WOMEN IDENTIFYING NEW GOALS OF SAFETY (WINGS) IN CONFLICT AFFECTED REGIONS OF UKRAINE

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WOMEN IDENTIFYING NEW GOALS OF SAFETY (WINGS)
IN CONFLICT AFFECTED REGIONS OF UKRAINE

CAPSTONE PROJECT PAPER

A paper submitted in partial fulfillment of the requirements for the degree of
Master of Public Health
in the
University of Kentucky College of Public Health
By
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Kyiv, Ukraine

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Abstract

According to Radio's Liberty (Radiosvoboda) analyses of data provided by United Nations Population Fund (UNFPA), the National Violence Hotline and the Geneva Center of Democratic Control of Armed Forces (DCAF), there were 1.85 million survivors of intimate partner violence (IPV) in Ukraine in 2014-2017, and of these, only 83,000 contacted the police. IPV and gender based violence (GBV) in Ukraine remain underreported due to the lack of law enforcement investigations, as well as due to stigma and shame. Women in conflict-ridden regions of Ukraine are at heightened risk for GBV/IPV. The project will IPV/GBV in Luhansk and Donetsk regions, where the conflict is ongoing, and Dnipropetrovsk, which borders conflict areas, has major military bases and military hospitals, and has a population of internally displaced persons exceeding 74,000. The target population will include internally displaced women, women who live close to the conflict zone, female partners and family members of veterans, all of whom are women at risk of violence due to conflict, displacement and economic crisis. The Applicant will train social workers from mobile psychosocial support teams to deliver an evidence-based intervention: Women Identifying New Goals of Safety (WINGS). WINGS is a screening, brief intervention, and referral to treatment (SBIRT) approach designed by the Social Intervention Group (SIG) at Columbia University for low-resource settings. It helps to raise awareness on different types of IPV/GBV, identify risks and reduce risks of repeated abuse via strengthening social support and safety planning. The patient-level effectiveness outcomes for this project will include changes from pre-test to post-test in participant-reported physical, sexual, verbal and economic abuse, which will be assessed using a shortened 20-item version of the Revised Conflict Tactics Scales (CTS2S). The provider-level effectiveness outcomes will be the number of clients served by each mobile team who were referred and successfully accessed violence prevention and HIV prevention services. The process evaluation will be guided by the RE-AIM framework. UFPH will use the RE-AIM Checklist for Study or Intervention Planning and RE-AIM Planning Tool and Adaptation to evaluate the project’s reach, adoption of the interventions, implementation outcomes (patient and provider acceptability, fidelity, and costs), and maintenance of the intervention one year after the project ends.
I. Target Population and Need

Intimate Partner Violence and Gender Based Violence in Ukraine

In 2017, the Ministry of Internal Affairs registered 110,000 cases of domestic violence in Ukraine, mostly comprising female survivors and male perpetrators. Gender based violence (GBV) and intimate partner violence (IPV) in Ukraine remain underreported due to the lack of law enforcement investigations, as well as due to stigma and shame [1]; [2]; [3]. According to Radio’s Liberty (Radiosvoboda) analyses of data provided by United Nations Population Fund (UNFPA), the National Violence Hotline and the Geneva Center of Democratic Control of Armed Forces (DCAF) [4], there were 1.85 million survivors of IPV in Ukraine in 2014-2017, and of these, only 83,000 contacted the police. Nearly 60% of law enforcement personnel surveyed believed that the majority of IPV reports were false, and 12% believed that IPV is acceptable in some cases. Due to the vast underreporting of GBV and IPV by governmental agencies in Ukraine, analyses of target population and needs for the proposed project are based on reports by international agencies and peer-reviewed literature.

Women in conflict-ridden regions of Ukraine are at heightened risk for GBV/IPV. According to United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) [5], one in four Ukrainians suffers from consequences of the conflict in eastern Ukraine. With shrinking resources, millions of people have to choose between food, medicine, shelter, heating, or their children’s education, and they rely on humanitarian assistance to survive. The contact line became a border between the government-controlled and non-government controlled areas, hampering access to essential services and goods. The 2017 Humanitarian
Response Plan was underfunded, with only US$71 million received (35% of the $204 requirement), leading to the termination of some critical humanitarian projects and reduced assistance to the most vulnerable people in need [5].

**Increased Risks for IPV and GBV due to Conflict**

The ongoing armed conflict has caused a significant humanitarian crisis for Ukraine, with 1.7 million internally displaced persons, 66% of whom are women [2, 6]; [7]. UNOCHA reports GBV/IPV as a significant risk in conflict affected regions of Ukraine [2]. Women and girls are at risk of violence by their partners, family members, law enforcement personnel, and military. Due to poverty, unemployment and limited resources, women and girls engage in “survival sex” to meet basic needs for their families, which increases their risk of GBV and trafficking [1, 5] [6]. Particularly at risk are internally displaced women and adolescent girls who live close to the contact line with high concentration of military and paramilitary groups, proliferation of weapons, weak law enforcement and impunity for perpetrators [2]. Internally displaced women have lost their social networks, income, access to housing, and opportunities for employment and professional development. [8] [6]

The conflict in Ukraine has undermined the ability of males to respond to social expectations, resulting in increasing reports of GBV/IPV [9]. The Organization for Security and Co-operation in Europe (OSCE) Special Monitoring Mission has received reports of GBV/IPV and violence against children in families of dismissed riot demobilized soldiers, as well increased poverty and alcohol abuse. The absence of services to treat these issues is likely to have direct and indirect effects on women and children, who may bear the consequences of the effects of PTSD and violence in the family unit [3]. Research from around the world, including Ukraine, has reported additional negative outcomes associated
with GBV/IPV, such as increased lifetime risk of HIV and other STIs [10] and increased risky health behaviors, including excessive alcohol consumption.

![Map of Internal Displacement in Ukraine](image)

**Figure 1.** Map of Internal Displacement in Ukraine [11].

**Targeted Regions of Ukraine**

The proposed project will target women in three conflict-affected regions of Ukraine: Luhansk and Donetsk regions, where the conflict is ongoing, and Dnipropetrovsk, which borders conflict areas, has major military bases and military hospitals, and has a population of internally displaced persons exceeding 74,000. The target population includes internally displaced women, women who live close to the conflict zone, female partners and family members of veterans, all of whom are women at risk of violence due to conflict, displacement and economic crisis.

**Community Needs and Resources**
The proposed project will build upon on the current activities of the Applicant organization—the Ukrainian Foundation of Public Health (UFPH)—capitalizing on resources, services, and partnerships that have been developed since 2015 through our existing project, “Strengthening humanitarian response to the need of most vulnerable women and female adolescents affected by armed conflict in Eastern Ukraine through multi-sectorial prevention and response to gender based violence and access to sexual and reproductive health services.” This foundational project was funded by the United Nations Population Fund in Ukraine (UNPF). Within the UNFPA-funded project, UFPH launched mobile psychosocial support teams (hereinafter – mobile teams or MTs) in these three regions. MTs provide screening, counseling and referrals to services for survivors of GBV/IPV. MTs each include a psychologist, two social workers, and a driver who conduct home visits with survivors of IPV/GBV and perform outreach work in underserved communities, including rural areas and communities close to the contact line.

In the proposed project, UFPH will train 10 MTs in Donetsk region, 8 MTs in Luhansk region, and 6 MTs in Dnipropetrovsk region to deliver an evidence-based intervention: Women Identifying New Goals of Safety (WINGS) [12]. WINGS is a screening, brief intervention, and referral to treatment (SBIRT) approach designed by the Social Intervention Group (SIG) at Columbia University for low-resource settings. UFPH will adapt the existing computerized WINGS tool for conflict-affected areas in Ukraine in order to help women to create safety plans, build social support and reduce risks of abuse in these low resource settings.

UFPH collaborates with other non-governmental organizations and United Nations agencies in the region to cover gaps and strengthen governmental services. MTs, which are...
run by UFPH, currently identify survivors of violence, provide screening and psychosocial counseling, and link them to legal counseling, behavior change intervention, law-enforcement, healthcare, humanitarian assistance, and shelters provided by our partner network (53 partner agencies in three project regions). In 2017, MTs reached and served over 16,000 survivors of GBV/IPV. However, an evidence-based approach to service delivery has not been attempted prior to this proposed project, and MTs have been free to determine on their own how to work with violence survivors.

Each targeted region has a government-funded social-psychological support center. These centers provide temporary shelter for survivors of violence as well as the following services: (1) information on crisis management, types of social benefits, and contact information for public services and institutions; (2) psychological counseling; (3) social-medical assistance via preventive and therapeutic activities, advice on health status, outreach programs to promote healthy lifestyle, and support for people with addictions; (4) legal counseling; and (5) temporary residence for survivors of violence for 1 to 3 months. To access temporary shelters, women must be referred by local police and provide medical certification confirming the absence of transmittable diseases (e.g., HIV, TB) [13]. All communities in each of the three project regions have governmental healthcare providers, including clinics, ambulances, and in-patient facilities. The majority of rural communities have healthcare workers who provide health counseling, basic screening, and referrals to clinics when needed.

