# REPORT

## ON FORMATIVE EVALUATION RESULTS OF THE YOUTH-FRIENDLY HEALTH SERVICES DEVELOPMENT PROJECT IN THE FERGANA PROVINCE AND THE TASHKENT CITY

**Tashkent, 2008**

unicef

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# LIST OF ACRONYMS AND ABBREVIATIONS

| | |
|---|---|
| ARP | Anti-Retroviral Prophylaxis |
| ART | Anti-Retroviral Therapy |
| HIV | Human Immunodeficiency Virus |
| WHO | World Health Organisation |
| GFATM/GF | The Global Fund to fight AIDS, Tuberculosis and Malaria / Global Fund |
| OAS | Open-Access Services |
| VCCT | Voluntary Confidential Consulting and Testing |
| SS | Sentinel Surveillance |
| ICT | Information and Communication Technologies |
| STI | Sexually Transmitted Infections |
| IEA | Immune-Enzyme Analysis |
| CC | Confidence Centre |
| IDR | Infectious Diseases Room |
| PLWH | People Living With HIV |
| MIA | Ministry of Internal Affairs |
| MH | Ministry of Health |
| M&E | Monitoring and Evaluation |
| MJ | Ministry of Justice |
| MC | Makhalla Committee |
| MMS | Male to Male Sex |
| NGO | Nongovernmental Noncommercial Organisation |
| UN | United Nations Organisation |
| IDU | Injection Drug Users |
| MARA/YP | Most at Risk Adolescents/Young People |
| MARA | Most at Risk Adolescents |
| PHCC | Primary Health Care Centre |
| PMTCT | Prevention of Mother-To-Child HIV Transmission |
| SSI | Semi-Structured Interview |
| AIDS RC | AIDS Republican Centre |
| RUz | Republic of Uzbekistan |
| SanPiN | Sanitary Regulations and Standards |
| RMC | Rural Medical Centre |
| CDC/CAR | Centre for Disease Control/Central Asian Region |
| CCC | Country Coordination Committee |
| MM | Mass Media |
| FP | Family Polyclinics |
| AIDS | Acquired Immune Deficiency Syndrome |
| WIS | Welfare Improvement Strategy |
| SW | Sew-Worker – an individual providing sexual services for consideration |
| YFHS | Youth-Friendly Health Services |

| | |
|---|---|
| YFS | Youth-Friendly Services |
| FGD | Focus Group Discussion |
| CMH | Central Municipal Hospital |
| CPH | Central Province Hospital |
| CDH | Central District Hospital |
| MDG | Millennium Development Goals |
| EAEC | Extraordinary Anti-Epidemic Committee |
| UNDP | UN Development Programme |
| UNICEF | UN International Children's Emergency Fund |
| UNODC | UN Office on Drugs and Crime |
| UNAIDS | Joint UN Programme on HIV/AIDS |
| UNFPA | UN Fund for Population Activities |
| USAID | United States Agency for International Development |
| PSI | Public Service International – an international NGO |

# EXECUTIVE SUMMARY

At present, fostering of healthy generation is prioritised in both individual countries and the world community as a whole. Modern youth problems draw attention of various social institutions. This attention is caused by the specificity of this population group as its development level immediately determines the future. Health care institutions play the leading part in healthy generation upbringing. The HIV/AIDS spread and the growing number of youth with risky social behavior require revision of current public control systems. In this context, the state pays great attention to professional development of health providers and improvement of clinical servicing quality.

Beginning from 1998, Uzbekistan implements the National Health Care Reforming Programme focussed on provision of constitutional rights of population to qualified medical services and social security, and establishment of institutional, economic and legal framework for improvement of medical services quality, healthy generation fostering and adjusting the health care system to on-going national reforms. The implemented reforms have resulted in a noticeable improvement of some institutional and demographic figures. However, for some of socially significant diseases such as HIV/AIDS, the situation remains strained.

Similarly to many other countries of the world, Uzbekistan has encountered the problem of the human immunodeficiency virus (and subsequent AIDS) spread among population. The first infection cases among nationals have been registered as early as 20 years ago, in 1987. Currently, experts consider the epidemic to be at the concentrated development stage, when HIV is predominantly accumulated within so-called at-risk groups, including, first of all, injection drug users, sex workers and men having sex with men. However, it is necessary to note that HIV gradually penetrates to the general population as well. This is greatly due to such factors as the demographic situation in the country and the population's awareness of HIV/AIDS. Uzbekistan is a young population country. The average age is 23.9 year, almost a half of population comprising youth under 16 years. According to experts' estimates, this youth demographic profile would prevail in the first half of the current century[1]. Evaluation of youth awareness of HIV/AIDS shows that the situation now is far from being ideal. Most of young people are poorly aware of HIV transmission ways and protection methods. Concurrently, a bigger number of young people practice unprotected sexual contacts with irregular sexual partners. All the above argues for youth programmes to be prioritised within HIV/AIDS prevention projects. Moreover, the top priority must be given to programmes for the specific youth group – most at risk adolescents and young people (MARA/YP).

A recently conducted Knowledge, Attitude, Practice and Behaviour (KAPB) Survey on HIV/STI and Drug Misuse among the Most At Risk Adolescents (MARA) aged 10-18 years who inject drugs and/or sell sex, or engage into male to male sex, showed that only 4% of adolescents involved in selling sex identifies accurately all modes of HIV transmission, or named all prevention means of reducing the risk of contracting HIV. 36% of these adolescent girls didn't know anything about HIV/AIDS. A relatively similar low level of awareness about HIV can be seen among adolescents injecting drugs. Unfortunately MARA consistently drop out from all existing HIV prevention programmes.

To address the above issues two sets of strategies were developed by UNICEF in close consultation with local partners, in order to introduce an integrated essential package of youth friendly health interventions for HIV prevention among the Most at Risk Adolescents (MARA) groups in selected hot spots of Uzbekistan.

A key element of the proposed strategy was to reach out to MARA through peer education and outreach work in areas with the highest concentration of injecting drug users and HIV prevalence. Another part of the overall strategy is seen to increase the performance of Youth Friendly Health Service providers.

According to existing national legislation selling sex and engaging into male to male sex are illegal in the country and every STI case must be investigated to trace the entire chain of contacts. These legal provisions are big obstacles to organize any effective prevention work among risk groups. In particular, this applies to groups of minors/adolescents (10-18 years old) forming the key target group of the YFHS Project. To overcome this issue at least on regional level, the Regional Health Department of pilot area adopted a Decree, which authorised the use of Unicode (unified identification code) system in referring MARA group representatives from primary health

[1] Cabinet of Ministers of the Republic of Uzbekistan. Analysis of situation and performance of HIV infection control measures in the Republic of Uzbekistan in 2003-2006.

care level to specialized services such as STI clinics and drug dispensaries.

The strategy is being implemented since 2006 in 3 hot spot areas of Ferghana region and Chilanzar district of Tashkent. Starting from March 2007, additional 3 hot spot areas were included under the YFHS project in Ferghana region e.g. (Kirgeli, Bagdad and Kuvasoy districts). As per recommendations from the government, it is planned to expand YFHS project in Andijan, Samarkand and Tashkent regions in 2008-2009. It is crucial to have reliable, accurate and comprehensive information on the YFHS project, e.g. its impact, achievements and constraints so that to most efficiently explicate the project pilot stage experience to other regions of the country. For this purpose, it was decided to conduct a comprehensive analysis and evaluation of the YFHS Project in order to generate relevant recommendations for further scaling up in other regions of Uzbekistan.

This report consists of two major sections. The first section contains the project environment analysis. The project was analysed for its compliance with both international guidelines and key documents and the national domestic policy. Analysis results have shown that basic directions of the YFHS initiative are in strict compliance with all key international documents aimed at improvement of adolescents and youth health care in different countries. These key documents include: the Millennium Development Goals; the Convention on the Rights of the Child; the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW); and Declaration of Commitment on HIV/AIDS. The YFHS Project is also fully consistent with national key documents including the Strategic Programme for Prevention of HIV Infection Spread in the Republic of Uzbekistan in 2007-2011, and the Welfare Improvement Strategy (WIS) (Chapters 1.1. and 1.2.)

Prior to key activities implementation, project executives performed the pre-project evaluation, which enabled formulation of the basic needs of MARA/YP, including access to reliable information on STI and HIV/AIDS; hazards of using drugs, in particular, the injection ones; and potential support from health providers to youth and adolescents in health servicing arrangements, etc. This facilitated the proper planning of main interventions for improvement of supportive initiatives (Chapter 1.3.).

This evaluation included the structural and functional analysis of the existing health care system at the primary care level, which allowed assessing of the system capacities for organisation of youth and adolescents friendly services and identify the areas of its improvement (Chapter 1.4.)

The second section of the report provides information about the project design, evaluation of its potential and the project impact (Chapters 2.1., 2.2 and 2.3.). During the project lifetime, great efforts were made to establish the national methodological basis of youth-friendly health services, and the initiative was practically implemented in the country capital and the Fergana Province – one of the most densely populated regions. The project team has developed and tested YFS introduction norms and standards. The YFS standards package was developed based on the advanced international experience. In addition, the international practice was appropriately adapted to local conditions. The developed standards were tested with involvement of different level experts, immediately with service providers in health care and non-medical sectors and with beneficiaries. Thus, the key principle of participation and involvement of a big number of stakeholders in discussion of the new initiative was adhered, and, as a result, the YFS standards package was developed. In addition, manuals were developed, youth service providers were trained, and local imitative groups were formed to introduce the YFS initiative.

In course of project activities, the expert team has developed the manual "Development and Introduction of YFHS Standards", including the standard introduction stages, stakeholder integration mechanisms and protocol development framework aimed at reduction of HIV/AIDS spread among most at risk adolescents. Moreover, the manual "Principles of Outreach Activity Arrangement" was developed to inform health providers on the philosophy of work with risk group members in the sphere of HIV/AIDS prevention, including the principles of involvement and training of volunteers from young people. In 2007, activities were carried out predominantly among MARA/YP groups in order to inform them of STI, HIV/AIDS and provide them with specific medical support.

Based on the evaluation results, the three provisional key areas with the most significant project achievements have been identified: advocacy, introduction of YFHS standards itself, and training and education of the key project groups in STI and HIV/AIDS issues.

Although the project executives gave a third-level priority to the advocacy of YFHS standards introduction in the national health care system as an additional component, the most considerable results were achieved exactly in

this sphere. Interests of most at risk adolescents and young people were promoted at all basic levels: national, regional and the level of individual cities/towns, districts, communities and groups.

Based on successful results of the YFHS initiative piloting, the Government has approved the YFHS standards for MARA/YP, their introduction at the national level and their inclusion in the National Programme for HIV/AIDS Prevention in 2007-2011. UNICEF/Uzbekistan, the Global Fund for Fight Against AIDS, Tuberculosis and Malaria and the Project "HOPE" were involved for support and efficient implementation of the programme.

According to the project evaluation results, the expert team has generated the key findings and provided the most important recommendations for further project extension to other regions of the country, and recommendations for improvement of the already implemented initiatives' sustainability.

Generally, the evaluation results may be summarized in the following key findings and conclusions:

The approach is integrated into current health care structures and practices, with its direct consequences being as follows:

- Activities are not only focussed on an individual population category, but also extend to other categories. As a result, one may expect a certain improvement of medical services quality for all potential clients of medical establishments, irrespective of belonging to a social or demographic category.
- Great involvement of medical personnel in provision of YFHS. Participation of health providers in outreach activity is a definite advantage of this approach.
- Project sustainability. Unavailability of a direct financing does not affect the activity cycles.
- Implemented activities are not considered as temporary/project-specific, but are of a prolonged nature
- Activities involve not only the personnel immediately dealing with this issue, but also other staff of medical establishments from head physician to security.

The project implementation has provided a synergy of various stakeholders. Notable are the active cooperative efforts of counterpart organizations such as local authorities, the Global Fund, and Ishonch va Hayot and Salomatlik+Ekologiya NGOs.

High fluctuation of local personnel has been reported. As a result, it is necessary to arrange regular orientation workshops to inform about main aspects of YFHS and associated standards. Moreover, the problem is also reflected in a low level of medical personnel's awareness of HIV/AIDS. In some cases, medical graduates are poorly aware of the above issues.

Project monitoring and evaluation system needs further improvement. The Project specificity excludes using of standard approaches to evaluation activity. In some cases, use of standard forms locally may bring to attempts of providing insufficiently reliable data and, thereby, to distortion of ultimate results.

# EVALUATION METHODOLOGY

The project was evaluated in accordance with the following key indicators: relevance/urgency; efficiency and impact; cost effectiveness; and sustainability.

For the project relevance/urgency indicator, the key foreign and domestic documents have been defined, against which conclusions have been made on the project's consistency with international basic principles of youth and adolescent's health care, and the primary national policies and programmes. The project urgency was evaluated in terms of compliance of its goals and tasks with the priority needs and demands of most at risk adolescents and young people from the viewpoint of potential STI and HIV/AIDS infection.

For the Efficiency/Impact indicator, the project was evaluated in terms of the achieved potential and impact on both the key target group of MARA/YP and the main institutions providing health care support. Within these important categories, particular attention was given to the issues of coordination, integration and coherent activities in both the health care sector and intersectoral cooperation of counterparts.

In course of the evaluation, consideration was also given to the cost effectiveness of the project and its justification from the viewpoint of inputs and resulting external environment effect as well as the further development potential. The project development potential was evaluated from the perspective of its sustainability and nation-level dissemination of positive experience. Another important element of the project evaluation was the considered advocacy component implemented in course of the programme execution.

Key questions were formulated for every of the basic indicators and underlay the evaluation strategy and data collection procedure.

The project evaluation methodology was based on a combination of several classical evaluation approaches. On the one hand, the external project environment evaluation or so-called situation analysis was made. Since the project was implemented within the general regional project representing the concept of HIV/AIDS spread prevention in the Central Asian Region, the situation analysis was performed with regard to relevant international and local guidelines and fundamental documents. In addition, the basic demands of the project key groups were analysed, and the existing practice of health care servicing of youth and adolescents was reviewed.

The second important component of the project evaluation methodology was the analysis of internal project environment and the assessment of impact on the key target groups and stakeholders. The project design, embedded potential and the achieved impact level were evaluated in detail. The key questions included:

- What has been done during the project period and what is being done now?
- Is ongoing activity consistent with the established tasks?
- Is this activity concentrated on the priority areas?
- Is it efficient in the priority areas?
- Why is this activity efficient or inefficient?

Information was collected with use of a combination of standard qualitative and quantitative methods: analysis of secondary data, semi-structured interviews (SSI) with key informants, standardised quantitative interviews (SI) with key informants, focus group discussions (FGD), and observation. The main information sources for each of the used methods were defined as follows. The secondary data analysis is based on the following documents:

1. General information on the country as a whole and on target regions of the project;
2. Information about the HIV/AIDS spread level and rate;
3. International and national documents immediately related to the YFHS introduction initiative and STI/HIV/AIDS prevention;
4. Information about developed strategies, programmes, procedures and their implementation mechanisms in the YFHS project sphere;
5. Project monitoring and evaluation data from the key regions; and
6. Available results of previous surveys/evaluations/programme reports, etc.

The following expert groups were defined for standardised and semi-structured interviews and discussions on given topics:

1. Interview with experts – representatives of local authorities and province, municipal and district health care departments involved in implementation of the YFHS introduction initiative.
2. Interview with project managers and their key counterparts in the selected regions.
3. interview with key medical staff of PHCC, outreach-workers and representatives of MARA/YP about their awareness of STI, HIV/AIDS.
4. Focus group discussions with representatives of basic PHCC-s involved in implementation of the YFHS project and MARA/YP representatives – YFHS users.

**Table 1. Distribution of FGD, SSI and SI numbers by regions and key evaluation groups**

| *Region* | *Focus-group discussions* | *Semi-structured interviews* | *Standardised interviews* |
|---|---|---|---|
| **Representatives of local authorities** | | | |
| Fergana Province | _ | 1 | |
| **Representatives of NGOs** | | | |
| Fergana Province | _ | 1 | |
| **Health providers** | | | |
| Fergana Province | 1 | 5 | 14 |
| Chilanzar District, Tashkent City | 1 | 4 | 8 |
| **Outreach-workers** | | | |
| Fergana Province | 1 | _ | 10 |
| Chilanzar District, Tashkent City | 1 | _ | 8 |
| **Most at risk adolescents** | | | |
| Fergana Province | 2 | 3 | 14 |
| Chilanzar District, Tashkent City | 2 | 1 | 15 |
| **TOTAL NUMBER of respondents during qualitative and quantitative data collection:** | **8** | **15** | **69** |

Field trips for collection of basic project performance data included focus-group discussions, semi-structured interviews and standardised interviews with the following groups (see the Table):

- Structured observations at the servicing level – visits to PHCCs in the Fergana Province and the Tashkent City;
- Individual semi-structured interviews with the key stakeholders and beneficiaries.
- Focus-group discussions with most at risk adolescents and young people with the view of studying their vision of such services.
- Focus-group discussions with outreach-workers in order to define difficulties and achievements of the YFHS project implementation.
- Focus-group discussions with health providers and main counterparts from MoH.
- Standardised interviews with health providers, outreach-workers and MARA/YP representatives aimed at determining their awareness of STI and HIV/AIDS.

The evaluation report provides the analysis of both quantitative and qualitative data. Certain measures were taken to ensure evaluation process ethicality and respondents' protection. Data sources remain anonymous, and the final report contains no indications of survey participants' personal data.

**The "Awareness of HIV/AIDS" Indicator Estimation System**

It is necessary to note that a standard set of several indicators is used for evaluation of awareness of HIV/AIDS. These indicators were incorporated in this survey's estimates. They include the following criteria:

- A respondent must correctly list/identify all exact ways of HIV/AIDS transmission
- A respondent must correctly identify all wrong options of HIV/AIDS transmission ways
- A respondent must mention at least 3 ways of HIV/AIDS transmission prophylaxis. In the questionnaire, this criterion is represented by the question: What measures do you know to prevent HIV/AIDS transmission between individuals?

The primary questions to determine the respondents' awareness level have been included in the special questionnaire developed by the working group for independent completion.

**The system of Evaluation of PHCCS for Their Compliance with the Youth-Friendly Health Servicing Standards**

Evaluation of PHCCs' compliance with YFHS quality characteristics was based on the indicators approved by the Ministry of Health. The indicators have three levels of implementation: minimum, average and maximum. Every level is related to a number of requirements, which are evaluated by both internal PHCC evaluation experts and external experts assigning appropriate values: yes or no. Then the indicators are counted and appropriate curves are drawn, indicating the main achievement and shortcomings of PHCC in adhering to standards. Details of counting results have been provided in Chapter 2.3. "Project Impact Evaluation" hereof.

# MAIN RESULTS OF THE EVALUATION

## SECTION 1. ANALYSIS OF THE EXTERNAL PROJECT PERFORMANCE ENVIRONMENT: INTERNATIONAL AND NATIONAL LEVELS

### 1.1. Project Compliance with the Basic International Documents in Terms of HIV Spread Prevention

Even in the most difficult periods of the young state establishment, Uzbekistan leadership along with other urgent problems paid particular attention to the social sphere as the most important and topical for people. The socially-oriented policy plays very significant part in the country with youth constituting a half of 27-million population. Reforms in this sphere in Uzbekistan, first of all, are focussed on public interests, welfare of growing generations, and long-term and dynamic advancement of the country. Health care system is one of the most important areas of national social reforms. Its structure, functions and the rights of citizens to medical services are defined in the Law of the Republic of Uzbekistan "On the Health Protection of Citizens" and other laws and regulations of the Republic of Uzbekistan. In 1998, the National Programme was adopted, which envisaged a stepwise transition to the National Health Care Model development. At present, Uzbekistan operates a unified system of medical aid to population, which represents a combination of governmental, private and other health care systems[2].

In course of implementation of the national health care policy, priority always has been and is given to the youth group. Various health care institutions carry out different activities for this group with regard to information and medical culture improvement, consultation and treatment. In spite of considerable achievements of on-going reforms, there are some areas where activities must continue and develop even more intensively. One of such areas is the prevention of HIV infection spread, the rates and level of which keep spreading over the country in the past ten years. Numerous studies of both local and international experts and organisations show that young people are particularly vulnerable to HIV-infection. It is necessary to bear in mind that the younger age groups are covered with prophylactic activities, the higher is the effect of HIV infection prevention.

**Table 2. Important youth-friendly health services**

| |
|---|
| ✓ General health (endemic diseases, traumas, tuberculosis, malaria) |
| ✓ Sexual and reproductive health (STI, contraception, pregnancy management) |
| ✓ HIV-related voluntary confidential consulting and testing (VCCT) |
| ✓ Sexual assault treatment |
| ✓ Psychic violence |
| ✓ Use of harmful narcotics (including injection drugs) |
| ✓ Information and consulting on some issues (such as reproductive and sexual health, use of harmful drugs, etc.) |

One of such important activities considering interests of youth and adolescents is the implementation of the international Youth-Friendly Health Services initiative. According to the initiative, young people must be provided with access to medical services of at least seven basic types: general health, sexual and reproductive health, HIV-related VCCT, treatment of sexual assault or psychic violence, prophylaxis of using harmful drugs including injective ones, and provision of information and advices on all interesting health care matters (see Table 2).

The fundamental spheres of the international initiative are closely coordinated with all key international documents adopted in order to improve youth and adolescents health care status in different countries. These key documents include: the Millennium Development Goals; the Convention on the Rights of the Child; the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW); and Declaration of Commitment on HIV/AIDS.

The Millennium Summit organised by UN in 2000 has gathered leaders of 189 states to draw their attention to the most urgent global challenges. The states have got the unique opportunity to combine their efforts for poverty control, improvement of access to basic services, reduction of diseases spread and environment protection. The Millennium Declaration has defined the global Agenda for the twenty first century and set the tasks aimed at achievement of eight specific goals known as the **Millennium Development Goals (MDG)**, which represent a road map of development until 2015. The Millennium Development Goals are a framework wherein the world leaders have agreed the most important actions to reduce poverty level and improve people welfare. It depicts eight interrelated development goals with

[2] Uzbekistan – The Independent Development Way, "Uzbekiston", Tashkent, 2006

specific timing, tasks and indicators, which can be used to measure the goals achievement progress. MDG focus the world community's efforts on attainment of essential and measurable improvements in people life and establish the evaluation criteria for achieved results:

GOAL 1 – Eradicate extreme poverty and hunger
GOAL 2 – Achieve universal primary education
GOAL 3 – Promote gender equality and empower women
GOAL 4 – Reduce child mortality
GOAL 5 – Improve maternal health
GOAL 6 – Combat HIV/AIDS, malaria and other diseases
GOAL 7 – Ensure environmental sustainability
GOAL 8 – Develop a global partnership for development

The first seven goals are aimed at reduction of poverty in all its aspects: hunger, insufficient incomes, poor education and health care quality, gender inequality and environment deterioration. The aggregate achievement of these goals ensures a comprehensive poverty reduction approach. The eighth goal facilitates the attainment of the first seven goals. First of all, it sets a mission for developed countries, urging them to take additional steps for reduction of indigent countries' debts and promotion of their development.

Being the signatory to the Millennium Declaration, Uzbekistan fulfills its obligations for MDG achievement. Having acknowledged their significance and urgency in the context of national development, the Government has set about formulating its own national tasks and MDG indicators in cooperation with donor organisations and civil society. A national expert group has undertaken important steps to analyse development directions for every goal through establishment of appropriate tasks and main indicators. National MDG have been formulated as follows: Reduction of indigence and deficient nutrition; Improvement of education quality in primary and secondary schools; Promotion of gender equality and empowerment of women; Reduction of child mortality; Improvement of maternal health; Combat against HIV/AIDS, tuberculosis and malaria; Provision of environmental sustainability; and Uzbekistan and global partnership for development.

The Government's recognition of MDG significance is confirmed, in particular, by their successful adaptation and integration in the Interim Document on the Population Welfare Improvement Strategy. It is also within the MDG framework that in 2003 the Strategy for Prevention of HIV Infection Spread in the Republic of Uzbekistan was developed and further extended and supplemented with new tasks for the period from 2007 to 2011. The project for introduction of youth-friendly health services significantly contributes to achievement of MDG with regard to nation well-being improvement – the health care service improvement component, and HIV/AIDS prophylaxis – the component for HIV/AIDS and drug addiction prevention among youth and adolescents.

In 1991, the Republic of Uzbekistan has obtained the independent state status, and in 1992 the country has joined the United Nations Organisation. The following basic international treaties on human rights were acceded to in accordance with the established procedure: the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights (including the Optional Protocol thereto), and many other international documents. Along with most of the world countries, Uzbekistan has ratified the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), which are immediately related to the implemented project.

