at local public health policy (e.g. letter of intent for support of the implementation signed) Network cooperation on national, model-region and cross-border level is realized
WP 5: Bridge research to practice	3 main relevant findings from HIV/STI sentinel and behavioral surveillance were formulated as research report in order to be discussed and updated by the regional network committees Recommendations for practical implementation of research findings in prevention were elaborated in a cooperative process between research and practice In elaboration of these recommendations, different public health stakeholders were involved Recommendations consider particularities of local contexts	The updated action plans of at least 70% of partners participating in WP5 integrate prevention concepts based on research findings These updated action plans were communicated to local health policy makers

	and target groups, especially gender-related aspects Recommendations contain HIV and STI as well as sexual and reproductive health issues The recommendations combine prevention, diagnostic and treatment The recommendations consider ethical principles	
WP 6: Early diagnostic	20 professionals exchanged expertise in different models of early HIV/STI diagnostic for most at risk groups, i.e. IDU and SW, Roma Professionals of HIV prevention, diagnostic and treatment were involved at equal parts Particularities of local contexts and target groups, especially gender-related aspects are considered Focus on HIV and STI, but sexual and reproductive health issues are considered too Early HIV/STI diagnostics are linked with prevention and treatment Ethical principles are considered	10% increase in rates of HIV/STI diagnostic service utilization by clients from most-at-risk groups among the participating services in WP6. HIV/STI diagnostic services for the high risk group in the partner countries follow the recommendations for early diagnostic Gender equity and human rights of the clients are respected by the HIV/STI diagnostic services
WP 7: Referral and treatment systems	Country-specific guidelines for referral and management of HIV co-infections are drawn up In elaboration of the guidelines, professionals of HIV prevention, diagnostic and treatment were involved at equal parts Particularities of local contexts and target groups, especially gender-related aspects are considered Guidelines contain HIV and STI as well as sexual and reproductive health issues The guidelines combine prevention, diagnostic and	The elaborated guidelines for referral and management of HIV Co-infections are applied by 70% of the partners participating in WP7

	treatment The guidelines consider ethical principles	
WP 8: Participatory approaches	Manual on effective intervention models for participatory community based HIV/STI prevention is published and disseminated The manual was developed in cooperation with public health stakeholders, target groups and civil society groups 20 multipliers were trained on 3 good practice models of participatory HIV prevention among ethnic minority/migrant groups Particularities of local contexts and target groups, especially gender-related aspects, are considered Focus on HIV and STI, but sexual and reproductive health issues are considered too Early HIV/STI diagnostics are linked with prevention and treatment Ethical principles are considered	Training programs in community HIV prevention among ethnic minority and migrant groups are available, developed by 70% of the partners participating in WP8, based on the published manual Different ethnic minorities, migrant groups, genders, sexual orientations are part of the community based HIV prevention
WP 9: Quality assurance in youth prevention	Online evaluation tool for quality assessments of youth prevention actions is piloted, evaluated and available in the Internet Guidelines for evaluation of various methods and measures of youth prevention are drawn up For the elaboration of the online tool for quality assessment, professionals of HIV prevention, diagnostic and treatment were involved at equal parts Behavioural, structural and biomedical prevention strategies are provided in the concepts in equal parts	70% of the partners participating in WP9 apply the online youth HIV prevention evaluation tool 70% of the partners participating in WP9 apply the guidelines for evaluation of youth prevention

	30 youth prevention workers and peer educators from 10 countries were trained in quality improvement of HIV/STI prevention and SRHR Particularities of local contexts and target groups and especially gender-related aspects are considered HIV and STI, but sexual and reproductive health issues are considered too Link between prevention, diagnostics and treatment is available Ethical principles are considered	

Table 2: Outputs and outcome indicators by work package

Analysis

The in depth-interviews were digitally recorded and fully transcribed. ATLAS ti 6.2 was used to support the analysis. In total, the hermeneutic unit contained 105 documents, whereas most of them were minutes of meetings and short reports. In accordance to the defined output and outcome indicators, 129 categories were developed and the documents were analyzed in view of information about these categories. After coding the material, a network view was drawn up to visualize the relations between the categories and to count their frequency of occurrence. The 15 interviews were also assigned to hermeneutic unit of ATLAS ti 6.2 and were coded along the developed categories of output and outcome indicators. The documents and the interviews were analyzed using content analysis in accordance to Mayring (2000). Data of the online-questionnaire was analyzed using the statistical program SPSS Statistics 19.0. Descriptive analyses were carried out employing frequency analysis and results were described by central tendency, dispersion (mean, SD) and distribution, where appropriate. Due to the small sample size (N=18), analysis of variance and Chi-Square-Tests were not possible to conduct.

Work Package 4: Interdisciplinary networks

The aim of the work package 4 was to scale up the implementation of «highly active prevention». The understanding of «highly-active prevention» brings prevention, diagnostic and treatment together. To achieve this outcome, network cooperation on national, model regional and cross-border level in CEE and SEE should be boosted in a three-year period, concepts for the transfer of highly active prevention in practice and a list of common health objectives should be developed. The building of local networks made possible that organizations get an overview of the field and meet partners across borders. SPI Research gGmbH described WP4 as a mix of a core work package and a horizontal work package, so-called «corizontal work package» (cf. P124: 29-37). In this work package, the different partners that participate in the BORDRNETwork project get the chance to develop a regional network regarding needs and challenges in the field of HIV/AIDS and STI prevention, diagnostics and

treatment on a regional cross border level. Work package 4 act as a core project for all the other work packages. It has provided the basis for the cooperation of the participating partners and framed the work of the other WPs under the label «combination prevention».

As output were defined transferable concepts for highly active prevention. That means that the concepts should focus on prevention, diagnostic and treatment and should promote behavioral, structural and biomedical prevention strategies. Moreover, these concepts should include not only HIV and STI, but also sexual and reproductive health issues. In elaboration of these concepts different public health stakeholders should be involved and particularities of local context and target groups, especially gender related aspects should be considered.

The achievement of outputs and outcomes of this WP depends therefore mostly on the achieved outputs and outcomes of the other WPs.