Community needs and resources were assessed by UFPH through our project activities in 2015-2018, including data collection from survivors of violence through screening, focus groups with service providers and stakeholders, regular quarterly meetings with local
authorities, participation in the national gender groups facilitated by the Ministry of Social Services and Parliamentary women’s groups, and supervisory meetings with the staff of local MTs. Additional UNFPA’s assessment of gender based violence [14].

In the proposed project, WINGS will be delivered by existing MTs. In 2016 and 2017, MTs reached over 1,000 survivors of GBV/IPV in each targeted community. UFPH’s resources, including MTs with trained staff and drivers who can reach remote areas, along with our extended partner network of 53 agencies and trust from the served communities, will enable us to reach the targeted number of individuals.

II. PROGRAM APPROACH

Women Initiating New Goals of Safety (WINGS)

The proposed project will adapt, pilot, and evaluate the WINGS evidence-based screening, brief intervention and referral to treatment (SBIRT) intervention for use with this new target population. WINGS is guided by social cognitive theory, which has been applied to intimate partner violence SBIRT models [15]; [16]. The intervention helps to raise awareness on different types of violence, increase motivation to reduce risks of abuse, strengthen social support and create a safety plan to reduce risks of repeated abuse. There are two modalities of WINGS (facilitator-based and computerized self-paced tool) that have been shown to be equally effective [17]. This program is eligible for replication under this FOA.

WINGS includes seven core elements: (1) raising awareness about different types of IPV and GBV, (2) screening for IPV/GBV women may be experiencing and providing individualized risk feedback; (3) increasing motivation to address IPV/GBV and relationship
conflict; (4) assisting with safety planning to reduce risks; (5) enhancing social support – case manager asks participants to identify family members and friends to whom they can turn for support, advice and practical help to prevent or reduce their risks of experiencing violence and for resolving relationship conflict; case manager then asks participants to identify steps they can take to strengthen different type of support in the next week; (6) setting goals to improve relationship safety and reduce risks of exposure to IPV/GBV; and (7) identifying and prioritizing service needs, including linkages to IPV/GBV services and others as needed. WINGS also includes an optional HIV counseling and testing module, as well as an optional session on overdose prevention and first aid in case of overdose.

MTs in conflict-affected Donetsk, Luhansk and Dnipropetrovsk regions will deliver WINGS to survivors of violence. The intervention will be delivered in two sessions with a six-month follow-up. Social workers will contact participants via phone at least two times between two sessions and follow-up in order to ensure high retention rates.

**The Science behind WINGS**

WINGS has been tested with women who use drugs in community corrections in NYC (USA)[17, 18], as well as with women in harm reduction programs in Kyrgyzstan[19]. A randomized controlled trial tested the effectiveness of the Facilitator WINGS versus the Computerized Self-paced WINGS with 191 women who use drugs in community corrections found that both modalities of WINGS were equally effective in identifying high rates of different types of intimate partner violence in the past year as well as linking women to IPV services, increasing social support and enhancing IPV self-efficacy from the baseline pre-intervention assessment to the 3-month follow up assessment [18]. Another randomized controlled trial that evaluated the effectiveness of a group-based computerized HIV and
intimate partner violence prevention intervention (WORTH) which included the WINGS SBIRT components among 306 women in community corrections found that participants assigned to Computerized WORTH were more likely to reduce incidence of sexual, physical and injurious intimate partner violence at the 12-month follow-up than participants assigned to the Wellness Promotion Attentional Comparison Condition [17]. Pilot trial of WINGS + HIV counseling and testing (HCT) among 73 women who use drugs found significant decreases in the experience of physical and injurious violence from intimate partners (intimate partner violence) and others (gender based violence) from baseline to the three-month follow-up as well as decreases in drug use, and increased access to violence prevention and HIV services. Over 90% of participants agreed to complete HIV counseling and testing (HCT) of whom 8% tested positive for HIV and all were linked to HIV care [19].

**Implementation of WINGS with the Target Population**

The facilitator assisted WINGS intervention will be delivered by social workers from MTs, which have been run by UFPH since 2015. Social workers will be trained to deliver WINGS, counsel and test for HIV, and refer to treatment and other resources when needed. Women will be linked to the following services and resources that are provided by project partners and include the following: primary care clinics, social services, police, shelters, humanitarian aid programs and other resources available in their community. WINGS will be delivered in locations of survivors' preference (i.e., at their homes, centers of social services and primary care clinics).

**Adaptations of WINGS**

For use with this new target population, we will adapt WINGS following the adaptation manual provided by its developers (Social Intervention Group) on the project website.
Adapting WINGS will involve customizing delivery of the intervention and ensuring that messages are appropriate for WINGS participants without altering, deleting, or adding to the intervention’s seven core elements. When adapting the intervention, we will consider the needs of the population to be served, our available resources, resources of our partner agencies, and the core elements of the intervention identified by its developers. Minor adaptations will include the following: (1) target population (WINGS was originally tested with women in the penitentiary setting, women who use drugs, and women in sex work); (2) lists of service providers for referrals (based on mapping of community resources in project regions); (3) addition of a second WINGS session to assess participants’ progress in meeting their goals and linking to services, as well as a six-month follow-up (in the original WINGS research, facilitators met with women for a single WINGS session); and (4) addition of an HIV counseling and testing module that was developed and tested in Kyrgyzstan; (5) the baseline and follow-up assessment will ask about incidence of abuse within previous 6 months, while the SCTS2 investigates the incidence of violence in the last year. The implementation manual and computerized WINGS tool will be translated from English to Ukrainian language. The Ukrainian adaptation of WINGS will be back-translated to English to ensure feasibility of the intervention. The translation will account for language and cultural particularities. Adapted Ukrainian WINGS will be back-translated to English and reviewed to its developers in order to ensure the fidelity of the intervention guidelines.

The proposed adaptations of WINGS will not affect the seven core elements of the intervention, which will be maintained without alteration to ensure fidelity, as recommended by the WINGS Implementation Manual [20]. To assess fidelity to the core elements of
WINGS, we will use the Facilitator Session Outline and Adherence form, which is included in Appendix 4 [20]. The adapted WINGS intervention will include the following sessions:

1. Screening for IPV/GBV, brief intervention and referral to treatment;
2. Follow-up session to check to support progress on goals and service acquisition, plus HIV counseling and testing;
3. 6-month follow-up to evaluate changes in IPV/GBV (primary project outcomes), access to HIV services, and social support.

**Community Mobilization and Community Advisory Group**

UFPH has been collaborating with regional administrations, governmental centers of social services, health departments, and police in Donetsk, Luhansk and Dnipropetrovsk regions since 2015. The proposed project will build on our experiences and resources and those of our partners, including the following:

1. MTs will reach out to survivors of IPV/GBV and deliver WINGS;
2. Centers of social services and primary care clinics will serve as locations for delivering WINGS; survivors reached at other locations (i.e. at their homes or other community facilities) will be referred to centers of social services, primary clinics and police for services when needed;
3. Local authorities will help to engage communities and stakeholders in the project, and promote interagency collaboration to address IPV/GBV in three project regions.

The Community Advisory Group (CAG) for the proposed project will engage social services, law-enforcement, healthcare, NGOs, and UN agencies in order to ensure a comprehensive response to IPV/GBV. Participation of local authorities in CAGs will help to promote and prioritize needs in PIV/GBV response at local levels, including assessing and
planning for future funding of MTs and WINGS from local budgets. The CAG will meet quarterly.