Three key articles of the **Convention on the Rights of the Child** clearly define the main spheres wherein the YFHS concept can be applied. First of them is Article 3 stating that: "States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision". Following this provision of the Convention, the project for introduction of youth-friendly health services provides for a specific-purpose work with health providers at different levels: from PHCC nurses to national-level decision-makers. The main purpose is to develop and introduce modern standards of health care servicing of adolescents and young people subject to their specific needs.

The second important provision of the Convention is Article 24 specifying the child's rights to use of the most advanced health care system services. This Article defines the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services. In order to achieve a progress in this sphere, basic measures should be taken so

that: (1) to diminish infant and child mortality; (2) to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care; (3) to combat disease and malnutrition, including within the framework of primary health care; (4) to ensure appropriate pre-natal and post-natal health care for mothers; (5) to ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health; and (6) to develop preventive health care, guidance for parents and family planning education and services.

In accordance with this Article, the YFHS concept contributes to reforming of PHCCs, provision of children access to information about health and treatment facilities, and prophylaxis of such diseases as STI and HIV/AIDS.

And, finally, it is important to notice Article 33: States Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances.

In the light of this Article, the strategy for an outreach work with most at risk adolescents and youth in order to prevent drug use, harmful sexual practice and consequent STI and HIV/AIDS infection, appears to be the important project component.

Among the international human rights treaties, the **Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)** takes an important place in bringing the female half of humanity into the focus of human rights concerns. The spirit of the Convention is rooted in the goals of the United Nations: to reaffirm faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women. The present document spells out the meaning of equality and how it can be achieved. In so doing, the Convention establishes not only an international bill of rights for women, but also an agenda for action by countries to guarantee the enjoyment of those rights. It should be noted that the Convention is the only human rights treaty, which along with civil rights pays particular attention to the urgent issue of reproductive and family planning rights. Thus, Article 12 of the Convention states that "States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning".

Based on the principles defined in this document, the Government of the Republic of Uzbekistan introduces international concepts in the sphere of reproductive health and reproductive rights. Achievements in the field of reproductive health have already resulted in better access of population to modern contraception techniques, enhanced knowledge of health providers and population, increased inter-birth interval and improved women and children health. At the same time, there are still some problems related to reproductive health support, such as involvement of general public, strengthening of families' and men's role in reproductive health care, and support from legislative bodies and communities. The YFHS project component for improvement of primary health care system provides for a work with adolescent general practitioners and adolescent gynecologists with the view of considering specific needs of girls in their health protection. It also contributes to information of girls and women about reproductive health, development of safe behaviour models and protection against STI, HIV/AIDS, etc.

The necessity of providing a specific support for young people from vulnerable groups and, particularly, MARA/YP in terms of STI and HIV/AIDS infection has been detailed in the **Declaration of Commitment on HIV/AIDS**. The Declaration was adopted at the Special Session of the UN General Assembly in June 2001. The Republic of Uzbekistan has acceded to the Declaration and undertaken the obligations for its fulfillment.

Thus, the National Strategy for HIV/AIDS control was developed in accordance with Article 48 of the Declaration: " By 2003, establish national prevention targets, recognizing and addressing factors leading to the spread of the epidemic and increasing people's vulnerability, to reduce HIV incidence for those identifiable groups, within particular local contexts, which currently have high or increasing rates of HIV infection, or which available public health information indicates are at the highest risk for new infection". The Strategy envisages the activities required in Article 53: " By 2005, ensure that at least 90 per cent, and by 2010 at least 95 per cent of young men and women aged 15 to 24 have access to the information, education, including peer education and youth-specific HIV education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection; in full partnership with youth, parents, families, educators and health-care providers".

In the sphere of reducing vulnerability, consideration is given to the requirement of priority attention to special groups including adolescents and youth, who practice risky injection drug use and unsafe sexual contacts, etc. The Project is also consistent with Article 62: "By 2003, in order to complement prevention programmes that address activities which place individuals at risk of HIV infection, such as risky and unsafe sexual behaviour and injecting drug use, have in place in all countries strategies, policies and programmes that identify and begin to address those factors that make individuals particularly vulnerable to HIV infection, including underdevelopment, economic insecurity, poverty, lack of empowerment of women, lack of education, social exclusion, illiteracy, discrimination, lack of information and/or commodities for self-protection, all types of sexual exploitation of women, girls and boys, including for commercial reasons; such strategies, policies and programmes should address the gender dimension of the epidemic, specify the action that will be taken to address vulnerability and set targets for achievement". Its framework envisages a study of external economic and socio-cultural environment of MARA/YP and existing behaviour patterns with regard to gender specifics of the group, etc.

And, finally, the Project's information component is concordant with Article 63 of the Declaration, which sets forth the requirement of "…ensuring access of both girls and boys to primary and secondary education, including on HIV/AIDS in curricula for adolescents; ensuring safe and secure environments, especially for young girls; expanding good quality youth-friendly information and sexual health education and counselling service; strengthening reproductive and sexual health programmes; and involving families and young people in planning, implementing and evaluating HIV/AIDS prevention and care programmes, to the extent possible". However, it is important to note that considering the group behaviour specifics the Project's information component provides for working with most at risk youth on the peer-to-peer basis, which is more reasonable and efficient than working within the education system framework.

It is also important to note that the youth-friendly health services introduction project was developed in accordance with the final requirement – observing the Triune Principle in implementation of HIV/AIDS prevention programmes. The Triune Principle includes the following: unified agreed framework of counteracting HIV/AIDS, forming the basis for coordination of all partners' efforts; a single national coordination body for HIV/AIDS with large intersectoral powers; and a single national coordinated monitoring and evaluation system. For the first provision of the Triune Principle – the agreed framework of counteracting HIV/AIDS, forming the basis for coordination of all partners' efforts – the Project envisages an integration of HIV/AIDS control strategies for the period from 2006 to 2010 into a strategy developed and approved by the Government. For the second provision – the national coordination body for HIV/AIDS with large intersectoral powers – the Project is aimed at strengthening the national coordination mechanisms with all activities to be discussed in detail and agreed by relevant authorities. And, finally, for the third provision – the nation-level coordinated monitoring and evaluation system – the Project assumes a close cooperation with UNAIDS, CDC and WB/RAPP to provide data for progress measurement, to receive planned results and to achieve the impact.

## 1.2. Project's Compliance with the Main National Documents in Terms of HIV Spread Prevention and Poverty Reduction and Welfare Improvement Programmes.

Having considered in details the Project's consistency with the key international documents, we cannot omit the issue of its goals and tasks compliance with the national key documents. These documents include the above-mentioned Strategic Programme for Prevention of HIV Infection Spread in the Republic of Uzbekistan in 2007-2011 and the Welfare Improvement Strategy.

**National Strategy for HIV/AIDS Prevention in 2007-2011**

The Strategy Programme developed for the period till 2006 was mainly aimed at reduction of the epidemic spread among the population categories most vulnerable to HIV infection risk: IDU, SW, MMS, prisoners and youth. The programme's focus on these groups was determined by peculiarities of HIV infection development and spread in the country, and its concentrated form. In 2006, based on evaluation results of the implemented programme performance and considering new data about HIV infection development features, the new Strategic Programme for Prevention of HIV Infection Spread in the Republic of Uzbekistan in 2007-2011 was developed. The programme goal was defined as: "Stabilisation of HIV infection at the concentrated stage through provision of general access to prophylaxis, diagnostics, treatment, care and support". Given the changing situation and already implemented measures, the new programme has incorporated three basic strategic directions (see Table 3.)

The first direction consists of improving the national HIV infection prevention policy. This direction includes: intensified activities under HIV prevention programmes planned by individual ministries and

departments (MoH, MLSS, MSSHE, MoJ, MIA, etc.); strengthening of Small Committees' activities in regions and improvement of their performance; revision of certain regulations regrind HIV and concerned population categories. The new programme assigns particular place and importance to establishment of a unified national system for programme efficiency monitoring and evaluation, and to the measures for its enforcement.

**Table 3. Key strategies of the Programme for Prevention of HIV Infection Spread in the Republic of Uzbekistan in 2007-2011**

| | |
|---|---|
| **1. Strategies for improvement of the national policy of the Republic of Uzbekistan for counteracting the HIV infection epidemic** | Strengthening of the governmental system for coordination, management and financing of HIV epidemic counteracting activities. |
| | Improvement of regulatory framework and law enforcement practice in the aspects related to HIV infection spread prevention. |
| | Development and implementation of a unified integrated monitoring and evaluation system for HIV epidemic counteracting activities. |
| **2. Prophylaxis strategies** | Implementation of prophylactic intervention among the population categories most vulnerable to HIV infection risk |
| | Extension and improvement of HIV and STI prevention programmes among youth. Training of youth on the basis of life skills development. |
| | Implementation of information and communication activities. |
| | Implementation of prophylactic activities for prevention of mother-to-child HIV transmission |
| | Implementation of HIV transmission prevention activities at medical institutions and post-contact prophylaxis |
| | Provision of population with general access to treatment of sexually transmitted infections |
| **3. Strategies for HIV treatment and provision of care and support of people with HIV** | Provision of quality treatment of people with HIV |
| | Provision of laboratory diagnostics |
| | Provision of people with HIV with access to medication aid |
| | Provision of people with HIV with access to support and care |

The second direction was defined as building capacities for prophylactic activities among HIV-infection most at risk groups and youth. These groups remain within the focus of the programme. In addition, it is planned to establish new programmes for such groups as pregnant women with HIV and child born from HIV-infected women with MTCHTP. Measures have been envisaged to improve efficiency of training programmes for youth and adolescents, based on the life skills development. It is planned to improve the awareness raising programmes through modern ICT. For certain groups of health providers facing HIV infection risk at their jobs, it is planned to toughen the pre- and pos-contact HIV prevention measures.

And, finally, the third key direction is the provision of HIV-positive people with access to support, treatment and care programmes. Here, the strategies are concentrated on improvement of medical service quality and accessibility for people with HIV, ensuring of continuous treatment with ART preparations, and social support; capacity building of medical institutions specialising in HIV/AIDS treatment through training of specialists and provision of laboratories with necessary diagnostic equipment, etc.

All concerned ministries and departments of the Republic of Uzbekistan actively participate in implementation of the HIV/AIDS epidemic counteracting policy within the established provisions of the National Strategic Programme. HIV prevention programmes are developed by the concerned ministries and departments of the country on the basis of the National Strategy. The new Strategy for the period till 2011 will be implemented mainly by the Cabinet of Ministers of RUz, The Council of Ministers of the Republic of Karakalpakstan, Khokimiyats of provinces and the Tashkent City, Ministry of Finances of RUz, Ministry of Defence of RUz, National Security Service of RUz, MIA RUz, MoH RUz, MLSS RUz, MSSHE RUz, Ministry of Economy of RUz, MoJ RUz, Ministry of Foreign Affairs of RUz, Council of the Trade Union Federation of RUz, Women Committee at the Cabinet of Ministers of RUz, public organisations of the country, etc.

**Poverty Reduction Strategic Paper**

The Welfare Improvement Strategy (WIS) identifies the main directions, mechanisms and measures for welfare improvement and poverty reduction among population of the Republic of Uzbekistan.

The primary goals of WIS include the improvement of nation living standards and reduction of the share of people with low incomes. The population well-being is determined not only by the income level, but also by other factors: accessibility and quality of social services, environment quality, etc. One of the key

tasks was defined as improvement of quality and equality of access to basic social services – first of all, education and health care ones.

Provision of access to quality health care services is the priority of sustainable human development. The country has made some progress in reforming the health care system and improvement of certain population health indicators. At the same time, further intensification of health care reforms is needed to improve reproductive health of population, prophylaxis of diseases and training of medical personnel up to the current requirements of medical sciences. The strategy programme for the nation well-being improvement defines a number of directions and measures for further development of the sector. Only few of them are mentioned below, which almost fully coincide with the tasks set for the youth-friendly health services programme (see Table 4).

**Table 4. Some development priorities and basic measures for reforming of the health care system as stated in the Welfare Improvement Strategy: Expanding the access of the population to medical services**

| Priority strategies | Basic implementation activities |
|---|---|
| **Expansion of access to medical services especially for rural and low-income population** | Strengthening of the primary health care system |
| | Intensified advocacy of healthy life-style |
| | Provision of primary health care system with modern medical equipment, vehicles and communication facilities |
| | Provision of necessary treatment and prophylaxis medicines and supplies |
| | Transition to the per-capita financing |
| **Training and retraining of medical personnel** | Implementation of international diagnostics and treatment methods |
| | Improving the staffing of the system with professional health care personnel |
| **Improvement of family medical culture and women health, and bearing and upbringing of healthy generation** | Implementation of international women and children health care standards |
| | Retraining of health care providers in arrangement of work with children |
| **Prevention and reduction of socially dangerous diseases** | Reduction of HIV infection spread rate |
| | Strengthening and quality improvement of HIV/AIDS prophylaxis and treatment activities |
| | Prevention of drug addiction among young people |
| | Training of school children in health protection methods and prevention of bad habits including drug use |
| | Active detection of drug users among risk groups |
| | Extension of open-access services and anonymous treatment centres |
| | Strengthening of logistical support, training up to WHO standards and staffing of narcological institutions with highly qualified personnel |

The table above shows that the main principles and standards of YFHS concept implementation are consistent with the governmental strategy for further improvement of the national health care system and population living standards. These include the strengthening of primary health care centres, implementation of up-to-date diagnostics and treatment standards, advanced training of health care personnel and intensification of work with youth and children for prevention and reduction of socially dangerous diseases.

## 1.3. Project Response to MARA/YP Needs: Preliminary Analysis of Awareness Level, Demands, Risky Behaviour, etc.

The introduction of youth-friendly health services is aimed, first of all, at different groups of youth and adolescents practicing risky behaviour in terms of potential HIV infection. The project activities included the assessment of "HIV/AIDS knowledge and behavioural practice of most at risk adolescents". The assessment was focused on adolescents practicing sexual services including MMS and injection drugs use. The age of respondents varied from 10 to 18 years. The survey results enables formulating of basic conclusions on the main problems and needs of MARA, HIV and STI knowledge level, and the risky behaviour level.

In course of this evaluation, the working group has collected additional information about the project target groups and their basic needs. For this purpose, a great bulk of secondary information about the reasons of such groups' occurrence was analysed, and interviews were held with representatives of authorities, health care experts providing specific services for MARA/YP, outreach-workers and representatives of these groups themselves. The implemented activity enabled the following important conclusions.

Generally, experts agree that the majority of most at risk adolescents and young people belong to so-called low-income category of population. The low income problem has arisen in Uzbekistan during the first years after getting the independence, and until now remains quite urgent. According to experts, in 1991 the average per capita income of 75% of population was below the minimum of subsistence, while in 1994 the same of 44.5% of 20,000 surveyed families was below the minimum wage. Owing to governmental actions to prevent economic slumps and improve social security of population, the drop in actual incomes was relatively small as compared to other CIS countries. Economic growth (beginning from 1996) ensured positive trends in living standards improvement. However, the share of low-income population decreased relatively slower. During the period from 1996 to 2001, the share of households with the average per capita income below one minimum wage has decreased only by three percentage points.

The low income problem in Uzbekistan has quite distinct demographic characteristics – first of all, families with many children and with lower shares of work force fall into the low-income category. The country has been and is the region with a large labour potential. Notwithstanding the relatively acceptable unemployment level making approximately 4% of economically active population, the problems of productive employment remain very urgent.

Specific demographic processes (in particular, high birth rate in 1980-es – 1990-es) make significant impact on the labour market, which is reflected in the annual increase of able-bodied population by more than 240,000 people. Furthermore, restructuring of enterprises results in a considerable release of labour force, which flows to unofficial employment sphere providing workers with unstable incomes[3].

Due to redundancy of workers and their poor qualification, this labour force has a low good value, i.e. scanty wage, and, therefore, entails low living standards with all social consequences and fates of concrete people. The majority of the thirty-percent share of youth and adolescents has to migrate within the country or abroad in search of education and employment. Almost a half of labour surplus comprises of women and girls.

Having failed to find their places in the labour relations system, young people are forced to be involved in the shadow and black economic spheres, namely, the spheres of commercial sex and drug traffic and use, which, in turn, reduce them to HIV/AIDS-vulnerable groups[4].

The STI and HIV/AIDS infection risk is aggravated by extremely poor awareness of potential infection ways and protection and prophylaxis methods among young people. The most prevalent health information sources are, basically, not health care providers and even not mass media, but elder and "experienced" mates. Naturally, the quality of such information leaves much to be desired.

Generally, most of questioned young people showed their indifference about their own health protection. Supposedly, this situation is determined on the one hand, by a lack of sufficient and objective information about existing risks and possibilities of getting an accessible medical aid, and on the other hand, by rare "making itself felt" of a young organism.

It is also important to note that the existing public health care system using procedures as a whole are such that in most cases a disease is diagnosed and treated only after its having grown progressively worse. The standards of regular preventive examinations at medical institutions are almost unavailable.

Experts also have noticed that apart from unavailability of job as a way to achieve material well-being and an opportunity of continued education, etc., youth also face a large number of psycho-social problems. Among them, the emphasis was placed on lack of mutual understanding and worsening relations with relatives and parents. The noticed weakening in functions of family as a social institution responsible for upbringing of a thoroughly developed individual, and loosened control by communities lead to disrupted links between parents and their children. Some parents are forced to leave abroad in search of a job and to provide a material well-being, while others are busy with their work "all day long", which hinders them from giving proper attention to their children.

Such a deficit of communication and control cannot be made good by either educational institutions or local communities. A plenty of free time and unaffordable participation in various hobby groups, computer clubs, etc. (requiring certain expenses) "pushes" youth out on the street. Here, young people foremost

[3] Welfare Improvement Strategy of the Republic of Uzbekistan, WB, 2006
[4] HIV/AIDS Awareness and Behavioural Practice of At-Risk Adolescent Groups, UNICEF - 2006

face the problems of building interrelations with their peers and elder mates. Trying to win prestige, young people begin to gain experience in smoking and use of alcohol and different drugs including the injection ones, enter in sexual relations, etc.

This entails a safety problem with regard to elder mates, criminalised structures and law enforcement bodies.

Considering the key problems of most at risk adolescents and young people, identified in course of the evaluation, the proposed youth-friendly health services introduction project is particularly urgent and important. On the one hand, it is intended to promote unhindered access of young people to medical aid and information about their health. On the other hand, it is aimed at establishment of a system for information of MARA/YP on the peer-to-peer basis about potential risks of STI and HIV/AIDS infection, through intensified outreach work and patronage.

**Table 5. Some of the most typical opinions of questioned experts about the problems of young people from risky behaviour groups**

*Interviewer: How are the youth problems related to health protection?*
*Respondent: Even if something disturbs them, they do not pay any attention to that. Today's ache will be over tomorrow. They merely do not understand how dangerous a disease may be if it suddenly becomes a chronic one. They do not care about their health.*

*FGD with outreach-workers*

*Respondent: Merely, there are people, who probably carry some diseases, but they don't know their symptoms. They don't know if it is normal or not. When we begin talking about diseases, that, say, manifestations or consequences may be such-and-such if condoms are not used, they fall into reflection. If they find such symptoms with themselves, they open up and say "Well, I have these things, indeed".*

*FGD with outreach-workers*

*Interviewer: In your opinion, what are the main problems facing young people today?*
*Respondent 1: Today many young people are unemployed. Many of them try to get a job. For example, many people leave for Russia to raise money. They all are searching for money. The situation is like that now. As a result, they leave us, leave the makhalla. And another place of residence influences them in different way. Finally, they go a wrong way.*

*Respondent 2: for example, now makhalla and parents do not take interest in children. Previously, all people worked together, talked to young people and asked about their problems. But now all people live by themselves. Everybody has his own concern. I think that young people are disregarded.*

*Respondent 3: I think that now parents do not look after their children. They do not interested in children, do not care if they go to school or not and why do they miss lessons. Parents go to work in early morning and come back late. Some parents leave abroad. They do not take interest in children and their doings here. Nobody asks, what are children doing, who are their friends, where do they go, etc. For example, if we ask them, they do not respond either. There is no contact between children and adults. Their life differs from ours. The most important for them now are their friends rather than parents. For example, when we visit a school, 30 pupils must study in a class, but only 15 of them are present. Where are the others?*

*Respondent 4: They are different. Some of them due to indigence in their families work on markets and carry buyers' goods in hand-carts. Others, who are well-to-do, go to computer clubs and play there different games, because they have a lot of money. Some of them have mobile telephones. When we visit a school, we ask to show us a class. Teachers and school committee are running around to find all pupils. After graduation from ninth form they enter colleges, but they do not study themselves. They loiter about by themselves, with their friends. They have a plenty of free time, and they will do whatever they like. They find some elder boy and do whatever he orders. For example, they do not listen to us or parents or a doctor from clinic, but they do everything their friends tell them.*

*FGD with health care personnel*

*Respondent: If we gather all good students of a college, then teachers would outnumber them. For example, teachers also have to control children. They are disregarded now. Nobody lends an ear to a child's problem. For example, if teachers communicate with them sincerely and ask about their problems, then children would also treat them kindly. It is still not the case. First, this is an economic problem. Children raise money on markets.*

*FGD with health care personnel*

*Interviewer: In your opinion, how serious and urgent is now the problem of risky-behaviour youth?*
*Respondent: I think that the youth problem is urgent at all times. We must pay more attention to their education, because they are out future. And we must instill in them what we want to see tomorrow, so that even children could follow their example.*

*Interview with a representative of a health care department*

## 1.4. Project's Compliance with the Existing Youth Servicing Practice (Structural and Functional Analysis of the Current Health Care System)

Successful Project implementation and expansion of its scope require a clear notion of the current youth and adolescents' health care servicing system, and understanding of its structural and functional features. This issue may be reviewed in detail in the light of already implemented reforms. First of all, consideration should be given to the PHCC system with its general services for population and specialised youth servicing systems such as STI dispensaries, AIDS Centres and drug dispensaries, and the obstetric-gynecological system providing services for women.

The implemented health care reforms have resulted in significant updating of the **primary population health care system** and ensured its accessibility and efficiency through networking of rural medical centres and introduction of a general practitioners system. 2852 rural medical centres function to date. The primary population health care system in country regions represents a network of Adolescent Polyclinics (from birth to 16 years) and Central District Polyclinics for adults (17 years and older) constituting the system of so-called Family Polyclinics. Geographically, Central District Polyclinics (CDP) and Adolescent Polyclinics may be located in one place or different places of a locality. All district polyclinics are subordinate to Central Province Hospitals. Activities of the polyclinics are often administered by CPH management. This is a result of reforms for decentralisation of health care management system. In practical terms, it means transferring of a higher management responsibility to administrative personnel at the province level. The implemented reforms have led to administrative staff reduction by more than 40% in two years. This was achieved mainly through transferring the responsibility from province departments to Central Province Hospitals[5]. Privatisation of some health care services has been started with some pharmaceutical and dental services having been substantially privatised. In 1995, private practice was allowed for doctors; a private practice establishment is licensed by the Ministry of Health.

In the capital of the country, almost all primary health care services are provided by Family Polyclinics for all age categories. Division is made on the geographical basis – by districts, and by numbers of people living in every specific area.

The following main services provided to population on the PHCC basis may be noted: consulting and information, laboratory and instrument diagnostics, and treatment. The main specialists providing consultations and information for PHCC clients include: general practitioners, adolescent doctors and a large number of doctors specialising in dentistry, cardiology, surgery, neuropathology, ophthalmology, etc. STI and HIV/AIDS prevention services available for population include consultations of gynecologists, urologists and narcologists. At the province level, population is provided with services of specialists in skin and venereal diseases and narcologists. In the capital, STI and narcologic services function separately from PHCCs. All services are rendered to population free of charge.

It is worthy to note that at the regional level the specific consultations of doctors specialising in STI and HIV/AIDS prevention are provided only at "adult" polyclinics - CDHs.

The national health care system retains the basic preventive medicine approaches. Treatment of socially dangerous diseases such as tuberculosis, STI, malaria and HIV/AIDS is warranted and budgeted by the state. At present, health care reforms are going on with their priorities including: maternity and childhood protection; primary health care improvement and further development; control and prophylaxis of infectious diseases, tuberculosis, syphilis and AIDS; and promotion of healthy life-style. The efficiency of the maternity and childhood protection system has been improved, and implementation of some large-scale National Programmes is under way, aimed at promotion of medical culture in families, improvement of women health and birth and upbringing of healthy generation. The main components of these programmes cover the perfection of national reproductive health care system, mother and child screening, development of continuous specialist retraining system, upgrading of blood transfusion services, and strengthening of logistical support to childhood and obstetrics institutions.