Output: Transferable concepts for highly active prevention

Output indicator: 2 concepts for highly active prevention approved by the regional committees against the background of the common health objectives are available

On the background of common health objectives, four concepts were developed in four work packages. For example in model region I, the following health objectives were defined:

1. Improvement of access and quality of HIV and STI testing and consultation
2. Sustainable sexual education for a responsible sexual behavior
3. Help and support for people living with HIV/AIDS and their relatives (Annex 2: 1622-2082)

The concepts that should be developed are:

1. Recommendations for practical implementation of research findings (WP5)
2. Exchange workshop on best practices in early HIV/STI diagnostic for most at risk groups (WP6)
3. Guidelines for referral and management of HIV and Hepatitis B/C co-infections (WP7)
4. Training seminars and competence building workshops in good-practice models of participatory HIV/STI prevention for ethnic minority/migrant groups (WP8)
5. Online evaluation and quality improvement tool for youth HIV/STI prevention, sexual and reproductive health and rights (SRHR) programs (WP9)

Whereas behavioral and biomedical strategies have been provided in almost equal parts, less structural prevention have been planned and implemented. The concepts contain HIV/STI issues as well as SRH topics and were combining diagnostic, prevention and treatment.

Output indicator: In elaboration of these concepts different public health stakeholders were involved

In the model region I and II different public health stakeholders in the field of HIV/AIDS prevention, diagnostic and treatment were involved into elaboration and

implementation of the concepts. These public health stakeholders are a group of experts and other activists from Mecklenburg-Vorpommern (model region I), Brandenburg (model region II) and Zachodniopomorskie (PL), where is located one of the biggest clinics in the region. Also involved were NGO's and self-help groups.

In the model region III the Aids-Hilfe Wien (Austria) and PRIMA (Slovakia) were involved. Also involved was the National HIV Reference Lab at the Slovak Medical University in Bratislava. It operated as subcontractor of PRIMA, responsible for the sentinel surveillance survey (WP5) and the treatment of HIV and Co-infections area of cooperation (WP7) (cf. P106: 4).

In model region IV, the National Institute for Health Development (NIHD), Tallinn, (Estonia), AIDS Information and Support Centre (AISC), Tallinn, (Estonia) and the Family Planning and Sexual Health Association (Papardes Zieds), Riga, (Latvia). With NIHD also a governmental organization was involved.

In model region V two non-governmental organizations established a cooperation. These were the Health and Social Development Foundation (HESED), Sofia, (Bulgaria) and the Romanian Association Against AIDS (ARAS), Bucharest, (Romania).

Output indicator: Particularities of local contexts and target group, especially gender-related aspects are considered

The activities were defined on the background of the experience of cross- border cooperation, whereas local particularities were taken into consideration. For every activity, the existing offers and programs, collaborations with public health stakeholders and the knowledge and skills in the field of prevention, diagnostic and treatment of the involved partners were analyzed. Beside the differences, cross-border commonalities were identified and were set as a concept that should implement in model region I and II.

Target groups were health professionals, physicians, multipliers, teachers, other educational staff, adolescents, MSM, male and female sex workers, migrants and ethnic minorities.

Outcome: Scaled up implementation of highly active prevention

Concerning self-evaluation of achievement of outcomes, 5/12 were completely or very convinced that highly active prevention had been scaled up by the different projects realized in the frame of BORDERNETwork, and 7 think that this aim had been achieved at least to some extent. 10/13 and 9/13 respectively were also completely or very satisfied with the outputs and outcomes of their WPs. Therefore we determined that most of the participants in online-survey share the opinion that the project BORDERNETwork achieved its overall goal more or less and were very satisfied with the developed deliverables.

Outcome indicator: Network cooperation on national, model-region and cross-border level is realized

One of the outcome indicators of WP4 was the network cooperation on national, model-region and cross-border level. This has been achieved and the 5 cross-border model regions were established. In the model region I and II (Germany-Poland) it was successful to establish good working networks on cross-border level. But the definition

of health-political goals on a cross-border level can only be realized if networks on local and later on cross-border level will be fully established (cf. P126: 242-250).

Outcome indicator: Concepts are planned to be introduced at local public health policy

In the online-survey, 7/15 mentioned that they were supported during the implementation of network cooperation and concepts by the local public health policy. In the model region I they met local public health stakeholders at round table discussions and one of the participating partners already signed a letter of intent with local public health stakeholders. But the support in general could be better. 10/13 were only little to somewhat satisfied with the support they got by public health policy makers. Also the available resources could be better. But they were quite satisfied with the support they get by their organizations. 10/13 were completely or very satisfied, 3 were somewhat satisfied with the support of their organization. The satisfaction is also high concerning cooperation within the work packages and with the project leader SPI research gGmbH. Thus 8/12 and 12/13 were very to completely satisfied with the cooperation in their work package(s) and with the leading house of BORDERNETwork respectively.

Work Package 5: Bridge research to practice

The aim of work package 5 was to advance the state of research and evidence of risks to HIV/STIs and to bridge findings to effective HIV/STI prevention and diagnostic. To achieve this outcome, recommendations for practical implementation of research findings into practice should be developed. Reports on findings of HIV/STI sentinel (incl. behavioral) surveillance and qualitative surveys of sex workers (incl. IDU) in 6 EU countries should indicate the progress of the implementation practice.

As a basis, an evidence based sentinel surveillance system was established in 4 countries. Further, a second generation HIV/STI behavioral surveillance on sub-population groups, e.g. SWs incl. IDUs, was implemented in 6 EU capital cities and 1 border-area.

Therefore work package 5 consisted of two parts: the first part was the sentinel surveillance that was conducted by the Robert Koch Institute RKI in Berlin, the second part was the HIV/AIDS and STIs Bio-Behavioral Surveillance Survey (BBSS) among male and female sex-workers in 6 EU countries, that was coordinated by SPI Research gGmbH, Berlin (cf. P140: 23).