**Table 1. The Community Advisory Group**

<table>
<thead>
<tr>
<th>Member</th>
<th>Rationale for participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Yarosav Balabolka</strong>, Director of Donetsk Regional Center of Social Services for Family, Children and Youth</td>
<td>He has access to at-risk populations, will ensure participation of governmental social services in the project, social services will refer women to WINGS and will provide premises to facilitate sessions.</td>
</tr>
<tr>
<td>2. <strong>Leonid Krysov</strong>, Director Luhansk Regional Center of Social Services for Family, Children and Youth</td>
<td>He has access to at-risk populations, will ensure participation of governmental social services in the project, social services will refer women to WINGS and will provide premises to facilitate sessions.</td>
</tr>
<tr>
<td>3. <strong>Ira Volkova</strong>, Director of Luhansk Regional Center of Social Services for Family, Children and Youth</td>
<td>She has access to at-risk populations, will ensure participation of governmental social services in the project, social services will refer women to WINGS and will provide premises to facilitate sessions.</td>
</tr>
<tr>
<td>4. <strong>Xiulo Puton</strong>, Director of Health Department of Donetsk Region</td>
<td>He will ensure participation of primary care clinics in the project, referrals to WINGS by MDs and premises at primary clinics to facilitate WINGS sessions.</td>
</tr>
<tr>
<td>5. <strong>Halia Nekrasova</strong>, Director of Health Department of Luhansk Region</td>
<td>She will ensure participation of primary care clinics in the project, referrals to WINGS by MDs and premises at primary clinics to facilitate WINGS sessions.</td>
</tr>
<tr>
<td>6. <strong>Nina Ruban</strong>, Director of Health Department of Dnipropetrovsk Region</td>
<td>She will ensure participation of primary care clinics in the project, referrals to WINGS by MDs and premises at primary clinics to facilitate WINGS sessions.</td>
</tr>
<tr>
<td>7. <strong>Ostap Stupka</strong>, Director of Police Department of Donetsk Region</td>
<td>He will ensure participation of police in the project and their collaboration with healthcare, social services and NGOs, will instruct police to refer survivors to WINGS.</td>
</tr>
<tr>
<td>8. <strong>Katia Ptashka</strong>, Director of Police Department of Luhansk Region</td>
<td>She will ensure participation of police in the project and their collaboration with healthcare,</td>
</tr>
<tr>
<td>No.</td>
<td>Name and Title</td>
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<td>---------------------------------------------------</td>
</tr>
<tr>
<td>9.</td>
<td><strong>Iulia Rybka</strong>, Director of Police Department of</td>
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<tr>
<td></td>
<td>Dnipropetrovsk Region</td>
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<tr>
<td>10.</td>
<td><strong>Kira Muratova</strong>, Deputy Head of Donetsk Region</td>
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<td></td>
<td>Civil–Military Administration</td>
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<tr>
<td>11.</td>
<td><strong>Vita Bandura</strong>, Deputy Head of Luhansk Region</td>
</tr>
<tr>
<td></td>
<td>Civil–Military Administration</td>
</tr>
<tr>
<td>12.</td>
<td><strong>Ihor Hulvisa</strong>, the Advisor on Social Issues of</td>
</tr>
<tr>
<td></td>
<td>the Governor of Dnipropetrovsk Region</td>
</tr>
</tbody>
</table>

**Planning and Preparatory Stage**

In the first six months of the project, UFPH will complete the following preparatory activities:

1. Convene and facilitate three meetings of the Community Advisory Group to ensure community engagement in the project and interagency referrals of survivors of IPV/GBV, as well as to plan project activities. The CAG will also monitor the project activities, and together with the project management team will ensure that all project milestones are met as planned.

2. Adapt computerized WINGS for the implementation in three project regions.

3. Pilot the adapted WINGS with 100 women in each region.

4. Finalize WINGS and prepare for program launch.
In addition to service provision, the proposed project will analyze data on needs and gaps in services and use these findings for further advocacy. These needs were identified by UNFPA’s assessment of gender based violence [14]. In delivering WINGS, we will use available resources in the target communities, including social services, healthcare, police, humanitarian aid from UN agencies, and community facilities (e.g., churches, city halls).

**Recruitment Strategies**

The WINGS intervention will be delivered by social workers from MTs. According to UFPA’s survey, survivors of IPV/GBV have low trust in governmental service providers (social services, police and healthcare), and are more willing to seek assistance from psychologists, representatives of NGOs, and women’s support groups [14]. MTs are run by UFPH and have built trust and a positive reputation in communities they have served for the past three years. They have also developed positive relationships with partner agencies (social services, health departments and police). MTs distribute cards with their contacts in their communities. Survivors of violence will reach them independently via phone calls, and may also be referred by partner agencies.

**Retention Strategies**

Social workers from MTs will administer two sessions of WINGS within two weeks in settings preferred by survivors (e.g., home, primary care clinics), and will later contact clients for a six-month follow-up. Those clients who identify the need for IPV/GBV or HIV services will be followed and assisted in accessing the services. The risk of attrition of internally displaced clients will be addressed through monthly follow-up calls by service providers, including frequent updates of contacts and location. Internally displaced clients who cannot
participate in the in-person follow up session will be encouraged to participate in an online WINGS session.

**Ensuring Inclusive and Appropriate Program Materials**

Healthcare, social services, police, NGOs, gender experts, and women will all be involved in the preparatory phase to ensure that all program materials are medically accurate, age appropriate, culturally and linguistically appropriate, and inclusive. UFPH has an extensive experience of serving disadvantaged and marginalized populations, and all staff are trained to provide non-discriminatory and non-stigmatizing services. UFPH will collect client Participant feedback forms (Appendix 4) in order to monitor claims.

**Planning for Sustainability and Dissemination**

Project sustainability is being considered from the early stages of the project planning by engaging local authorities in the Community Advisory Group. These members provided support letters for the proposed project, in which they expressed their commitment to fund MTs and WINGS from local budgets after the grant funding ends if the intervention proves effective. The computerized WINGS tool and translated Ukrainian implementation manual will be available in open access on the UFPH website. Service providers from other regions will be encouraged to download and use the intervention. Trained staff of MTs will provide expert support for organizations that decide to incorporate WINGS in their services in the future.

Additionally, UFPH will advocate on the national level for the inclusion of WINGS into the Ukrainian state service system through its activities in ministerial and parliamentary gender groups. UFPH actively participates in the Civic Council of the Ministry of Social Policy of Ukraine, through which the civil society and NGOs participate in governmental activities and help to develop and implement gender, violence prevention and other policies. Finally,
UFPH continuously participates in annual Parliamentary hearings on prevention of IPV/GBV, providing another avenue for dissemination and advocacy activities regarding program sustainability.

Challenges to sustainability include the unstable economic and political situation in Ukraine. Despite intentions, local administrations may not have money to fund WINGS and MTs after the project ends. In spring 2019, Ukraine is holding presidential elections, which may change the political situation and affect the will to prioritize violence prevention services. In case of budgetary deficiency, UFPH will seek for additional funding from international donors and UN agencies in order to sustain the intervention through crisis. In case of political changes, UFPH will advocate for continued funding and support of violence prevention services from the national and local budgets in three project regions.

The project’s Gantt Chart and Logic Model are attached in Appendices 2 and 3, respectively.

II. Performance Measures & Evaluation

The proposed program will use an experimental study design with pretest and posttest evaluation of experimental and control groups. The project will engage 24 MTs that already identify and serve survivors of IPV/GBV in three conflict affected regions in Ukraine: 10 MTs in Donetsk region, 8 MTs in Luhansk region, and 6 MTs in Dnipropetrovsk region. We will randomize MTs to experimental and control groups in the following manner: 5 experimental and 5 controls in Dnipropetrovsk region, 4 experimental and 4 controls in Luhansk regions,
and 3 experimental and 3 controls in Dnipropetrovsk region, with a total of 12 experimental and 12 control MTs. Communities served by experimental group MTs will receive WINGS, and communities served by control group MTs will receive treatment as usual (TAU). Cluster randomization of MTs will ensure the comparability of the intervention and control groups. TAU involves the current services provided by MTs, which are not structured or systematized and are not based on an evidence-based program. At the end of the project, if the adapted intervention is found to be effective, the control group MTs will also be trained to deliver WINGS in their communities.

Three levels of data will be assessed: patient-level outcomes, provider-level outcomes, and process variables. Data will be collected and analyzed for continuous quality improvement. UFPH will hire and train research staff to collect and analyze data for this project. Research staff will be supervised by our research consultant Dr. Maria Kowalski, PhD. Dr. Gilbert is an Associate Professor at Columbia University and co-Director of the Social Intervention Group, the developers of WINGS. Dr. Kowalski has conducted several large scale efficacy and effectiveness trials of interventions to reduce IPV/GBV and HIV risks and has published over 150 peer-reviewed articles from this research.

Patient-Level Outcome Evaluation

The patient-level effectiveness outcomes will include changes from pre-test to post-test in participant-reported physical, sexual, verbal and economic abuse. We will collect the following data to measure patient-level outcomes:

1) 2,700 screening forms on the incidence of sexual, physical, psychological, and economic IPV/GBV [21];
2) 2,100 six-month follow-up surveys on the incidence of sexual, physical, psychological, and economic IPV/GBV with participants who complete two sessions of WINGS;

3) 20 in-depth interviews with selected staff about WINGS experience;

4) 30 in-depth interviews with selected participants about WINGS experience.

MTs will collect data for all WINGS participants. The screening tool is embedded in WINGS intervention and is used to assess risks in the first session and to assess changes in the incidence of IPV/GBV at the six-month follow-up. Data will be monitored and analyzed quarterly by the project research staff in order to monitor progress and address challenges.

Primary outcomes of changes in IPV/GBV victimization from pre- to post-intervention will be assessed using a shortened 20-item version of the Revised Conflict Tactics Scales (CTS2S, described below). Decreased physical, sexual, verbal, and economic abuse will serve as indicators of program success. The participants will be asked whether or not and the number of times they experienced specific types of IPV/GBV using five CTS2S subscales at baseline and at the 6-month follow-up.