In view of considerable growth of STI prevalence, the programmes concerning sexual health and risks of irregular and unsafe sex, particularly sexually transmitted diseases, take on special significance. Until recently, the **STI service** retained its monopoly for diagnostics and treatment of STI among population.

[5] Cabinet of Ministers of the Republic of Uzbekistan. Analysis of situation and performance of HIV infection control measures in the Republic of Uzbekistan in 2003-2006. Tashkent, 2006.

This service is vertically structured at the republican, province and district levels. The network of STI institutions comprises 62 dispensaries, 22 departments at CDHs and 174 STI centres. This service is also under reforming. A network of private venerologic centres has been established, which handle the need for STI treatment on conditions of full anonymity and confidentiality[6].

Retention of free-of-charge STI treatment in the public health care system is a positive aspect. However, the logistics base of STI institutions prevents them from implementation of up-to-date methods of STI treatment and detection of such infections as clamidiosis and ureaplasmosis.

The World Bank's survey notes that actions of governmental structures dealing with STI prophylaxis and treatment still resemble police supervision; in particular, until now militia participates in detaining SWs and their delivery to STI dispensaries for compulsory treatment. The STI service seems unattractive for representatives of vulnerable categories of population due to remaining approaches to interaction with law enforcement bodies, compulsiveness of examination and treatment and poor confidence guaranty of a patient's disease and personality.

The health care system is the key instrument of HIV infection prevention in the country. The Ministry of Health of the Republic of Uzbekistan has established a network of specialised treatment and prophylaxis institutions – **AIDS Centres** – intended for provision of medical aid to people living with HIV. The network's activities are regulated by laws of the Republic of Uzbekistan and regulations of the Ministry of Health. The first AIDS Centre was opened in Tashkent in 1989. The Republican AIDS Centre provides organisational and methodological guidance of HIV-related activities in the country. The structure of AIDS RC consists of a clinic department, epidemiologic, organisational and methodological, dispensary departments, AIDS diagnosis laboratory and other divisions. There are 15 regional AIDS Centres in the country: 14 province and the Tashkent City Centres, and ninety AIDS diagnosis laboratories.

People with psychoactive substance dependence are attended by the **specialised drug service** with vertical hierarchical structure, represented at the national, province and district levels. The general coordination of the service's activity is performed by the special department of socially significant diseases within the Ministry of Health of the Republic of Uzbekistan. In addition, narcological assistance is provided by 16 private drug clinics licensed by the Ministry of Health. In the cases when concomitant diseases are detected, drug users may resort to other specialised services (STI, tuberculosis, AIDS services, etc.) or general medical institutions on a common basis.

In Uzbekistan, out-patient and in-patient treatment and consultancy are the predominating types of narcological aid along with the remaining compulsory examination and treatment. In-patient departments of narcological institutions basically offer to their patients the detox-therapy, which is the most wide-spread and accessible type of treatment. However, in most cases it is provided at the expense of patients and with use of expensive symptomatic therapy (so-called, psychopharmacological treatment model), which considerably constrain patients' access to this type of treatment. Moreover, the detox-therapy provided separately without further dependence therapy and long-term programmes of medical-psychological and social rehabilitation of patients, causes the distrust of drug-addicts and their relatives to the narcological treatment system.

The narcological service maintains close relations with law enforcement bodies as regards exchanging of information about registered drug users and compulsive treatment of a registered drug user evading voluntary treatment. This results in a high level of drug users' distrust to narcological institutions due to unwarranted confidentiality of information about patient's disease and identity.

Interaction between nongovernmental organisations and state-owned organisations seems insufficient and episodic except few NGOs opened with participation of governmental institutions and working on implementation of joint projects.

The choice of treatment methods in the country is very limited, there are only two in-patient rehabilitation programmes, an institution of addiction therapists is not established, and medical-psychological and social rehabilitation programmes are not available. Coverage of drug users with harm reduction programmes is insignificant (5-10%). There are no unified approaches and standards for arrangement of narcological aid and development of harm reduction programmes. Thus, the scope and quality of services are insufficient for effective establishment of narcological aid and HIV prevention programmes. On the one hand, all these factors restrain the opportunities for drug addicts treatment and rehabilitation, and on

[6] Except for syphilis. It is also worthy to note that doctors of STI dispensaries "are obliged to inform law enforcement bodies of every case of STI detected among minors" (according to questioning of DVD representatives under this survey).

the other hand contributes to retention of a considerable population of drug users, unsafe injection and sexual behaviour practices, and, thereby, to spread of HIV infection in the country.

Qualified and specialised **obstetric-gynecological and perinatal care** in Uzbekistan is provided by the Obstetrics and Gynecology Research Institute with four regional branches, the Republican Perinatal Centre, 46 obstetrics complexes, 280 departments within medical and research institutes, medical centres, CDHs (CMHs), and by 71 antenatal clinics and 1917 women centres. 205 adolescent obstetrician-gynecologists have been trained for consultation of minors.

The Order of the Ministry of Heath No. 500 dated 13.11.2003 "On Reorganisation of Activities of Maternity Complexes (Departments)" provides for measures to improve perinatal care efficiency and prevent hospital infections in accordance with WHO recommendations. This has resulted in building of capacities and implementation of cost-effective and high-performance techniques (mother and baby friendly hospital initiative, safe maternity, partner-present labour, and breastfeeding promotion). In the country, there are over 50 trainers having international certificates in breastfeeding; reproductive health; safe maternity; and newborn resuscitation.

## SECTION 2. ANALYSIS OF INTERNAL PROJECT FUNCTIONING ENVIRONMENT AND IMPACT EVALUATION

### 2.1. Project Design Evaluation

The project for implementation of youth-friendly health services was proposed in order to reduce the risk of STI and HIV/AIDS spread among adolescents and youth belonging to specific groups practicing "highly vulnerable to HIV infection behaviour". The Project model is aimed at "Introduction of youth-friendly health services for implementation of HIV infection spread preventive activities among socially isolated young people and adolescents in at-risk groups". The goal achievement strategy consisted, on the one hand, in creating a supportive environment for HIV prevention and implementation of youth-friendly services integrated in the existing health care system, and on the other hand, in enhancing the efficiency of MARA/YP-oriented HIV prevention interventions.

**Table 6: Project goal, tasks and components**[7]

| **General aim** | Central Asia AIDS Control Project:<br>Reduction of HIV/AIDS epidemic spread in Central Asia during the period from 2005 to 2010 |
|---|---|
| **Project objective** | Reduction of MARA/YP risky behaviour |
| **Project Component 1**<br>**YFHS Capacity Building** | **Project Component 2**<br>**Targeted HIV Prevention among MARA/YP** |
| Established model YFHS norms and standards<br>Developed supportive policies and legal frameworks for YFHS implementation<br>Reduced MARA/YP stigmatisation and discrimination<br>Enhanced potential of service providers in youth-friendly interventions and field activities for MARA/YP | Improved quality and effectiveness of youth-friendly and data-based HIV prevention activities: information and counselling; condoms; harm reduction; STI; VCT and HIV-testing<br>Raised awareness of HIV preventive measures among MARA/YP |

Two key components have been identified for successful implementation of the strategy. The first component consists in YFHS capacity building including: development of youth-friendly health services' standards, establishment of legal framework for their implementation, capacity building of youth-friendly service providers and reduction of MARA/YP stigmatisation and discrimination. The second component addresses the targeted HIV prevention among adolescents and youth in at-risk groups through improvement of quality and effectiveness of preventive measures – information and counselling, distribution of condoms, harm reduction, STI treatment, and VCT and HIV-testing (see Table 6.)

The Project was launched in the Republic of Uzbekistan in 2005. It has started its activity with concurrent development of both components: Component 1. Development of a national model of youth-friendly health services as a basic instrument of HIV/AIDS prevention among youth, and Component 2. Improvement of MARA/YP access to friendly health services in order to prevent HIV spread[8]. On the one hand, local experts proceeded to review of information about the international initiative for youth-friendly health services implementation. As stated above, the status of youth servicing in the primary health care sector was assessed. In addition, the key behaviour patterns and needs of adolescents and youth practicing STI and HIV/AIDS infection-risky behaviour were analysed. On the other hand, the work with MARA/YP group was started to achieve the maximum results in informing them about STI and HIV/AIDS infection risk-related problems and provide them with access to protection and infection prophylaxis means.

[7] UNICEF/CAR: The Project Proposal "Introduction of youth-friendly health services for implementation of HIV infection spread preventive activities among socially isolated young people and adolescents in risk groups".
[8] See Annex 1 for details of the project logic analysis system.

The priority project tasks were defined as follow:

1. In cooperation with government and nongovernmental organisations, to establish a system for information, consultation and distribution of condoms among youth;
2. To create favourable conditions for increase in youth's demand for relevant medical services and goods including sterile needles and syringes, condoms, VCT and STI treatment, and support;
3. to develop a new system of MARA/YP referral to youth-friendly service providers in order to ensure the best access to key interventions: STI diagnostics and treatment, HIV-related voluntary confidential counseling and testing, etc.

The additional long-term tasks of the common project strategy were focussed on capacity building of youth-friendly health service providers through implementation of the following provisions:

1. Development of health care providers' potential in work with adolescents and youth;
2. Implementation of regional and national standards and systems of YFHS national certification and monitoring;
3. In the longer term, to attain amendment of the existing legislation and political actions with the view of creating a supportive environment for HIV prevention and reduction of HIV-relate stigmatisation and discrimination.

The Fergana Province of the Republic of Uzbekistan (Kergeli, Margilan, Kuva, Kuvasay and Bagdad) and the Tashkent City (Chilanzar District) were defined as the **pilot areas** of the Project.

**Key Stakeholders of the Project**

As noted above, representatives of the health care sector and other sectors dealing with youth-friendly service provision were involved in project planning and implementation. These included experts from the Ministry of Health and the Republican AIDS Centre at the national level, and representatives of local authorities, province and municipal health care departments, internal affairs departments, drug and STI dispensaries, and PHCCs at the level of the Fergana Province and the Tashkent City. Officials, members and volunteers of such public organisations as NGO Mekhr Tayanch, Ishonch va Hayot, Salomatlik+Ekologiya as well as key figures of community-based organisations – local self-governments – makhallas were actively involved in the project[9].

**Key Project Executives**

The Project was implemented by the Ministry of Health of the Republic of Uzbekistan through the "Tarikat" Republican Children and Adolescents Reproductive Health Centre and the Tashkent Advanced Medical Training Institute with support from UNICEF/Uzbekistan.

The project implementation was partnered by NGOs Mekhr Tayanch and Ishonch va Hayot in the Tashkent City and NGO Salomatlik+Ekologiya in the Fergana Province.

The key international partners, which have supported the project, included: UNICEF-Uzbekistan, the Global Fund Programme for HIV/AIDS and Tuberculosis Control in Uzbekistan, and the international public organisation PSI.

**Project Target Groups**

Adolescents and young people following unsafe sexual and drug use practices from the viewpoint of high HIV infection risk were defined as the key target group (beneficiaries) of the Project. These include such categories as IDU, SW, MMS and children without adequate family custody.

The age boundaries of the group were initially limited to 10 to 24 years. However, it should be noted that during the Project implementation the age criteria of the group were not strictly adhered to and underwent some modifications. For example, in course of project application preparation it was recommended to select MARA/YP within the limits from 10 to 24 years. In 2005-2006, when preparing the project application for the pilot part of the project, the age limits were defined as from 10 to 18 years. However, it is important to note that in course of the project implementation the services were provided to young people aged 10 and older. In other words, the upper age limit was not strictly observed, and people at the age of 25 to 35 and sometimes older than 35 years were registered in the Project.

In order to ensure the most efficient access to MARA/YP the Project envisaged the training of initiative groups for preventive activities: IDU Group, SW Group, and MMS Group. In addition, nurses as representatives of the lower level of PHC have been gathered and trained within a separate group.

[9] See Annex 2 for details of the Project Stakeholders Analysis.

**Key Approaches Used in Work with Target Groups**

In course of project planning and its further implementation, two different approaches were used in work with the target groups. Thus, in Tashkent the work was arranged as follows: volunteers out of most at risk adolescents and youth were selected and trained as outreach-workers. They were provided with information about STI and HIV/AIDS, infection ways, protection methods, etc. After the training stage, volunteers worked immediately in so-called "hotspots": on streets, in the places of MARA/YP gathering, at clubs, discos and bars. They worked on the peer-to-peer basis and informed youth about STI and HIV/AIDS, and the places where consultations of doctors, narcologists and psychologists can be obtained, etc. They also distributed condoms.

In addition, outreach-workers made special referrals – "vouchers" – for those young people who wished to receive a consultation. These vouchers were intended for PHCC personnel and included coded client data. The use of this voucher system ensured the anonymity of young people resorted for medical aid.

Within this approach, resources of the Ishonch va Hayot and Mekhr Tayanch were additionally used to reach the target groups. These resources facilitated the access to such groups as injecting drug users (Ishonch va Hayot) and to children without adequate family custody (Mekhr Tayanch).

The second approach was used in the Fergana Province, where paramedical personnel of PHCCs (basically, polyclinic nurses) were specially trained as outreach-workers. They were charged with door-to-door visiting of households (patronage) and detecting of the most disadvantaged families with adolescents and young people most vulnerable to STI and HIV/AIDS infection risk. These households were provided with information, booklets and brochures about HIV/AIDS and protection methods, and youth-friendly health services based on anonymity and confidentiality principles. The voucher system was not used in this approach. Pilot polyclinics received all young peoples who came for consultations, and doctors entered coded data about clients to internal documents, also having observed the anonymity principles.

Every of the applied approaches has its advantages and considerable disadvantages, which have been analysed in course of evaluation and presented in Table 7.

**Table 7. Comparative characteristic of basic advantages and disadvantages of the two key models used by the Project for arrangement of work with MARA/YP target groups[10].**

| Primary aspects of the approaches | Approach 1. Outreach-workers | | Approach 2. Visiting nurses | |
|---|---|---|---|---|
| | ***Advantages*** | ***Disadvantages*** | ***Advantages*** | ***Disadvantages*** |
| **Outreach-workers selection system** | Outreach-workers are selected out of youth, MARA/YP or at-risk groups | Instability of a group due to practicing of risky behaviour patterns (e.g., drug misuse) | Outreach-workers are selected out of PHCC paramedical staff | Outreach-workers are poorly aware of MARA/YP groups |
| **Outreach-workers training system** | Outreach-workers do not need detailed explanation of an at-risk group behaviour pattern. | Outreach-workers need detailed explanation of STI and HIV/AIDS spread specifics and mechanisms of protection against infection | No need to emphasize STI and HIV/AIDS prevention as the group is relatively trained in medical issues | Outreach-workers need to be instructed on at-risk group behaviour features. They also need additional psychological techniques for stress relief. |
| **Level of of contacts with target group representatives** | Very high level of contact and mutual understanding with at-risk groups | Potential risk of outreach-workers' return to IDU and SW circles | ——— | Low level of contacts with at-risk groups<br><br>Potential risk of an outreach-worker's joining an at-risk group in case of his/her poor psychological resistance |

[10] It is necessary to note that Tashkent was conditionally separated from Fergana Province towns. The patronage system was also used in Tashkent, though to a less extent, while outreach-workers out of at-risk groups worked in some towns of the Fergana Province.

| | | | | |
|---|---|---|---|---|
| **Target group accessibility** | The Project enjoyed access to all at-risk groups: MMS, SW, IDU and children without adequate family custody | Basically, the most communicative representatives of at-risk groups are accessible, who retain social activity and, partially, social relations. More hidden groups remain inaccessible. | Access to groups is ensured through outreach work coverage of at-risk group members' residence places. An area is thoroughly surveyed almost in full. | Under the Project, such groups as MMS and children without adequate family custody were hardly identifiable and almost inaccessible. |
| **Observance of target group age criteria** | The Project enjoyed access to all age categories | _____ | _____ | In course of the project, access to minors - MARA/YP was complicated |
| **Outreach-workers safety in work with TGs** | Knowledge of at-risk group behaviour patterns was a kind of warranty of outreach-workers safety. Outreach-workers practice similar behaviour patterns, appearance, slang, etc., therefore they cannot be distinguished among at-risk groups as aliens. | Potential risk of outreach-workers' return to IDU and SW circles | _____ | Potential risk of conflicts with criminalised representatives of at-risk groups.<br><br>Additional training in safe work wit at-risk groups must be arranged<br><br>In some cases, probably, outreach groups must be guarded<br><br>Potential risk of an outreach-worker's joining/involvement in an at-risk group in case of his/her poor psychological resistance |
| **Outreach-workers safety in work with law enforcement bodies** | _____ | Outreach-workers safety may be disrupted by law enforcement bodies. Great efforts will be required to achieve agreements. | Safety may be ensured by oral or written agreements with law enforcement officials | _____ |
| **Outreach-workers motivation system** | Provision of material incentives by Project partners | Instability of such a motivation after project completion | Sustainable performance as instructed by PHCC managers / administration | Motivation exclusively through persuading of the mission importance, not rewarded either morally (e.g. prizes) or financially |
| **MARA/YP motivation system** | Provision of free information materials, condoms and disposable syringes | _____ | Provision of free information materials, condoms and disposable syringes | _____ |
| **Sustainability of outreach-workers' arrangements** | Possibility of continued informing of their surrounding – friends and familiars from at-risk groups | Subject to stability of outreach-workers and accepted safe behaviour patterns. | Subject to PHCC administration's consistency.<br><br>Subject to clearness of developed instructions and receipt of required instructions from management | Potential turnover of staff due to work complexity and specificity |

| | | | | |
|---|---|---|---|---|
| **Institutional capacity of the approaches** | Possibility of transfer for further implementation by public organisations | Immediately subject to project financing duration.<br><br>Subject to stability of a public organisation and its financial steadiness. | Subject to clearness of developed instructions and receipt of required instructions from management | Potential turnover of staff due to work complexity and specificity<br><br>An additional motivation system is to be set up |

The table above shows that every of the used approaches has its own advantages and disadvantages. The certain advantages of the approach used in the capital include close relations between outreach-workers and at-risk groups, good knowledge of behaviour patterns prevailing in these groups and specificity of interrelations within the groups, which is one of important aspects in accessing the groups. In addition, outreach-workers trained on the peer-to-peer basis are almost undistinguishable from at-risk groups as strangers, since they have a good command of slang and dress and behave in similar manner. This knowledge is a kind of warranty of outreach-workers' convenience in taking preventive measures, freedom of actions, and a warranty of safety.

The used outreach-workers' material motivation system is another important advantage in arrangement of efficient work. Moreover, after the project completion the knowledge received by outreach-workers from at-risk groups can be transferred to other group members in day-by-day informal communication with/ consulting of friends and familiars.

Among disadvantages of the approach, it is necessary to note the relative instability of this group, as some of its trained members may revert to usual behaviour patterns (e.g. drug misuse) and drop out from the project staff.
Sustainability of outreach-workers' activity depends on their thorough selection and accepted safe behaviour patterns of the workers.

Given the behaviour pattern specifics of this group of outreach-workers, similarising them to other at-risk group members, it is necessary to elaborate their work safety procedures in cooperation with law enforcement bodies, so that preventive measures would be conducted freely.

This group requires a more detailed training in STI, HIV/AIDS and infection preventing methods. Finally, it is worthy to note that the most disputable are the sustainability and institutionalisation of activities of peer-to-peer trained outreach-workers from at-risk groups. Upon expiry of external project financing, their activities most likely would be finished or reduced to an insignificant minimum.

The second approach also has its positive and negative aspects. Training of outreach-workers among PHCC paramedical personnel (nurses) is likely to be eased by lesser efforts for training in STI and HIV/AIDS specifics and infection preventing measures. At-risk groups are accessed by means of outreach work coverage of at-risk group members' residence – door-to-door visiting of households. An area assigned to a concrete outreach-worker (nurse) is thoroughly surveyed almost in full. Safety with regard to law enforcement bodies is easily arranged both during negotiations at job place and through an advance notice to district militia officers of the activities to be performed. This type of outreach work is automatically institutionalised through introduction of additional functions of district nurses, while its sustainability and efficiency immediately depends on a correctly developed system of motivation and supervision by management (PHCC administration).

Considerable disadvantages of this approach are as follow: necessity of additional training of nurses in at-risk group behaviour specifics, and in psychological methods of protection against a potential stress from communication with the groups and close perception of their problems. In case of low psychological resistance of outreach-workers they may be involved in at-risk groups (e.g. begin to use drugs). Perhaps, a special psychological service for outreach-workers should be arranged within PHCCs.

Importantly, the outreach-workers' unawareness of at-risk group behaviour specifics and patterns may compromise their safety at working in the most criminalised hot spots where MARA/YP flock. Mechanisms of outreach-workers protection against such situations must be in place.

As regards sustainability and institutionalisation of the arranged activities, there is a potential risk of staff turnover in the absence of additional moral and material motivation of workers.

**Project Monitoring and Evaluation System**

In course of project planning, the Project team has provided for a performance monitoring system. Preliminary monitoring and evaluation of the existing situation were carried out in the pilot regions. Meetings with policy-makers and managers of youth-friendly service providers were held. In addition, the existing situation was analysed through questioning of health care providers, service provider managers and service recipients. Furthermore, a joint evaluation of needs was carried out among young people in the pilot regions. Survey and joint need evaluation results have been used in project designing, development and testing of manuals, and adjustment of the national policy and quality standards for youth-friendly services.

A system of qualitative and quantitative indicators was developed specially for tracking the progress of youth-friendly health services implementation. The indicators correspond to the three key progress levels: low, medium and high. These indicators are very convenient for monitoring and evaluation of YFHS standards implementation efficiency, and enable assessment of the achieved Project outcomes.

However, some shortcomings are noteworthy in the M&E process planning and organisation. The main planned monitoring activities (working group's field monitoring) are, in fact, a tracing of performed activities against the scheduled project actions. It is not an error of itself. However, this activity is fully lacking in analysis and evaluation of achieved results against the expected impact. This can be explained by the unavailability in project applications of a clear system of *expected outcomes* and *indicators*, which could be used for the progress measurement.

The project team also failed to use the developed qualitative indicator system for measuring the achieved results during YFHS standards implementation, and specific progress evaluation was not made.

When analysing the submitted project documentation, the evaluation expert team has endeavoured to logically analyse the Project and undertaken actions. The overall system is presented in detail in Annex 1 hereto. The Annex clearly illustrates the main achievements and failures of both the project system as a whole and the system of monitoring and evaluation of its results, in particular. Successful performance requires building of a general logical monitoring and evaluation system from the national level to the project level – its pilot parts in the capital and the Fergana Province. In practical terms it means that the nation-level general expected outcomes and indicators based on the national strategy for HIV epidemic control among youth must be subdivided into smaller project performance indicators for every city/town and individual PHCC. The project-level expected outcomes and indicators based on the triune principles and commitment to integration in the unified monitoring and evaluation system must form an integral part of the national strategy's key indicators.

As stated above, the Project involved some key executives, who established their own quantitative indicators for impact assessment. For example, the PSI Project concentrated on the Chilanzar District (Tashkent) had the following key indicators:

- At least 5% of MARA/YP in the target district are covered with peer-to-peer educational programmes
- At least 3% of MARA/YP have accurate information about HIV/AIDS and protection methods and visit YFHS centres.

Another more general indicator was stated for the Fergana component of the Project: “At least 30% of MARA/YP covered with outreach programme have been referred to YFHS in all hot spots”.

However, in both cases the project executives have not evaluated the achieved project effectiveness, while an external evaluation is impossible because of lack of reliable information about MARA/YP group sizes in the Project regions. Nevertheless, the evaluation of MARA/YP group awareness of STI and HIV/AIDS was successful, and data of the achieved progress are given in the relevant section below. The awareness measurement methodology was based on the National Monitoring and Evaluation Indicators of the Strategic Programme. It has been described in the section "Methodology" hereof and can be used thereafter by the project working group for independent tracing and assessment of informative activity performance.

As for the qualitative evaluation indicators of YFHS implementation at the selected PHCCs, the task has been quite realisable, and its results are given herein below. The data collection and calculation methods are described in detail in the section "Evaluation Methodology", and the project team also can use them in future independently.

## 2.2. Project Implementation/Potential Evaluation

The main stages of Project activities are specified in Annex 1 – Project Logframe Analysis Matrix, including timing, responsible executives and implementation partners, and expected outcomes. The basic project implementation achievements are outlined below.

