A QUALITATIVE ANALYSIS OF HIV/AIDS POLICY IN RUSSIAN FEDERATION:
CREATING AN ADVOCACY MODEL

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<td>AFEW</td>
<td>AIDS Foundation East-West</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>HAART</td>
<td>Highly Active Antiretroviral Therapy</td>
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<tr>
<td>ARV</td>
<td>Antiretroviral</td>
</tr>
<tr>
<td>BMJ</td>
<td>British Medical Journal</td>
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<tr>
<td>CAS</td>
<td>Complex Adaptive Systems</td>
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<tr>
<td>CBO</td>
<td>Community Based Organisation</td>
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<tr>
<td>CCHI</td>
<td>California Centre for Health Improvement</td>
</tr>
<tr>
<td>CCM</td>
<td>Country Coordinating Mechanism</td>
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<tr>
<td>CEDPA</td>
<td>Centre for Development and Population Activities</td>
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<tr>
<td>CIS</td>
<td>Commonwealth Independent States</td>
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<tr>
<td>CSW</td>
<td>Commercial Sex Workers</td>
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<tr>
<td>ECA</td>
<td>Europe and Central Asia</td>
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<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
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<tr>
<td>HIA</td>
<td>Health Impact Assessment</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>ICL</td>
<td>Imperial College London</td>
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<tr>
<td>IDU</td>
<td>Intravenous Drug Users</td>
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<tr>
<td>IEC</td>
<td>Information Education and Communication</td>
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<tr>
<td>ILO</td>
<td>International Labour Organisation</td>
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<tr>
<td>IMF</td>
<td>International Monetary Fund</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MDRTB</td>
<td>Multidrug Resistant Tuberculosis</td>
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<tr>
<td>MOH&amp;SD</td>
<td>Ministry Of Health and Social Development</td>
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<tr>
<td>MSM</td>
<td>Men Having Sex With Men</td>
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<tr>
<td>MTCT</td>
<td>Mother-To Child Transmission</td>
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<td>NGOs</td>
<td>Non Governmental Organisations</td>
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<td>NHS</td>
<td>National Health Services</td>
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<tr>
<td>ODI</td>
<td>Overseas Development Institute</td>
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<tr>
<td>PLWHA</td>
<td>People Living With HIV/AIDS</td>
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<tr>
<td>RAPID</td>
<td>Research and Policy in Development</td>
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<td>RF</td>
<td>Russian Federation</td>
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<tr>
<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>SEAT</td>
<td>State Education Action Team</td>
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<td>SIDA</td>
<td>Swedish International development Agency</td>
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<td>SMO</td>
<td>Social Movement Organisations</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<tr>
<td>TACIS</td>
<td>Technical Assistance to CIS</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>TPAA</td>
<td>Transatlantic Partners Against AIDS</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<tr>
<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organisation</td>
</tr>
<tr>
<td>UNFP</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Special Session</td>
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<tr>
<td>UNICEF</td>
<td>United Nations International Children Emergency Fund</td>
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<tr>
<td>UNODC</td>
<td>United Nations Office on Drugs and Crime</td>
</tr>
<tr>
<td>UNRISD</td>
<td>United Nations Research Institute for Social Development</td>
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<tr>
<td>US</td>
<td>United States</td>
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<tr>
<td>USSR</td>
<td>Union of Soviet Socialist Republics</td>
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<tr>
<td>WB</td>
<td>The World Bank</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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NARRATIVE

This thesis is organized in seven chapters. Description of the chapters below provides guidance about the structure of the thesis.

Chapter 1: This chapter briefly describes the development of the HIV/AIDS epidemic in relation to the Russian Federation. Definition of the problem and the main shortfalls of Russian government in addressing the problems caused by epidemic are discussed. The chapter also frames the aims and objectives of the thesis.

Chapter 2: Policy, as a main target of advocacy is broadly discussed and analysed in this chapter. It also discusses different scholars' approaches to analysis of policy, the policy making process and policy implementation. Related concepts of power and its influence on the policy process are discussed to inform the understanding of how policies are developed and how change occurs. Different theories of decision-making and problem prioritisation help to understand why certain policy is chosen and the opportunities available to ground decisions, making them evidence based. Special application of these theories and approaches to health care system and HIV/AIDS are also considered. The chapter relate the discussion of policy development to the Russian Federation and its HIV/AIDS policy specifically. A lens through which Russian HIV/AIDS policy is analysed is presented in the chapter. It outlines the concepts and main definitions related to policy, which will help to understand the perspective from which the issue is viewed and approach to the solution of the problem.

Chapter 3: Chapter describes the historic development of advocacy, providing different definitions and understanding of the advocacy process worldwide. The chapter presents the aims of advocacy and its different applications in both the general policy process and health policy process particular. The implementation of advocacy in the health care setting in general and specifically as a tool to initiate change in the area of HIV/AIDS policy is discussed. Different types of advocacy are described and experiences from other countries of successful implementation of advocacy to initiate policy change leading to an improved response to the epidemic are presented. The chapter suggests an analysis of the policy process and advocacy schemes, which will be used to develop an advocacy model for the Russian Federation. Also a scheme for advocacy model development chosen as appropriate for the Russian Federation is described. The latter will contribute to an
understanding of the ways advocacy operates, as well as how it could be implemented to initiate HIV/AIDS policy change in the Russian Federation.

**Chapter 4:** The chapter describes the development of HIV/AIDS epidemic in the Russian Federation, its health, economic and political context. The development of HIV/AIDS policy and associated legislative acts are discussed and analysed. Factors which facilitate the growth of epidemic, statistical data, transmission modes and government response to combat the epidemic are described. Statistics of describing the development of the HIV/AIDS epidemic in the data collection sites: Altai Krai and Volgograd Oblast are presented. The chapter also discusses the funding available in the context of HIV/AIDS. Scenarios of the further development of the epidemic and its impact on the country's future development and its economic consequences are also presented. This chapter will help to understand the context for HIV.