**Short Form of the Revised Conflict Tactic Scale (CTS2S).** The CTS2 is the most widely used instrument for measuring IPV. A short 20-item CTS2 (the CTS2S) is used when testing time is limited. Straus and Douglas [21] found that the short form is comparable in validity to the full CTS2.

**Qualitative Interviews with Participants.** In-depth interviews will be conducted with 30 participants (10 from each region) who received WINGS. A semi-structured interview guide will include open-ended questions to elicit information about participants’ experiences with WINGS, their satisfaction with the program, barriers they encountered, and other feedback they want to share. Interviews will be audiorecorded and transcribed, then coded by
the research team to identify recurring themes. Examples of interview guides are included in Appendix 5.

**Table 1. Description of the primary outcome measure CTS2S**

<table>
<thead>
<tr>
<th>Name of selected measure:</th>
<th>Shortened Revised Conflict Tactics Scales (CTS2S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construct this instrument measures:</td>
<td>Intimate partner violence</td>
</tr>
<tr>
<td>Population used in instrument development:</td>
<td>Unmarried students enrolled in introductory sociology and psychology courses at a New England university in 1998, 1999, and 2000. Data was analyzed from students who had been in a dating relationship of at least 1-month duration in the past 12 months</td>
</tr>
<tr>
<td>How administered:</td>
<td>Self-Administered via paper or computerized tool</td>
</tr>
<tr>
<td>Number of items:</td>
<td>20</td>
</tr>
<tr>
<td>Response category format:</td>
<td>Likert scale (1 = Once in the past year, 2 = Twice in the past year = 3-5 times in the past year, 4 = 6-10 times in the past year, 5 = 11-20 times in the past year, 6 = More than 20 times in the past year, 7 = Not in the past year, but it did happen before, 8 = This has never happened)</td>
</tr>
<tr>
<td>Evidence for</td>
<td>Concurrent validity was assessed using the correlation between the short form and full scales. These ranged from .77 to .89 for</td>
</tr>
<tr>
<td>Validity:</td>
<td>Perpetration of the behavior measured by each scale, and from .65 to .94 for being victimized by a partner who engaged in these behaviors. These are inflated concurrent validity coefficients because the items for the short form were selected by taking the items that had the highest correlation with the total scale and because they are part-whole correlations. Construct validity was evaluated by computing a test of the significance of the differences between the short and long CTS2 for each of the pairs of risk factors. Most of the partial correlations of five risk factors for partner violence with the CTS2 scales and the full CTS2 scales were parallel. Only one pair of correlations (of 25) revealed a statistically significant difference in the results from using the short and full form of CTS2. These results indicate that, with one exception, the short form scales produce the same results as the full scale.</td>
</tr>
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<tr>
<td>Evidence for reliability:</td>
<td>Internal consistency reliability cannot be validated for the CTS2S because there is no total score. The instrument consists of five separate scales that are not intended to be summed to obtain a total score. It's not appropriate to compute reliability coefficients for each of the five scales because each scale consists of only two items.</td>
</tr>
</tbody>
</table>
Provider-Level Outcome Evaluation

The provider-level effectiveness outcomes will be the number of clients served by each MT who were referred and successfully accessed violence prevention and HIV prevention services. Referrals will be recorded by social workers, who will help to schedule appointments.

Qualitative Interviews with Providers. In-depth interviews will be conducted with 20 MT staff who delivered WINGS. A semi-structured interview guide will include open-ended questions to elicit information about providers’ experiences with WINGS, their satisfaction with the program, barriers they encountered, and other feedback they want to share. Interviews will be audiorecorded and transcribed, then coded by the research team to identify recurring themes. Examples of interview guides are included in Appendix 5.

Process Evaluation

The process evaluation will be guided by the RE-AIM framework [22]. UFPH will use the RE-AIM Checklist for Study or Intervention Planning (Appendix 6) and RE-AIM Planning Tool and Adaptation (Appendix 7) to evaluate the project’s reach, adoption of the interventions, implementation outcomes (patient and provider acceptability, fidelity, and costs [23]), and maintenance of the intervention one year after the project ends. For the fidelity assessment, we will use the fidelity checklist provided in the WINGS implementation manual (Appendix 8) [20].

Design Considerations

We chose to use an experimental research design in order to demonstrate that the outcomes are a result of the program. Random assignment of MTs to experimental and control groups should result in balance across groups of measured and unmeasured
confounding factors. Participants will be blinded (i.e., they will not be informed that they are in experimental group). It will not be possible to blind the MT staff who measure outcomes, because post-test measures at 6-month follow-up will be administered by the same service providers who delivered WINGS or TAU. There are no major ethical issues for randomization because we do not yet know if the adapted WINGS intervention will be effective in this new target population and the control group will receive the usual treatment delivered by MTs.

**Potential Challenges**

There may be challenges in recruiting enough participants to find a significant effect size of the intervention, although we anticipate that 300 participants per region per year (total N = 2700) should be adequate. Power to detect a significant effect will be reduced somewhat because we are randomizing MTs, not individuals, to treatment or control. Participants will thus be clustered within 24 MTs (12 experimental and 12 control), and clustering must be accounted for in analyses. Additionally, loss to follow up may be a risk for internal validity. We will address these risks through intensive outreach to potential participants, follow-up phone calls to maintain a connection to the MTs and to ensure that contact information is updated, and the delivery of WINGS sessions in locations of participants' preference.

### III. Capacity and Experience of the Applicant Organization

As the Applicant for funding, UFPH has extensive experience in implementing IPV/GBV prevention projects in Ukraine since 2005. Our projects address health and social crises made worse by human rights violations, with a particular focus and expertise on women’s health, including women’s right to information and equal access to protection and
quality care. We currently have ongoing projects in Kyiv and 15 regions of Ukraine, with a total of 15,000 people reached by our services in 2017.

UFPH was founded by and shares key staff and resources with the international health and human rights organization HealthRight International (hereinafter HealthRight). Since 2014, HealthRight has been working with the College of Global Public Health (CGPH) at New York University (NYU) to advance research, programming and policy on health issues affecting marginalized populations around the world. Drawing from resources across NYU, this affiliation bridges the traditional divide between rigorous public health research and complex program implementation at the ground level. The goal of the partnership is to enhance opportunities for each institution to build lasting access to wellness and health services for excluded communities. HealthRight and NYU will provide guidance and training on the WINGS intervention, conduct monitoring and evaluation procedures, and assist with data collection and analyses for the purposes of this project.

The proposed project aligns with UFPH’s mission, which is to improve life quality and enable our target populations to exercise basic rights by ensuring their access to social, health and mental services, introducing innovative social technologies, developing the sphere of health and social services, and building capacities of civil society organizations. Our projects have been funded by UN Women, UNFPA, European Union, UNICEF, UNODC, CDC, USAID, and private donors, including International Renaissance Foundation, Elton John AIDS Foundation, and others, with a total budget of $760,000 in 2017. Our annual financial audit statements are available on our website [24]. We have an established team of highly engaged workers, and our staff turnover has not exceeded 10% in the last three years. UFPH’s Executive Director Halyna Baluvana has 20 years of management experience in
business and non-profits. She receives mentorship and supervision from HealthRight New York based project directors. All office and field staff are provided with health insurance, paid vacations and sick leaves, as well as professional (clinical) supervision to prevent burnout.

UFPH is one of the leading organizations in the prevention of IPV/GBV in Ukraine, and we have implemented projects in this field since 2010 with funding from UN Trust Fund to End Violence Against Women (2011-2014), European Commission (2014-2017), UN Women in Ukraine (since 2016 till present), and UNFPA (since 2015 till present). Our national partners include the Ministry of Social Policy, Ministry of Internal Affairs, Ministry of Health. Our local partners in project regions include local governments, city halls, police and state departments, centers of social services, NGOs and United Nations agencies. Together with partners the Applicant strengthened service systems and interagency response to gender based and intimate partner violence, adapted the legislation on prevention of domestic violence, which was adopted and came into force in December 2018.

Since 2015, UFPH has implemented a foundational project addressing IPV/GBV among internally displaced women in Ukraine. This project started in five regions and currently operates in 11 regions of Ukraine. For this project, we collaborated with United Nations Population Fund (the project’s donor and partner), the Ministry of Social Policy, Ministry of Health and Ministry of Internal Affairs, and communities, including city councils and administrations, centers of social services, healthcare providers, and police in project regions. We work closely with communities and establish local partnerships to deliver health services. At the same time, we provide training and equipment and improve systems to enable our partners to deliver services on their own. Our goal is to create lasting change that supports access to health while strengthening human rights. For the purposes of the
proposed project we will use our leadership, national and regional partnerships to engage stakeholders and decision makers from the community in the Community Advisory Group.