In 2005, the YFS implementation norms and standards were developed and approved. The YFS standards package was developed with regard to the advanced international experience. In addition, the international practice was adapted to local conditions as appropriate. The developed standards were tested with involvement of different level specialists: immediately with service providers in health care and non-medical sectors, and with beneficiaries. A series of programme discussions was arranged for specialists and experts from different sectors providing youth-friendly services. Thus, the key principle of numerous stakeholders' participation and involvement in discussion of the new initiative was observed and resulted in development of the YFS standards package. Moreover, training manuals were developed and training of youth-friendly service providers was conducted, and local initiative groups for YFS implementation were formed.[11]

**Table 8. List of key standards for provision of medical aid to adolescents and youth within the PHCC system**

| | |
|---|---|
| 1 | The standard of youth-friendly health services for provision of service confidentiality |
| 2 | The standard of youth-friendly health services for provision of institution accessibility |
| 3 | The standard of youth-friendly health services for client information about institution activities |
| 4 | The standard of youth-friendly health services for provision of institution comfortability |
| 5 | The standard of youth-friendly health services for staff training, skills, attitudes and values |
| 6 | The standard of youth-friendly health services for integration of institutions' activities |
| 7 | The standard of youth-friendly health services for improved access for all youth groups |
| 8 | The standard of youth-friendly health services for involvement of young people in institution activities |
| 9 | The standard of youth-friendly health services for activity monitoring and evaluation and client feedback |
| 10 | The standard of youth-friendly health services for provision of basic clinical services at an institution |

The key YFHS standards accepted and described in project documents represent a group of basic provisions aimed at health care system reforming at its primary level. In total, there are ten key standards as presented in Table 8.

Implementation of project activities in 2006 has resulted in the following achievements. The expert groups has developed the training manual "Development and Implementation of YFHS Standards" including standards implementation stages, stakeholders integration mechanisms and principles of protocol development for reduction of HIV/AIDS spread among most at risk adolescents. In addition, the training manual "Outreach Work Organisation Guidelines" was developed to inform health care providers of the principles of work with at-risk group members for HIV/AIDS prevention, including approaches to involvement and training of volunteers out of young peoples.

In addition, a number of meetings with imitative groups was held to discuss YFHS principles, policy and protocols. District-level YFHS policy was drafted, and planned regional activities and standards implementation process were discussed.

With the view of project activities coordination with key stakeholders, several meetings were held with such decision-makers as khokimiyat officials, managers of province and district health care departments, primary health care institutions and specialised establishments, for approval of project policy and protocols, including the infrastructure of interaction among institutions and participants and their functions and resources.

Meetings with most at risk young people were held to define the risky behaviour features of at-risk groups in the region and their potential involvement in PHCC activities.

[11] Source: "Assistance in Youth-Friendly Services Implementation" and "Assistance in HIV/AIDS Spread Control Among Risky Behaviour Youth" Projects. Report on activities of the “Tarikat” Republican Children and Adolescents Reproductive Health Centre for 2005-2006

Youth-friendly health service providers were trained in implementation of standards and development of protocols of YFHS so that to build capacity of the working group for YFHS introduction and implementation monitoring in regions. Besides, capacity building workshops were arranged for service providers, focussed on servicing of at-risk groups and training in outreach work organisation guidelines.

As noted above, immediate project implementation has revealed some essential differences in work arrangements in the capital and the Fergana Province towns. These differences were due to local specifics with regard to local authorities' support, PHCC resources and capacities, public organisations' interest and involvement, availability of MARA/YP groups and peculiarities of their behaviour, etc. Some of the most essential features are outlined below.

**Organisation of Project Activity in the Chilanzar District, Tashkent City**

*Project resources.* The Chilanzar District was selected for project implementation in the capital. According to experts' estimates, the biggest number of most at risk adolescents and young people using drugs and selling sexual services is concentrated in this district. Three Family Polyclinics were selected for provision of MARA/YP group members with health care services. Doctors responsible for servicing of youth and adolescents were defined at every polyclinic. In total, the project involved 18 general practitioners and 3 gynecologists, and one expert in adolescent medicine, endocrinology, neuropathology, surgery, ophthalmology and dentistry at every polyclinic. As stated above, STI doctors from Open-Access Services and Confidence Centres (2 experts) were involved to maintain anonymity and confidentiality.

It is necessary to note that important additional project resources were provided by PSI staff inputs to its implementation. Specialists of this organisation coordinated the project activities at all levels from arrangement of cooperation with district health care departments and individual polyclinics to negotiations with district militia departments and supervision of outreach-workers.

*Organisation of work with MARA/YP group.* As noted above, the project implementation in the capital was strictly within the age boundaries of MARA/YP group, which were defined as from 10 to 25 years. The selection of adolescents and young people included representatives of all main at-risk groups: IDU, SW, MMS and children without adequate family care. The group was contacted with use of public organisations' resources and outreach work in so-called "hot spots" – young people flocking places: parks, café, discos. The used approach to work with MARA/YP groups is featured above in Section 2.1 Project Design Evaluation.

15 outreach-workers were selected and trained for work with the MARA/YP group in Tashkent. For this purpose, PSI has conducted trainings in July and October 2007. The training programme comprised different interactive techniques providing for specifics of work with at-risk groups, including those with game elements. The programme included not only training of outreach-workers, but also training of trainers from among them, who would be capable to conduct peer-to-peer education in at-risk groups.

Outreach-workers selected group members and performed their initial informing and testing of their awareness of STI and HIV/AIDS, evaluated their needs for medical and social aid, and attended or referred them to PHCC, CC, OAS or NGO specialists. Implementation of the project for most at risk adolescents and young people envisaged the following services to be provided:

- Consultation and diagnostics at Family Polyclinics Nos. 24, 28 and 46;
- Provision of information about STI, HIV/AIDS, drug misuse and youth-friendly health services;
- STI treatment at open-access centres;
- HIV testing at the Confidence Centre of AIDS RC;
- Psychologist and lawyer consultations at Mekhr Tayanch and Ishonch va Khayot public organisations;
- Use of services of the Children Centre for waif adolescents aged 12 to 18 at the Mekhr Tayanch public organisation; and
- Distribution of information materials about HIV/AIDS, condoms and syringes.

According to estimates and findings of outreach-workers and project coordinators, the project services (at the primary contact level) were used by more than 3,500 adolescents and young people from at-risk groups, which is a very high achievement within relatively short project duration.

The anonymity of MARA/YP group members' selection and their transferral/attendance to relevant YFHS centres was ensured by introduction of the unique *coding* and *voucher* system.

Under the unique coding system, names of adolescents are not mentioned at their registration, and the

code comprises first two letters of client's mother and father names, gender digit (1 – male, 2 – female), and two last digits of client's birth year, for example: MOFA289. All unique codes of clients are entered in a specially developed database for registration and monitoring and evaluation. Apart from registration of client unique codes, the database shows MARA/YP group coverage, number of educational sessions and distributed informational materials, and number and scheme of referrals and attendances.

Outreach workers and polyclinic personnel used the voucher system for referral of adolescents to PHCCs. Vouchers are the documents indicating the client code, date of referral to a PHCC, name of referring outreach-worker, organisation whereto a client is referred with its location scheme, name of receiving doctor, etc. For the clients' convenience, the voucher underside contains information about polyclinics providing youth-friendly health services, specialities of receiving doctors and their names. The used vouchers were registered in client registration logs at PHCCs and then transferred to outreach-workers for registration in the database.

**Organisation of project activities in the Fergana Province towns**

*Project resources.* The following key towns were selected for project implementation in the Fergana Province: Fergana, Kuva, Kuvasay, Bagdad, Kergeli, Kokand and Margilan. In these towns, 17 polyclinics were selected for introduction of youth-friendly health services. Every polyclinic has assigned a project coordinator, a general practitioner (adult polyclinics) and adolescent doctors (adolescent polyclinics). In addition, subspecialty doctors, OAS and CC specialists working at some PHCCs, gynecologists, STI doctors and drug centre specialists were involved – in total, nearly 100 specialists in various medical fields.

Apart from doctors, the project activity in the Fergana Province involved paramedical personnel (nurses), which performed outreach and visiting functions under the project. In some regions, activities also involved trained outreach-workers from MARA/YP groups. In particular, Salomatlik+Ekologiya NGO has trained outreach-workers from a SW group in Kokand.

Training of visiting nurses as outreach-workers was conducted in cooperation with PSI. In September and December 2007, PSI has trained 25 outreach-workers/trainers from six districts of the Fergana Province: Fergana, Kuva, Kuvasay, Bagdad, Kergeli, Kokand and Margilan.

*Organisation of work with MARA/YP group.* For the purposes of accessing at-risk groups, every PHCC has mapped and identified the areas with the highest concentrations of MARA/YP group representatives. Primary contacts with representatives of the group were established mainly during visiting nurses' inspections of their areas, when they provided information about YFHS. Regional PHCCs used "ballot-boxes" for anonymous study of youth needs and demands as a mechanism of getting feedback from MARA/YP.

It is necessary to note that depending on some regional features (geographic specifics, availability of frontiers, population number, availability of job places, employment profile, etc.) and the level of outreach-workers' training and activeness, one or another group of MARA/YP clients prevailed in some towns. Basically, SW and IDU groups were the most easily accessible. MMS group turned out to be inaccessible for the project staff. Children without adequate family custody practically were not registered as well. Importantly, the age limits of the Project were not strictly observed here, and people older than 25 years were registered as clients, while groups aged below 18 were registered only in few cases.

Implementation of the project for most at risk adolescent and young people in the Fergana Province envisaged provision of the following services:

- Consultation and diagnostics of MARA/YP at adolescent, adult and family polyclinics;
- Provision of information about STI, HIV/AIDS, drug misuse and youth-friendly health services;
- STI treatment at open-access centres. In Kokand, the Salomatlik+Ekologiya NGO assisted in provision of free instrument diagnostic services (ultrasound) for MARA/YP; and
- Distribution of information materials about HIV/AIDS, condoms and syringes.

The voucher and unique code systems were also used in the Fergana Province. However, it should be noted that a client registration database was not used here, and data were coded in registration logs. The voucher system was applied mainly when health providers had to refer a client to another medical establishment for additional examination or consultation of subspecialty doctors.

One of the significant project achievements in the Fergana Province was the active cooperation between project staff and representatives of local authorities, militia departments and self-governments (makhalla committees).

## 2.3. Project Impact Evaluation

Based on the evaluation results, the three provisional key areas with the most significant project achievements have been identified: advocacy, introduction of YFHS standards itself, and training and education of the key project groups in STI and HIV/AIDS issues. Each of these areas is scrutinised below.

**ADVOCACY**

Although the project team gave a third-level priority to the advocacy of YFHS standards introduction in the national health care system as an additional component, the most considerable results were achieved exactly in this sphere. Interests of most at risk adolescents and young people were promoted at all basic levels: national, regional and the level of individual cities/towns, districts, communities and groups.

At the national level, the project implementation involved key executives from the Ministry of Health of RUz and the Republican AIDS Centre. Resulting from the activities performed with key stakeholders, the deviant behaviour of young people (tobacco smoking, alcoholism and drug use) and the growing incidence of diseases among them were identified as the most urgent national problems. It was emphasised that the current situation is determined by poor awareness of adolescents and young people and insufficient training of health providers and other youth-friendly service providers.

In connection with the identified problems, the Ministry of Health has issued the Order No. 562 dated 18 December 2006 "On Implementation of the Youth-Friendly Health Services Principles in the Republic of Uzbekistan". The Order establishes the basic standards of youth-friendly health services and specifies key responsible persons and implementation measures.

Based on successful results of the YFHS initiative piloting, the Government has approved the YFHS standards for MARA/YP, their introduction at the national level and their inclusion in the National Programme for HIV/AIDS Prevention in 2007-2011. UNICEF/Uzbekistan, the Global Fund for Fight Against AIDS, Tuberculosis and Malaria and the Project "HOPE" were involved for support and efficient implementation of the programme.

In course of the project evaluation, experts have noticed a successful coordination of all concerned parties at the national level. It was recommended to involve key figures from the Ministry of Justice and the Ministry of Internal Affairs (see Annex 1) to further expand the scope and area of project activities and to strengthen the advocacy component.

Certain important successes were also achieved in the Fergana Province and in the capital. Thus, in course of the project implementation in 2006, Khokims (Mayors) of the Kokand, Margilan and Kuva towns have adopted the policies for reduction of HIV/AIDS prevalence. These policies pay particular attention to implementation of YFS standards in health care institutions. The Health Care Department of the Fergana Province Khokimiyat has issued the Order No. 221 on promotion of HIV/AIDS and STI prevalence control and introduction of the youth-friendly health services (YFHS) project in pilot institutions of the Kokand, Margilan and Kuva towns. Afterwards, the project area was extended with inclusion of the Bagdad, Fergana (Kergeli) and Kuvasay towns.

In the capital, the main activities were performed together with key figures from the health care system and the Chilanzar District Health Care Department, which ensured efficient coordination of activities among all project executives (PHCCs). These activities also involved representatives of PSI, the international NGO, and local public organisations, district department of internal affairs and individual makhalla committees.

At the level of individual PHCCs, modifications took place both in preparation and approval of particular regulations and policies, and in changing the knowledge, attitudes and practices of health providers with regard to MARA/YP groups. The selected institutions (PHCCs) in all pilot regions have developed their own internal confidentiality policies and YFHS protocols. Health care establishments began to involve risky-behaviour youth in their activities on the peer-to-peer basis. Contacts with most at risk young people were established in order to build their capacities for outreach work.

The project coordination was specific for involvement of municipal/district departments of internal affairs in the project implementation with the view of ensuring unhindered performance of outreach-workers and visiting nurses. The coordination by the main project executives – Tarikat, TAMTI, PSI – was highly appreciated. Experts underscored the efficient coordination of activities with participation of PSI personnel, who had held a number of meetings and discussions in relation to problems arisen in course of the project implementation in the capital. Officials of Tarikat have ensured continuous feedback from Fergana PHCCs and the Salomatlik+Ekologiya NGO in the Kokand town.

Experts were more conservative in evaluating the coordination efforts between PHCCs in the capital and the Fergana Province towns, and between individual PHCCs in the Fergana Province – on the average, 3 of maximum 5 scores. Basically, coordination was limited to referral of MARA/YP representatives to other health care establishments for additional examination and diagnostics. The lowest scores were given to district and municipal drug and STI dispensaries. In the capital, OAS of the municipal dispensary was the main participant of the project, while in regions such a direct cooperation was not observed since PHCCs had their own drug and STI specialists.

In Tashkent, makhalla committees were poorly involved as MARA/YP groups were accessed mainly by outreach-workers and, to a less extent, by visiting nurses. In the Fergana Province, MCs worked more efficiently and actively supported nurses and outreach-workers in their door-to-door round of households.

Other public organisations – Mekhr Tayanch and Ishonch va Hayot – largely worked in the capital with MARA/YP groups in cooperation with PSI. Individual initiative groups of IDU, SW, MMS and children without adequate family custody have not been formed. In Tashkent, activities were performed by outreach-workers having some access to all groups. In the Fergana Province towns, separate groups also were not formed, and coordination was carried out basically through contacts with key representatives of the groups – IDU and procuresses. MMS group was inaccessible for coordination and targeted prophylaxis (see Annex 1).

In order to improve performance, particularly the advocacy component, experts recommended to establish closer contacts with all municipal/district militia departments, drug and STI dispensaries; to consider potential experience sharing mechanisms among individual PHCCs; and to get into touch with leaders of MARA/YP groups: IDU, SW, MMS, and children without adequate family custody.

Another important advocacy component is the achieved *level of key stakeholders involvement in, and awareness of the Project.* As stated above, high indicators of awareness of the Project, its tasks, objectives and implementation were observed at the national level. Province/town administrators had a general notion of the YFHS initiative, and some of questioned managers could hardly explain what the YFHS initiative and its components were, and how it should be adapted to regional needs and demands. In this context, it is recommended to intensify informing of key figures at all levels about the programme. At the regional level, this can be done with participation of CCC Small Committees comprising all concerned figures from province departments of key ministries and agencies involved in the national programme for HIV spread control.

Finally, the *change of public opinion*, including health providers' opinion of most at risk adolescents and young people, which has been repeatedly mentioned by experts questioned in course of the evaluation, is the undoubted and essential achievement of the Project.
Thus, the questioning of key town/province administrators and CPH/CDH managers provided the following results.

- The questioned experts consider most at risk young people as ordinary youth undistinguishable from other young people. In their opinion, those are also citizens of the country and have all rights guaranteed by the state. Experts believe that considering the current life circumstances these people are first of all deprived of attention and care from adults (family members) and, therefore, they need particular concern and support.

- Many of questioned representatives of local authorities and health providers are not indifferent to the fate and health of most at risk adolescents and young people. They think that all possible efforts must be made to protect this group against potential STI and HIV/AIDS infection.

- Representatives of administrations and health care personnel consider the YFHS project goals as the priority ones for MARA/YP groups and communities, since they are aimed at prevention of risky behaviour from the viewpoint of drug misuse and STI and HIV/AIDS prevalence.

- Representatives of administrations and local self-governments have noticed that communities begin to change their attitude to MARA/YP groups, even if slowly. Previously, representatives of this group were treated accusingly and some of them even had undergone attempted expelling from concrete localities (makhallas), while after elucidative work of YFHS project staff some community members came to the conclusion that more efforts should be made to work with youth. The questioned experts recommended livening up of collaboration with young people at

the level of educational institutions and medical establishments, with involvement of community members and parents associations.

- The questioned experts – health care providers stated that initial attitudes to these groups of adolescents and young people were negative, combined with fear of some of the groups (IDU). After participation in the Project, the majority of medical personnel noted that their attitude to youth became more tolerant, free of prejudice and disapproval, and was guided by medical ethics and every client's rights to medical aid.

**IMPLEMENTATION OF YFHS STANDARDS**

Another essential project achievement is the implementation of youth-friendly health services at pilot PHCCs. As stated above, every selected medical establishment has introduced its policy and procedures with regard to servicing of MARA/YP clients. Every PHCC has its own implementation policy specifics determined by its resources, structures, functioning conditions, etc. Therefore, every centre implemented the project strategy in its own way, however there were some general quality indicators outlined below.

**Evaluation of Youth-Friendly Clinic Services from the Viewpoint of Established YFHS Standards**

As stated above, this evaluation was based on the observation method, according to which the evaluation working group has surveyed the main PHCCs – project participants in the Tashkent City and in the Fergana Province of the Republic of Uzbekistan. Annex 3 hereto contains the summary data including information about conditions of facilities, availability of required YFHS information and coordinating body, offered services and compliance with the key standards of confidentiality and anonymity, and the accessibility of establishments for MARA/YP groups. This section outlines some general advantages and required additional improvements. Tables 9.1 and 9.2 provide comparative analysis of strengths and weaknesses as well as advantages and disadvantages of PHCC functioning. The following indicators were selected as the key categories for internal environment analysis: conditions of facilities, availability of visual information, record keeping, coordination of YFHS activities and basic services.

The evaluation has shown a satisfactory condition of the selected establishments, availability of special rooms for group consultations and their accessibility for MARA/YP groups. Many PHCCs have YFHS information and youth-oriented visual media available. The assigned officials responsible for YFHS implementation keep all necessary project records and regular report on them. The selected personnel are able to provide MARA/YP with required scope of planned services (see Table 9.1.)

The following basic weaknesses were defined for further improvement of PHCC activities: need for provision of free consultation rooms subject to confidentiality at those PHCCs where they are not available yet; preparation and production of special information posters/banners of YFHS clinics network for information of population; enhancement of skills of both practicing specialist and YFHS coordinators in client registration, monitoring and evaluation of activities, including creation of a common monitoring and evaluation system for all PHCC; where one PHCC cannot provide the whole range of services for MARA/YP, then a network of servicing centres should be established with accurate system of client referral and coordinated activities.

**Table 9.1. SWOT-analysis of key PHCCs selected for evaluation and providing youth-friendly health services: Analysis of internal PHCC functioning environment**

| Key indicators | | Strengths | Weaknesses |
|---|---|---|---|
| 1. | Status of facilities | Generally, the condition of selected facilities meets all necessary requirements. Many establishments have carried out repair works, prepared special consultation rooms, and improved their adjacent territories. Most of the establishments are located so that they can be easily accessed by clients. | One of the surveyed PHCCs temporarily services MARA/YP at another clinic.<br><br>Some of Fergana PHCC do not have special/ separate rooms for confidential counseling. |
| 2. | Visual media | Personnel of some of the surveyed PHCC have prepared visual media stands informing clients of youth-friendly services availability.<br><br>At some PHCCs, MARA/YP consultation rooms are supplied with health life style posters depicting young people. | Some PHCCs do not have information about YFHS, while others have already removed this information as the Project, in their opinion, is completed.<br><br>Almost all PHCCs have noted the necessity of developing standard YFHS information stands for clients and their placing in the PHCC network. |

| | | | |
|---|---|---|---|
| 3. | Record keeping | PHCCs have received the basic YFHS policy documents: lists of personnel and assigned codes, minutes of medical staff meetings on outreach work (Fergana), territory mapping documents, Confidentiality Policy and lists of Quality Groups.<br><br>YFHS documents are available: minutes of staff meetings, MoH Orders, cooperation agreements with partners, and information about psychological and legal assistance services for MARA/YP (Tashkent).<br><br>Doctors register clients in logs and code their data. Reception of MARA/YP is summarised monthly.<br><br>Registration books of condoms and disposable syringes handover and acceptance are kept | At present, current reporting is unavailable due to high workload of doctors.<br><br>Doctors at some clinics believe that record keeping and client registration take much time and efforts, and do not need to be concentrated on them.<br><br>At Tashkent PHCCs, the voucher system had been used only until the PSI-supported project component was on. Now, when the outreach work is complete, the voucher system is not in use.<br><br>Fergana PHCCs used the voucher system mainly if clients were to be referred to other clinics for additional examination. |
| 4. | Coordination of YFHS activities | There is an official responsible for the YFHS Project. He/she keeps all minutes of meetings, lists of MARA/YP visits, information about provided consultations, examinations and referrals if any. | Insufficient monitoring and evaluation skills of YFHS responsible officials. |
| 5. | Basic services | YFHS consultations are provided by all general practitioners and subspecialty doctors, whose services are required for MARA/YP. Information materials, condoms and syringes are being distributed.<br><br>At some Fergana polyclinics there are popular doctors and specialists, who can receive Russian-, Uzbek- and Tajik-speaking clients.<br><br>At Fergana PHCCs, there are STI and drug doctors providing consultation and treatment. In Tashkent, clients are referred for such consultations to CC and OAS.<br><br>In Tashkent, lawyears and psychologists from partner NGOs provide additional services for MARA/YP. | Almost all PHCCs have no opportunity to provide the whole range of services for MARA/YP, due to:<br>- structural and functional division of PHCCs into adolescent and adult clinics (Fergana Province) and absence of drug and STI doctors (metropolitan PHCCs);<br>- lack of conditions for full laboratory and instrument diagnostics; and<br>- absence of some key specialists and, therefore, necessity of referrals to other clinics for additional examination and consultation.<br><br>In the Fergana Province, lawyer and psychologist services for MARA/YP were unavailable because of impossibility of making appropriate partnership agreements (similar to those made with NGOs in Tashkent). |

The external impact was evaluated by the following indicators: organisation of access to MARA/YP, distribution of protection means and information materials and work with partners (see Table 9.2.).

**Table 9.2. SWOT-analysis of key PHCCs selected for evaluation and providing youth-friendly health services: Analysis of external PHCC functioning environment**

| Key indicators | | Advantages | Disadvantages |
|---|---|---|---|
| 6. | Organisation of access to MARA/YP | Doctors of all PHCC have mapped their areas in order to identify MARA/YP among population living on the territories assigned to clinics.<br><br>Office hours of PHCC has been adjusted to clients' demands<br><br>In Tashkent, contacts with groups are established mostly by PSI outreach-workers. At the same time, nurses inspecting their areas also get in touch with vulnerable groups, inform them about polyclinic activity and invite them to visit a medical establishment (most frequently in the Fergana Province than in the capital).<br><br>Some Fergana PHCCs have established contacts with at-risk group members, mainly, SW and IDU. | Reliable information about number, types and age structure of MARA/YP groups is unavailable.<br><br>Involvement of young people from among MARA/YP is complicated as outreach-workers have ceased their activities after the Project completion (in Tashkent), and PHCC nurses have no contacts with them.<br><br>In the Fergana Province, attraction of youth to polyclinics is also problematic; therefore age limits of the group have not been strictly adhered to, and adolescents aged 10 to 18 practically have not been involved.<br><br>Management has noted lacking/insufficient |

| | | | |
|---|---|---|---|
| | | | skills of communication with at-risk group youth among all PHCCs' personnel.<br><br>MMS group members have been covered with prophylactic activities only in Tashkent.<br><br>Organisation of work with MARA/YP in Tashkent included such methods as conducting of special actions and discos. In the Fergana Province, such a resource has not been used. |
| 7. | Distribution of protection means and information materials | General practitioners have registers for registration of visits and distributed goods (syringes, condoms, booklets) for MARA/YP living in the areas assigned to doctors. GPs monthly report to YFHS coordinating doctor on the number of MARA/YP visits.<br><br>In the Fergana Province, syringes and condoms are distributed by visiting nurses. | Specialists of all PHCCs have reported an undersupply of disposable syringes, condoms and gloves.<br><br>All PHCCs experience a deficit of informational handouts. |
| 8. | Work with partners | PSI personnel have made written partnership agreements with all YFHS partners.<br><br>District doctors cooperate with makhalla committees and makhalla members assigned to PHCCs, and provide YFHS information and advocacy.<br><br>Polyclinics together with makhalla committees perform activities for HIV/AIDS prevention among population.<br><br>Management of a clinic in the Fergana Province has established contacts with law enforcement bodies and keeps other structures informed about YFHS activities. | Only one polyclinic of the Fergana Province has established a network and cooperation among CMH, Confidence Centre and Adult and Children Polyclinics with the view of more efficient referring of clients and their servicing.<br><br>Other PHCCs have not made any agreements with particular structures. Basically, the existing agreements are verbal.<br><br>The most of polyclinics do not have any special agreements with internal affairs departments on reciprocal cooperation. |

The following project advantages identified through the SWOT-analysis are worthy to note: use of outreach-workers and visiting nurses for contacting the at-risk groups, flexible office hours of specialists for clients' convenience, and distribution of protective means, syringes and information materials. Especially appreciated are the efforts of PHCC personnel in organisation of work with partners: governmental structures, local self-governments and public organisations.