**Chapter 5:** This chapter presents the research methods and the process of data collection and analysis. A qualitative analysis of HIV/AIDS stakeholders' opinions was conducted in Altai Krai, the Volgograd Oblast and at the Federal level during the period from February 2004 to June 2005. The study adopted in-depth interviewing and documentary analysis for information collection. Purposeful non-probability sampling followed by snowball sampling was used to identify individuals for the interviews. The stakeholder analysis was conducted among those are actively involved in HIV/AIDS at the time in the Russian Federation and among the potential stakeholders who are currently not involved, but could play significant role in resolving challenges suggested by HIV/AIDS. Collected data was transcribed and coded. Data analysis conducted using thematic and domain analysis. The limitations of the study are also presented in this chapter.

**Chapter 6:** This chapter presents the results and main findings of the data analyses. To identify the behaviour of stakeholders and understand the underlying meaning of the experiences, attitudes, and beliefs they describe, 153 stakeholders been interviewed. Interviewees were current and potential stakeholders of HIV/AIDS issues: HIV/AIDS Intersectoral Committee members, authorities from governmental organisations, NGO and private sector representatives. Results of the research are presented in accordance with the questionnaire structure and coding of transcripts. Codes been analysed by grouping gained information into emerging themes and further grouped into sub-themes allowing further categorization of the data. In addition to main ideas summarizing
respondents' thoughts, citations are quoted and tables are presented to support main findings.

Chapter 7: This chapter presents discussions and conclusions based on analysis of results. Based on main findings, this chapter also discusses the advocacy model, developed based on the results and discussions. The model is developed for the Russian Federation aiming to initiate policy change for better response to HIV/AIDS epidemic. Based on findings, a model is developed to campaign for wider prevention activities, which will increase knowledge of population, policy makers and professionals who are involved in HIV/AIDS response and most importantly could decrease stigma among all above-mentioned groups towards infected communities. It is presumed that the increased knowledge will prevent new infections, as well as, will help to develop tolerant attitude towards infected population assuring their human rights. Simultaneously, increased knowledge of population and professionals, and active public support will demand policy makers to give more priority to HIV/AIDS issues and adjust existing policy. In this chapter also discussed conclusions and possible further related research to be conducted.
ABSTRACT

The Russian Federation has one of the highest growth rates of HIV infection in the world. The main shortcomings of the Russian Government efforts in preventing the spread of epidemic are: (i) insufficient funding for HIV/AIDS programmes; (ii) low political commitment from the country's political leaders and policy makers; (iii) reluctance to cooperate with international donors and NGOs; (iv) failure in the implementation of international commitments signed by the government; and (v) widespread stigma towards PLWHA in society and the lack of determined efforts on the part of the State to overcome this. All of the above have hindered effective efforts to counter the spread of the infection so that the incidence of HIV continues to rise.

Aim: The aim of this thesis is to explore the policy process as regards to HIV/AIDS in the Russian Federation and how advocacy might be used to change HIV policies at regional and federal levels. The research uses qualitative methods to analyse stakeholders' attitudes and perceptions to HIV and to inform an advocacy strategy to enhance HIV control efforts.

Objectives: The objectives of the research were to:

a. Describe the policy formation process in the Russian Federation as applied to HIV/AIDS;

b. Explore the extent of stakeholder participation and their attitudes towards HIV/AIDS and identify the barriers and enablers to developing effective policies to address HIV/AIDS;

c. Review the existing international advocacy experience and develop an advocacy model, applicable to the Russian context, which can be used to support policy change to tackle HIV/AIDS.

Conclusion: The poor response to HIV epidemic was due to other competing priorities within the country, financial problems, lack of political commitment and leadership, structural and organisational problems, inadequate information, poor attitudes towards the issue, and stigma. The interrelated causes of these problems necessitate careful consideration of the linkages in any advocacy process to avoid unintended consequences and harm. Only an approach which acknowledges and works through the complexity of causal change can bring about the desired outcomes of improved HIV prevention,
treatment and care. The research shows that the main reason for poor response to the epidemic is the stigma and the perception that the epidemic is a problem of marginalised groups, not yet affecting the general population and the elite. Hence, the problem root is not poor implementation of policy but reluctance to implement policy. Thus the solution to the problem is to change the perception of the Russian authorities on the nature of the epidemic.
Chapter 1: INTRODUCTION

The Russian Federation face substantial challenge with one of the fastest growth rates of human immunodeficiency virus (HIV) incidence in the world. However, to date policies aimed at addressing the epidemic has been inadequate. Although a number of studies have explored the reasons for this slow and inadequate response (Amirkhanian et al., 2001; Atun et al., 2005b; Bobrik & Twigg, 2007; Feshbach & Galvin, 2005) these studies have not explored whether this response was due to lack of capacity at policy and operational level or policy resistance to address the epidemic.

This thesis will explore the reasons for this inadequate policy response to epidemic. But before this exploration it is important to understand the nature of HIV/AIDS in the Russian Federation and its trajectory, as the understanding of the nature and extent of the problem will influence the perceptions of Russian stakeholders to this problem, which in turn will shape their responses and subsequent policy decisions.

1.1 Background

1.1.1 HIV Infection: A brief description

HIV was first discovered in 1983 (All About AIDS, 2005; Facts About HIV/AIDS, 2005; Medical Encyclopedia, 2005). There are two known types of HIV; HIV-1 (the most common type found worldwide) and HIV-2 (found mostly in West-Africa) (WHO, 2005c). Generally HIV refers to the more widespread and pathogenic type 1. HIV-2 has the same effects as HIV-1, but it is less transmittable and slower to cause AIDS (hereafter only HIV-1 is discussed) (All About AIDS, 2005; Oster, 2004). Infection with HIV leads to the gradual destruction of the immune system, eventually progressing to acquired immune deficiency syndrome (AIDS). This immune deficiency increases the risk of opportunistic infections (Medical Encyclopedia, 2005), eventually leading to death within two years if untreated and around ten years with treatment.