Output: Recommendations for practical implementation of research findings

Output indicator: 3 main relevant findings from HIV/STI sentinel and behavioral surveillances were formulated as research report in order to be discussed and updated by the regional network committees

The relevant findings that were available at the time of the analysis from the HIV/STI sentinel and behavioral surveillances were:

- Access to points of health care of some populations groups, such as ethnic minorities is limited in some countries.
- Sex-workers, IDU and MSM are difficult to reach, mainly due to fear of punishment or stigmatization (different legal issues in the four countries).

- Use of culture for gonorrhea diagnosis is not the routine test in many settings, resistance in Neisseria gonorrhea will become a problem in the future. Unavailability or no routine use of NAATs for chlamydia diagnosis.
- 60% of the surveyed sex workers have no health insurance
- Access to HIV VCT is relatively high, but access and uptake of STI and sexual health services is concerning low. More than 50% didn't see a gynecologist and 70% never visited an STI specialist in the last year.
- Reported condom use with the last paying client is high, relatively high at the same time is the inconsistent condom use by vaginal and oral sex in the last month.

Output indicator: Recommendations for practical implementation of research findings in prevention

On the basis of these findings recommendations for practical implementation in prevention were formulated. Firstly, the accessibility of health institutions for vulnerable groups should be improved by low-threshold and minimal barriers for attendance in order to reach people who are most at risk for acquiring HIV or STI. Secondly, the outreach-work should be used for prevention, as well as healthcare support on the spot. These offers can also minimize barriers for the usage of healthcare structures. Thirdly, the current national testing strategy should be reconsidered. Especially in Romania and Bulgaria, (compulsory) syphilis testing still plays an important role, but testing everyone for syphilis is very time-, labor- and cost intensive. Therefore, current diagnostic tests should be improved, and anonymous and free-of-cost tests for STIs, as option for resource-poor settings should be offered. These recommendations combine prevention, diagnostic and treatment.

Output indicator: Recommendations were elaborated in a cooperative process between research and practice

Participating countries and partners in WP 5 were AIDS Hilfe Wien (Vienna), Aids-Hilfe Potsdam (Potsdam), Health and Social Development Foundation (Sofia), Romanian Association Against AIDS (Bucharest), C.A. PRIMA (Bratislava), National Institute for Health Development (Tallinn) AIDS Information and Support Centre (Tallinn), Latvias Family Planning and Sexual Health Association (Riga), Robert Koch Institute (Berlin) as well as SPI Research gGmbH (Berlin).

To elaborate the recommendations in a cooperative process between research and practice, RKI visited different participating partners and organizations. In Romania, the project team of the RKI Berlin visited the WHO-Country-Office; in Austria they visited different clinics in Linz and Vienna. In addition to the visits, also cross-border-meetings happened between Slovakian and Austrian physicians for the exchange and to meet each other. One of the topics of these meetings was how to handle HIV and Co-infections especially Hepatitis (cf. P140: 55).

Output indicator: In elaboration of these recommendations, different public health stakeholders were involved

In the sentinel surveillance system, different public health stakeholders were involved. These were: public health offices (specialized on STI-/ HIV- care), specialized outpatient departments ("ambulances", etc.), University clinics, District Dispensaries for Dermato-Venereal Diseases, Policlinics, Practitioners specialized in STI/HIV, (Private) Consultants (Dermato-Venerology, Gynecology, Urology), Outreach programs, and Drop-in clinics.

A stakeholder meeting to inform about the results and difficulties in the different countries took place in November 2011. The ministries of Austria, Slovakia, Romania, and Bulgaria and also the European Center of Disease Control and Prevention were involved. Following this meeting, the ECDC organized a workshop about this issue on its annual meeting in February 2012 in Stockholm.

Output indicator: Recommendations consider particularities of local contexts and target groups, especially gender-related aspects

In all countries, the same instrument was used to make the results comparable. But the different healthcare structures, as well as varying sentinel sites limit the comparison of results for all four countries (Austria, Slovakia, Romania, and Bulgaria) as a whole. But the recommendations were formulated on the basis of the identified particularities and the identified lacks of the countries (see recommendations).

The project team of RKI Berlin visited hospitals in Austria, Bulgaria and Romania to get feedback for developing the questionnaire and the implementation of the sentinel surveillance system. To inform about their sentinel surveillance project they also visited together whit the local NGOs the ministry of health in Bulgaria, to show the importance of the project (cf. P140: 47).

Also the different languages of the participating countries were considered. The questionnaire was translated into five and ten languages respectively (cf. P140: 79).

The surveillance activities focused on subpopulations, such as men who have sex with men (MSM), Roma communities, intravenous drug users (IDU) or commercial sex-workers (CSW).

The recommendations of the BBSS-Survey in sex workers take account of the differences in:

- Sex work regulatory contexts throughout the seven surveyed countries
- Sex work scenes – indoor and outdoor (street sex work)
- Overlaps between sex work and drug use scenes

Output indicator: Recommendations contain HIV and STI as well as sexual and reproductive health issues

The recommendations are containing HIV/STI issues and sexual and reproductive health issues. Most of the male and female sex-workers are well informed about HIV, but not at all about STIs and sexual health issues. The recommendations are, to offer access to sexual and reproductive health issues as well as access to gynecologists for STI testing and counseling (cf. P126: 548). Also in the anamnesis for the tests sexual and reproductive health issues were included (cf. P140: 113-115). This output indicator was closely linked with the output indicator of work package 6, whereas most of the partners, who participated in the BBSS survey for Sex workers, designed accordingly. For example, based on the identified needs, AHP (Germany) and Papardes Zieds (Latvia) conducted a special diagnostic campaign for SWs, offering Chlamydia/Gonorhoea and pregnancy tests.

Output indicator: Recommendations consider ethical principles

Ethical principles were considered in the surveillance sentinel study. These were anonymity, confidentiality, voluntary participation of institutions and informed consent of the patients. The research protocol was approved by the national ethical committees (cf. P140: 31). The HIV and STI testing approach was based on ethical

principles and human rights, voluntary, confidential, undertaken with pre-test information discussion and consent. The test results were handed out exclusively in a context of a post-test counseling and referral to health care services when needed.

Outcome: Effective HIV combination prevention

The aim to improve the state of research and evidence of risks to HIV/STIs and to bridge findings to effective HIV/STI prevention and diagnostic has been achieved. Also the self-evaluation showed, that 7/12 were completely or very convinced that research-based HIV-combination prevention had been implemented.