UFPH manages 24 MTs that cover a total of 38 administrative units in the three project regions (Donetsk, Luhansk and Dnipropetrovsk), including underserved areas close to the conflict lines. Each MT has a car, a driver, a psychologist, and two social workers. MTs reach out to IPV/GBV survivors, provide IPV/GBV screening and counseling at survivors’ homes, and provide referrals to other health and psychosocial services. MTs closely collaborate with centers of social services, healthcare facilities, NGOs, shelters for GBV survivors, and educational facilities. They also have established partnerships with community leaders, stakeholders, and decision makers.

For more than a decade, UFPH has maintained strategic partnerships with donor agencies (UNFPA, UN Women, UNICEF etc.), with multiple projects funded by each agency. We have signed collaboration agreements with the Ministry of Social Services, Ministry of Health and Ministry of Internal Affairs which help us to access local partners when necessary and achieve our project goals. For example, our collaboration with the Ministry of Social Policy resulted in the adoption of the new Law on Prevention of Domestic Violence in 2018, and inclusion into the governmental services of several UFPH models, in particular mobile teams, shelters and halfway houses for survivors of GBV and domestic violence. Our collaborations with community stakeholders and decision makers helps us to reach our target populations and provide referrals to additional quality care when needed.

UFPH includes monitoring and evaluation activities in all projects in order to ensure high quality of performance. Data are collected in accordance to our quality standards and requirements of donors. Data from projects and services are presented at our quarterly Board
Report meeting in the New York HealthRight office, as well as in reports for partners, donors, stakeholders, and decision makers. Data are used to monitor progress, analyze and address challenges, improve project performance, and achieve planned outcomes.

Finally, all UFPH employees sign our organization’s policy papers that prohibit discrimination in the provision of services on the basis of age, disability, sex, race, color, national origin, religion, sexual orientation, or gender identity.

IV. Partnership and Collaboration

Project Partner Ministries

UFPH has been collaborating with local administrations and services in the project regions since 2015. UFPH has built strong partner relationships with regional administrations, governmental centers of social services, health departments and police.

Our national level partner will be the Ministry of Social Policy of Ukraine. This partnership will be guided by the Collaboration Memorandum signed in 2012. With the support of the Ministry of Social Policy, from 2012 to 2017 UFPH successfully implemented three projects in 16 regions of Ukraine that were funded by the UN Trust Fund to End Violence Against Women, European Commission in Ukraine, and UN Populations Fund. In these projects, UFPH built interagency responses to violence against women in Ukraine; trained social workers, police and health care to collaborate in addressing violence against women; and introduced new service models for survivors of violence, including halfway houses for survivors and MTs. These service models were ultimately incorporated into the
state service system, with the support of the Ministry of Health. Also, UFPH in collaboration with the Ministry of Social Services participated in the adaptation and advocated for the adoption of the new Law “On Addressing Domestic Violence,” which came into force in January 2019. UFPH also signed collaboration agreements with the Ministry of Health and Ministry of Internal Affairs in 2012, and these agreements are still active.

**Community Partners**

The proposed project will build on the existing MT service model that has operated in the project regions since 2012. MTs were established and operated by UFPH with funding from the United Nations Population Fund and involve close partnerships with local centers of social services, healthcare providers and police. Partnerships with local service agencies help with assessments of communities in need and cover them with necessary services that include psychological and social services to survivors of violence, including in remote villages, impoverished and underserved areas close to the contact line. In 2017, MTs identified and served 18,260 survivors of IPV/GBV. In collaboration with local partners, UFPH recently opened one shelter for women survivors of violence in Dnipropetrovsk region and two shelters in Donetsk regions.

**Table 2. Agencies that signed support letters for the project**

<table>
<thead>
<tr>
<th></th>
<th>1. Donetsk Regional Center of Social Services for Family, Children and Youth</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>Luhansk Regional Center of Social Services for Family, Children and Youth</td>
</tr>
<tr>
<td>3.</td>
<td>Luhansk Regional Center of Social Services for Family, Children and Youth</td>
</tr>
<tr>
<td>4.</td>
<td>Health Department of Donetsk Region</td>
</tr>
<tr>
<td>5.</td>
<td>Health Department of Luhansk Region</td>
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<tr>
<td>6.</td>
<td>Health Department of Dnipropetrovsk Region</td>
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<td></td>
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<td>---------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>7</td>
<td>Ministry of Social Policy of Ukraine</td>
</tr>
<tr>
<td>8</td>
<td>Ministry of Health of Ukraine</td>
</tr>
<tr>
<td>9</td>
<td>Ministry of Internal Affairs of Ukraine</td>
</tr>
<tr>
<td>10</td>
<td>Donetsk Region Civil–Military Administration</td>
</tr>
<tr>
<td>11</td>
<td>Luhansk Region Civil–Military Administration</td>
</tr>
<tr>
<td>12</td>
<td>Governor of Dnipropetrovsk Region</td>
</tr>
</tbody>
</table>

**Roles of Project Partners**

UFPH will coordinate all project partners, recruit CGA, hire, and train and supervise service providers and key project personnel. UFPH will be responsible for project implementation, data collection and analyses, continuous quality improvement, and communication and collaboration of all project partners on the national and local levels.

Three Ministries will help to engage social services, shelters, police and healthcare providers in the project regions. UFPH will engage representatives of the Ministries, UN agencies, and NGOs from these regions in Community Advisory Groups (CAGs) to lead the community mobilization and planning activities. CAGs will engage social services, law-enforcement, healthcare and NGOs in order to ensure comprehensive response to IPV/GBV and address various needs of survivors. Participation of local authorities in CAGs will help to promote and prioritize needs in GBV response at local levels, including budgeting of these services and planning for the future funding of MTs and WINGS delivery from local budgets.

Local partners, including Donetsk Regional Center of Social Services for Family, Children and Youth, Luhansk Regional Center of Social Services for Family, Children and Youth, Luhansk Regional Center of Social Services for Family, Children and Youth, Health
Department of Donetsk Region, Health Department of Luhansk Region, Health Department of Dnipropetrovsk Region were key partners in UFPH’s foundational project, “Strengthening humanitarian response to the need of most vulnerable women and female adolescents affected by armed conflict in Eastern Ukraine through multi-sectorial prevention and response to GBV and access to sexual and reproductive health services.” This foundational project was implemented from 2015 until the present, with funding from UN Population Fund in Ukraine. The project is addressing humanitarian needs of most vulnerable woman and female adolescents affected by armed conflict in Eastern Ukraine through strengthening of the multi-sectorial coordination, protection and prevention systems, and by enhancing access to legal, health and social-psychological care services for survivors of IPV/GBV. Community partners for the proposed project were engaged in addressing immediate needs of IPV/GBV survivors through coordination, assessment of IPV/GBV prevalence, and advocacy and multi-sectorial referrals in their regions, with over 30,000 survivors screened and engaged in care. For the proposed project, the same community partners will engage participants, ensure interagency referrals for services, provide premises to deliver WINGS, and help to maintain the intervention through funding from local budgets after the project ends.

VI. Project Management

The Project Management Team will include the Project Director, Project Coordinator, Research Manager, Financial Manager, Administrative Manager, Research Assistant and an Advocacy Consultant who are currently employed in UFPH’s project funded by UNFPA. The project will pay salaries to 24 MTs that operate in three conflict affected regions and will employ a biostatistician from the College of Public Health at NYU, who will be in charge of
data analyses. The project will engage a Research Consultant, Dr. Maria Kowalski, from the Social Intervention Group at Columbia University.

**The Project Director** will be responsible for overall project management, recruitment and supervision of a Project Coordinator, establishment of the project referral network with local and national partners, project planning, monitoring and reporting, project fiscal and budgetary oversight, outreach, training, capacity building, regional travel to project sites and other activities to fulfil project objectives. The Project Director will monitor the overall program and collect information from all project staff via by-weekly meetings or Skype calls, in order to identify and address or prevent potential challenges, track progress and completion of the project, as well as to ensure quality of all program objectives and activities. The Project Director will serve as liaison between the project and the Donor, will report to the Donor on progress and will consult on addressing challenges.

**The Project Coordinator** will provide coordination and support for all project activities in three project sites, including project monitoring and evaluation. The Project Coordinator will monitor implementation partners, and will coordinate activities between the management team and project service sites. The Project Coordinator will facilitate meetings of the Community Advisory Group (SAG), will collect data and performance measures from mobile teams and will share it with the project research staff and Project Director.

**The Research Manager** will coordinate data collection and analyses. The Research Manager will be responsible for obtaining research approval of Ethical Committee. The Research Manager will communicate with project Research Consultant Dr. Kowalski to develop study protocols and train staff on data collection, working with human subjects (CITI
certification). The Research Manager and Research Consultant Dr. Kowalski will also consult project service staff on data collection and working with data.