Further improvement of activities should take account of such additional factors as the necessity of reliable information about number, activity profiles and age structure of at-risk groups; enhancement of outreach-workers', nurses' and doctors' skills of working with MARA/YP; whenever possible, combination of outreach work and nurses' visits in an individual district/town; use of informal approaches to contacting the groups – organisation of contests, actions, discos; provision of continuous supply of all PHCCs with handouts, protection means and syringes; and involvement of governmental partners (use of resources of CCC Small Committees), local self-governments and public organisations.

Apart from the above SWOT-analysis based on the observation method, the survey team has evaluated the PHCCs' compliance with developed and approved YFHS standards. This compliance is detailed below (the used evaluation methodology is described in the relevant section above).

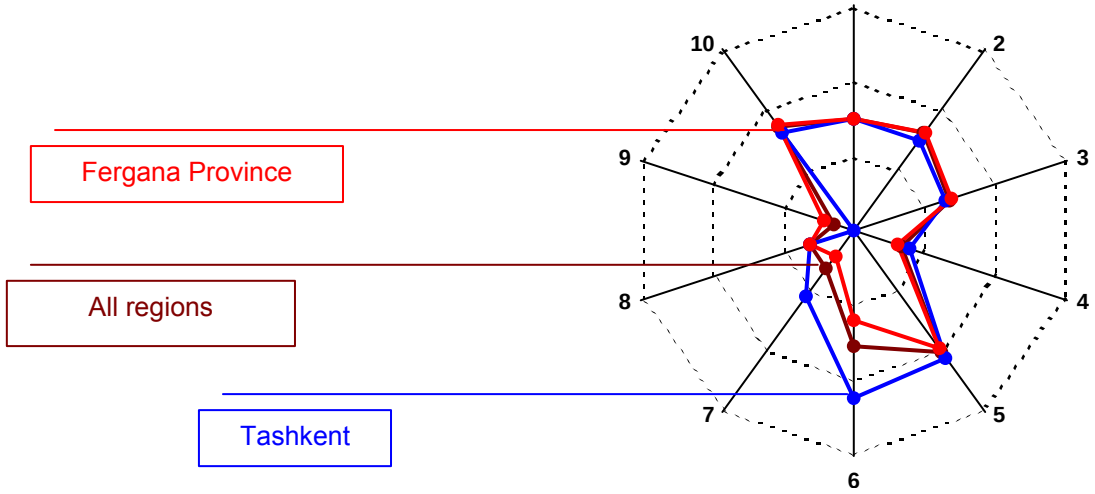
**Analysis of YFHS quality indicators**

Monitoring of YFHS implementation in the Fergana Province and in the Tashkent city enables determining of on-going reforms' successfulness and identifying of complexities and difficulties facing health providers and young people. This analysis allows avoiding of such difficulties in future. The YFHS quality indicators as given in the developed and approved list[12] were used in evaluation of standards. The figure below (Fig. 1) shows 10 key standards (10 axes). Dotted lines indicate service quality compliance

[12] See the Practical Manual on Implementation of Youth-Friendly Health Services in Health Care Institutions for the list of indicators divided into 3 key levels by their integration in the YFHS system – minimum, average, high.

levels: the first internal circle means the minimum compliance level; the middle internal circle means the average compliance level; and the external circle means the highest compliance level.

**Figure 1. YFHS standards implementation levels in the key project regions and on the whole**




The points indicate the standards compliance areas as calculated from the received evaluation data. Values for the Fergana Province are denoted by the red curve, and those for the Tashkent City are denoted by the blue curve. The brown curve indicates the average distribution of values for both regions.

When evaluating the extent of YFHS standards applicability at the clinics surveyed in the Fergana Province and in Tashkent, we may point out the service quality improvement trend, which is common for both regions. Moreover, at the current stage a partial observance of YFHS standards can be noticed among the surveyed clinics. The data received for regions and the average indicators practically coincide.

The Figure above shows that the following four indicators conform with the minimum implementation level:

(4) Comfortability arrangements at the facilities;
(7) Extended access for all youth groups;
(8) Involvement of young people in activity of the facilities; and
(9) Monitoring and evaluation of activities and clients' feedback

The most of key aspects – 6 indicators – correspond to the average implementation level:

(1) Provision of services confidentiality;
(2) Provision of facility's accessibility;
(3) Information of clients about facility's activities;
(5) Staff training in skills, attitudes and values;
(6) Integration of facilities' activities; and
(10) Provision of basic clinical services at the facility

Finally, two indicators are a little above the average level in Tashkent: the staff training in skills, attitudes and values and the Integration of PHCCs' activities.

In order to increase the youth-friendly health services usage rate, clinics in both regions have developed their unique systems of informing about clinics' activities. Conducted staff trainings in adolescent age features including physic-physiological, psychical and socio-economic specifics ensure adequate work of YFS clinic personnel with at-risk group clients. Adolescents and young people have the opportunity to learn about services offered by YFS clinics from different information publications. Use of such crossed terms as "pregnancy test", "anonymity" and "confidentiality", etc. in reference materials enables risky-behaviour young people to gain an appropriate insight in activities of these organisations.

The YFHS standard for provision of service confidentiality is half-implemented (50%) at the surveyed clinics. The clinics have the confidentiality policy developed and formally approved by their managers, which is regularly reviewed. All clinic personnel have been acquainted with the policy and are bound to keep secret all information received from a client. Institutions cooperating with clinics are also aware of

the policy requirements and adhere to them. There are proper documents about cooperating polyclinics' policy. All information materials issued by YFS clinics contain a reference to anonymity. Keeping of records and assurance of confidentiality promote young people's trust in provided services.

It is necessary to note the low satisfaction of youth with medical facilities' equipment. Standard rooms of clinics have standardised typical interior causing a depression at waiting and the very visiting. Survey data point to availability of a small amount of visual media attracting clients' attention and providing information about services of the clinic and cooperating institutions. Illustrative materials, handbooks, and information about helplines, offered by clinics are not always snapped up by young people, which is partially due to languor of youth groups predisposed to risky behaviour.

The highest indicators of compliance with the standards in both Fergana Province (65.5%) and Tashkent (70.0%) correspond to facility personnel awareness of the existing youth-friendly methods. Thus, the project organisers have ensured the appropriate training of personnel dealing with problems of most at risk adolescents and young people. Personnel of the clinics are trained in skills of work with vulnerable youth and in legal aspects of treating adolescents under 16 years and the Convention on the Rights of the Child. Generally, the personnel demonstrate their friendly attitude to a client from the very first moment of his/her visiting a clinic. Qualification of the personnel enables competent counselling on sexual behaviour with regard to healthy life-style advocacy.

The system of health care establishments' integration is much better arranged in the Tashkent City than in the Fergana Province. Most of Tashkent clinics have in place the developed procedures of client referral in case if required specialist services are unavailable. Personnel of the clinics are aware of activities of specialised health care establishments. Information exchange among clinics has been established, and STI prevention measures are implemented within youth organisations. Owing to regular trainings and workshops conducted by cooperating clinics, personnel of other institutions are also aware of the YFS principles. There is an opportunity of learning about psychological and other rehabilitation centres existing in the city. Various information materials for independent acquaintance with services offered by other clinics and their policies are freely available for clients.

The system of clinics location with regard to accessibility for all groups of adolescents and young people has been implemented in both regions to the equal extent. Places of medical servicing of youth and reception hours are defined based on youth demands. There is a system of receiving patients visiting clinics by recommendations of outreach-workers. Availability of special cards precludes long waiting, wins adolescent's favour and eliminates embarrassment and uneasiness. Where a doctor is incompetent in a specific problem, a client may be referred to a cooperating institution providing required medical services. Some clinics have specially built ramps and toilets enabling reception of handicapped persons.

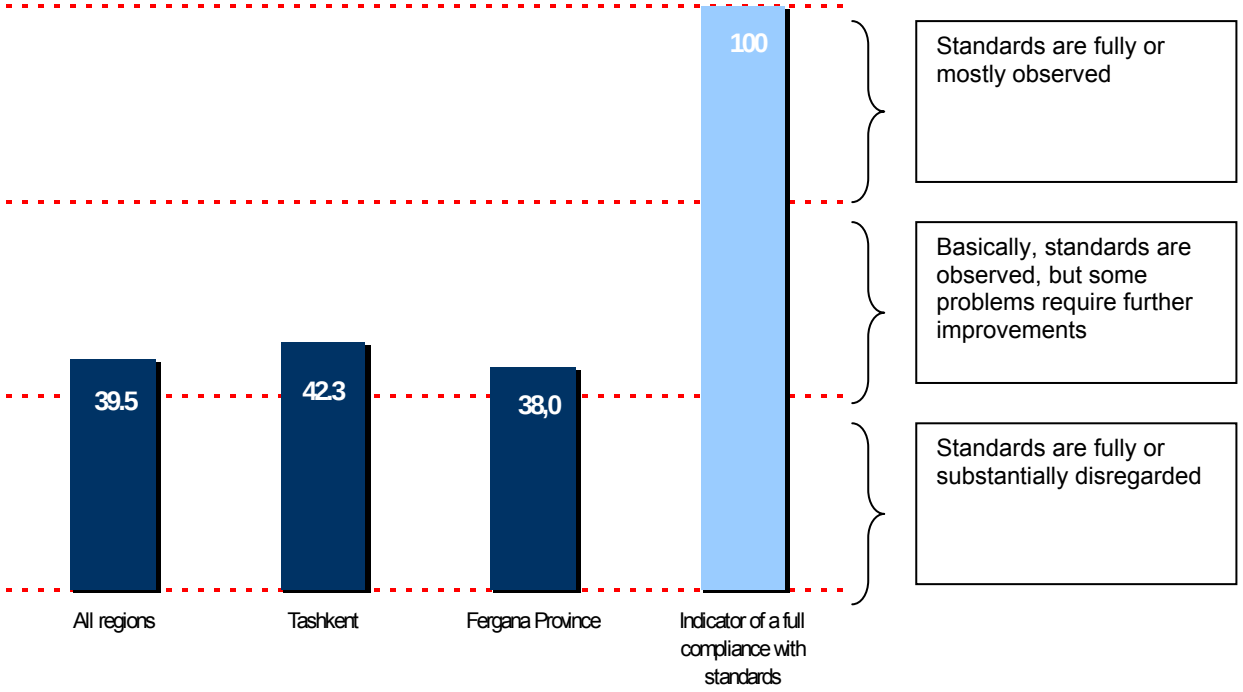
In contrast to the Fergana Province, where personnel's awareness of youth not covered with services of YFS establishments is insignificant, the personnel of Tashkent clinics provide health care services to different categories of vulnerable youth including handicapped persons. Information about available medical services including the free ones is disseminated through representatives of various youth groups, organisations, narcological establishments, etc. In both regions services are provided to all young people irrespective of age, gender, ethnicity and socio-economic status. Clinic personnel are familiar with specifics of helping adolescents and young people from risky-behaviour groups.

The problem of efficient impact of clinics to overcome the growing number of deviant adolescents is largely due to absence of objective information about youth problems. In this context, involvement of youth in development of effective schemes for risky behaviour prevention is an integral part of successful YFS implementation programme. Monitoring data for the Fergana Province and Tashkent show an inconsiderable (20.0%) percentage of youth involved in project implementation, dissemination of information, etc. It is necessary to actively use mass media and other sources of public information for involvement of youth in active life, provision of psychological support to their peers and assistance to social workers in solving youth problems.

The initial stage of YFHS implementation determines the absence of proper field monitoring systems defining how urgent the applied methods are. Evaluation of activities with participation of all concerned parties for improvement of service quality has not been carried out at the surveyed clinics in Tashkent. Survey data point to lack of such quality criteria as regular internal audits at the clinics, enabling revision of servicing policy with regard to received results. The method of clients questioning about their satisfaction with provided service quality is not used. Thus, a feedback from young people is unavailable, and internal audits at clinics are of subjective-statistical nature.

Generally, the system of basic clinical services is properly organised in health care establishment of the Fergana Province and the Tashkent City. Young people are provided with consultations on reproductive health issues. Personnel of clinics control the correctness of contraceptives utilisation. Adolescents and young people may turn to a clinic for assistance by themselves without parents' attendance or notification. These services are confidential which allows adolescents to confide in clinic personnel and easily get the required assistance. In case of necessity, referral procedures may be used with provision of addresses and contact points of relevant institutions dealing with specific problems and distribution of free condoms and pregnancy tests.

**Figure 2. YFHS standards compliance level for all surveyed PHCCs – project participants**




Data presented on Figure 2 reflect the average level of compliance with YFHS standards at the surveyed clinics, and visually confirm the analysis findings. Thus, observance of standards is of relative nature. Only minimal service quality criteria are met. Considering the initial (pilot) stage of friendly health care techniques implementation, we may state that personnel have studied the basic principles and working methods of this system, however attention should be paid to further improvement of the servicing quality.

**Evaluation of service quality at youth-friendly clinics by MARA/YP**

The majority of respondents (93.1%) know about the polyclinics providing youth-friendly health services. Information about these organisations and specifics of their activities was received by youth in Tashkent from outreach-workers, and in the Fergana Province – from doctors and PHCC staff.

Most of young people in Tashkent (60%) and the Fergana Province (50%) have visited an YFHS polyclinic for the first time in 2007. 89.6% of young people voluntarily visit medical establishments providing friendly services. The frequency of visiting youth-friendly polyclinics by questioned young people varies on average from one time (men) to several times (women) a week. Clinics are oftener visited in Tashkent – 2 times a month (46.6%), while in the Fergana Province this indicator is lower – once a month (42.8%).

Medical facilities provide young people with free access to various contraceptives and offer condoms, syringes and needles. In addition, they distribute information materials: free brochures and booklets, which are easily available for all comers. Availability of such materials and the possibility of access to the simplest contraceptives determine the high percentage of youth satisfied with the YFHS confidentiality level.

According to questioned young people, the following indicators of YFHS quality evaluation are fully observed: service confidentiality, free medical services and consultations, anonymity, convenient location and office hours of YFHS clinics, and friendly attitude of doctors and nurses. Survey data show that young people are relaxed when received by doctors, and consultations proceed quickly and in comprehensible language. Only 1/3 of respondents feel discomfortable when waiting at clinics for a

reception; consultations to young people under 15 years and older than 24 years (mostly, men) are provided in presence of strangers (other medical staff), which causes a distrust from these groups of youth.

Most of respondents confide in doctors of YFHS clinics; patients may also independently turn for consultation to a doctor, who is most friendly for them and, in their opinion, is more competent.

The Fergana Province accounts for the most cases (71.4%) of youth referral for different specialist services – mainly, for blood testing, receipt of condoms and additional consultations. The major part of referrals to STI dispensary was for young people aged 18 to 21, 23 and older than 24 years. Young people also have no doubts about the anonymity of these services.

Analysis of youth questioning data points to high skills of outreach-workers in psychological support and sharing of available information with young people predisposed to a risky behaviour; this is owing to involvement of youth in outreach activities on the peer-to-peer basis. The highest indicators of outreach work quality have been noted for dissemination of information about existing support services, their anonymity and ability to keep secret the information received from risky-behaviour youth. Only few adolescents under 15 expressed their doubts about confidence in outreach-workers and their ability to maintain anonymity.

The survey shows that young people are satisfied with outreach-workers' services for distribution of brochures, condoms, syringes and needles. The indicators of consultative services are somewhat lower: 2/5 of young people in the Fergana Province gave an average mark to consultations of outreach-workers.

Involvement of young people under the YFHS programmes allows enhancing of vulnerable youth's trust and applying of friendly approaches to risky-behaviour youth groups. The friendly environment at YFHS clinics is reflected in survey data. 96.5% of questioned young people recommend their acquaintances and friends to visit such clinics. All respondents in Tashkent and the majority of respondents in the Fergana Province will continue their visits to YFHS clinics and get required information materials and protection means, thus opting for the health life-style.

In the respondents' opinion, the following is necessary to improve the existing friendly attitude to at-risk youth: dissemination of additional information about these problems and holding of conversations at clinics, schools and in makhallas about prevention of young people's risky behaviour. The respondents offered the following "slogans" for the YFHS programme: BE HEALTHY EASILY WITH YFHS!; Stop! AIDS!, Think of Your Health Now; Your Health is Your Concern, etc.

**ACHIEVED AWARENESS OF STI AND HIV/AIDS AMONG KEY PROJECT GROUPS**

Evaluation of key project executives' (medical staff, outreach-workers and MARA/YP group) awareness of STI and HIV/AIDS was carried out in accordance with requirements of the national monitoring and evaluations system. Detailed calculations of data are presented in the "Methodology" section. It should be noted only that generally a standard set of several indicators is used for evaluation of awareness of HIV/AIDS. These indicators were incorporated in this survey's estimates. They include the following criteria:

- A respondent must correctly list/identify all exact ways of HIV/AIDS transmission
- A respondent must correctly identify all wrong options of HIV/AIDS transmission ways
- A respondent must mention at least 3 ways of HIV/AIDS transmission prophylaxis.

It is only in case of correct answers to all three questions that a respondent is included in a group of HIV/AIDS-aware people. If any of the criteria is not met, such a respondent is not included in the group.

**Evaluation of medical personnel's awareness of STI and HIV/AIDS**

22 health care providers have been questioned in two regions including 8 women aged 30 to 45 and older in the Tashkent City and 14 people (10 women and 4 men) in the Fergana Province aged 25 and older.

The main STI cited by the questioned health providers included HIV, syphilis, gonorrhea and hepatitis C and B in the Fergana Province, and gonorrhea, syphilis and AIDS in Tashkent. Health providers in both regions (87.5% - Tashkent, 92.8% – Fergana Province) consider condom as the most common measure for prevention of these STIs. Use of disposable syringes by IDU and other people, and personal hygiene for prophylaxis of any diseases were mentioned by respondents in the Fergana Province among other protective methods against these infections. Respondents in Tashkent pointed to regular sanitary activities and use of modern contraceptives as the prophylactic measures.

Generally, the average level of health providers' awareness of HIV transmission ways is quite low. Only 27.3% of the total questioned medical personnel have correct knowledge of actual infection transmission ways. The level of health providers' awareness is higher in the Tashkent City, where a half of them have proper notion of possible HIV/AIDS infection; in the Fergana Province, only 14.2% of respondents have correctly specified all HIV transmission ways. In this context, it is very important to improve personnel's competence and awareness of existing transmission ways of STI and, particularly, HIV.

Most of respondents in both regions have attributed use of condoms and clean syringes to protective methods against HIV/AIDS. A half of health providers think it essential to take precaution in blood transfusion. Among preventive measures, this group of respondents also cited personal hygiene and sanitation, permanent vigilance and prudence. Every third health provider in the Fergana Province thinks it necessary to raise public awareness of HIV/AIDS problems, hold conversations with IDU and energise confidence centres.

Three fours of questioned medical personnel consider television and dissemination of relevant brochures and posters as the main source of information about HIV/AIDS. Considerable percentage of them receive information about new trends in handling HIV and STI prevalence and prevention from their colleagues, senior doctors and health providers working at other institutions. Every third physician in Tashkent has got information about HIV/AIDS from workshops and lectures on relevant topics. Newspapers, magazines, radio and Internet were mentioned among other information channels.

According to the survey, 100% of health providers in Tashkent are aware of youth-friendly health services standards. The same indicator of their Fergana counterparts is a little lower – 85.7%. Generally, these indicators point out the basic knowledge of effective youth-oriented working techniques.

Health providers in both Tashkent and Fergana Province cited the following main YFHS standards: friendly attitude, referral to subspecialty doctors, and provision with condoms and syringes (62.5%). Every second physician in Tashkent also mentions the necessity of anonymity and coding. Respondents in the Fergana Province consider it necessary for every YFHS polyclinic to develop its own policy, provide patients with valuable information and continuously improve personnel skills.

Health providers offered the following messages to attract adolescents and young people to YFHS: Future is Hands of Youth; Enter the Future Without AIDS; Healthy Mother – Healthy Generation, etc.

**Evaluation of outreach-workers' awareness of HIV/AIDS**

Outreach activity specificity implies openness, anonymity and, primarily, information of youth about the possibility of free consultations, anonymous necessary examinations, full turnabout of life and getting the essence of healthy life-style.

Under the Project, eight young people (5 men and 3 women) have been involved in Tashkent as outreach-workers acquainted with goals and tasks of this activity and ensuring field work with at-risk groups. In the Fergana Province, outreach activity was performed by 10 paramedical personnel (nurses). The average age of outreach-workers was 20 to 29 years.

Considering the specific activity of these workers immediately contacting adolescents and young people, it is necessary to thoroughly assess their background in issues concerning STI and HIV/AIDS transmission ways and prevention methods. Survey results point out a superficial comprehension of STI- and HIV/AIDS-related problems by the concerned group of respondents. Generally, the average percentage indicator of awareness in regions makes 11.1%, which predominates in the Fergana Province. Most of outreach-workers cited gonorrhea, syphilis, HIV, herpes, trichomoniasis, chlamydiosis and hepatitis C and B as the known sexually transmitted infections. This group of respondents believes that the main HIV/AIDS and STI prevention measures include use of contraceptives – first of all, condoms; sex abstinence before marriage or having a regular sexual partner; use of disposable syringes by IDU; and personal hygiene.

Basically, outreach-workers' acquaintance with STI characteristics is assisted by health providers, doctors and consultant of the YFHS programme (77.7%). The outreach-workers obtain additional information about HIV/AIDS from Internet resources, newspapers and magazine. Female outreach-workers also mentioned such information channels as the Youth-Friendly Assistance Programme, PSI and television.

Given such a low percentage of outreach-workers' awareness of HIV infection ways, young people to be involved in outreach activity at further YFHS implementation stages should be clued up in more details. This is the priority requirement in view of immediate contacts between them and most at risk adolescents and young people.

Generally, outreach-workers show a satisfactory level of YFHS standards comprehension. The better knowledge of YFHS standards was demonstrated by outreach-workers aged 20 to 29 (55.5%) and 35 to 45 and older (22.2%). This group of respondents mentioned such indicators as awareness of YFHS, countenance, and confidentiality. Girls have underscored also the active use of outreach work, supply with necessary resources and reduction of infected people number.

When reviewing the MARA/YP questioning results, we may emphasise the essential component of psychological support provided by outreach-workers. This reaffirms the relevance of such activities to the youth-friendly health services implementation tasks.

According to the survey analysis, young people working with risky-behaviour adolescents and youth are motivated by the opportunity of distributing free condoms and providing information about prevention of undesired pregnancy, STI and HIV infection and drug misuse among adolescents and young people from vulnerable subcultures. In addition, outreach-workers form links between YFHS clinics and risky-behaviour youth since they disseminate information about free and confidential medical services provided by YFHS clinics.

Outreach-workers suggested using the following slogans in preparation of relevant information materials for attraction of youth to YFHS:

***Protect Yourself, Open your Eyes!***
***The Future Without HIV/AIDS***
***We Are Strong Together***
***Knowledge Arms Safety***

Outreach activity enables a young individual to opt for the healthy generation way and make his/her contribution to building of bright future. These factors are the primary leitmotif of outreach-workers' motivation.

**Evaluation of MARA/YP's awareness of HIV/AIDS**

29 young people have been questioned on the whole including 17 make and 12 female respondents. 15 young people have been questioned in Tashkent, of them, 14 people are below 21 and one person is older than 24 years. In the Fergana Province, 14 people at the age of 18 and older have been questioned.