There are four known modes of transmission of HIV: (i) sexual intercourse (vaginal, anal and oral) or through contact with infected blood, semen, or cervical and vaginal fluids; (ii) blood transfusion or transfusion of infected blood products; (iii) injecting equipment such as needles or syringes, or skin-piercing equipment; (iv) mother to infant
transmission which occurs during pregnancy, labour, and delivery, or as a result of breast feeding (Medical Encyclopedia, 2005; WHO, 2005c). On average, the incubation period of the disease, when the symptoms are not expressed, is 10 years. The 'window period', the period between the onset of infection with HIV and the appearance of detectable antibodies to the virus, is about three weeks, and has been reducing over time as the sensitivity of diagnostic tests increase (WHO, 2005c).

Though the first AIDS cases were diagnosed in mid-1980s, it took almost ten years to develop comprehensive responses in terms of appropriate policies globally (Stover & Johnston, 1999). Stover and Johnston (1999) analysed the response to the problem and its development process summarising it in four phases. They described the first phase as the medical response phase, when countries tried to treat the disease as a medical problem through interventions such as blood screening, organising safe medical practice, establishing surveillance systems and research into the disease. The second phase, the public health response, occurred when governments tried to incorporate public health activities to address the problem, investing in interventions such as promotion of safe sex, condom distribution, counselling and mass media campaigns aimed at informing and educating the general population. In the third phase, the multisectoral response, international organisations began to stress the disease impact on the social fabric and economic development of countries, thus calling for involvement of different sectors and disciplines to create a comprehensive integrated response to epidemic. The fourth phase they describe is characterised by treatment and prevention, with a focus on promotion of preventive activities, emphasising ethical and resource challenges linked to introduction of new prevention and treatment options.

Countries have adopted widely different mechanisms to confront and mitigate the impact of the epidemic (UNAIDS, 2001). In some, these included appropriate policies in each stage of the epidemic to develop appropriate responses, while in others the responses were frail. These responses evolved as new knowledge was gained on the development of the epidemic and its influence on the society. As the magnitude of the epidemic became apparent, different international organisations were established, and global efforts targeted to confront the epidemic (UNAIDS, 2004b; WHO, 2003). In some countries, such as Brazil, Senegal, Thailand and Uganda, these collaborative efforts and specifically targeted activities have moderated the growth of the epidemic.
In the early 1980s, HIV infection led almost inevitably to an early death from AIDS. Zidovudine or AZT, a nucleoside reverse transcriptase inhibitor, was the first antiretroviral drug, approved in 1987. This treatment slightly prolonged the patients’ life, but was still considered ineffective. The major changes in HIV treatment came in the mid-1990s with the development of non-nucleoside reverse transcriptase inhibitors and protease inhibitors which block HIV replication. However, it was the use of these multiple drugs in combination, which reduced viral loads and reconstituted immune system, while preventing the virus from rapidly developing resistance. At first some failure occurred because sub-optimal treatment had already undermined future treatment, and also if too for dose i.e. two were used in combination (Holmes et al., 2008). While not providing a 'cure', these antiretroviral regimens can restore and preserve immunologic function, suppress viral load and thereby reduce the mortality and morbidity associated with the disease. Improved care of people living with HIV/AIDS (PLWHA) incorporating clinical management, palliative care and social support (WHO, 2000) has helped improve the quality of life of PLWHA. (Panel on Clinical Practices for Treatment of HIV Infection, 2004). Yet 95% of the 36 million HIV-infected individuals in the world live in low-income countries, and only a tiny fraction of these people have access to HAART (Initial Antiretroviral Treatment of HIV Infection; Consensus Statement on Antiretroviral Treatment for AIDS in Poor Countries, 2001).

By the end of 2006, worldwide, the estimated total number of PLWHA was 40 million, with an estimated 4.3 million new cases contracted and three million deaths (UNAIDS, 2006). In spite of comprehensive international efforts, the epidemic is worsening. The rate of growth varies in different regions of Eastern Europe and Central Asia (ECA). The region facing the fastest-growing epidemic in the world (Goodwin et al., 2003; Grassly et al., 2002; The World Bank, 2003a; UNAIDS, 2003a; WHO, 2002), with a 40% increase in the number of PLWHA between 2001 and 2002. In 2005, there were an estimated 270,000 newly infected people in the ECA Region (UNAIDS, 2006), with the Russian Federation (hereafter Russia) experiencing the worst epidemic in the region (UNAIDS, 2006). Against a background of political and socio-economic turmoil, very high levels of injecting drug use (IDU), sexually transmitted infections (STIs), and tuberculosis are contributing to an explosive spread of HIV infection (UNAIDS, 2003a).
1.2 Definition of the Problem

Russia and Ukraine accounts for 90% of HIV infections in the ECA Region (UNAIDS 2006d). According to AIDS Foundation East-West (AFEW), as of February 2007, there were 362,068 PLWHA registered in Russia (AFEW, 2007), and 14,757 deaths amongst the PLWHA. Of those infected in 2005, 80% are young people in the age group 15-29 years (Feshbach & Galvin, 2005). The epidemic is driven by IDU and unsafe sex (Rhodes et al., 2002). But between 1998 and 2003 there was a sharp increase in mother-to-child transmission (MTCT) from 125 to 3531 cases. HIV/AIDS has affected all the regions of Russia, but 70% of the epidemic is concentrated in the 10 most developed and populated regions adversely affecting the demographics, economy and defence of Russia (Vinokur & Semenchenko, 2004).

The epidemic has begun to spread from high-risk groups to the general population (Tedstrom, 2003; UNAIDS, 2004a). Officially-registered cases, which point to five new infections every hour (UNICEF, 2003), underestimate the gravity of the public health problem and the number of PLWHA, estimated to be two to four times greater than the official figures (Amirkhanian et al., 2001; Gorbach et al., 2002; Kelly & Amirkhanian, 2003; UNICEF, 2003). A more detailed analysis of the epidemic in Russia is described in chapter 4.