Outcome indicator: The updated action plans of at least 70% of partners participating in WP5 integrate prevention concepts based on research findings

Within Work Package 5, relevant findings from the HIV/STI sentinel and behavioral surveillance are formulated as recommendations for the practical implementation of these research findings in prevention. Recommendations are the implementation or intensification of outreach work in the HIV and STI prevention, offers of healthcare support on the spot (i.e. mobile testing), revision of current national testing strategies in the field of HIV/STI, improvement of current STI/HIV testing, and offers of anonymous and free-of-cost HIV/STI testing sites. As outcome indicator was defined that the participation partners of WP 5 should integrate these researched-based recommendations into their previous work. The goal was that at least 70% of the participating partner of WP 5 would update their action plans. The results of the online-survey show that all partners of WP 5 had implemented at least one of the concepts based on the research report and updated their action plans respectively, whereas the most intensified or implemented measure was the outreach work in the field of HIV and STI prevention. A revision of current national strategies was only few realized. Other concepts and their frequencies were shown in Table 3.

	n	%
Implementation or intensification of outreach work in the HIV and STI prevention	9	81.8%
Offers of healthcare support on the spot, i.e. mobile testing	7	63.6%
Revision of the current national testing strategies in the field of HIV/STI	2	18.2%
Improvement of current STI /HIV testing	7	63.6%
Anonymous and free-of-cost STI/ HIV testing	7	63.6%

Table 3: Integrated research-based concepts into prevention work (N=11)

In Estonia and Latvia a testing strategy for partners of sex-workers has been developed. In Germany a testing strategy for gonorrhea-diagnostic has been established as a direct outcome of the research work in WP 5 and WP6 (cf. P126:535). This confirms the importance of the cross-cutting links between the fields of research, prevention and diagnostics.

Outcome indicator: These updated action plans were communicated to local health policy makers

A further indicator for the outcome of this work package is that updated action plans have been communicated to local health policy makers by 70% of the partner in WP 5. All WP 5 participants informed at least one public health policy stakeholder about the implemented strategies and measures. Mostly mentioned were the National Ministry of

Health and HIV-specialists (9/11 each), followed by social services (7/11) and local health authorities (6/11). But the updated action plans were also communicated to health centers (5/11), hospitals, foundations and the responsible administration at regional level (4/11 each).

Work Package 6: Early diagnostic

The aim of work package 6 was to intensify efforts for two years in early diagnosis of HIV and STIs for most at risk groups based on human rights and gender equity to decrease the number of those unaware of their infection status. To achieve this outcome an exchange workshop on best practices in early HIV/STI diagnostic for most at risk groups should be developed.

In order to identify the population groups most in need of HIV/STI services and the gaps and barriers in the existing system, all partners conducted a short literature review of the situation within their countries. Nine countries were participating: Austria, Bulgaria, Estonia, Germany, Latvia, Poland, Romania, Slovak Republic, and Ukraine as an non-EU collaboration partner.

In all countries the highest burdens of HIV and hepatitis can be found among IDUs, MSM, Roma community, migrants, sex workers, and others. STIs are also common among general population, especially youth. HIV situation has stabilized in recent years, after outbreaks in the 1990ies and early 2000s. In Eastern European countries (Estonia, Latvia, Ukraine) IDUs constitute the main risk group, in Central and Western European countries MSM and migrants are most at risk. Higher HIV and STI burden among sex workers can be found in all regions, with higher blood-borne infections prevalence among those sex workers who also inject drugs. In all countries there are special organizations and on-site services for STIs, HIV and hepatitis targeting vulnerable groups. Different barriers for testing were identified, which are in accordance with the evidence from across Europe:

1) Sociocultural barriers (personal beliefs – fear of names being reported; fear of the negative attitudes of the health care staff; low risk perception);
2) Socioeconomic barriers (lack of health insurance, no citizenship);
3) Geographical barriers (distance from services);
4) Organizational barriers (inconvenient opening hours, not knowing the procedures needed to access services).

Output: Exchange workshop on best practices in early HIV/STI diagnostic for most at risk groups

Output indicator: 20 professionals exchanged expertise in different models of early HIV/STI diagnostic for most at risk groups

A 2-day workshop on improving early access to HIV and STI services and referral to treatment service for people who inject drugs and sex workers has been conducted in May 2011 (P34, 2:95-2:347) in Tallinn. The main focus of the workshop was the discussion and the exchange of experiences on successes and barriers in improving early access to HIV and STI services and referral and treatment for the key population groups (P34, 2:1480-2:1739). The meeting was conducted in conjunction with AIDS2011 (the European Region HIV Conference) in order to ensure wider participation of specialists and stakeholders.

Existing services of HIV/STI testing were identified and good practices of HIV/STI services were discussed. In most cases testing services are anonymous and free of charge for the clients. In many countries there are systems that provide services free of cost also for non-citizens. On the other hand, treatment is not anonymous. HIV treatment is free of charge, but this is not always the case with STI and hepatitis treatment, where patients often have to pay for drugs themselves or must have some form of health insurance. For assessing the good practice level of a HIV counseling and testing, the "Self-Assessment Checklist for Voluntary Counseling and Testing" was used. This self-assessment checklist is based on the Code of Good Practice for NGOs responding to HIV/AIDS (more information can be found at www.hivcode.org)

The following models of HIV/STI testing were discussed:

1) An effective pilot early diagnostic campaign through community based HIV and STI testing for a high risk group. It was delivered by Professor Dirk Avonts (Ghent University). Community-based settings, such as gay sauna, bars and clubs were chosen in order to provide low threshold testing offer and to assure acceptability by the target group (P57, 9:570-9:739).

2) HIV COBATEST project (HIV community-based testing practices in Europe HIV COBATEST) was delivered by Dr Jordi Casabona (Centre for Epidemiological Studies on HIV/AIDS/STI in Catalonia), project's principal investigator. The project brings together public health bodies and NGOs that have integrated community based VCT (CBVCT) in their work (P57, 9:1909-9:2484).