Survey results have shown that most of young people have a superficial knowledge of sexually transmitted infections. HIV/AIDS, syphilis and gonorrhea are the infections most known among questioned youth. Young people in the Fergana Province also mentioned fungal infections. Basically, Tashkent surpasses the Fergana Province in the awareness of various STIs and their prevention ways. According to the questioning results, use of condoms and disposable syringes is the main method of HIV/AIDS prevention. Women are better informed of the main ways of protection against STIs and their prevention methods. This group of respondents considers necessary to be examined monthly, to have a regular partner and to be informed about new self-protection methods.

Generally, in all regions the better awareness was noted for young people aged 18 to 21 and those older than 24 years. For men, protection against STI is predominantly associated with use of condoms (81.25%). Women believe that along with use of condoms the measures protecting them against sexually transmitted diseases include monthly medical examinations, regular sexual life and keeping abreast of new contraception means and methods.

Young people most frequently receive information about HIV/AIDS and STI from mass media, particularly, television (52.2%). A half of youth in Tashkent supplement their knowledge of these diseases owing to outreach-workers. In addition, friends and relatives are not the least source of knowledge about HIV/AIDS and STI. However, this source does not guarantee the truth. Considering the rather poor awareness of youth with regard to actual HIV/AIDS transmission ways, we may prioritise the information by health care establishments and, in particular, outreach-workers. Survey results show that school-based education in prevention of these diseases is extremely poor.

**Table 10. Some of the most typical opinions of surveyed experts regarding project impact and extension**

**Coordination**

*Interviewer: How is the YFHS Project coordinated by the Government at the level of your district?*

*Respondent: There is a large-scale national programme for AIDS prevention. This is the big strategic programme. In last year, we have discussed all shortcomings and advantages. The Coordination Council works at our Khokimiyat, comprising representatives of internal affairs departments, health care establishments, national educational institutions, etc. They are the Council members. They had provided us with recommendations and we developed a programme. The District Khokim has approved this programme. We hold discussions quarterly. We must provide friendly services to HIV-positive young people.*

*Interview with a representative of local authorities*

*Interviewer: Are nongovernmental organisations, commercial and specialised clinics involved in the Project?*

*Respondent: For example, the Salomatlik + Ekologiya Centre cooperates with us. NGO members are also involved in the activities. We have the Institute of Health in our country. This Institute has branches in provinces and centres in districts. They are concentrated on prophylaxis. All members and doctors of the Institute of Health are involved in the Project.*

*Interview with a representative of local authorities*

**Change of public opinion**

*Interviewer: Do you think that the attitude of communities in your town towards risky-behaviour youth has changed after implementation of the youth-friendly health services? If yes, then how did it change?*

*Respondent: I cannot say that it has changed much, because all people cannot change at once. Everything will change gradually. For example, educated people will understand them. We shall give step-by- explanations to people, housewives, elders, and everything will change in that way. These girls and boys (MARA/YP) are also children; loved children of their parents. We cannot humble them and tell everybody not to be friends, not to play with them, not to talk to and not to employ them. We have no right to that. Our people are humane. They are our youth.*

*Interview with a representative of local authorities*

*Interviewer: What is your attitude to most at risk adolescents and young people?*

*Respondent: They are not born with such behaviour. They do not come into the world as drug users or prostitutes. It is inattention, bad education and unemployment why young people cannot find their course of life.*

*Interviewer: Do you think that this youth is worthy of a support?*

*Respondent: Surely, they also have right to that. We must treat them friendly. It is a must. They are citizens of Uzbekistan, too. They also are entitled to exercise their rights and advantages. They can use medical services. If we neglect a prophylaxis or do not pay attention to them – that would be bad for the society, because the future of our country depends on youth.*

*Interview with a representative of local authorities*

*Interviewer: Did the health providers alter their attitude to MARA/YP while participating in YFHS?*

*Respondent: Yes, they did. For example, previously we forced them. However, now we have a working method. We must work with them sensibly. First of all, we must explain them our work. After that, they will understand us themselves. We should be patient. Now the attitude has changed.*

*Interview with a representative of a municipal health care department*

*Respondent: For example, I can tell you one thing. Our makhalla committee, members of the committee, advisers, and deputy Khokims have arranged a round table. At the end of the meeting, committee members said that they always tried to expel such young people from our territory. If they leave us then we have no problems and the task is solved. Now they have recognised that this is a wrong way. If we are friendly towards them, hear their problems then we would be able to show them a right way. And then we can reduce the spread of infections. We should give them friendly advices and gain their trust. In this way, we shall improve the situation. Things will turn for the worse if we let them go to another territory. This was the advantage of the round table; and not even the round table only but of the project in whole.*

*After that, we met with officers from an internal affairs department. They told us that when they had found such people (MARA/YP), they forced them to undergo a blood test, because these people did not do that voluntarily. We have explained to them the situation and told that after the project completion would undergo blood tests themselves and would not need our. At the end of the meeting, the officers understood that and decided to cooperate with us. And deputy Khokims also understand that. They recommended all polyclinics to work with the Project, because this Project is the best prophylaxis of HIV and AIDS. Therefore, administration also understands us, and this is important.*

*Interview with a representative of NGO*

*Interviewer: how dis the situation in your district change after implementation of YFHS?*

*Respondent: I think, after the survey you also will see the changes for the better. Now our doctors and nurses at polyclinics show good attitude to all patients. They treat them equally, without enmity. We can see this everywhere. We should not distinguish them as bad, "black" people of a community. They are people too, and they also have the right to live and enjoy the life. Our doctors understand that and handle patients friendly.*

*Interview with a representative of local authorities*

**Use of YFHS**

*Interviewer: How effective are the youth-friendly health services in tour region? Can you refer to any positive results?*

*Respondent: Positive results? First, young people begin to come themselves; it is not you but they who search for their doctors and visit them. They come not only by themselves but also with friends, which is a very positive effect. Young people understand that there is a doctor, who is like a close friend – tells nothing to anybody, but helps.*

*Interview with a representative of a Province health care department*

**Project extension and associated difficulties**

*Interviewer: We are going to expand the Project throughout the country. Do you think it sensible to extend YFHS to other regions of the country?*

*Respondent: I think so. For example, initially three districts were selected, and then other three ones were added. Hence, the result was good. I think it would be good, if the Project is expanded throughout the country. It will be beneficial for everybody. It is my opinion. However, doctors and nurses must work in a responsible manner. They must provide friendly services. Doctors must provide prophylaxis. This is our priority task. The Project must be developed and more work is to be done.*

*Interview with a representative of local authorities*

*Interviewer: Are there any difficulties hindering YFHS implementation in other regions?*

*Respondent: Yes, our mentality is different. We cannot frankly talk to children, for example, about a sexual contact. It will be difficult to discuss the problem with girls. However, we have to do so.*

*Interview with a representative of a municipal health care department*

*Respondent: For example, a family comprises parents, children and elders. Frankly speaking, parents because of their problems are inattentive to children. They think that schools will educate and teach their children. Surely, we work with children, but it will be difficult for us to work alone. Therefore, parents also have to pay attention to their children. Children must be controlled, and then administration will feel easy too.*

*Interview with a representative of a municipal health care department*

*Interviewer: What means or methods should be considered in motivation of medical personnel?*

*Respondent: They should be countenanced, for example, in two ways. First, they may be publicly honoured at meetings arranged during festivals or events. Second, they may be rewarded materially.*

*Interview with a representative of a municipal health care department*

*Interviewer: Which organisations may be involved in the Project during its extension to other regions?*
*Respondent: For example, advisers from makhalla committees, because they immediately work with families. At present, women, who live in makhallas and are respected by people, can be committee advisers. The visit all households, get acquainted with all family members and study them. In addition, they know risky-behaviour young people.*
*Furthermore, psychologists work at our educational institutions, at every school and college. We cannot say that all pupils are good, because they all are different. Some of them behave riskily. We cannot distinguish them, but psychologist can do so. Psychologist can also work with them. It would be good if they are involved in the Project too.*

*Interview with a representative of local authorities*

# CONCLUSIONS

**BASIC CONCLUSIONS ON THE PROJECT EXTERNAL ENVIRONMENT ANALYSIS RESULTS**

Health care reforms in Uzbekistan always were of the highest importance for the national Government. Youth has been and is the priority groups for implementation of the national health care policy. Various medical establishments carry out some activities for this group in the sphere of information and improvement of their medical culture, counselling and treatment.

Despite of considerable achievements of the on-going reforms, there are some spheres, where activities must continue and develop even more intensively. One of such spheres is the prevention of HIV spread, the rates and extent of which have kept growing in the country for the past ten years.

Adolescents and young people aged 10 to 25 are most vulnerable to HIV infection, especially those from so-called most at risk groups: children without adequate family custody, SW, IDU and MMS.

The performed analysis of main needs, knowledge and behavioral practice of most at risk adolescents has enabled identification of this group's problems whereon the primary efforts must be focussed.

The majority of most at risk adolescents and young people belong to so-called low-income category of population. The low income problem has arisen in Uzbekistan during the first years after getting the independence, and until now remains quite urgent. The low income problem in Uzbekistan is related to socio-demographic characteristics and national economic development paces. On the one hand these include high birth rates resulting in the annual increase of new manpower supply on the labour market (in case of youth, an unskilled labour). On the other hand, these are relatively slow economic development paces, restructuring of enterprises and deficiency of jobs.

Due to redundancy of workers and their poor qualification, this labour force has a low good value, which entails low living standards and all social consequences. A considerable part of youth has to migrate within the country or abroad in search of education and employment. Almost a half of labour surplus comprises of women and girls.

Having failed to find their places in the labour relations system, young people are forced to be involved in the shadow and black economic spheres, namely, the spheres of commercial sex and drug traffic and use, which, in turn, reduce them to HIV/AIDS-vulnerable groups.

Apart from unavailability of job as a way to achieve material well-being and an opportunity of continued education, etc., youth also face a large number of psycho-social problems. These include misunderstanding between them and elder generations, relations with peers, various forms of deviations typical for awkward age, etc.

Problems facing young people are of different significance and depict the key needs for material support; psychological support; reliable information about drug use harm, STI and HIV/AIDS and protection methods; and health care services, etc.

One of important preventive activities considering interests of youth and adolescents is the implementation of the international Youth-Friendly Health Services initiative. According to the initiative, young people must be provided with access to medical services of at least seven basic types: general health, sexual and reproductive health, HIV-related VCCT, treatment of sexual assault or psychic violence, prophylaxis of using harmful drugs including injective ones, and provision of information and advices on all interesting health care matters.

The fundamental spheres of this international initiative are closely coordinated with all key international documents adopted in order to improve youth and adolescents health care status in different countries. These key documents include: the Millennium Development Goals; the Convention on the Rights of the Child; the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW); and Declaration of Commitment on HIV/AIDS.

The YFHS Project is fully consistent with the national key documents: Strategic Programme for Prevention of HIV Infection Spread in the Republic of Uzbekistan in 2007-2011 and the Welfare Improvement Strategy (WIS).

Similarly to the national strategy for HIV spread control, the YFHS Project provides for revision of some regulatory provisions regarding HIV and concerned population categories, particularly, the MARA/YP group. It is also aimed at capacity building in the sphere of preventive actions among highly vulnerable to HIV infection groups and young people. These groups are in the focus of the National Programme in whole and the Project in particular, with the only difference that the Programme sets age limits of the group between 15 and 25 years, while the YFHS Project covers the group aged 10 to 25.

The main principles and standards of YFHS concept implementation are consistent with the governmental strategy for further improvement of the national health care system and population living standards. These include the strengthening of primary health care centres, implementation of up-to-date diagnostics and treatment standards, advanced training of health care personnel and intensification of work with youth and children for prevention and reduction of socially dangerous diseases.

In 2005, the Project team has performed an analysis before commencing the main activities and identified some problems, upon which the implementation of all activities has been modelled. The existing problems of the basic youth servicing system were identified as follows:

- Absence of unified operation standards and regulations of establishments providing services to youth in accordance with YFS principles
- Absence of competent specialists for handling of adolescent problems in compliance with basic YFS principles
- Insufficient integration of activities of health care sector establishments
- Insufficient integration of intersectoral activities of institutions providing services to youth
- Training programmes for health care providers are inconsistent with YFS principles
- Youth-friendly service providers in other sectors are unaware of YFS principles

In course of this evaluation, the survey team performed an additional analysis of the health care services system with regard to specific needs of youth and, particularly, minors, which enabled some conclusions on the project external environment. Consideration of these data will contribute to further adjusting the project model and accentuating some of its components.

*Access to key services.* The primary health care system in Uzbekistan has been designed so that young people under 16 can consult with doctors at adolescent polyclinics, except for the capital, where adolescent polyclinics are combined with the "adult" ones. As for the target group of the Project – adolescents and young people behaving riskily in terms of STI and HIV/AIDS infection – they can easily consult with an adolescent doctor or a therapist. However, they have to visit "adult" polyclinics for consultations of gynecologists, urologists and drug or STI doctors. In fact, an adolescent first have to visit an adolescent polyclinic and then an "adult" one. Considering the psychological specific of this group, which have been detailed in the Practical Manual for Implementation of Youth-Friendly Services at Health Care Establishments, it is important to note that organisation of MARA/YP consultation and treatment in different areas of a locality is one of the factors affecting appealability. It would be more preferable to concentrate such services in one place (within a medical establishment) so that adolescents at their first visiting could get the maximum of support. Moreover, convenient location of services concentrated in one place may encourage MARA/YP for further visits.

In the capital, consultations of drug or STI specialists cannot be obtained at primary health care centres (polyclinics), as these services are provided separately by STI and drug dispensaries. Under the Project, this problem was solved through arrangements with drug and STI specialists working at OAS and CC in the selected district of the capital (Chilanzar). If the Project is to be extended to other districts of the city, it would be necessary to work out a procedure of such services subject to their maximum convenience for the target groups.

*Anonymity and confidentiality.* It is the duty of STI and drug dispensaries personnel to inform internal affairs departments of minors' recourses. In addition, they must register coming young people of the full legal age. In doing so, anonymity of visits is not ensured as provision of assistance requires submission of passport data. Moreover, STI doctors in the capital may provide medical aid only at district STI dispensaries subject to patient's registration area.

Owing to support from local authorities and the Province Health Care Department, the Project managed to ensure anonymity of young people visits at the level of individual polyclinics in the Fergana Province.

In the capital, this problem was solved in another way. Young people from MARA/YP groups were referred for consultation and treatment to OAS and CC located at the Republic AIDS Centre, and their personnel provided services in full compliance with anonymity and confidentiality procedures. However, many of questioned experts were inclined to think that this issue should be resolved cardinally, through abolition/amendment of relevant legislation and regulations.

*Consultation and treatment of minors.* During the project implementation, negotiations were held with every polyclinic for anonymous reception and confidential consultation of minors from MARA/YP groups without attendance by elder relatives. However, it should be noted that such arrangements would be insufficient if the Project is to be extended. It is time to programme mechanisms and procedures for unhindered access of minors to consultations. Surely, services of therapists, dentists, oculists and other specialists can be provided in this case without any hindrance. Generally, this should also apply to specific services related to reproductive health, pregnancy, STI and HIV/AIDS.

Experts have particularly noticed the "minors' pregnancy" as consultations on this issue are provided by doctors in presence of parents or teachers of an educational institution wherein a client is enrolled. Moreover, such cases must be immediately reported to juvenile controls. If this service is to be retained among YFHS, it is necessary to elaborate a procedure of its provision without detriment to existing instructions and regulations.

*Diagnostics and Treatment.* As noted above, PHCC services are free for population. However, this applies mainly to consultation and laboratory diagnostics. As regards instrument (ultrasound, X-ray) diagnostics, many establishments tend to cover maintenance and consumables costs at the expense of clients by introducing paid services. In course of the evaluation, many PHCC specialists stated that to solve this problem they referred visitors to polyclinics providing such diagnostics free of charge. Nevertheless, in case of the Project extension this issue should be given more attention and all possible options should be reviewed in order to ensure support of the group.

This also concerns purchase of necessary medicines prescribed by physicians. As a rule, those are quite expensive and MARA/YP group representatives (especially, minors) would hardly buy them on their own. This issue can significantly affect both quality of provided support, which may not go beyond consultations, and motivation of MARA/YP to visiting medical establishments.

**MAIN CONCLUSIONS ON THE INTERNAL PROJECT ENVIRONMENT ANALYSIS AND IMPACT EVALUATION RESULTS**

The project for implementation of youth-friendly health services was proposed in order to reduce the risk of STI and HIV/AIDS spread among adolescents and youth belonging to specific groups practicing "highly vulnerable to HIV infection behaviour".

The Project model is aimed at "Introduction of youth-friendly health services for implementation of HIV infection spread preventive activities among socially isolated young people and adolescents in at-risk groups".

The goal achievement strategy consisted, on the one hand, in creating a supportive environment for HIV prevention and implementation of youth-friendly services integrated in the existing health care system, and on the other hand, in enhancing the efficiency of MARA/YP-oriented HIV prevention interventions.

Two key components have been identified for successful implementation of the strategy. The first component consists in YFHS capacity building including: development of youth-friendly health services' standards, establishment of legal framework for their implementation, capacity building of youth-friendly service providers and reduction of MARA/YP stigmatisation and discrimination. The second component addresses the targeted HIV prevention among adolescents and youth in at-risk groups through improvement of quality and effectiveness of preventive measures – information and counselling, distribution of condoms, harm reduction, STI treatment, and VCT and HIV-testing.

The Fergana Province of the Republic of Uzbekistan (Kergeli, Margilan, Kuva, Kuvasay and Bagdad) and the Tashkent City (Chilanzar District) were defined as the pilot areas of the Project. The Project was implemented by the Ministry of Health of the Republic of Uzbekistan through the "Tarikat" Republican Children and Adolescents Reproductive Health Centre and the Tashkent Advanced Medical Training Institute with support from UNICEF/Uzbekistan. The project implementation was partnered by NGOs Mekhr Tayanch and Ishonch va Hayot in the Tashkent City and NGO Salomatlik+Ekologiya in the Fergana Province.

The key international partners, which have supported the project, included: UNICEF-Uzbekistan, the Global Fund Programme for HIV/AIDS and Tuberculosis Control in Uzbekistan, and the international public organisation PSI.

Adolescents and young people following unsafe sexual and drug use practices from the viewpoint of high HIV infection risk were defined as the key target group (beneficiaries) of the Project. These include such categories as IDU, SW, MMS and children without adequate family custody.

In course of project planning and its further implementation, two different approaches were used in work with the target groups. The first approach consisted in the following: volunteers out of most at risk adolescents and youth were selected and trained as outreach-workers. They were provided with information about STI and HIV/AIDS, infection ways, protection methods, etc. After the training stage, volunteers worked immediately in so-called "hotspots": on streets, in the places of MARA/YP gathering, at clubs, discos and bars. They worked on the peer-to-peer basis and informed youth about STI and HIV/AIDS, and the places where consultations of physicians, narcologists and psychologists can be obtained, etc. Under the second approach, paramedical personnel of PHCCs (basically, polyclinic nurses) were specially trained as outreach-workers. They were charged with door-to-door visiting of households (patronage) and detecting of the most disadvantaged families with adolescents and young people practicing behaviour highly vulnerable to STI and HIV/AIDS infection. These households were provided with information, booklets and brochures about HIV/AIDS and protection methods, and youth-friendly health services based on anonymity and confidentiality principles.

In course of project planning, the Project team has provided for a performance monitoring system. Preliminary monitoring and evaluation of the existing situation were carried out in the pilot regions. Meetings with policy-makers and managers of youth-friendly service providers were held. In addition, the existing situation was analysed through questioning of health care providers, service provider managers and service recipients. Furthermore, a joint evaluation of needs was carried out among young people in the pilot regions. Survey and joint need evaluation results have been used in project designing, development and testing of manuals, and adjustment of the national policy and quality standards for youth-friendly services.

A system of qualitative and quantitative indicators was developed specially for tracking the progress of youth-friendly health services implementation. The indicators correspond to the three key progress levels: low, medium and high. These indicators are very convenient for monitoring and evaluation of YFHS standards implementation efficiency, and enable assessment of the achieved Project outcomes.

In 2005, the YFS implementation norms and standards were developed and approved. The YFS standards package was developed with regard to the advanced international experience. In addition, the international practice was adapted to local conditions as appropriate. The developed standards were tested with involvement of different level specialists: immediately with service providers in health care and non-medical sectors, and with beneficiaries. A series of programme discussions was arranged for specialists and experts from different sectors providing youth-friendly services. Thus, the key principle of numerous stakeholders' participation and involvement in discussion of the new initiative was observed and resulted in development of the YFS standards package. Moreover, training manuals were developed and training of youth-friendly service providers was conducted, and local initiative groups for YFS implementation were formed.[13]

Implementation of project activities in 2006 has resulted in the following achievements. The expert groups has developed the training manual "Development and Implementation of YFHS Standards" including standards implementation stages, stakeholders integration mechanisms and principles of protocol development for reduction of HIV/AIDS spread among most at risk adolescents. In addition, the training manual "Outreach Work Organisation Guidelines" was developed to inform health care providers of the principles of work with at-risk group members for HIV/AIDS prevention, including approaches to involvement and training of volunteers out of young peoples. In 2007, the activities were chiefly concentrated on MARA/YP groups to inform them of STI, HIV/AIDS and provide them with targeted medical support.

[13] Source: "Assistance in Youth-Friendly Services Implementation" and "Assistance in HIV/AIDS Spread Control Among Risky Behaviour Youth" Projects. Report on activities of the “Tarikat” Republican Children and Adolescents Reproductive Health Centre for 2005-2006.

Based on the evaluation results, the three provisional key areas with the most significant project achievements have been identified: advocacy, introduction of YFHS standards itself, and training and education of the key project groups in STI and HIV/AIDS issues.

Although the project team gave a third-level priority to the advocacy of YFHS standards introduction in the national health care system as an additional component, the most considerable results were achieved exactly in this sphere. Interests of most at risk adolescents and young people were promoted at all basic levels: national, regional and the level of individual cities/towns, districts, communities and groups.

Based on successful results of the YFHS initiative piloting, the Government has approved the YFHS standards for MARA/YP, their introduction at the national level and their inclusion in the National Programme for HIV/AIDS Prevention in 2007-2011. UNICEF/Uzbekistan, the Global Fund for Fight Against AIDS, Tuberculosis and Malaria and the Project "HOPE" were involved for support and efficient implementation of the programme.

Another essential project achievement is the implementation of youth-friendly health services at pilot PHCCs. As stated above, every selected medical establishment has introduced its policy and procedures with regard to servicing of MARA/YP clients. Every PHCC has its own implementation policy specifics determined by its resources, structures, functioning conditions, etc.

The evaluation has shown a satisfactory condition of the selected establishments, availability of special rooms for group consultations and their accessibility for MARA/YP groups. Many PHCCs have YFHS information and youth-oriented visual media available. The assigned officials responsible for YFHS implementation keep all necessary project records and regular report on them. The selected personnel are able to provide MARA/YP with required scope of planned services.

The following basic weaknesses were defined for further improvement of PHCC activities: need for provision of free consultation rooms subject to confidentiality at those PHCCs where they are not available yet; preparation and production of special information posters/banners of YFHS clinics network for information of population; enhancement of skills of both practicing specialist and YFHS coordinators in client registration, monitoring and evaluation of activities, including creation of a common monitoring and evaluation system for all PHCC; where one PHCC cannot provide the whole range of services for MARA/YP, then a network of servicing centres should be established with accurate system of client referral and coordinated activities.

The following project advantages identified through the SWOT-analysis are worthy to note: use of outreach-workers and visiting nurses for contacting the at-risk groups, flexible office hours of specialists for clients' convenience, and distribution of protective means, syringes and information materials. Especially appreciated are the efforts of PHCC personnel in organisation of work with partners: governmental structures, local self-governments and public organisations.

Further improvement of activities should take account of such additional factors as the necessity of reliable information about number, activity profiles and age structure of at-risk groups; enhancement of outreach-workers', nurses' and doctors' skills of working with MARA/YP; whenever possible, combination of outreach work and nurses' visits in an individual district/town; use of informal approaches to contacting the groups – organisation of contests, actions, discos; provision of continuous supply of all PHCCs with handouts, protection means and syringes; and involvement of governmental partners (use of resources of CCC Small Committees), local self-governments and public organisations.

When evaluating the extent of YFHS standards applicability at the clinics surveyed in the Fergana Province and in Tashkent, we may point out the service quality improvement trend, which is common for both regions. Moreover, at the current stage a partial observance of YFHS standards can be noticed among the surveyed clinics. Medical facilities provide young people with free access to various contraceptives and offer condoms, syringes and needles. In addition, they distribute information materials: free brochures and booklets, which are easily available for all comers. Availability of such materials and the possibility of access to the simplest contraceptives determine the high percentage of youth satisfied with the YFHS confidentiality level.