Without political commitment, policies aimed at addressing HIV epidemic will fail (Family Health International, 1998). An enabling social and political environment with appropriate laws, regulations and policies and multisectoral responses with active involvement of the community, civil society, non-governmental organisations (NGOs) the private sector, and religious institutions are needed to reduce the spread of HIV/AIDS (The World Bank, 2003b; Kirby, 2001). In particular, NGOs provide an effective channel for reaching and influencing the target risk groups, such as IDUs, commercial sex workers (CSW) and prisoners. Multisectoral responses will help to ensure the policies developed take into consideration the broader socio-cultural context in which HIV/AIDS exists, rather then framing it just as a health problem (Canadian Public Health Association, 2000; The World Bank, 2001), as the epidemic goes beyond population health impacting on the economy (on micro and micro level), social life, and development of the countries affected. Migration, wars, prison regimes, drug control services all affect the spread of HIV. Hence, broader analysis of the context within
which HIV policies and programmes sit is critical to development of policies that can be implemented (Atun et al., 2005a; Atun et al., 2006; Coker et al., 2005).

The political, social and economic environment of a country, availability of resources for change, government responsiveness to proposed changes, skills for problem solving, public capacity to express their interests and government willingness to involve the community in decision-making affect the way policies are made and implemented (Wälti & Kübler, 2003). In this context, advocacy, defined as an organised effort to exert influence on the policy making process, (AIDSCAP, 2005) also has an important role in policy development—to inform policy makers and other key stakeholder of the evidence, ('what works'), and to clearly articulate a particular position of public in relation to a policy.

1.3 Russian Government's Response to Combat the HIV Epidemic

The Russian Government's efforts to address the epidemic has been described by the World Bank (WB) as “weak and patchy” (The World Bank, 2002a; The World Bank, 2005c), with political mobilisation, epidemiological and behavioural surveillance, effective prevention, care and treatment, as well as the removal of judicial constrains on effective action seen as critical activities to strengthen the current response (The World Bank, 2005c).

As a part of Union of Soviet Socialist Republics (USSR), Russia responded to first registered HIV-positive case through a decree “On Measures for Prophylaxis Against Infection with the AIDS Virus” in August 1987, which “reflected only the interests of society and had a restrictive (and repressive) effect on citizens’ rights” (Polubinskaya, 2004). In 1990, the Law “On Prophylaxis of AIDS Disease”, adopted by the USSR, defined rights to social and medical care for PLWHA with free transportation to medical facilities, free outpatient medication, access to pensions for infected by medical professionals. The same Law stipulated anti-discrimination provisions against PLWHA. Following the break up of the USSR, from 1995, Russia adopted series of Federal Laws to define the State activities to combat the epidemic (Polubinskaya, 2004). Based on the Federal Laws and regulations, 69 regions of Russia developed their regional HIV
prevention programmes (Davis & Dickinson, 2004; Rodrigez, 2002). Russia also signed international charters and declarations of Joint United Nations Programme on HIV/AIDS (UNAIDS), World Health Organisation (WHO) and United Nations General Assembly Special Session (UNGASS) on HIV/AIDS. Currently UNAIDS is working with Russian authorities to develop a National AIDS policy framework for Russia, to implement “three ones” strategy.

However, implementation of the Federal Laws and Regulations have faltered (Polubinskaya, 2004), often influenced the contextual (such as the prevailing political and socio-cultural environment) and health system factors in regions (Atun et al., 2005b). The enforcement has strayed far from the provision written in Law (TPAA, 2005b). For example, although the Federal Laws provide voluntary testing of specific groups, in practice, the majority of those tested have no prior counselling and are tested without consent—a violation of the ‘3 Cs’ (confidential, counselling, consent) advocated by UNAIDS (UNAIDS & WHO, 2004). The Law addresses ethical, human rights aspects, and identifies State obligations to offer social protection and provide benefits to PLWHA and their families. However, stigma and discrimination means these are not observed in practice, while confidentiality of the HIV-infected persons is frequently breached (TPAA, 2004). The Law adopted in 1995 and 1997, stipulated benefits for personnel working in HIV control. These Laws have been amended to provide one-time allowances. Although the Law prevents any occupational restriction of those infected with HIV, stigma remains widespread, with many companies requiring HIV-testing prior to employment (TPAA, 2004). Cases when doctors refuse to provide care and when schools refuse to accept children because of their HIV/AIDS status are not infrequently reported. The 1995 Law suggests deportation from Russia of HIV infected foreigners (RF Law No.38) (Grisin & Wallander, 2002). The government has also failed to provide free treatment to PLWHA, with only 4% of the need for Highly Active Antiretroviral Therapy (HAART) currently met. More detailed analysis of legislation and treatment, as well as funding and consequences of the epidemic are discussed in the chapter 4.

Funding for HIV/AIDS control programmes is also an issue (Polubinskaya, 2004), as the financial allocation for HIV-control activities is deemed to be low (UNAIDS, 2004d). According to Russian health authorities, $97 million ($26 million from the Federal Budget and almost $70 million from regional budgets) is needed to implement
for the five-year programme envisaged in the Federal Law (Tedstrom & Narkevich, 2004). But, on average, this allocation has amounted to approximately $5 million a year (Grisin & Wallander, 2002), against estimated need of a minimum of $19 million per annum. This financial shortfall in the budget is met by the donor agencies operating in Russia, which contributed $13 million in 2004—almost three times more than the Federal budget (Tedstrom & Narkevich, 2004).