**The Financial Manager** will be responsible for project budgeting, accounting, salaries and payments, taxes, reporting to donors. The Financial Manager will evaluate the cost-effectiveness of WINGS.

UFPH will train the project staff and partners how to work with data. MTs will be trained by Research Consultant Dr. Kowalski from the Social Intervention Group to deliver WINGS to survivors of violence; Dr. Kowalski will also assist MTs in completing human subjects protection training through the CITI certification program. MTs will be trained how to provide gender sensitive and non-discriminatory care to survivors of violence from all socio-economic groups, as well as marginalized populations (i.e. women living with HIV, women engaged in transactional sex, women who use drugs or abuse alcohol). Project management staff involved in these activities have relevant qualifications and over five years of experience in project management and grant management in prevention of violence.

UFPH conducts annual staff evaluations, which assists in identifying needs in staff training and professional development. UFPH also pays for monthly professional group supervision for management and service staff. We hire local staff to implement projects in target communities and invest in their training and capacity building. The MTs that will deliver WINGS in three conflict affected regions will continue to use the knowledge and skills gained within UFPH projects for the benefit of their communities.

UFPH will continue to provide professional supervisions to the project management and service staff, and will pay competitive salaries in order to address staff burnout and
turnover. To ensure active engagement of staff in the project, the Applicant will offer training to enhance their professional development.

References:


### VII. List of Appendices

Appendix 1. Budget and Budget Justification

Appendix 2. Gantt Chart

Appendix 3. Logic Model

Appendix 4. WINGS Session Outline and Adherence Form

Appendix 5. Questionnaire for in-depth interviews on Experience of WINGS

Appendix 6. RE-AIM Checklist for Study or Intervention Planning

Appendix 7. RE-AIM Planning Tool and Adaptation
# Appendix 1. Budget and Justification

September 1, 2019 - August 31, 2022

<table>
<thead>
<tr>
<th>Personnel</th>
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**Contractual Costs**

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**Total Direct Costs**

- Year 1: $285 110
- Year 2: $208 216
- Year 3: $223 140

**F&A**

- Year 1: $4 200
- Year 2: $4 200
- Year 3: $4 200

**Total**

- Year 1: $289 310
- Year 2: $212 416
- Year 3: $227 340

**GRAND TOTAL**

$729 066
**Budget Justification**

The proposed project will pay salaries to the Project management staff, which were calculated based on their current salaries and their time contribution to the project. Project Director will work in this project 25% of time and will be paid $4,000 annual salary and receive $2,395 of fringe benefits. This position directs overall project management, monitoring of project activities, tracking progress, addressing challenges, reporting to donors. This position relates to all objectives.

**Project Coordinator** will contribute to the project 50% of their time and will receive $5,500 salary and 4,259 fringe benefits per year from the project budget. Provide coordination and support for all project activities in three project sites, including project monitoring and evaluation. Project Coordinator will monitor implementation partners, and will coordinate activities between the management team and project service sites. This position relates to all project objectives.

**Research Manager** will contribute to the project 40% of their time and will be receive $3,200 salary and $3,152 fringe benefits per year. This position will be related to the Objective 2 and Objective 4. The Research Manager will organize staff training, coordinate data collection and analyses. Research Manager will be responsible for obtaining research approval of Ethical Committee. Research Manager will communicate with project Research Consultant to develop study protocols and train staff on data collection, working with human subjects (CITI certification). Research Manager will consult project service staff on data collection and working with data.
**Financial Manager** will be responsible for project budgeting, accounting, salaries and payments, taxes, reporting to donors. Financial Manager will evaluate the cost-effectiveness of WINGS. This position relates to all objectives.

The project will cover 80% of salaries of 24 social workers from mobile teams ($172,800 per year) and 41,664 fringe benefits. Social workers will identify, screen participants and deliver WINGS. This position relates to Objective 3.

The project will hire the Biostatistician from the College of Public Health at NYU, who will work 15% for the project with $16,350 annual salary and $4,401 fringe benefits. This position relates to the Objective 2 and Objective 4. Biostatistician will help to design the study, analyze data and prepare reports.

**Advocacy consultant** will contribute to the project 20% of their time and will be paid $1,600 salary and $1,576 fringe benefits per year. Advocacy consultant will be responsible for community engagement, recruiting and facilitation of Community Advisory Group, dissemination of research findings among stakeholders and advocacy for the further funding. This position will relate to the Objective 1 and Objective 5.

The project will cover expenses for travel and accommodation for the unpaid international Project consultant, that will include two round-trips “New-York – Kyiv” and accommodation in Kyiv. Also the project costs will include printing of questionnaires and reports, office rent and office expenses, courier and postal services, communication expenses, banking fees.
## Appendix 2. Gantt Chart

### Gantt Chart for Project “Women Initiating New Goals of Safety” in Conflict Affected Regions of Ukraine

<table>
<thead>
<tr>
<th>Objective by Activities</th>
<th>Anticipated Outcomes</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
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<tr>
<td><strong>Objective 1: Launch WINGS tool for women in conflict affected regions of Ukraine</strong></td>
<td></td>
<td></td>
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<tr>
<td>Activity 1.1. Adapt WINGS Tool</td>
<td>1.1. WINGS tool adapted for women in conflict affected regions of Ukraine</td>
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<tr>
<td>Activity 1.2. Pilot adapted WINGS tool with 300 women</td>
<td>1.2. WINGS tool piloted with 300 women in 3 regions (100 women in each region)</td>
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<tr>
<td>Activity 1.3. Finalize WINGS tool</td>
<td>1.3. WINGS tool adapted for women in conflict affected Donetsk, Luhansk, and Dnipropetrovsk regions of Ukraine</td>
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<td>Activity 1.4. Convene Community Advisory Group for the project</td>
<td>1.4. 12 members Community Advisory Group ensured community engagement in the project</td>
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| Objective 2: Obtain IRB approval and train research staff | | | |
| Activity 2.1. Obtain research approval of Ethical Committee | 2.1. Approval of Ethical Committee is obtained | | | |
| Activity 2.2. Develop Study Protocols | 2.2. Study protocols developed | | | |
| Activity 2.3. Hire and train study staff | 2.3. Study staff is sufficiently trained | | | |

| Objective 3: Implement WINGS in three conflict affected regions of Ukraine | | | |
| Activity 3.1. Train 12 mobile teams (the intervention group) in three conflict affected regions to administer WINGS | 3.1. 12 mobile teams from the intervention group have sufficient knowledge and skills to facilitate WINGS for women in conflict affected regions | | | |
| Activity 3.2. Screen for eligibility 2,700 participants, and enrol 2,100 participants in WINGS | 3.2. 2,700 participants are screened for eligibility, and 2,100 participants are enrolled in WINGS | | | |
| Activity 3.3. Assess fidelity of WINGS (screen 48 sessions for fidelity) | 3.3. 48 WINGS sessions are screened for fidelity | | | |
| Activity 3.4. Conduct 6-month follow-up Audio Computer-Assisted Self-Interview (ACASI) surveys on primary outcomes with 2,100 participants who complete WINGS | 3.4. Conduct 6-month follow-up surveys with 2,100 participants who complete WINGS | | | |
| Activity 3.5. Conduct in-depth interviews with selected staff of mobile teams and 30 participants about WINGS experience | 3.5. Data is collected and analyzed for primary outcomes | | | |
| Activity 3.6. Train 12 mobile teams (the control group) in three conflict affected regions to administer WINGS | 3.6. 12 mobile teams (control group) have sufficient knowledge and skills to facilitate WINGS for women in conflict affected regions | | | |

| Objective 4: Evaluate WINGS effectiveness on primary outcomes (decrease in intimate partner and gender-based violence) | | | |
| Activity 4.1. Prepare manuscripts, final report, presentations on results of the project | Manuscripts, final report, presentations on the project outcome evaluation are prepared for presentation and dissemination | | | |
| Activity 4.2. Develop Policy and Program Recommendations based on project outcome evaluation | Policy and Program Recommendations based on outcome evaluation are developed and prepared to use for advocacy | | | |

| Objective 5: Advocate for dissemination and scale up of WINGS and other GBV prevention services throughout Ukraine | | | |
| Activity 5.1. Package WINGS tool, technical assistance manual; disseminate through social media, websites, meetings and other activities with stakeholders | WINGS tool and technical assistance manual are disseminated and used to advocate for scale up of WINGS and other GBV prevention services for women in conflict affected areas of Ukraine | | | |
## Appendix 3. Logic Model