3) EU funded project Imp.Ac.T. – Improving Access to HIV/TB testing for marginalized groups (Nadia Gasbarrini (Villa Maraini Foundation, Italy)). The general aim of the project is to broaden the access to HIV/AIDS and Tuberculosis (TB) testing, prevention, treatment and care for special vulnerable groups – IDUs and migrant drug users (P57, 10:1248-1441).

In the exchange workshop, only HIV/STI diagnosis and treatment issues were discussed. Sexual and reproductive health issues were not considered. But in some countries early diagnostic was linked with prevention (i.e. in Estonia and Latvia, also in Slovakia and Poland (P132: 31)). Moreover, the priority of early HIV/STI diagnosis and the relation to referral, treatment and prevention of further HIV infection was emphasized (P34, 7: 805-599)

Output indicator: Professionals of HIV prevention, diagnostic and treatment were involved at equal parts

HIV experts and policy makers from European institutions and other European (Public Health Programme) projects and HIV/STI practitioners and service providers were adressed (P34, 2:342-2:533). Approximately 40 professionals from more than 12 countries took part. Represented were the majority of BORDERNETwork's associated and selected collaborating partners, some of the NON EU countries experts, ECDC, WHO, EU/EAHC The Public Health Programme), other EU funded HIV/AIDS projects (HIV COBATEST, Imp.Ac.T.) (P34, 2:688-2:1063).

Output indicator: Particularities of local contexts and target groups, especially gender-related aspects are considered

The workshop combined the ambitious goal to bring together European policies and recommendations for early HIV diagnostic with bottom up practice driven examples from different countries and to open space for discussion of barriers (P34, 11:672-11:899). While almost all countries offer free of charge and anonymous/confidential

HIV testing, this is not the case for several most wide spread STI as e.g. Syphilis, Gonorrhea, HPV, HBV, HCV.

Along with HIV, only rapid screening tests for Syphilis/HBV/HCV are available and free of charge in the low threshold offers for most vulnerable groups. There are restrictions which professionals are allowed to diagnose STI (Estonia, Poland and Ukraine), the tests in some countries are not anonymous. The majority of the low threshold services, such as the community based testing covers only HIV testing, medical professionals and technical equipment, but prerequisites for complex STI diagnostic are lacking.

In some contexts, in case of a positive diagnosis the affected persons have to attend a general practitioner or specialized physician to receive the needed prescription, which again has to be paid, as it is not covered fully by the health insurance in most countries. In Romania, the Syphilis test is confidential and free of charge as it is the treatment prescription, while the HIV test is not free of charge (P57, 5:1110-5:2344).

The most organizations have different target groups. There is a special focus on IDU and sex workers (P34, 2:1480-2:1739). The Latvians worked with partners of sex-workers, the Polish worked with prisoners (cf. P132: 99).

But there are also models of good practice in HIV/STI testing for MSM and migrant IDU. The access and uptake of the STI diagnostic services for vulnerable groups would be much higher, if the affected persons would get the treatment by the same service.

Output indicator: Ethical principles are considered

In discussion of different models of practice and policies, ECDC guidelines for HIV testing were presented:

1) Voluntary, confidential, undertaken with informed consent
2) Access to treatment, care and prevention services
3) Political commitment
4) Reduce stigma
5) Remove legal and financial barriers
6) Access to HIV testing is an integral part of national strategies
7) Involvement of stakeholders (P34, 7:1235-7:1584)

Outcome: Decreased number of people who are unaware of their HIV infection status

The outcome of the work package 6 was to intensify the efforts in early diagnosis of HIV and STIs for most at risk groups and to decrease the number of people who are unaware of their HIV infection status. In the self-evaluation of the outcome achievement, participants in the online-survey considered that their projects intensified early diagnostics of HIV and STIs for most of the at risk groups and that the rate of persons with unknown infection status had been decreased.

Outcome indicator: 10% increase in rates of HIV/STI diagnostic service utilization by clients from most-at-risk groups among the participating services in WP6.

The increase of more than 10% of HIV/STI diagnostic service utilization by clients from most-at-risk groups was used as an outcome indicator.

Seven of the participating partners in WP6 completed the questionnaire of the online-survey but only 5 answered the questions about testing offers. In spite of this limitation, results show that all of them offer HIV/STI testing sites tailored to the specific needs of men who have sex with men (MSM), sex workers, intravenous drug users (IDU), migrants, and ethnic minorities. Two of the partners do also offer testing sites for adolescents and the general population. But the use of the services differed by target group. 4/5 mentioned that MSM use their services less than once a month. Sex workers and IDUs visit the testing sites frequently, ranging from daily to several times per week. Rarely was the utilization by migrants and ethnic minorities. They visit the client-tailored HIV/STI testing sites only one to three times per month or less. But all of the 7 participants in online-survey reported an increase in utilization of their HIV/STI testing services. The utilization by MSM and sex workers has been increased up to 20%, also in ethnic minorities. Only from the migrants have been almost no increases in use of the services. Therefore the number of persons who are unaware of their infection status seems to remain at a high level in this population.

Outcome indicator: HIV/STI diagnostic services for the high risk group in the partner countries follow the recommendations for early diagnostic

As a further indicator, the HIV/STI diagnostic services for the most vulnerable groups in the partner countries should follow the recommendations that were developed for early HIV and STI diagnostics in WP 6. All of the 7 participants know these guidelines and think mostly that they consider particularities of local context and were differentiated according to the target group. 5/7 completely or very strongly agreed with the statements that the recommendations for early HIV/STI diagnostics were comprehensible and helpful. Only 2/7 thought that the recommendations were complicated or unnecessary. But 5 mentioned that the recommendation were quite costly to implement. But most of the participants were convinced that these recommendations helped to improve their testing services and offers.

Outcome indicator: Gender equity and human rights of the clients are respected by the HIV/STI diagnostic services

Ethical principles were one of the core points in the recommendations. Especially gender equity and human rights of the clients should be respected by the HIV/STI diagnostic services. All testing sites follow the ethical principles according to the ECDC guidelines for HIV testing (see above).