The following indicators of YFHS quality evaluation are fully observed: service confidentiality, free medical services and consultations, anonymity, convenient location and office hours of YFHS clinics, and friendly attitude of doctors and nurses. Survey data show that young people are relaxed when received by doctors, and consultations proceed quickly and in comprehensible language.

Most of respondents confide in doctors of YFHS clinics; patients may also independently turn for consultation to a doctor, who is most friendly for them and, in their opinion, is more competent.

Generally, the average level of health providers' awareness of HIV transmission ways is quite low. Only 27.3% of the total questioned medical personnel have correct knowledge of actual infection transmission ways. The level of health providers' awareness is higher in the Tashkent City, where a half of them have proper notion of possible HIV/AIDS infection; in the Fergana Province, only 14.2% of respondents have correctly specified all HIV transmission ways.

In this context, it is very important to improve personnel's competence and awareness of existing transmission ways of STI and, particularly, HIV.

Considering the specific activity of these workers immediately contacting adolescents and young people, it is necessary to thoroughly assess their background in issues concerning STI and HIV/AIDS transmission ways and prevention methods. Survey results point out a superficial comprehension of STI- and HIV/AIDS-related problems by the concerned group of respondents. Generally, the average percentage indicator of awareness in regions makes 11.1%, which predominates in the Fergana Province. Most of outreach-workers cited gonorrhea, syphilis, HIV, herpes, trichomoniasis, chlamydiosis and hepatitis C and B as the known sexually transmitted infections. This group of respondents believes that the main HIV/AIDS and STI prevention measures include use of contraceptives – first of all, condoms; sex abstinence before marriage or having a regular sexual partner; use of disposable syringes by IDU; and personal hygiene.

Survey results have shown that most of young people have a superficial knowledge of sexually transmitted infections. HIV/AIDS, syphilis and gonorrhea are the infections most known among questioned youth. Young people in the Fergana Province also mentioned fungal infections. Basically, Tashkent surpasses the Fergana Province in the awareness of various STIs and their prevention ways. According to the questioning results, use of condoms and disposable syringes is the main method of HIV/AIDS prevention. Women are better informed of the main ways of protection against STIs and their prevention methods. This group of respondents considers necessary to be examined monthly, to have a regular partner and to be informed about new self-protection methods.

Officials of province/municipal health care departments and local authorities consider that YFHS implementation in other regions faces the following challenges:

- Difficulty in overcoming local mentalities presuming strict tabooing of any discussions about sexual education of adolescents and, particularly, girls.
- Reduced part of families in education of growing generation. In experts' opinion, families increasingly often and readily shift off educational and controlling functions to schools. This results in children remaining without proper control and care from elder generations. Therefore, such children are oftener subjected to bad influence from others and may be involved in use of alcohol and drugs including injective ones. Most likely, they also may have early sexual contacts or be involved in sex-business.
- Current overload of of PHCC paramedical personnel. Medical personnel are not motivated to undertake additional duties for information and consulting of MARA/YP. Lack of additional incentives for outreach work with MARA/YP.
- Exposure of PHCC paramedical personnel to MARA/YP, who mostly are highly criminalised.
- Lack of paramedical personnel's skills of communication with MARA/YP groups: communication specificity, calling into frankness, psychological methods of at-risk group consultation, stress relief methods, etc.
- Miscomprehension of a friendly attitude to MARA/YP by law enforcement bodies; therefore, they should be also involved in development of standards.

# RECOMMENDATIONS

**PRIMARY RECOMMENDATIONS FOR PROJECT EXTENSION**

Extension of the YFHS Project to other regions of the country seems very important for the purposes of continuing and expanding health care reforms considering the interest and needs of youth. The lessons learnt from implementation of this initiative in the capital and Fergana Province towns should be taken into account for the process to be the maximally efficient. Based on the project evaluation and findings, we may provide the following key recommendations.

1. Prior to project commencement, a pre-project evaluation should be made in selected regions, including at the minimum the following key analytical tasks:
    a. Evaluation of PHCC structure and performance in targeted project areas including evaluation of basic services available for youth and adolescents, interaction among different health care providers, management system, human and material resources, etc.
    b. Assessment of STI and HIV/AIDS prevalence in selected project regions, based on data from MoH RUz and the Republican AIDS Centre.
    c. Analysis of project stakeholders with use of strategic planning methods or, probably, a simpler option – a Venn diagram.
    d. Fast evaluation of quantity and qualitative composition of MARA/YP groups present in the targeted project districts.
    e. Evaluation of needs and demands of the identified project target groups: SW, IDU, MMS, adolescents without adequate family custody.
    f. Inter alia, basic measurements of project target groups and key participants (medical personnel and outreach-workers) by indicators of awareness of STI and HIV/AIDS in accordance with the national monitoring and evaluation indicators.
    g. Evaluation of needs and demands of key project participants – PHCC medical personnel – from the viewpoint of potential work with MARA/YP: psychological spects of activities with at-risk groups, observance of medical ethic standards with regard to at-risk groups, preparedness for outreach work, motivation system, etc.

2. Based on the performed pre-project evaluation, the man goals and objectives of the Project extension to new target districts should be formulated.

3. Formulation of objectives should take into account every individual district's specifics: functioning system of PHCC and relayed health care providers, stakeholders, structure and needs of MARA/YP groups, and requirements of key project participants, etc. Perhaps, a unique model of the most efficient YFHS initiative implementation would emerge for every individual region.

4. Future project monitoring and evaluation system should be revised prior to its commencement. In order to overcome potential difficulties in building of a general project M&E logical system, the following primary tasks should be addressed:
    a. Revision of nation-level indicators system and instructions on their collection for potential integration of project indicators in the general M&E system in compliance with the triune principles.
    b. Development of a unified project logframe specifying goals, key tasks, actions, all responsible participants, expected outcomes and indicators of their evaluation. In addition, development of indicators collation methods: questionnaires for their collection (quantitative part), protocols and other project documents wherefrom qualitative data can be derived, etc. Importantly, indicators should be assigned not only to individual actions, but also to tasks and general goal of the Project.
    c. Involvement of all key participants of the future Project in development of the project M&E system so that to avoid conflicts and misunderstandings in course of project implementation and collection of information about achieved results.
    d. Pre-project fast assessment to determine approximate number of MARA/YP in the targeted regions (see item 1 of these Recommendations)
    e. Pre-project sample survey of MARA/YP groups to study the level of awareness of STI and HIV/AIDS. Scheduling of the same survey upon project completion for establishing of dynamics and achieved effects (see item 1 of these Recommendations).
    f. Evaluation of awareness in conformity with universal requirements of the National monitoring and evaluation system to youth awareness of STI and HIV/AIDS, and with national indicators set forth in the Strategic Programme for HIV/AIDS Prevention.

g. Survey of selected PHCCs for potential provision of youth-friendly health services in maximum proximity to YFHS standards.
h. Development of the monitoring system to include regular procedures of PHCC evaluation for their compliance with YFHS standards.
i. If the Project team is inexperienced in development of a unified M&E system, external consultants should be involved for methodological support of the whole process and correct facilitation of participant's activity.
j. The overall process of M&E logframe establishment may be documented and transferred to key figures of the health care system for review and potential subsequent application in other projects and programmes. In this case, it can be considered as an input to reforming of the health care management system and published as a separate manual or within a general manual on YFHS initiative implementation features.

5. According to experts' recommendations provided in course of the evaluation, the legislation should be analysed in detail for its compliance with the key principles of YFHS, and recommendations on necessary amendments should be provided at both regional (separate regulations and instructions) and national (legislative framework) levels. Perhaps, recommendations on the nation-level legislative amendments are to be made in parallel with implementation of the strategic programme tasks for HIV/AIDS prevention, as individual provisions of the strategy also provide for such amendments.

6. The lessons learnt from the pilot project should be taken into account in stakeholders' analysis and involvement of project partners. When evaluating the Project, experts have noticed successful coordination of all concerned parties at the national level. It was recommended to involve key figures from the Ministry of Justice and the Ministry of Internal Affairs to further expand the scope and area of project activities and to strengthen the advocacy component.

7. Introduction of the YFHS initiative basics in medical curricula requires key figures from the specialised secondary and tertiary education system to be involved in the Project.

8. Experts recommended to establish closer contacts with all municipal/district militia departments, STI and drug dispensaries so that to enhance region-level activities and, particularly, the advocacy component.

9. Establishment of close contacts with leaders of MARA/YP groups: IDU, SW, MMS, children without adequate family custody. Where public organisations servicing such groups are available in the project target regions, their involvement in the Project should be considered.

10. As far as possible, provision for combination of different approaches to work with at-risk groups – outreach work, organisation of awareness raising campaigns and events, and work of visiting nurses – for the purposes of the most efficient access to MARA/YP groups.

11. Consideration of advisability and possibility of expanding the region-level project resources with involvement of such public organisations as the Makhalla Fund, the Kamolot Public Youth Movement and the Women Committee (as recommended by experts).

12. Province/town administrators have only a general notion of the YFHS initiative, and some of questioned managers can hardly explain what the YFHS initiative and its components are, and how it should be adapted to regional needs and demands. In this context, it is recommended to intensify informing of key figures at all levels about the programme. At the regional level, this can be done with participation of CCC Small Committees comprising all concerned figures from province departments of key ministries and agencies involved in the national programme for HIV spread control.

13. In course of the evaluation, experts repeatedly mentioned the educational system (public education system – schools, colleges and higher-education institutions) as the important component representatives of youth services. In this context, consideration should be given to involvement of educators in work with MARA/YP groups. For example, information of adolescents about HIV/AIDS within the public education system can be arranged via school medical stations having energised school nurses' activities. At the level of colleges and universities, these activities can be implemented at student polyclinics and medical stations.

14. In order to strengthen the interaction among different project stakeholders, consideration should

be given to potential coordination and experience sharing mechanisms at the national and regional levels, including exchange of information about organisation of work with at-risk groups ( success stories and improvements to be made) among individual PHCCs.

**BASIC RECOMMENDATION ON MAINTAINING THE PROJECT SUSTAINABILITY**

The Project extension to other regions of the country should proceed in parallel with maintaining of its sustainability and securing of its results in the pilot regions of the Tashkent City and the Fergana Province. The project evaluation has noticed a trend to delaunching of PHCC activities – in the capital, outreach work with MARA/YP groups has been almost stopped, and nurses practically have no contacts with the groups. In the Fergana Province, reduction of field visits has been observed and a deficit of information, protection means, etc. is evident. Activities in both regions are not monitored due to current personnel overload. In this connection, it is necessary to intensify the following activities:

1. Review of national HIV/AIDS prevention programmes and individual programmes of international organisations for their harmonisation with the Project activities and involvement of additional human and material resources for its support and development.

2. Development of a system for coordination of project activities of PHCCs in the capital and the Fergana region with involvement of key figures. Incorporation of further steps for extension and sustainability of the achieved project results.

3. Planning and implementation of additional measures to improve health providers' tolerance to most at risk youth. Involvement in these measures of all concerned structures with the health care system.

4. Development of tolerant attitude to MARA/YP groups among key stakeholders from internal affairs departments, local self-governments and the system of public specialised secondary and tertiary education.

5. Training of PHCC key personnel in project monitoring and evaluation. Strengthening of local YFHS implementation monitoring component focussed on the selected establishments, adherence to performance standards, age limits of service recipients, etc.

6. Development of establishments' certification system in terms of YFHS standards implementation. Introduction of regular audit procedures at YFHS establishments, with evaluation of M&E participants' performance and possibility of evaluation by independent experts.

5. Development of PHCC-clients feedback procedures for study of youth conditions and provided services. Involvement of youth in evaluation of YFHS performance. Active use of youth potential would contribute to reliable analysis of young people needs and improvement of service quality and competence.

6. In cooperation with relevant internal affairs departments, development and approval of policies ensuring external safety of service providers when working with most at risk youth in their highest concentration places.

7. Development and approval of documents for safety practice of outreach-workers and nurses when working with at-risk groups. Additional training of PHCC personnel in specifics of consulting of at-risk groups, stress relief techniques, field work safety, etc.

8. Given the quite low percentage of awareness of HIV/AIDS among outreach-workers, further stages of YFHS implementation should allow for detailed instruction of young people involved in outreach activity. This is the priority requirement in view of immediate contacts between them and most at risk adolescents and young people.

9. Detailed updating of medical personnel on the latest data about STI and HIV/AIDS prevalence in their regions, infection ways and protection methods. Organisation of regular medical personnel testing on their STI and HIV/AIDS awareness level.

10. Improvement of the system of information, registration and referral of clients or most at risk youth, perhaps, through establishment of an information and resource centre with a standing hotline.

11. Provision of continuous supply of Open-Access Services, Confidence Centres and PHCCs with protection means, syringes, disinfecting agents and information materials to be distributed among MARA/YP.

12. Expanded scope of information activity of these establishments is the integral part of necessary efforts for involvement of youth and other people to help most at risk adolescents in finding themselves in the world and building their future based on the healthy life-style principles. Information boards/banners about existing services for youth and adolescents and posters about the YFHS initiative, etc. should be developed and supplied to operating PHCCs.

13. Attention should be paid to external appearance and interior of clinics and to the places enabling independent movement and self-servicing of disabled people.

14. The existing friendly attitude to most at risk youth should be strengthened through extended dissemination of problem-related information and conversations on prevention of risky behaviour of youth within polyclinics, makhallas, schools, colleges and institutes/universities.

# INFORMATION SOURCES USED FOR SECONDARY DATA ANALYSIS


1. Ministry of Health of the Republic of Uzbekistan. Prikaz (Order) No. 562 dated 18 December 2006 "On Implementation of the Youth-Friendly Health Services Principles in the Republic of Uzbekistan".

2. Special Session of the UN General Assembly, Declaration of Commitment on HIV/AIDS, 27 June 2001.

3. Sanitary Regulations and Standards and Hygienic Standards of the Republic of Uzbekistan. "Sanitary Regulations and Standards of Medical Examination for HIV/AIDS Presence and Organisation of Medical Care of HIV/AIDS Patients", SanPiN No. 0187-2005, approved by the National Chief Sanitary Inspector of the Republic of Uzbekistan on 6 October 2005.

4. Prikaz of the Ministry of Health of the Republic of Uzbekistan No. 420 dated 23 September 2004 "On Improvement of HIV/AIDS Preventive Activities in the Republic of Uzbekistan".

5. Prikaz of the Ministry of Health of the Republic of Uzbekistan No. 480 dated 23 September 2004 "On Improvement of HIV/AIDS Preventive Activities in the Republic of Uzbekistan".

6. The Programme " Scaling up the Response to HIV/AIDS: A Focus on Vulnerable Populations" under the grant of the Global Fund for Fight Against AIDS, Tuberculosis and Malaria (UZB-304-G01-H): Report of the Working Group of local and international experts on review of HIV/AIDS-related laws of Uzbekistan. Tashkent, 2005.

7. The Programme " Scaling up the Response to HIV/AIDS: A Focus on Vulnerable Populations" under the grant of the Global Fund for Fight Against AIDS, Tuberculosis and Malaria (UZB-304-G01-H): Joint Situation Analysis and Evaluation of the Strategic Programme for Prevention of HIV/AIDS Epidemic Spread in the Republic of Uzbekistan in 2003-2006, February 2007.

8. Anenx to the Resolution of the Republican Extraordinary Anti-Epidemic Committee No. 3 dated 27 May 2003, Strategic Programme for Prevention of HIV/AIDS Epidemic Spread in the Republic of Uzbekistan in 2003-2006

9. Annex to the Minutes of Meeting of the field session of the Republican Extraordinary Anti-Epidemic Committee No. 1 dated 03 July 2007r, Strategic Programme for Prevention of HIV Infection Spread in the Republic of Uzbekistan in 2007-2011, Tashkent, 2007.

10. Uzbekistan – Independent Development Way, "Uzbekiston", Tashkent, 2006.

## Annex 1. Project Log-frame Analysis Matrix

(January 2006 – December 2007)

| Project tasks: | Project activity | Date/Responsible parties/Partners | Expected outcomes | Indicators | Collation methods |
|---|---|---|---|---|---|
| **National level:** Component 1. Development of a national YFHS model as the main tool of HIV/AIDS reduction among youth | | 2005<br>TAMTI<br><br>Tarikat Republican Children and Adolescents Reproductive Health Centre<br><br>National University of the Republic of Uzbekistan | YFHS within the health care system are provided in the project priority districts in compliance with international standards. | - Drafted YFHS standards package<br>- Developed manuals and conducted training for youth service providers<br>- Formed local initiative groups<br>- Established information and resource centres in 3 districts (Kokand, Margilan, Kuva) | Project application – 2007. Tarikat |
| Component 1.2. Strengthening of YFHS implementation for assistance in HIV spread reduction | 1.2.1. Integration and coordination of local YFHS working groups for development of a regional policy for implementation of standards and adoption of protocols | 2007<br>Province Health Care Department<br>Province Khokimiyat<br>Tarikat Republican Children and Adolescents Reproductive Health Centre<br>17 polyclinics in above-mentioned localities. | Developed and approved YFHS strategy and policy for prevention of HIV/AIDS among MARA/YP at the level of priority districts and establishments.<br><br>Developed and approved YFHS protocols of service providers.<br>Developed manual for medical personnel on work with at-risk groups. | YFHS indicators | The strategy and policy have been incorporated in resolutions of Khokimiyats of the Fergana Province and the Chilanzar District of Tashkent |
| | 1.2.2. Survey of risk groups-specific behaviour determinants | | Examination of existing situation and specifics of most at risk adolescents' behaviour | Awareness indicators | Report on survey results |
| | 1.2.3. Development and introduction of monitoring and evaluation indicators | 22.06.06 – 14.10.06 | Developed monitoring system and evaluation indicators of YFHS implementation aimed at MARA/YP. | Evaluation for capacity building and enhancement of the monitoring system. | Report on evaluation results |
| | 1.2.4. Development of a YFHS standards implementation manual: | 10.03.06 – 13.04.06. | Built up capacities of working group members for work with | Testing indicators for work with | Testing results тестирования |

| Project tasks: | Project activity | Date/Responsible parties/Partners | Expected outcomes | Indicators | Collation methods |
|---|---|---|---|---|---|
| | implementation stages, mechanisms of stakeholders integration, principles of protocols development. | | at-risk groups.<br><br>Developed manual on YFHS standards implementation for prevention of HIV/AIDS spread among MARA/YP. | MARA/YP<br><br>YFHS Manual | |
| | 1.2.5. Development of a manual for organisation of work with most at risk adolescents including principles of involvement and training of volunteers from among young people | 13.04.06 – 13.05.06 | An initiative group formed of most at risk adolescents | Group performance indicators | Reports on group performance |
| | 1.2.6. Holding of a district-level meeting with working group members to discuss the principles of YFHS policy and protocols development; drafting of a district-level YFHS policy. Discussion of scheduled regional activities and standards implementation process | 15.04.06 – 24.04.06<br>Kokand, Margilan and Kuva (Fergana Province) | Regional conference for discussion of efficiency of activities performed in the pilot districts. | Evaluation forms of workshop participants | Report on workshop results |
| | 1.2.7. Selection of the Chilanzar District (Tashkent) for preparation of YFHS standards implementation at health care establishments. Five meetings with youth health care service providers and representatives of MARA/YP. | 10.04.06 – 25.08.06<br><br>3 polyclinics | Work in the Chilanzar District enabling gaining of experience of YFHS implementation taking into account specifics of urban population. | Evaluation of metropolitan PHCC performance. Used indicators – YFHS standards | Reports on PHCCs' progress in the capital.<br><br>Reports on results of evaluation of compliance with YFHS standards |
| Component 2. 1. Tashkent Improvement of MARA/YP access to youth-friendly health services to prevent HIV spread | | Chilanzar District of the Tashkent City<br>Tashkent, 2006 - 2007<br>Tarikat<br>PSI<br>Mekhr Tayanch<br>Ishonch va Hayot | At least 5% coverage of MARA/YP in the target district with peer-to-peer educational programmes.<br><br>Provision of at least 3% of MARA/YP with reliable information about HIV/AIDS and protection methods, and their visiting of YFHS Centres. | Indicators are unavailable<br><br>Indicators are provided in the questionnaire, but should be improved | Reports on project activity results |
| | Trainings for outreach-workers in the capital | Tashkent<br>July – October 2007<br>PSI | Trained outreach-workers | Evaluation of outreach-workers' awareness (questionnaire) | Report on evaluation results |
| | Trainings for outreach-workers in the Fergana Province | Tashkent<br>September – December 2007 | Trained 25 outreach-workers / trainers | Evaluation of outreach-workers' | Report on evaluation results |

| Project tasks: | Project activity | Date/Responsible parties/Partners | Expected outcomes | Indicators | Collation methods |
|---|---|---|---|---|---|
| | | PSI | | awareness (questionnaire) | |
| | Final training in outreach activity development for outreach- and social workers. | January 2008<br>PSI<br>Ishonch va Hayot | | Evaluation of outreach-workers' awareness (questionnaire) | Report on evaluation and training results |
| | Educational events for MARA/YP (disco) | Tashkent, 2006 - 2007<br>PSI | Conducting of 4 events covering about 180 adolescents | Evaluation of awareness (questionnaire) | Progress reports. Test forms |
| | Attendance of waif adolescents to YFHS family polyclinics | Tashkent, 2006 - 2007<br>PSI<br>Mekhr Tayanch | Attendance of 140 adolescents | Evaluation of MARA/YP's awareness (questionnaire) | Progress reports. Test forms |
| | Referral MARA/YP to family polyclinics | Tashkent, 2006 - 2007<br>PSI | Referral of 647 adolescents | Number of used vouchers | Progress reports. Test forms |
| | Informing of MARA/YP about STI, HIV/AIDS. | Tashkent, 2006 - 2007<br>PSI | Conducting of 4094 hours of educational sessions in MARA/YP gathering places | Evaluation of MARA/YP's awareness (questionnaire) | Progress reports. Test forms |
| Component 2.2. Fergana Province. Improvement of MARA/YP access to youth-friendly health services to prevent HIV spread. | Meetings with decision-makers – representatives of Khokimiyats, managers of province and district health care departments, primary health care centres and specialist institutions, for approval of draft policy and protocols including institutions' interaction infrastructure, concerned parties, their functions and resources. | 2006-2007<br>Fergana Province<br><br>18.04.06 – 25.04.06<br>Fergana (Kergeli), Margilan, Kuva, Kuvasay, Bagdad.<br><br>Province Health Care Department<br>Province Khokimiyat<br>Tarikat<br>17 polyclinics in above-mentioned localities, STI dispensary, drug dispensary, AIDS Centre, CC, OAS | Capacity building of service providers for work with most at risk groups<br>Servicing of youth by personnel of concerned health care establishments in the pilot district, in accordance with YFHS principles.<br><br>Certified compliance with standards for all regional health care establishments providing youth services, including STI dispensaries, adolescent polyclinics, drug dispensaries, AIDS Centres, CC and OAS. | Evaluation of compliance with YFHS standards | Report on evaluation and observation results |
| | Trainings in development and introduction of policy and protocols | 04.05.06 – 30.05.06 | Capacity building of the working group as the main initiators of immediate YFHS introduction and its monitoring in regions. | Evaluation of service providers' awareness of STI, HIV/AIDS.<br><br>Evaluation of | Report on evaluation results |

| Project tasks: | Project activity | Date/Responsible parties/Partners | Expected outcomes | Indicators | Collation methods |
|---|---|---|---|---|---|
| | | | | changed attitude towards MARA/YP | |
| | Capacity building workshops for service providers, focussed on servicing of at-risk groups, and training in outreach activity organisation principles | 05.06.06 – 14.06.06<br>Province Health Care Department<br>Province Khokimiyat Tarikat<br>17 polyclinics in above-mentioned localities.<br>PSI | Distribution of the YFHS system in the project priority regions.<br><br>Capacity building of service providers and medical personnel for organisation of outreach activity and networking of at-risk group to this end. | Evaluation of PHCCs' compliance with standards.<br><br>Evaluation of service providers | Report on evaluation results |
| | Meetings with representatives of most at risk youth with the view of determining the specifics of risky behaviour of at-risk groups in the region, and their potential involvement in activities of institutions in cooperation with confidence centres in every individual region. | 30.05.06 – 24.05.06 | Forming of initiative groups.<br>Establishment of feedback from most at risk youth for monitoring of changes.<br>Capacity building of volunteers-peers for prophylactic activities among at-risk groups.<br><br>By the project completion, coverage of at least 30% of MARA/YP group in the target regions with outreach programme and their referral to YFHS providers | Lists of IG<br>Evaluation of outreach-workers' awareness<br><br>Initial data about the number of group members in project regions are unavailable.<br>There are no exact data about the number of supported groups. | List of involved IG<br>Report on evaluation results |
| | Final conference "Structural Model of YFHS Implementation in the Fergana Province and Methods of Involvement of Most At Risk Youth" | 03.11.06<br><br>Participants: all working group members, policy-makers and managers of governmental and non-governmental establishments providing services for youth. | Improvement of the YFHS model in the Fergana Province and identification of its further extension ways. | Number of participants | Lecture materials<br><br>Report on conference results |