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Activities</th>
<th>Outputs</th>
<th>Short-Term Outcomes</th>
<th>Mid-Term Outcomes</th>
<th>Long-Term Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Resources of Communities:</strong> primary care clinics, centers of social services, shelters for survivors of violence, humanitarian aid programs, violence prevention and HIV services for referrals</td>
<td>Adapt, pilot and finalize facilitator WINGS tool for conflict affected regions in Ukraine</td>
<td>Adapted and finalized WINGS tool for conflict affected regions in Ukraine</td>
<td>Service providers have sufficient capacity to identify and deliver WINGS intervention to women who have experienced violence</td>
<td>Evidence based interventions are incorporated in GBV response services in Ukraine</td>
<td>Evidence based interventions are incorporated in GBV response services in Ukraine</td>
</tr>
<tr>
<td></td>
<td>Train social workers in 3 regions to deliver WINGS</td>
<td>24 social workers trained to provide nondiscriminative GBV/IPV screening, safety planning and referral to services using WINGS</td>
<td>Women who completed one session of WINGS are aware of different types of GBV and are able to assess their risks</td>
<td>Women who completed one session of WINGS are aware of different types of GBV and are able to assess their risks</td>
<td>Women who completed one session of WINGS are aware of different types of GBV and are able to assess their risks</td>
</tr>
<tr>
<td><strong>Project resources:</strong> Mobile teams (social workers, cars and drivers to reach underserved communities), expertise, training, supplies and technologies (tablets for administering computerized WINGS, cell phone to follow up with clients, stationary)</td>
<td>Identify and deliver WINGS to violence survivors and deliver WINGS intervention</td>
<td>2,700 survivors of violence identified and screened</td>
<td>GBV survivors and women at risk have access to evidence based WINGS intervention</td>
<td>WINGS are funded from local budgets</td>
<td>WINGS up-scaled in other regions of Ukraine</td>
</tr>
<tr>
<td></td>
<td>Link survivors to violence prevention and HIV services</td>
<td>2,100 survivors of violence will receive project services and decreased risks of repeated abuse</td>
<td>GBV survivors and women at risk have access to evidence based WINGS intervention</td>
<td>WINGS are funded from local budgets</td>
<td>WINGS up-scaled in other regions of Ukraine</td>
</tr>
<tr>
<td><strong>State-level resources:</strong> policies addressing GBV, support of the Ministry of Social Policy, Ministry of Health and Ministry of Internal Affairs</td>
<td>Evaluate project outcomes, prepare and disseminate report</td>
<td>Outcome evaluation found WINGS effective for the project target population</td>
<td>Outcome evaluation found WINGS effective for the project target population</td>
<td>Stakeholders are aware of WINGS and supportive for the upscale</td>
<td>Stakeholders are aware of WINGS and supportive for the upscale</td>
</tr>
<tr>
<td></td>
<td>Advocate for the maintenance and upscale of the intervention</td>
<td>WINGS and outcome evaluation presented to local and ministerial partners</td>
<td>WINGS and outcome evaluation presented to local and ministerial partners</td>
<td>WINGS and outcome evaluation presented to local and ministerial partners</td>
<td>WINGS and outcome evaluation presented to local and ministerial partners</td>
</tr>
<tr>
<td>Section/Topic (Allotted Time)</td>
<td>Was Topic Addressed?</td>
<td>If Yes, How Adequately? (a)</td>
<td>Actual Time Spent on Activity (b)</td>
<td>Comments: Any unusual events occurred? Any additional content added? Reasons for spending too little or too much time on an activity? (c)</td>
<td></td>
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<td>----------------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>1. Welcome and IPV information (5 min)</td>
<td>Y N</td>
<td>1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Identifying Relationship Conflict: IPV assessment and feedback (5 min)</td>
<td>Y N</td>
<td>1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Cons of Relationship Conflict assessment, feedback (5 min)</td>
<td>Y N</td>
<td>1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Empowerment and reducing relationship conflict (5 min)</td>
<td>Y N</td>
<td>1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Safety Planning (10 min)</td>
<td>Y N</td>
<td>1 2 3</td>
<td></td>
<td></td>
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<tr>
<td>6. Social Support Map (5 min)</td>
<td>Y N</td>
<td>1 2 3</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>7. Goal Setting (5 min)</td>
<td>Y N</td>
<td>1 2 3</td>
<td></td>
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<tr>
<td>8. Service Referrals (10 min)</td>
<td>Y N</td>
<td>1 2 3</td>
<td></td>
<td></td>
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<tr>
<td>9. Wrap-up and Good-bye (5 min)</td>
<td>Y N</td>
<td>1 2 3</td>
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</tr>
</tbody>
</table>

1. Please describe material that was covered/discussed that was outside of the written protocol as well as the time spent (in minutes) for each outside topic.

2. Describe anything challenging that occurred during this session.

3. Please describe any unusual or notable events that you observed during the session.

4. How would you rate the participant’s engagement throughout the session?

5. What, if any, type of help did participants request with referrals for services? What help did you provide?
Participant Feedback Form

Thank you for participating in the WINGS PROJECT. In order to make our project the best it can be, we need your feedback. Please answer the following questions. Your honest opinions are very valuable to us. Thank you.

1. Overall, how satisfied were you with the WINGS Service Session?
   0. Not at all satisfied
   1. Slightly satisfied
   2. Somewhat satisfied
   3. Very satisfied
   4. Extremely satisfied

2. Overall, how comfortable were you with the facilitator who worked with you in WINGS?
   0. Not at all comfortable
   1. Slightly comfortable
   2. Somewhat comfortable
   3. Very comfortable
   4. Extremely comfortable

3. Overall, how honest did you feel during the WINGS session?
   0. Not at all honest
   1. Slightly honest
   2. Somewhat honest
   3. Very honest
   4. Extremely honest

4. How much did the session help you become aware of different types of intimate partner violence?
   0. Not at all
   1. Slightly
   2. Somewhat
   3. Very
   4. Extremely

5. How much did the session help you identify risks for intimate partner violence?
   0. Not at all
   1. Slightly
   2. Somewhat
   3. Very
   4. Extremely

---

1. Participant ID number: __ __ __ __
2. Date of Rating: __ __ / __ __ / __ __ __ __ (dd/mm/yyyy)
3. Date of Session: __ / __ / __ (dd/mm/yy)
4. Location: __ __ __ __ __ __ __ __ __
5. Staff ID: __ __ __
6. How much did the session help you explore ways to reduce your risks for intimate partner violence?
   0. Not at all
   1. Slightly
   2. Somewhat
   3. Very
   4. Extremely

7. How helpful was the relationship safety assessment?
   0. Not at all helpful
   1. Slightly helpful
   2. Somewhat helpful
   3. Very helpful
   4. Extremely helpful

8. How much did goal setting help you think about ways to improve your relationship safety?
   0. Not at all
   1. Slightly
   2. Somewhat
   3. Very
   4. Extremely

9. How much did the session help you identify your needs for services and find referrals?
   0. Not at all
   1. Slightly
   2. Somewhat
   3. Very
   4. Extremely

10. How did you feel about using the laptop computer?
    0. Did not like at all
    1. Liked a little
    2. Liked a lot

11. Did you have any problems using the laptop computer?
    0. No
    1. Yes

11(a). If yes,
    0. It was difficult to follow
    1. The keys were hard to find
    2. I did not understand how to use it

12. How did you hear about WINGS?
    0. Flyer
    1. Friend
    2. Other (please explain) _____________________________________________

13. Do you think you would have preferred to participate in WINGS with a case manager or on a computer?
    0. With a case manager
    1. Independently on a computer
14. What did you like best about the WINGS service session?
_________________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________________

15. What did you like least about the WINGS service session?
_________________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________________

16. What are your suggestions for improving the WINGS service session?
_________________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________________

17. Why did you participate in WINGS?
_________________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________________

18. How comfortable did you feel about receiving this service session in this setting?
_________________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________________
Reach - Extent of Representativeness of Participants

In designing your study, consider purposeful sampling from diverse groups of participants (e.g. low-income, older adults, and racially-diverse) to enhance external validity. Consider recruitment methods and intervention features that enhance the reach within populations of persons and settings. Carefully review exclusion criteria and consider whether by excluding certain types of participants you are also decreasing ability to generalize results.

Estimating Reach and Recruitment of Individuals

- Based on the available literature, your experience, and with formative evaluation, try to anticipate the primary barriers to participation of your program. How can you minimize or introduce methods to address these barriers in order to enhance participation?

- Estimate the number and percentage of people in your local population that have the targeted risk factor of interest. (e.g., number and % of smokers, sedentary adults, post-myocardial infarction cases)

- Estimate the approximate percent of this targeted population that will be eligible due to specific study inclusion/exclusionary criteria. (e.g., of all adult hypertensives, what percent are excluded due to medication, other diseases, language barriers)

- Record the actual number and percent of persons excluded from your study.

- Report the percent of eligible participants who agree to participate in your study.

- Compare differences between those participating and those not participating on illness status, sociodemographics, geography and other key variables.