Work Package 7: Referral and treatment systems

The aim of work package 7 was to augment by mid-2012 the country-specific evidence on treatment and care of HIV and co-infections and to enhance interlinks in referral systems for diagnostic, treatment and care of STIs, HIV/AIDS and co-infections. To achieve these outcomes, guidelines for referral and management of HIV co-infections should be developed.

Output: Guidelines for referral and management of HIV and Hepatitis B/C co-infections

Output indicator: Country-specific guidelines for referral and management of HIV and Hepatitis B/C co-infections are drawn up

The leaders of WP 7 decided not to use the term «guidelines». Guidelines are mainly used in the context of professional societies of the physician or in Eastern and Central European countries from ministries of health. Guidelines have a binding character for the physicians (cf. P129: 49). The leaders from WP 7 advised to use the term «recommendations» instead of «guidelines». The recommendations for referral and management of HIV and Hepatitis B/C co-infections according to the international treatment guidelines are drawn up (cf. P129: 47-59) and were available since 05. October 2012. This includes training materials to educate physicians in handling HIV and Hepatitis B/C co-infections. There exists also education material for the treatment of late presenters and post-exposure prophylaxis. The recommendations were developed and discussed during two workshops in Germany and Poland (P129: 37). The main focus of these workshops was to augment the interlinking in referral systems for diagnostic, treatment and care of HIV and Hepatitis B/C co-infections, therefore no sexual and reproductive health issues were included. Also prevention issues, i.e. vaccine campaigns were only marginally mentioned and were used to identify vulnerable groups (P129, 14:88-93).

Output indicator: In elaboration of the recommendations, professionals of HIV prevention, diagnostic and treatment were involved at equal parts

In the first workshop in Germany, 19 participants from 4 EU-Countries and 1 Non-EU-Country were involved. In the second workshop in Germany/Poland 17 professionals from 3 EU-Countries and 1 Non-EU-Country participated. There were mainly professionals of HIV diagnostic and treatment, but also professionals of prevention were involved (cf. 129: 93-97).

Output indicator: Particularities of local contexts and target groups, especially gender-related aspects are considered

In 7 European countries (Bulgaria, Romania, Estonia, Slovakia, Ukraine, Poland, and Germany), the country-specific medical conditions in diagnostic and treatment of HIV and Hepatitis B/C co-infections were analyzed. The overall aim of the stocktaking survey was to collect relevant data about the current situation of HIV/AIDS and co-infections for country specific guidelines on HIV/AIDS and Hepatitis B/ co-infections (P60, 2:46-2:152).

The physicians from the participating countries were aware of the particularities of their local contexts and helped to consider them. Also they used the elaborated training material in their own country (cf. P129: 32).

Target groups for the recommendations and the training material respectively were especially private physicians, but also the participating partners in WP 7. Moreover, public health policy makers should be aware of these recommendations and support the implementation in their countries (P129, 21:144).

Output indicator: The recommendations consider ethical principles

There were no ethical principles discussed in the workshops, because WP7 leaders and participating partners didn't see any problems with anonymity or informed consent of patients in HIV/STI testing and treatment settings in their countries. But in some

countries testing is voluntary but not anonymously. There is a need for a change, but without political support it will be difficult to realize (P129, 17:104-115).

Outcome: Enhanced interlinks in referral systems for diagnostic, treatment and care of HIV and Hepatitis B/C co-infections

The enhancement in referral systems for diagnostic, treatment and care of STIs, HIV/AIDS and co-infection was defined as the outcome of this work package. But the self-evaluation in the online-survey shows, that only 5/12 considered that the referral systems for diagnostic, treatment and care of STIs, HIV/AIDS and co-infections were enhanced by the output of WP7. Seven thought the referral and management of infections were little to somewhat enhanced.

With regard to the other aim of the work package, we identified the same pattern: 5/12 were convinced that the aim to augment the country-specific evidence in treatment and care of HIV and co-infections had been achieved. Seven thought that this aim is only little to somewhat achieved.

Outcome indicator: The elaborated recommendations for referral and management of HIV and Hepatitis B/C co-infections are applied by 70% of the partners participating in WP7.

An indicator for the achievement of this outcome has been that 70% of the partners participating in WP7 would apply the elaborated recommendations for referral and management of HIV co-infections. The information about whether this aim has been achieved or not, is limited due to the fact that only 5 partners participating in WP7 completed the online-questionnaire. WP leaders itself were missing. However, 4/5 knew the recommendations and applied them in their clinics or organizations. They also consider these recommendations as very helpful and participants reported that they improved the collaboration between diagnostic, treatment and care. Only one participant thought that the guidelines for referral and management of STI, HIV/AIDS and co-infections were complicated or unnecessary.

Work Package 8: Participatory approaches

The aim of work package 8 was to improve HIV/STIs in a two-and-a half-year period community based prevention and sexual health for ethnic minorities (e.g. ROMA) and migrant groups. To achieve this outcome, a capacity building in participatory prevention models should be developed. As outputs were defined a manual on effective intervention models for participatory community based HIV/STI prevention and two training seminars in three good practice models in participatory HIV/AIDS prevention for ethnic minority/migrant groups.

Output: Training seminars and competence building workshops in good-practice models of participatory HIV/STI prevention for ethnic minority/migrant groups

Output indicator: 20 multipliers were trained on 3 good practice models of participatory HIV prevention among ethnic minority/migrant groups

Participants of the exchange seminar were 30 professionals and peers (incl. facilitator's teams) from 7 EU and 1 NON-EU country (See Annex 2). Target groups were only involved in the POL training or as basis of evidence for a model of participatory approach. Trainers of community based outreach workers and cultural

mediators (e.g. ROMA) build capacity in use of the evidence-based method POL and three further methods in participatory HIV/STI community based prevention. The other 3 methods were:

1) The Aids&Mobility model, co-developed and presented in the projects by the Estonian A&M partner, the Aids Information and Support Centre (Tallinn, Estonia);

2) The PARC model, developed and presented by AHW (Vienna, Austria);

3) The PaKoMi model, developed by DAH, WZB (supported by the German Ministry of Health) and presented by DAH (Berlin, Germany) (P104, 3:1879-3:3068)

Output indicator: Manual on effective intervention models for participatory community based HIV/STI prevention is published and disseminated

One of the defined outputs of this work package was a manual for developing trainings on community-based HIV prevention. Further training programs in community HIV prevention among ethnic minority and migrant groups should base on this manual.