Studies to date suggest identify a number of shortcomings in the Government response, including: (i) insufficient funding for HIV/AIDS programmes; (ii) low political commitment by the country’s leaders; (iii) reluctance to cooperate with international donors and NGOs; (iv) failure to implement international commitments signed by the government; and (v) widespread societal stigma towards PLWHA and a lack of determined efforts by government to overcome this. Collectively, these have hindered efforts to counter the spread HIV (Atun et al., 2005b; Bobrik & Twigg, 2007; Frolov, 2003; TPAA, 2005a).

1.4 Aim and Objectives of the Thesis

Aim: The aim of this thesis is to explore the policy process as regards HIV/AIDS in the Russian Federation and how advocacy might be used to change HIV policies at regional and federal levels. The research uses qualitative methods to analyse stakeholders’ attitudes and perceptions to HIV and to inform an advocacy strategy to enhance HIV control efforts.

Objectives: More specifically, research objectives are to:

a. Describe the process of policy formation as applied to HIV/AIDS, drawing on:
   • an analysis of the current response to the epidemic by the Russian government;
   • a review of the current policy documents and regulatory frameworks related to HIV/AIDS;
   • the views of key stakeholders in relation to HIV/AIDS policy formulation.

b. Review the existing advocacy experience by:
   • analysing the historical roots of the advocacy process for HIV/AIDS;
• exploring the current advocacy campaigns aimed at initiating effective policy change;
• exploring the international practice in the development of advocacy models in public health generally, and HIV/AIDS particularly.

c. Identify the nature of stakeholder participation in policy development and their attitudes towards HIV/AIDS by:
• analysing their attitudes, opinions and knowledge of HIV/AIDS related issues;
• exploring their perception of HIV/AIDS as a problem;
• elucidating their views on the barriers and enablers to development of effective policy;
• identifying the channels used for distributing knowledge to the Russian stakeholders involved in HIV/AIDS and which of these have worked in practice.
d. Develop an advocacy model applicable in the Russian context to stimulate policy change to tackle HIV/AIDS more effectively.

The research uses qualitative methods to achieve these aims and objectives. The research interviews were conducted from February 2004 to May 2005 with concomitant collection of contextual epidemiological and documentary data. The data on epidemiological and the legislative framework were revisited and updated in February 2007. Where up-to-date data was unavailable the latest available information was presented. The economic, socio-cultural situation in Russia is very dynamic and has changed following data collection. Obviously the study represents the situation for the period of data collection and may not reflect all the recent developments in the country.

This chapter briefly presented a background to the HIV/AIDS epidemic globally and in Russia, summarising the Russian Government’s response to the epidemic, and the aim and objectives of the thesis. The next chapter focuses on policy making and the policy process.
Chapter 2: Policy Making and the Policy Process

A range of concepts and frameworks have been described to illuminate policy making and the policy process. Some of these are descriptive and analyse the process through which policies are made. Others are prescriptive and suggest how policies should be made or changed. This chapter presents and discusses these concepts and frameworks, and explores in detail policy-related notions of power, influence, and change generally, as applied to health and to HIV/AIDS particularly.

2.1 Understanding Policy

Notions of policy can be traced back to Italian political philosopher Niccolo Machiavelli who lived in the XVIth century. More recent and scientific analysis of the subject owes its beginnings in 1943 to the work of Lasswell (Brunner, 1997). “The policy science is concerned with the knowledge of and knowledge in the decision process of the public and civil order” (Lasswell & Kaplan, 1963; Robinson, 1999) cited Robinson referring to Lasswell, while the study of public policy explore the translation of peoples’ thoughts and actions into collective decisions, leading to collective impact (Jones, 2002).

Public policy is about the public and its problems. As Parsons stated: “The main focus of the policy is concerned with how issues and problems are defined and constructed and how they appear on the political and policy agenda” (Parsons, 1995). Policy is a group of rules formulated by government aimed at influencing the behaviour of citizens, professionals and themselves, to achieve certain goals. Policy is a statement of intended actions for governments, businesses, faith-based organisations, and amongst others, NGOs and can have different forms and formats including: general statements of national or organisational priorities; rules and regulations; guidelines, procedures, standards to be achieved; and formal and written, or informal, unwritten but widely recognised and accepted practices (AIDSCAP, 2005). Policies also involve consequent decisions related to the implementation and enforcement of intended actions (Walt, 1994).
Five types of policies have been described, based on the effects policies have and the application of public power in their design and implementation (Hill, 1997; Nicholson, 2002; Walt, 1994). These are:

i. distributive – directed to a particular group, without resulting in any disadvantage or reduction of benefits to others;

ii. regulatory – cause restrictions on the behaviour of individuals or groups;

iii. self-regulatory – regulates and controls organisation interests;

iv. constituent – related to population and is directed to change parameters of behaviour;

v. redistributive – deliberate government attempts aimed at changing distribution of income or wealth.

Not surprisingly, the choice of policy has consequences for equity, social conflict, corruption, and political participation (Nicholson, 2002).

Policy and polity* are strongly dependent on the outcome of discursive interactions. Hajer (2003) argues that the policy process reveals how policy deliberation becomes the central site of policies and creates a challenge for serious reflection of policy analysis implications in the institutional crisis. Policy analysis oriented to practical solutions makes it vulnerable to becoming the handmaiden of government agencies. Hence, there is a need to shift the disciplinary orientation and rethink the reciprocal connection of policy analysis and political theory, and to connect the theory development with empirical research (Hajer, 2003).

Hanberger (2003) suggest that attention should be paid to interaction of public policy and legitimacy, which is the product of satisfying felt-needs and solving perceived problems. He argues that crises in legitimacy, frequently observed nowadays, could be explained by the inconsistency between high expectations created in the policy discourse and the lack of government capacity to offer sustainable solutions to ongoing problems. He proposes that legitimacy can be restored through creation of realistic policies and new division of power between government stakeholders (Hanberger, 2003).

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* political organisation of the group
Despite the extensive work done on the area of political science, policy science and political economy, many questions left unanswered on the policy process change, agenda setting, decision-making, implementation remain unanswered (Grindle & Thomas, 1991). Pielke (2004) identifies three external threats to sustainability of modern policy science traditions: (i) relevance to prediction, (ii) axiology of science and (iii) politicisation of science. The solution to these problems is identified as institutionalisation of policy science into a conventional discipline (Pelletier, 2004).