## Annex 2. Project Stakeholders Analysis

**Identification of stakeholders' groups by the following indicators: Significance, Involvement, Impact, Coordination**

| *Organisations/Groups* | **Significance** of organisation involvement for Project successfulness 1 2 3 4 5 | **Involvement** of organisation in Project implementation 1 2 3 4 5 | **Impact** of organisation's activity on Project implementation 1 2 3 4 5 | **Coordination** of organisation with partners during Project implementation 1 2 3 4 5 | Comments |
|---|---|---|---|---|---|
| **Governmental organisations – National level** | | | | | |
| Ministry of Health | 5 | 5 | 5 | 5 | Main Project executive |
| Ministry of Justice | 5 | _____ | _____ | _____ | Not involved, but needed for the Project extension and institutionalisation of advocacy programmes |
| Ministry of Internal Affairs | 5 | _____ | _____ | _____ | Not involved, but needed for the Project extension and institutionalisation of advocacy programmes |
| Republican AIDS Centre | 5 | 3 | 4 | 3 | Poorly involved in the Fergana Province |
| **Province/Municipal Level** | | | | | |
| Tashkent City Department of the Ministry of Internal Affairs | 5 | _ | _ | _ | Not involved, but needed for the Project extension and institutionalisation of advocacy programmes |
| Fergana City Department of the Ministry of Internal Affairs | 5 | _ | _ | _ | Not involved, but needed for the Project extension and institutionalisation of advocacy programmes |
| District Departments of the Ministry of Internal Affairs (Kergeli, Kuva, etc.) | 5 | 3 | 4 | 3 | Involved to contact at-risk groups and clued up on YFHS principles |
| Local Authorities – Province, City/Town and District | 5 | 5 | 5 | 5 | Fergana Province administration has actively supported the Project and prepared necessary documents for its implementation |

| *Organisations/Groups* | **Significance** of organisation involvement for Project successfulness **1 2 3 4 5** | **Involvement** of organisation in Project implementation **1 2 3 4 5** | **Impact** of organisation's activity on Project implementation **1 2 3 4 5** | **Coordination** of organisation with partners during Project implementation **1 2 3 4 5** | Comments |
|---|---|---|---|---|---|
| Khokimiyats | | | | | |
| Tashkent Advanced Medical Training Institute | 5 | 5 | 5 | 4 | One of the Project executives, should be more actively involved in arrangement of paramedical personnel training in YFHS |
| Tarikat Adolescents and Youth Reproductive Health Centre | 5 | 5 | 5 | 4 | One of the Project executives. Coordination is especially efficient in the Fergana Province. Interaction with Tashkent partners is less developed, particularly, with regard to monitoring and evaluation. |
| Province/City/Town Drug Dispensaries | 5 | 2 | 2 | 2 | Poor coordination in regions at the administrative level, probably, because of presence of consultants from this organisation at regional PHCC. |
| Tashkent City Drug Dispensary | 5 | 4 | 4 | 3 | Arrangements and coordination at the level of individual specialists |
| Tashkent City STI Dispensary | 5 | 1 | ——— | ——— | In course of training programmes, the initiative was regarded with favour; however some consultants spoke of its legislative consolidation so that to maximally reduce the risk of violation of STI dispensary instructions with regard to minor MARA/YP (duty of informing law enforcement bodies of STI cases, pregnancy, etc.) |
| Fergana Province STI Dispensary | ——— | ——— | ——— | ——— | Coordination at the level of individual practitioners within PHCC |
| Polyclinics – Tashkent City | 5 | 5 | 5 | 3 | Main Project executives coordinated mainly with Tarikat, PSI, outreach-workers, individual specialist services of OAS and CC, and makhallas. |
| Polyclinics – Fergana Province | 5 | 5 | 5 | 3 | Coordination is available with Tarikat, but not with other partners and among themselves |

| *Organisations/Groups* | **Significance** of organisation involvement for Project successfulness<br>**1 2 3 4 5** | **Involvement** of organisation in Project implementation<br>**1 2 3 4 5** | **Impact** of organisation's activity on Project implementation<br>**1 2 3 4 5** | **Coordination** of organisation with partners during Project implementation<br>**1 2 3 4 5** | Comments |
|---|---|---|---|---|---|
| **Public Organisations / Initiative Groups** | | | | | |
| Community-Based Organisations / Makhalla Committees – Tashkent City | 5 | _____ | _____ | _____ | Practically, were not involved, but should be considered as partners in case of the Project extension. |
| Community-Based Organisations / Makhalla Committees – Fergana Province | 5 | 3 | 4 | 3 | Actively involved and participated in arrangement of field visits. Coordination with PHCCs |
| Mekhr Tayanch NGO – Tashkent City | 5 | 4 | 4 | 3 | Active Project implementation participant in the Tashkent City. Work with children without adequate family custody. Primary coordination with PSI |
| Ishonch va Hayot NGO – Tashkent City | 5 | 4 | 4 | 3 | Active Project implementation participant in the Tashkent City. Work with at-risk groups. Currently, the main successor of outreach activity. |
| Salomatlik+Ekologiya NGO - Kokand | 5 | 3 | 4 | 3 | Primary coordination with PHCCs in the Fergana Province and Kokand. Currently, the project continuators. |
| Group of Nurses Trained for Outreach Activity – Fergana Province | 5 | 4 | 4 | 3 | Main coordination with Tarikat. Efforts for continuing of regional distribution of protection means and syringes. |
| IDU Initiative Groups for Outreach Activity – Fergana Province | 5 | 4 | 4 | 2 | Only individuals from the groups were involved, but not in all regions. Basically, activity was implemented by nurses. |
| SW Initiative Groups for Outreach Activity – Fergana Province | 5 | 4 | 4 | 2 | Only individuals from the groups were involved, but not in all regions. Basically, activity was implemented by nurses. |
| MMS Initiative Groups for Outreach Activity – Fergana Province | 5 | _____ | _____ | _____ | Were inaccessible for visiting nurses at the regional level. Even individual representatives were not found. |
| IDU Initiative Groups for | 5 | 5 | 4 | 4 | A separate group was not formed, but the |

| *Organisations/Groups* | **Significance** of organisation involvement for Project successfulness<br>**1 2 3 4 5** | **Involvement** of organisation in Project implementation<br>**1 2 3 4 5** | **Impact** of organisation's activity on Project implementation<br>**1 2 3 4 5** | **Coordination** of organisation with partners during Project implementation<br>**1 2 3 4 5** | Comments |
|---|---|---|---|---|---|
| Outreach Activity – Tashkent City | | | | | common group of outreach-workers out of MARA/YP worked. The IDU group was not actively involved |
| SW Initiative Groups for Outreach Activity – Tashkent City | 5 | 5 | 4 | 4 | A separate group was not formed, but the common group of outreach-workers out of MARA/YP worked. The SW group was not actively involved |
| MMS Initiative Groups for Outreach Activity – Tashkent City | 5 | 3 | 3 | 3 | A separate group was not formed, but the common group of outreach-workers out of MARA/YP worked. The MMS group was involved, though less actively. |
| **International Partners** | | | | | |
| UNICEF-Uzbekistan | 5 | 5 | 5 | 4 | Main Project execution partner |
| PSI International NGO | 5 | 5 | 5 | 4 | Project partner in the Tashkent City |
| Global Fund Programme | 5 | 4 | 4 | 4 | Project partner, main supplier of protective means and disposable injective supplies |

## Annex 3. Assessment of PHCC Condition As Per Observations Made By the Project Evaluation Working Group

| Name of the surveyed facility | Key assessment categories | Achievements | Shortcomings |
|---|---|---|---|
| **Tashkent City** | | | |
| **Family Polyclinic No. 46.** | Facility condition | 3-storey well-maintained building with adjacent territory. | |
| | Visual media | Lobby is furnished with pictures, advertisements and different medical information materials. There is an announcement near to registry informing about youth-friendly health services provided by FP. | |
| | Record keeping | There are YFHS documents: minutes of staff meetings, Orders of MoH, agreement on cooperation between FP No. 46 and PSI NGO, and information about services providing psychological and legal support to MARA/YP.<br>Doctors keep records in client reception books with coding of client data. Reception of MARA/YP is summarised at the end of each month. | The voucher system had been used only until the PSI-supported project component was active. Now, when the outreach work is stopped, the system is not in use. |
| | Personnel responsible for YFHS | At the polyclinic, there is a doctor responsible for YFHS, who collects reports from doctors providing youth-friendly services. There are minutes of held informational meetings (trainings) for the polyclinic personnel. | |
| | Basic services | There is a confidence centre within the polyclinic.<br>Special rooms for MARA/YP reception have been prepared. The rooms are light, clean and furnished with posters depicting young people. Clients are received by one doctor. | |
| | Accessing MARA/YP | Confidence centre specialists refer their clients for examination to GP and subspecialty doctors. | There is a problem of most at risk youth attraction to the polyclinic. Outreach-workers from PSI are unavailable, and doctors and nurses are not skilled in attracting MARA/YP to the polyclinic. |
| | Distribution of protection means and information materials | In order to identify MARA/YP among population living in the area assigned to the polyclinic, doctors of FP No. 46 have mapped their districts, and general practitioners keep logs for registration of visits and amount of distributed supplies (syringes, condoms, brochures) | The polyclinic lacks for informational handouts |
| | Partnership | Head physician works with representatives of makhalla communities, which are territorially assigned to FP No. 46 (meetings and discussed issues have been recorded). | |
| **Family Polyclinic No. 28.** | Facility condition | 3-storey well-maintained building with adjacent territory. | |
| | Visual media | Lobby is furnished with pictures, advertisements and different medical information materials. | There is no a signboard stating that the polyclinic provides youth-friendly services. |
| | Record keeping | There are YFHS documents: minutes of staff meetings, Orders of MoH, agreement on cooperation between FP No. 28 and PSI NGO, and information about services providing psychological and legal support to MARA/YP.<br>Doctors keep records in client reception books with coding of client data. Reception of MARA/YP is summarised at the end of each month. | The voucher system had been used only until the PSI-supported project component was active. Now, when the outreach work is stopped, the system is not in use. |
| | Personnel responsible | There is an official responsible for the YFHS Project. He/she keeps all minutes of | |

| Name of the surveyed facility | Key assessment categories | Achievements | Shortcomings |
|---|---|---|---|
| | for YFHS | meetings, lists of MARA/YP visits and information bout consultations, examinations and referrals, if any. | |
| | Basic services | YFHS consultations are provided in all rooms of GPs and other doctors, whose services are needed for MARA/YP. The rooms are light, clean and furnished with posters depicting young people | The polyclinic does not have a confidence centre and a room specially intended for MARA/YP consultations. |
| | Accessing MARA/YP | | |
| | Distribution of protection means and information materials | General practitioners keep logs for registration of visits and amount of supplies (syringes, condoms, brochures) distributed among MARA/YP living in the areas assigned to these doctors. GPs monthly report on the number of MARA/YP visits to a doctor – YFHS coordinator. | The polyclinic lacks for informational handouts |
| | Partnership | District doctors cooperate with representatives of makhalla committees (MC) and population of makhallas assigned to FP No. 28, and perform YFHS information and advocacy activities. | Attraction of youth from among MARA/YP is problematic, since outreach-workers have stopped their activity after the Project completion. |
| **Family Polyclinic No. 24** | Facility condition | 3-storey well-maintained building with adjacent territory. | |
| | Visual media | Lobby is furnished with pictures, advertisements and different medical information materials. | There is no a signboard stating that the polyclinic provides youth-friendly services. |
| | Record keeping | There are YFHS documents: minutes of staff meetings, Orders of MoH, agreement on cooperation between FP No. 28 and PSI NGO, and information about services providing psychological and legal support to MARA/YP.<br>Doctors keep records in client reception books with coding of client data. Reception of MARA/YP is summarised at the end of each month. | The voucher system had been used only until the PSI-supported project component was active. Now, when the outreach work is stopped, the system is not in use. |
| | Personnel responsible for YFHS | There is an official responsible for the YFHS Project. He/she keeps all minutes of meetings, lists of MARA/YP visits and information bout consultations, examinations and referrals, if any. | |
| | Basic services | YFHS consultations are provided in all rooms of GPs and other doctors, whose services are needed for MARA/YP. The rooms are light, clean and furnished with posters depicting young people | The polyclinic is insufficiently staffed with subspecialty doctors.<br><br>Deficit of orders for secondary examinations including US and X-ray (lack of films)<br><br>Poor awareness of youth-friendly services among the polyclinic personnel |
| | Accessing MARA/YP | In order to identify MARA/YP among population living in the area assigned to the polyclinic, doctors of FP No. 24 have mapped their districts | Attraction of youth from among MARA/YP is problematic, since outreach-workers have stopped their activity after the Project completion.<br><br>Management has reported the FP personnel's inexperience in communicating with most at risk youth. |
| | Distribution of protection means and | General practitioners keep logs for registration of visits and amount of supplies (syringes, condoms, brochures) distributed among MARA/YP living in the areas | Insufficient supply with disposable syringes and gloves. |

| Name of the surveyed facility | Key assessment categories | Achievements | Shortcomings |
|---|---|---|---|
| | information materials | assigned to these doctors. GPs monthly report on the number of MARA/YP visits to a doctor – YFHS coordinator. | The polyclinic also lacks for informational handouts |
| | Partnership | District doctors cooperate with representatives of makhalla committees (MC) and population of makhallas assigned to FP No. 24, and perform YFHS information and advocacy activities. | |
| **Fergana Province. Margilan town** | | | |
| **Polyclinic No. 6** | Facility condition | The polyclinic is located far from a road, inside a housing estate. The adjacent territory is well-developed, the building has been overhauled. | |
| | Visual media | Registry has the information about the YFHS Policy of the Polyclinic. In addition, there is an information stand with brochures about HIV/AIDS. | |
| | Record keeping | All documents have been presented: Orders on the YFHS Policy, doctors' codes, area maps, workshop and training materials, registration logs for handover and acceptance of condoms and disposable syringes | |
| | Personnel responsible for YFHS | At the polyclinic, there is a doctor responsible for YFHS, who keeps YFHS documentation. | |
| | Basic services | All rooms are provided with equipment and information materials. Clients are received by GPs.<br><br>The polyclinic has two branches, where medical personnel also provide YFHS, keep documents and distribute supplies (syringes and condoms). | |
| | Accessing MARA/YP | Working hours of the polyclinic are established in accordance with clients' demands.<br>When inspecting their districts, nurses contact at-risk groups and invite them to medical establishments. | Attraction of youth to the polyclinic is problematic. |
| | Distribution of protection means and information materials | Supplies (condoms and syringes) are distributed by nurses. | The polyclinic also lacks for informational handouts |
| | Partnership | Cooperation with makhalla committees is established | |
| **Fergana Province. Fergana town** | | | |
| **Polyclinic No. 6, Kirgulu** | Facility condition | The Polyclinic is situated on the CMH territory inside a housing estate, near to road, in a 2-storey building in average repair | |
| | Visual media | Visual media for youth are available. | |
| | Record keeping | There is a file containing documents and orders of the Province Health Care Department, Confidentiality Policy documents and doctors' codes | |
| | Personnel responsible for YFHS | Documents with YFHS records are kept by a gynecologist.<br><br>The polyclinic has doctors-trainers, who have trained all medical personnel in 5 subjects and monitored their knowledge. | |
| | Basic services | Clients are received by GPs. Working hours of doctors are shown on every room's | Rooms are properly furnished, but small and dark. |

| Name of the surveyed facility | Key assessment categories | Achievements | Shortcomings |
|---|---|---|---|
| | | door.<br>All doctors receive clients at the polyclinic simultaneously, there is a narcologists.<br><br>At the polyclinic, there is a confidence centre with volunteers working with at-risk groups. | |
| | Accessing MARA/YP | Service recipients come themselves according to preliminary arrangements with nurses. | There were many visitors, corridors are not ventilated |
| | Distribution of protection means and information materials | Supplies (syringes and condoms) are distributed by visiting nurses.<br><br>The system and practice of syringes disposal are well established – they are burnt in muffle furnaces. | The polyclinic also lacks for informational handouts |
| | Partnership | The Polyclinic provides YFHS together with a children polyclinic (reporting on performed activities)<br><br>The Polyclinic together with makhalla committees carries out activities for HIV/AIDS prevention. | |
| **Fergana Province. Kuvasay town** | | | |
| **Polyclinic No. 1.** | Facility condition | The main building of the polyclinic is under major repair (repair works are complete, new equipment and furniture for rooms are to be supplied). | The Polyclinic is temporarily located inside the Central Hospital, in an old one-storey non-repaired building. Clients are received by 5 doctors within the same very crowded and noisy room. |
| | Visual media | | There is no information about YFHS in the temporary building. |
| | Record keeping | The polyclinic management participated in round-tables related to clarification of the YFHS initiative for town administration (Khokimiyat). There is the Confidentiality Policy, which is applied in the polyclinic. | |
| | Personnel responsible for YFHS | At the polyclinic, there is a doctor responsible for YFHS, who keeps a file with YFHS implementation documents (orders and minutes of meetings).<br>All personnel were trained and certified in 5 spheres: Confidentiality Policy, HIV Infection Spread, Consultation Skills, Harm Reduction and Outreach Activity of Medical Personnel.<br>All personnel of the polyclinic have undersigned to the Confidentiality Policy.<br>Personnel are divided into Quality Groups having been assigned individual Codes.<br>The polyclinic has formed the Monitoring Group (a population monitoring was performed) | |
| | Basic services | MARA/YP and at-risk groups are contacted confidentially.<br>Medical staff of the polyclinic includes popular doctors and specialists able to receive Russian-, Uzbek- and Tajik-speaking clients.<br>The polyclinic has a STI doctor and a narcologist, who provide consultations and treatment. | It is important to note that doctors have to go out to a yard or a corridor so that to keep their conversations confidential |
| | Accessing MARA/YP | In order to identify MARA/YP gathering places, the medical personnel of the | |

| Name of the surveyed facility | Key assessment categories | Achievements | Shortcomings |
|---|---|---|---|
| | | polyclinic have mapped both urban and rural areas.<br>Contacts with sex service providers (den holders) have been established. Medical personnel work with MARA/YP during door-to-door rounds; there are volunteers out of MARA/YP. | |
| | Distribution of protection means and information materials | Nurses distribute condoms and syringes.<br>The Polyclinic keeps documents for registration of clients and distributed condoms and syringes; reports are submitted to the Fergana Province Health Care Department. | The polyclinic also lacks for informational handouts |
| | Partnership | A network has been established and activities are coordinated among CMH, Confidence Centre and adult and children polyclinics. (The children polyclinic has a copy of the Convention on the Rights of the Child). | |
| **Fergana Province. Bagdad town** | | | |
| **Polyclinic No. 1.** | Facility condition | The polyclinic is located in a 2-storey building in the town centre, not far from CMH, whereat a children polyclinic is situated. Both polyclinics are subordinate to CMH. | |
| | Visual media | At the entrance to the polyclinic, there is an information board notifying of youth-friendly health services being provided by the polyclinic. The polyclinic's lobby is furnished with many informational posters dedicated to youth, in corridors there are benches for waiting visitors. | |
| | Record keeping | Commitment to the Confidentiality Policy is regularly mentioned at meetings and briefings.<br><br>Responsible doctor keeps a YFHS file (CMH orders, internal polyclinic orders, materials of trainings and workshops). | At present, current reporting is not maintained due to overload of doctors |
| | Personnel responsible for YFHS | The Confidentiality Policy has been introduced, medical personnel has been acquainted with YFHS. Quality Groups have been established, all medical personnel have individual codes. | |
| | Basic services | At the polyclinic, there is a popular STI doctor.<br>Blood tests are made at the polyclinic, clients take test results themselves.<br>Rooms for reception of MARA/YP are comfortable, furnished with many information posters, flowers on sills; paramedical personnel are amiable. | |
| | Accessing MARA/YP | In order to determine the at-risk group concentration places, the medical personnel have mapped the area assigned to the polyclinic. Only SWs have been identified, who are being persuaded into visiting the polyclinic. Contacts with sex service providers (procuresses) have been established. There is one volunteer – a SW girl. Service recipients visit the polyclinic mainly in the afternoon, when the main inflow of patients drops. | MMS and IDU have not been identified. |
| | Distribution of protection means and information materials | Nurses distribute condoms and keep records of the distribution. | The polyclinic also lacks for informational handouts |
| | Partnership | | |
| **Fergana Province. Kokand town** | | | |

| Name of the surveyed facility | Key assessment categories | Achievements | Shortcomings |
|---|---|---|---|
| **Family Polyclinic No. 6.** | Facility condition | The polyclinic is situated inside the Khimgorodok housing estate, in the Kokand town outskirts. This is a one-storey building with developed adjacent territory. | |
| | Visual media | Walls are pasted over with informational medical posters. | |
| | Record keeping | The polyclinic has adopted the Confidentiality Policy; all personnel are aware and trained; doctors have individual codes; Quality Groups have been formed; and the area has been mapped. | |
| | Personnel responsible for YFHS | Persons responsible for YFHS are available | |
| | Basic services | There is the Confidence Centre where an assistant makes blood tests.<br><br>YFHS are provided by three doctors (for adults)<br><br>According to the questioned population, the gynecologist is in favour; her room has been visited. She receives clients on a confidential basis and keeps documents on work with MARA/YP. The doctor uses vouchers to refer patients for further examination or treatment (e.g., for US scanning). | |
| | Accessing MARA/YP | Both SWs and IDUs live in the area assigned to the polyclinic. Contacts with sex service providers have been established.<br><br>Service recipients of this medical establishment include mainly residents and temporary dwellers (SWs lodging with procuresses) of the Khimgorodok. | |
| | Distribution of protection means and information materials | Recipients come to the Confidence Centre and receive supplies (syringes and condoms). The Confidence Centre is used for scrapping and disposal of used needles and syringes. | The polyclinic also lacks for informational handouts |
| | Partnership | Personnel of the polyclinic cooperate with representatives of makhallas and an educational institution (there is a school in the housing estate).<br><br>These organisations are aware of the polyclinic's YFHS activity. | |
| **Fergana Province. Kuva town** | | | |
| **Central Polyclinic No. 1.** | Facility condition | The polyclinic is situated in the town centre, near to a market.<br>This is a standard 3-storey building with developed adjacent territory, in average repair. There is a new paid WC in the polyclinic's patio. | |
| | Visual media | Corridors in the polyclinic are furnished with different posters depicting young people; there are places for waiting visitors. | |
| | Record keeping | Documents are available (a file containing orders and YFHS protocols, lists of personnel with assigned codes, and minutes of staff meetings on outreach activities). The polyclinic has adopted the Confidentiality Policy and Quality Groups have been formed.<br><br>The polyclinic has been included in the YFHS Project less than a year ago. The Head Physician of the polyclinic prioritises introduction and observance of the Confidentiality Policy among personnel and gaining of confidence among at-risk | |

| Name of the surveyed facility | Key assessment categories | Achievements | Shortcomings |
|---|---|---|---|
| | | groups rather than keeping statistics on visits number. | |
| | Personnel responsible for YFHS | The Head Physician of the polyclinic is the doctor responsible for YFHS. | |
| | Basic services | The polyclinic works in a customary regime. Clients are received confidentially, and specific codes are assigned to MARA/YP.<br>There is a Confidence Centre.<br>The Head Physician personally gives a talk to MARA/YP.<br>The questioned service recipients have expressed their satisfaction with service provision and distribution of supplies. | |
| | Accessing MARA/YP | Visiting nurses perform outreach activity and invite youth to the polyclinic.<br>Among MARA/YP, YFHS services of this polyclinic are used by SWs; there are no IDUs.<br><br>Medical personnel of the polyclinic have established contacts with sex service providers. SWs visit the polyclinic and receive medical care as necessary (most of girls have arrived from other districts). | |
| | Distribution of protection means and information materials | A nurse of the Confidence Centre registers clients (assigns codes) and distributes condoms. | The polyclinic also lacks for informational handouts |
| | Partnership | The polyclinic management has established contacts with law enforcement bodies and representatives of makhalla committees. Other structures are kept abreast of YFHS activities | |