In the online-survey participants differed in their statements regarding whether the manual has been published or not. Only 4 of the WP8 partners completed the online-survey. Whereas 2 of them said that the manual was published, the other 2 said that it hasn't yet been published. The same answer pattern was shown in the question about distribution of the manual.

But the manual is in elaboration. A draft for a common structure of the manual has been developed, which aims to present the experiences of the 4 models for participatory involvement and community-based prevention (P104: 21:971-21:1177). The final version will be presented at the project evaluation conference that will take place in Berlin, 22-23, October 2012.

Output indicator: Particularities of local contexts and target groups, especially gender-related aspects are considered

All 4 online-survey-participants agreed that the manual considered particularities of local contexts and gender specific concerns and questions.

Target group of the POL method training were 19 young men of a Roma community. The other 3 methods were suitable for migrants, female and male sex workers and migrants MSM. The A&M model was especially developed for ethnic minority communities of Russians in Estonia.

Gender issues were especially addressed in "communication about sexuality". This topic has a cornerstone importance when addressing the issues of HIV/STIs risks and when having to handle various gender and cultural norms and stereotypes spread in different communities.

Output indicator: Focus on HIV and STI, but sexual and reproductive health issues are considered, too

The manual on community-based HIV prevention also integrated questions concerning sexual and reproductive health issues. The 19 POL acquired correct knowledge about HIV/AIDS/STIs, safe sex practices and risk assessment. The Estonian A&M Training of cultural mediators contained HIV and STI issues, as well as SRH-issues. Moreover it contained also harm reduction for IDU (P104: 9:1880-10:231)

Topics were:

1. Migration and HIV/AIDS
2. Basic knowledge of HIV/AIDS
3. Basic knowledge of hepatitis
4. Support system and services
5. Living with HIV/AIDS
6. Family planning and sexual health
7. Why don't we talk about sexuality?
8. Basic knowledge of harm reduction (exchange of syringes, safer use, substitution)

The PARCproject had five key messages that focused on HIV and STI but not on other SRH-issues:

1. HIV/AIDS is not a death sentence!
2. Know your status – get tested!
3. Using a condom prevents you from getting HIV!
4. Social contacts with HIV+ don't put you at any risk!
5. Hepatitis B is a viral infection of the liver – get vaccinated! (P104, 7:1474-7:1539)

Output indicator: Ethical principles are considered

All of the participants of online survey confirmed that ethical principles have been taken into consideration while working with community-based approaches and have been included in the manual, too.

HESED as the leading partner of the work package 8 has an own ethical commission that independently reviews the projects in WP 8 (cf. P136: 237).

Outcome: Improved community based prevention and sexual health for ethnic minorities and migrant groups

The outcome of this work package was to improve community based prevention and sexual health for ethnic minorities and migrant groups. In self-evaluation 6/11 considered that this outcome has been achieved, whereas 3 had the opinion that the outcome has been little to somewhat achieved. Actually 2 said that community based prevention and sexual health for ethnic minorities and migrant groups were not at all improved by WP8.

Outcome indicator: Different ethnic minorities, migrant groups, genders, sexual orientations are part of the community based HIV prevention

Community-based participatory HIV prevention among Roma Community in Bulgaria has been established. The POL (public opinion leader) method was used to train leaders in the Roma Community (P28, 1:20-1:99) for participatory prevention work. During the training period of 3 months, 19 Roma young men aged from 16 to 25 from 4 different friendship networks and part of the Fakulteta Roma neighborhood in Sofia, Bulgaria were trained in POL method. All of them had less than a primary education. They were gathered during the regular outreach work. Most of them are selling sex to men. Most of them have rich experience in experimenting with different kind of drugs (marihuana, cocaine, heroin etc.) (P28, 1:239-1:722).

All 19 trained POLs conducted approximately 230 prevention conversations with friends and 59 boys were tested voluntarily for HIV, Syphilis, Chlamydia and Gonorrhea (P28, 3:3352-4:156).

Community-based prevention in Austria focused on migrants from Sub-Saharan-Africa. Within a period of 3 months a total of 5195 person were reached and trained in the Mapping method. 80% of them had African origin, the rest were partners of persons with African origin, or others affiliated to the African community. The bigger part were male representatives, around 3000, 2000 were female (P104, 3:1879-3068).

In Germany and Estonia, migrants, female and male sex workers and migrant MSM were part of the community-based prevention.

Work Package 9: Quality assurance in youth prevention

The aim of work package 9 was to enhance accountability and evidence-based evaluation in youth HIV/STIs prevention, sexual and reproductive health and rights (SRHR) programs by end of 2011. To achieve this outcome, an online evaluation and quality improvement tool for youth HIV/STI prevention, sexual and reproductive health and rights (SRHR) programs should be developed.

Output: Online evaluation and quality improvement tool for youth HIV/STI prevention, sexual and reproductive health and rights (SRHR) programs

Output indicator: Online evaluation tool for quality assessments of youth prevention actions is piloted, evaluated and available in the Internet

An online tool for quality assessment of youth prevention was developed, piloted and evaluated by the participating partners of WP9.

A process documentation section has been added to the tool which now consists of three steps: documentation of project processes, evaluation and quality improvement. A first print version of the online tool QUIET was developed.

A first version of the tool was programmed and made accessible online at the second expert meeting in March 2011. Each partner reported his experience in using the QUIET tool to evaluate and improve their ongoing projects. Divided into three working groups the online version of the tool was analyzed and suggestions for improvement were documented.

The tool contains mostly behavioral prevention strategies but biomedical and structural strategies are provided too. Moreover the tool does not only focus on HIV/STIs prevention, but questions about sexual and reproductive health issues were also integrated. Ethical principles were not considered (P112: 77).