2.2 Policy Making

The context of policy making has evolved as the relationship between science and society changed. So has changed the role of knowledge in decision-making, to the extent that scientific experience can now be negotiated instead of being just accepted as evidence. The conditions under which public policy is made are also constantly changing (Hanberger, 2003). Policy studies are now recognised as a special field of knowledge contributing not only to policy science but also to decision-making, legislation or jurisdiction (Montgomery, 1999). Modernization, globalisation and individualization have affected institutions, affecting their position in the policy locus. Governments previously considered effective and legitimate currently lack the authority, focus and problem perception to resolve new problems (Hajer, 2003).

Walt has described macro- and micro-views about the policy making process. The macro theories analyse power in political systems reached through consensus or conflict. The micro theories focus more on mechanisms and the administrative routine of policy making. In both theories the determining factor is the influence on the policy process and decision-making (Walt, 1994). Court referring to Roe suggests that policies are often based on arguments, scenarios and narratives that have not been studied (Court, 2004).

The policy making process typically involves the elected politicians, appointed civil servants and the civil society through pressure groups as NGO or community based organisations (CBO). There are differing views on how policy decisions should be made (Jones, 2002; Simon, 1957). In a perfect situation, the policy makers would use available information and evidence, come up with policy options to address a particular
problem and choose the best course of action (Nigro, 1984; Walt, 1994). But the reality is far from perfect, and views vary on the optimal model of policy making process and the extent to which the process should be rational (Braybrooke & Lindblom, 1970; Grindle & Thomas, 1991; Hall & Quinn, 1983; Parsons, 1995; Pollitt et al., 1979; Simon, 1957; Walt, 1994). For example Dror suggests six models, Braybrook and Lindblom suggest four, Walt and Pollitt discuss three, while Hall suggests the 3Rs. These models are briefly summarised below in Box 1.

The rational model is normative or prescriptive, whereas the disjointed incremental model is explanatory or descriptive. The mixed scanning model involves both prescription and description. The rational and mixed scanning models restrict external pressure on the policy making process, whereas the incremental model accepts plurality and participation (Hogwood & Gunn, 1984; Walt, 1994).

Whether public policy making is participatory (direct and indirect) depends on the historical development of the country—its sense of national sovereignty, the political system of the country (liberal-democratic, egalitarian-authoritarian, traditional-inegalitarian, populist, authoritarian-inegalitarian) and its political stability (Walt, 1994). Policy making is also constrained by other factors, such as social and legal features of the society and resource constraints: grouped by some as situational, structural, cultural and environmental factors (Sabatier, 1988; Walt, 1994). In a non-democratic society, public policies are compulsory and authoritative collective choices. Bryder points to the role of ideology and propaganda in public policy making, highlighting the importance of well-defined ideological discourse which could provide an orientation for priorities, 'steering' information overloads and linking separately developed policies. In democratic systems propaganda could be used as an instrument for effective control of policy makers by constructively channelling debates (Bryder, 2004).

There are 'pluralist', 'elitist', 'structuralist' and 'bounded pluralist' views of influence in the policy process (Hill, 1997; Walt, 1994). Dahl (1958), the main proponent of the pluralist view advanced the theory of representative democracy: when power is diffused through society and there is no dominating group to suppress others' opinions (Dahl, 1958; Hill, 1997; Walt, 1994). As a result of such a policy process the policy outputs are 'wise' and represent public interests (Walt, 1994). But, even in most democratic countries, though power is held by different societies and groups, in practice these
groups are not equally active and there exist imbalances in their influence on policy. Furthermore, conflicts of interests mean there will be different approaches to resolve policy issues.
Box 1: Models of Policy Making

**Rational or synoptic model** – This model puts forward the idea of a comprehensive analysis of alternatives and their consequences and selection of the alternative which will maximize align with the decision-makers values. Rational decision making suggests that policy makers do not always manage to define problems correctly; lacking information to identify fully the options available to tackle the problem the resolution of the problem is based on their preferences, experience and past policy in that area. This is considered an ideal model, suggesting how policy makers think the decisions are made. But there are certain aspects which it doesn’t consider: i) whose values and objectives should be used as a directive; ii) the issues of conflicting interests and goals, e.g. the goal of the organisation does not always represent public interests; iii) its very structured, logical and purposeful approach is far from practical implementation; iv) the separation of facts and values, means and ends.

**Random model** - This model suggests the opposite to rational approach and views the organisations as recipients of external pressure and excludes the possibility of purposive action.

**Reasonable model** – This model stands between the rational and random models and suggests that decisions and actions are taken within institutional and environmental framework with actors pursuing different positions and agendas, but still allows that judgments are made and paths followed.

**Disjointed incremental model** – This model examine policies which incrementally differ from each other, as well as from the status quo; decisions are based on sketchy analysis limited by comparisons of marginal differences in expected consequences. The incremental model considers decision making to be by policy makers under political pressure which constraining the process. The model suggests that objectives and the means of implementation are not distinct; limited options are considered and the chosen option is politically feasible.

**Mixed scanning and normative optimal models** – This model is a combination of realism and idealism and states that policy makers consider broad implications of policy and avoid detailed explorations of options. The model suggests that in order to produce better decisions, there is a need to invest resources in designing procedures for making policies. Small procedures could bring about significant change, but only when they occur within a larger structure where they can act synergistically with other procedures. Otherwise procedures could be circular or dispersed.
An important alternative to pluralism is the *theory of elite*. The elitist view (or Marxist theory) believes that policy choice and change is determined by certain social classes/institutions, which are represented in the policy making positions, and the state ensures the continuing dominance of those classes/institutions. Elites could achieve their position through: i) revolutionary defeat; ii) military invasion; iii) control of key economic resources; iv) developing large-scale organisations/institutions in different areas of life which support their existence (Hill, 1997). The latter are the sources of power for the elite (Mills, 1956). This theoretical perspective illuminates well the policy process in Russia, as the decision-making is highly concentrated at the level of Federal authorities.