- Record reasons that participants refused to participate in the study.
Estimating Attrition

Do the following for each study condition:

- Record how many _____ and when (what week of the intervention) _____ subjects dropped from the study.
- Compare differences between those completing and those not completing the study on adverse events, illness status, sociodemographics, geography, baseline scores on dependent variables, and other key variables.

Efficacy - Short-Term Impact/Outcomes for Participants

Consider including objective measures of outcome (in addition to self-report):

- Consider multiple outcome measures to triangulate an intervention effect.
- Consider specifying a theoretical framework that might explain change in behavior.
- Measure relevant theoretical constructs to assess mediational relationships between the intervention and anticipated change in the outcome variable(s).
- Record adverse outcomes and assess quality of life to judge unintended consequences.
- Track costs of all aspects of the intervention e.g., intervention materials, equipment, personnel, time, and space requirements.

Adoption - Interface between Researchers and Potential Program Settings

Conduct formative evaluations to identify what intervention features potential program adoptees (e.g., health systems, physician offices, elementary schools) would like.

- Consider the ease and feasibility of your intervention modality and staff requirements in terms of transferring the strategies to a practice setting.
- Prepare your intervention, training and materials to be easily replicated or disseminated to a practice setting.
Estimating Setting Level Participation and Adoption

If you are recruiting organizations or other intact groups to participate, consider the following elements:

- Based upon the literature, your experience, and with formative evaluation, try to anticipate primary barriers to participation in your program for settings and for potential intervention agents (e.g. teachers, physicians, peer counselors). How can you minimize or introduce methods to address these barriers in order to enhance participation?

- Estimate the number and percentage of settings or organizations in your local population that you hope to target. (e.g., "blue collar" worksites, elementary schools, HMO's)*

- Estimate the number and percentage of settings or organizations in your targeted group that meet your defined criteria. (e.g., no previous health promotion program in last 2 months, no immediate merger planned, classroom configuration to support study)*

- Record the number of settings that you exclude from participation and why.

- Record the percent of eligible settings that agree to participate in your study.

- Compare differences between those participating and those not participating on relevant characteristics such as size of organization, type of business, previous health promotion programs, number of employees/students/constituents, any policies regarding the target behaviors of interest or other key variables.

- Record reasons that settings/organizations refused to participate in the study.

Estimating Attrition

Do the following for each study condition:

- Record how many _____ and when (what week of the intervention) _____ program adoptees dropped from the study.

- Compare differences between those settings or agents completing and not completing the study on resources, staff expertise, size, physical and social environments, and other key variables.
**Implementation - Fidelity or Intervention Integrity**

- Identify the potential "implementers" of your intervention and meet with them to gain an understanding of their job duties and competing demands. Conduct formative evaluation to get feedback on how your intervention will fit their usual responsibilities and will fit into the organizational environment. Ask for suggestions to improve the implementation of your program.

- Record the extent to which participants and organizational settings complete or make use of various components of your intervention.

- Measure the extent to which agents deliver the intervention as stated in the protocol (e.g., percent of scheduled phone calls completed). If possible, have multiple intervention agents from different backgrounds, levels of training, etc., and document the implementation (and outcome levels) of each agent.

- Consider in your outcome analyses and conclusions the characteristics of participants who have higher versus lower levels of program use.

**Maintenance - Both Individual Participant and Program/Setting Level**

- Consider long-term follow-up of at least 6 months to 1 year following your last intervention contact.

- Consider continued contact and consultation to participating organizations or settings who wish to continue the intervention after your study has ended.

- Debrief with intervention agents and organizational decision makers after the intervention and identify what they liked best and least about the program, and which aspects they would be interested in continuing or modifying.

- Collect information on whether the setting or organization continues the program after your investigation is completed to estimate the potential for sustainability. *Many estimates can be made using existing public and vital statistics data (see links)*
**RE-AIM PLANNING TOOL**

The RE-AIM Planning Tool is intended as a series of “thought questions,” which serve as a checklist, for key issues that should be considered when planning an intervention. The best way to use this section would be to think about the issues raised, their pertinence to your intervention(s) and to help you make any relevant changes before launching the intervention. The questions listed are generalized and meant as self-checks, so don't worry about not answering the ones that are not relevant to your unique program and situation.

### PLANNING CHECKLIST

**Questions to Improve REACH**

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<table>
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<tbody>
<tr>
<td>1. Do you hope to reach all members of your target population? If yes, provide a number or estimate for your target population. If no (due to large size of the target population or budget constraints), provide the proportion of the target population that you want to reach ideally given constraints.</td>
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<tbody>
<tr>
<td>2. What is the breakdown of the demographics of your target population in terms of race/ethnicity, gender, age, and socioeconomic status?</td>
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<tbody>
<tr>
<td>3. How confident are you that your program will successfully attract all members of your target population regardless of age, race/ethnicity, gender, socioeconomic status and other important characteristics, such as health literacy?</td>
<td></td>
</tr>
</tbody>
</table>

1 2 3 4 5 6 7 8 9 10
(where 1 = not at all confident, 5 = somewhat confident, and 10 = completely confident)

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<tbody>
<tr>
<td>4. What are the barriers you foresee that will limit your ability to successfully reach your intended target population?</td>
<td></td>
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<tr>
<td>5. How do you hope to overcome these barriers?</td>
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<tbody>
<tr>
<td>6. Rate how confident you are that you can overcome these barriers?</td>
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</tbody>
</table>

1 2 3 4 5 6 7 8 9 10
(where 1 = not at all confident, 5 = somewhat confident, and 10 = completely confident)
<table>
<thead>
<tr>
<th>Questions to Improve EFFECTIVENESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Would you categorize your intervention as evidence-based or a new innovation?</td>
</tr>
<tr>
<td>2. Why did you choose this intervention and its components?</td>
</tr>
<tr>
<td>3. What are the strengths of your intervention?</td>
</tr>
<tr>
<td>4. Have you come to agreement with key stakeholders about how you will define and measure “success”?</td>
</tr>
<tr>
<td>5. List the measurable objectives that you wish to achieve in order to accomplish your goal.</td>
</tr>
<tr>
<td>6. What are the potential unintended consequences that may result from this program?</td>
</tr>
<tr>
<td>7. Are you confident that your intervention will achieve effectiveness across different subgroups, including those most at risk and having the fewest resources? If no, what can be done to increase the chances of success for these groups?</td>
</tr>
<tr>
<td>8. Rate your confidence that this intervention will lead to your planned outcome?</td>
</tr>
</tbody>
</table>

1  2  3  4  5  6  7  8  9  10

(where 1 = not at all confident, 5 = somewhat confident, and 10 = completely confident)
### Questions to Improve ADOPTION

1. What percent of other organizations such as yours will be willing and able to offer this program after you are done testing?

2. How confident are you that your program will be adopted by those settings and staff who provide services for people in your target population who have the greatest need?

   1 2 3 4 5 6 7 8 9 10

   (where 1 = not at all confident, 5 = somewhat confident, and 10 = completely confident)

3. What do you think will be the greatest barriers to other sites or organizations adopting this program? Do you have a system in place for overcoming these barriers?

4. What percent of your organization (e.g., departments, relevant staff, etc.) will be involved in supporting or delivering this program?

### Questions to Improve IMPLEMENTATION

1. How confident are you that the program can be consistently delivered as intended?

   1 2 3 4 5 6 7 8 9 10

   (where 1 = not at all confident, 5 = somewhat confident, and 10 = completely confident)

2. How confident are you that the program can be delivered by staff representing a variety of positions, levels and expertise/experience of the organization?

   1 2 3 4 5 6 7 8 9 10

   (where 1 = not at all confident, 5 = somewhat confident, and 10 = completely confident)

3. Is your program flexible (while maintaining fidelity to the original design) to changes or corrections that may be required midcourse?
4. Do you have a system in place to document and track the progress of the program and effect of changes made during the course of the program?

5. What is the greatest threat to consistent implementation and how will you deal with it?

Questions to Improve MAINTENANCE (individual)

1. What evidence is available to suggest the intervention effects will be maintained six or more months after it is completed?

2. How confident are you that the program will produce lasting benefits for the participants?

   1 2 3 4 5 6 7 8 9 10

   (where 1 = not at all confident, 5 = somewhat confident, and 10 = completely confident)

3. What do you plan to do to support initial success and prevent or deal with relapse of participants?

4. What resources are available to provide long-term support to program participants?

Questions to Improve MAINTENANCE (community)

1. How confident are you that your program will be sustained in your setting a year after the grant is over and or a year after it has been implemented?

   1 2 3 4 5 6 7 8 9 10

   (where 1 = not at all confident, 5 = somewhat confident, and 10 = completely confident)
2. What do you see as the greatest challenges to the organizations continuing their support of the program?

3. What are your plans for intervention sustainability? Will additional funding be needed?

4. Do you have key stakeholder commitment to continue the program if it is successful?

5. How will the intervention be integrated into the regular practice of the delivery organization?