Output indicator: Guidelines for evaluation of various methods and measures of youth prevention are drawn up

At the first expert meeting different models were discussed. The “Evidence and rights based planning and support tool for SRHR/HIV prevention” by World Population Foundation & Stop Aids Now was introduced. SPI and Aids-Hilfe Wien selected (cf. P112: 20-30) this model due to its evidence based approach, comprehensive scope of HIV prevention and SRHR promotion, focus on youth projects and systematic structure on intervention mapping.

This tool was the basis to develop an own tool for measuring quality in youth prevention, the QUIET tool.

Output indicator: For the elaboration of the online tool for quality assessment, professionals of HIV prevention, diagnostic and treatment were involved at equal parts

The elaboration of the tool was done by 16 partners mostly professionals of (youth) prevention. The tool was adapted in a participatory process, involving all project partners according to criteria of easy manageability and covering of core issues of the youth projects.

Output indicator: 30 youth prevention workers and peer educators from 10 countries were trained in quality improvement of HIV/STI prevention and SRHR

Two training expert meetings and a lunchtime seminar in the frame of the IAC 2010 took place. Whereas in the first meeting different models of quality assessment were discussed and a first draft of the QUIET tool was drawn up, in the second meeting the tool was evaluated. At the lunchtime seminar the tool was presented and other interactive youth prevention models were demonstrated (Youth prevention in action: Demonstration of Dance4Life: delivered by JAZAS, Serbia).

Output indicator: Particularities of local contexts and target groups and especially gender-related aspects are considered

The WP9 including 5 NGOs from Germany (AHP and MAT), Poland (POMOST), Latvia (LAFPSH, Papardes Zieds, partner since July 2011) and Romania (ARAS) and 2 state organizations from Estonia (NIHD) and Poland (SPWSZ).

All associated partners contributed to the compiling of RAR, to the development and review of the QI instrument, exchanged good practice in youth prevention during the first expert meeting and developed jointly the guidelines for quality improvement of youth prevention. In the next phase they evaluated their youth projects and participated, planned and conducted the Lunchtime Satellite Seminar at the IAC. All partners tested the QUIET tool on one of their running projects and their suggestions for improvement were included. The online versions of the QUIET were analyzed in a participatory process and all partners' suggestions for alterations were included.

The target groups for using the QUIET were professionals in youth prevention. The addresses different youth populations, ranging from general youth in age groups (12 to 15, 15 to 24 or up to 30 years) to young people from risk groups. Gender-aspects were considered in form of questions especially for Boys and girls.

Outcome: Enhanced accountability and evidence-based evaluation in youth HIV/STI prevention and SRHR programs

In self-evaluation, 4/8 reported that the accountability and evidence-based evaluation of youth HIV/STIs prevention and SRHR programs were enhanced and 3 thought that this aim was little to somewhat achieved. Only one participant considered that the outcome was not at all achieved.

Outcome indicator: 70% of the partners participating in WP9 apply the online youth HIV prevention evaluation tool

As an indicator for achievement of the outcome, 70% of the partners participating in WP9 should apply the online youth HIV prevention evaluation tool. Unfortunately only 1 of the partners participating in WP9 completed the questions concerning WP9.

Therefore we had no information about the use of the tool and its usability and can't make any statement about the achievement of this outcome.

Conclusion

The external evaluation shows that most of the expected outputs and outcomes of the project BORDERNETwork have been achieved. The project especially maintained the balance between HIV/STI prevention, diagnostic and therapy. In every work package, prevention, diagnostic and treatment issues were tried to combine and behavioral and biomedical interventions were developed. Therefore, combined prevention had really been scaled up. Also the particularities of local contexts and target groups were reflected by collecting target-group related data and country-specific experiences of the involved partners. Civil society resources were mobilized by the involvement of target groups into prevention, especially in the community-based prevention projects. Different public health stakeholders were also integrated and were also supporting the project, especially National Ministries of Health.

Also in view of the participating countries and the partners of BORDERNETwork respectively, the outcomes were achieved. Only concerning improvement of community based prevention and sexual health for ethnic minorities and migrant groups and enhancement of interlinks in referral systems for diagnostic, treatment and care of HIV and Hepatitis B/C co-infections, the participants were not completely convinced that these aims have been achieved.

The participating partners were also very satisfied with the support they got from their organizations and the Leading House SPI Research, gGmbH, Berlin. This shows that a good coordination and a research-based framework for the development of the concepts were part of the successful realization of the project BORDERNETwork. Moreover, the political and financial situation in the Central and Eastern European countries, especially in the period of the ongoing economic crisis in Europe were quite difficult and complicated the realization of the project. Therefore, the project BORDERNETwork did a great effort to achieve the aims.

For sustainability of the project BORDERNETwork and to maintain the developed concepts and to support their implementation, it is very important that the public health policy makers commit to the outputs and outcomes of the project and the different work packages respectively. First steps into this direction were already made by meeting local public health stakeholders at round table discussions. One of the participating partners already signed a letter of intent with a local public health stakeholder. These efforts should be intensified and more public health policy makers should be won. Moreover, also financial resources are necessary to sustain and refine the highly active prevention across sectors and borders in Central, East and Southeast Europe.

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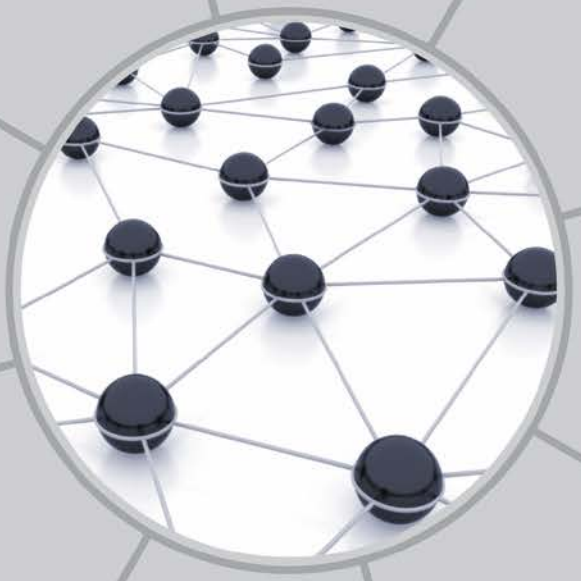

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