As with the elite theory, the *structuralist theory* see political action determined by powerful forces—not human forces but those which are beyond human control. Theory suggests that political choice is predetermined by demographic, social and economic factors, which are powerful constraints over human action and which should be addressed to achieve fundamental change (Hill, 1997). This theory elaborates on the relationship between structure and action, but fails to consider the conditions essential for supporting the actions to initiate social change.

Another view, *bounded pluralism* suggests the issues of high policies (economic, national security issues) are decided through the elite, whereas low policy issues (domestic, social issues) are decided through pluralism. This view presents the government as open to legitimate influence. Though health policies are considered to be low policies, due to interventions from various groups they could become high policy (Walt, 1994). Frequently, authors (Bachrach & Baratz, 1962; Walt, 1994) differentiate policy issues into important and un-important (high/low), suggesting that approaches to these differ. The argument will be that there are no unimportant issues (and accordingly no any single action), but each important issue consists of a chain of unimportant issues and actions to resolve these unimportant issues develop attitudes which in its turn determine the way important issues are resolved. So not to ‘lose’ their influence and ‘weaken’ their positions policy makers should ‘keep their hand on the pulse’ of events and constantly exert their power. As the people who deal with unimportant issues are appointed by officials in higher positions dealing with important issues (to ‘please’ those who ‘trusted’ them), ‘a chain’ which serves the same goal is established. However, even low policies have their elites who determine the direction
of policy development. In most cases this elite is highly dependant in its decisions on
the elite making high policies, especially as the high policy making elite decides on
resource allocation.

Pluralist, elitist and structural theories give a passive role to the state in policy process.
These contrast with theories which see a more active role for the State in the public
policy process (Baggott, 2000; Hill, 1997; Parsons, 1995; Sabatier, 1988; Smith, 1993;
Walt, 1994) and describe several models of policy making: i) institutional or
organisational, ii) corporatist theory or pressure-group politics, and iii) policy
knowledge and policy learning (Baggott, 2000; Sabatier, 1988). These are discussed
below.

2.2.1 Institutional Approach to Policy Making

This approach analyses the influence of relationships between institutions on agenda
setting, policy formation and the implementation of policy (Baggott, 2000; Kim, 2002;
Nicholson, 2002). Key concerns are accountability, efficiency and effectiveness. Hill
defines three types of institutional relationships (Hill, 1997):

- Bureaucratic – with established rules and hierarchical organisational principals.
  Based on type of authority bureaucracy could be charismatic (based on
  devotion to an exemplary character), traditional (based on established beliefs
  and a tradition of authority) and rational-legal (based on normative rules and
  rights developed by authorities). All these three forms are the result of the
  development of complex economic and political systems.
- Market – with private ownership maintaining its interests and organizing its
  relationships according to incentives or prices.
- Community – with collective self-restraint guided by norms and values.

March and Olsen comment that institutional approach “… characterizes politics in more
integrated fashion, emphasizing the creation of identities and institutions as well as their
structuring effects on political life” (Arts, 2004; March & Olsen, 1996; Sabatier, 1988).
Institutional factors play two fundamental roles in the behaviour of policy actors: by influencing the degree of power any actor has over policy outcomes and by controlling an actor's definition of their own interests through establishing their responsibilities and relationships to other actors within the institution (Barker, 1996). The established rules and routines, norms, values, relationships, power structures and standard operating procedures govern organisational activities with an institution and need to be considered when analysing the policy process (Burns, 2000; Hill, 1997), especially the extent to which these factors impose explicit constraints and conditions for change. Two key issues explored by the institutional approach to policy making relate to government accountability to people and mechanisms for policy implementation, which if ineffective, can increase costs and distort outputs.

Early on the institutional approach treated human beings as units of labour to be used efficiently without considering their needs, attitudes and emotions. But as the theory evolved the importance of human relationships' in organisational performance was explicitly recognised, so that organisations have been viewed as living social structures which maximise resources. The approach also begins to consider internal organisational power and the external context within which the organisation operates, as the context influences the policy process (Hill, 1997). The theory goes further to consider the decision-making process and the models (bureaucratic rationality, professional treatment or moral judgment) used when making policies.

2.2.2 Corporatist Theory

Corporatist theory analyses the interactions between different interest or pressure groups both outside and within the state and the influences of these relationships to power and policy making (Arts, 2004; Hill, 1997). There are two forms of corporatism:

- State – characterised as authoritarian and anti-liberal.
- Societal – which accepts plural political systems developed as a result of changes in institutions of capitalism, through concentration of ownership, and competition between national economies.
Several theories analyse how the relationship between the State and interest groups influences the policy process. The Transaction theory and sociological studies of inter-organisational relationships suggest that powerful organisations (separate from the State) develop over time ways of cooperating to achieve stability (if they need to work with each other) and determine how to influence the State. While the pluralist theory suggest pressures from different groups influences the State, Marxist theory sees the State as a source of capitalism. An alternative is the exchange theory which states that both the State and organisations need each other—pressure groups need to influence policy, and State institutions need support of powerful outside groups. The economic theory of bureaucracy analyses how interests within the State influence the policy process. According to the public choice theory parties competing to win power respond to demands of pressure groups and influence the government to yield to these demands by offering benefits: an approach known as the ‘demand-side’ of state behaviour. The State can also display ‘supply-side’ behaviour, as described in the monopoly theory, where the public bureaucracies monopolise goods and services, and in the absence of cost constraints create a market oversupply of commodities (Hill, 1997).

When describing the State’s role in the policy process, a further notion relates to the ‘strong’ and ‘weak’ State. Strong States employ a sense of their main legitimacy when taking public action and can confront the public power exercising their authority, whereas weak States bargain between legitimate interests.

### 2.2.3 Policy Knowledge and Policy Learning

Policy knowledge and policy learning relates to the analysis of the interplay of ideas and knowledge during the policy process: particularly how the problem of identification and decision-making are used to resolve issues which arise. Sabatier (1988) suggests rationalisation-models of policy making, which consider analytical debate, nature of the forum in which the debate occurs and the level and intensity of conflict over beliefs as key processes in policy change. This model, analyses how the interaction between opposing coalitions and ideological conflicts leads to incremental policy changes. Knowledge and beliefs incorporate ideology about the causal relationships affecting
material interests and information on the cause of the problem, as well as consequences of policy options (Baggott, 2000; Heintz & Jenkins-Smith, 1988; Sabatier, 1988).

Giddens (1984) suggested the *Structuration theory* to explain relationship between the knowledgeable human actions and the structuring of social system (Arts, 2004; Giddens, 1984). Policy learning can take place between as well as within political systems. When developing local policies, successes or failures experienced elsewhere can be used as lessons for replication of successes or avoidance of mistakes (Baggott, 2000).

### 2.3 Policy Analysis

The views on policy process and its analysis have evolved over time along with political and social development. A diversity of ideas within the literature precludes a single unifying structure for describing policy making and policy analysis. Instead, a range of approaches are used to analyse specific policy issues and when developing policies. Accordingly, the solutions will depend on the issue and the context, for example the political environment, the extent of civil society participation, cultural norms, professional attitudes, and external influences.

Policy analysis investigates plans and regulations developed by government, business or other institution, and how these polices affect specific groups (Sprechmann & Pelton, 2001). Earlier literature (Hill, 1997; Parsons, 1995) suggests two objectives for policy analysis: to understand the policy; (i.e. analysis of policy) and to improve the quality of policy (i.e. analyses for policy). In mid-80s, institutional approach used for policy analysis helped to relate policy outputs to organisational structures, norms and incentives (Nicholson, 2002).

Policy makers and legislators use policy analysis poorly to inform decision-making. Distributive and institutional theories support the view that decision makers are less concerned by the eventual outcome of adopted policies, but more by the immediate position they take. Policy makers refer to policy analysis to inform their decisions if the issue is highly salient or subject of conflict; whereas when an issue is not sensitive they
use the results selectively to create a match with their complex purposes (Greenwald & et al., 2003).

Policy analysis can provide a useful framework for advocacy development as it enables a logical approach to exploring the process, providing a critique and judging positions taken by each actor. It is naive to accept that policy analysis is a rational process, as often it is used not for representing the beliefs of policy coalitions but for policy making clients, officials or interest groups who have political legitimacy and authority. One way of influencing policy decisions is through influencing the policy context by judicious tailoring of analytical issues to policy forum.

Policy decision-making needs to be analysed in its organisational context (Simon, 1957). Policy analysis should be rooted in classical economics, and public and private management theories, as the policy process itself is complex and several external factors (political, environmental, donors, etc.) influence its formation (Hill, 1997; Krone, 1980). Each approach to analysis have pros and cons. Some models are suitable for analysing low conflict issues, whereas others are more suited to high conflict and intractable issues. So no one model of policy analysis could be used to inform advocacy, but combination of styles would be needed. An experienced policy analysts can use a combination of approaches to adopt their analyses to the policy context (Heintz & Jenkins-Smith, 1988).

As policy analysis is essential for informing advocacy, the summary below presents a number of policy analysis models well-described in the literature.

2.3.1 Herbert's Model

This model suggests that policy analysis should be based on: (i) country specifics; (ii) subject of policy change (taking into account sensitivity of subject to change, public perception of the issue, and the enabling and impeding factors), (iii) possible consequences of change, and (iv) external and internal environment for change.
2.3.2 Arts’ Model

This model suggests that policy could be analysed in four dimensions:

- **Policy coalitions** – who share resources and develop similar policy goals through a policy process, trying to achieve those goals by either supporting or challenging each other.
- **Rules of the game** – institutions have a set of rules to guide and constrain the behaviour of actors within them. These rules determine the appropriated behaviour (normative approach institutionalism), form the basis of exchange between utility-maximizing actors (rational choice institutionalism), or are used by the government system to influence decision-making (historical institutionalism).
- **Policy discourses** – interpretative schemes that actors make use of through mobilising resources to achieve outcomes in social relations.
- **Resources** – there is asymmetric distribution of resources in a society which cause dependency between actors and power exercised to gain resources.

These four dimensions could initiate policy innovation by involving new actors in policy making or coalition creation; rearranging power relationship (which could be as a result of resource reallocation), changing the rules of the game underpinning the policy, and reformulating policy discourses (Arts, 2004).

2.3.3 Hogwood and Gunn’s Model

This model suggest a scheme for policy analysis (Hill, 1997; Hogwood & Gunn, 1984), comprising:

- **Studies of policy content**: to analyse the genesis and development of a particular policy.
- **Studies of policy process**: to analyse the stages through which issues pass and assesses the influence of different factors on the development of the issue.
- **Studies of policy output**: to explain differences of expenditure and service provision between countries and local governments.
• Evaluation studies: to analyse impact of policy and could be descriptive or prescriptive.
• Information for policy making: concerns the data collection which assists policy makers in decision-making.
• The process advocacy: conducted for policy to improve policy making systems.
• The policy advocacy: press specific options and ideas in policy process through pressure groups or individually.

2.3.4 Nelson's Model

While analysing the role of economists in policy making, Heintz, referring to Nelson, describes different types of the political processes which underpin conflicts over the role of policy analysis (Heintz & Jenkins-Smith, 1988):

• Progressive – this model suggests that the policy analyst, after evaluation of the impact of different options, identifies and suggests to the decision maker the most efficient option. The decision maker will render its decision after reviewing the analysis. Administrator, in collaboration with policy analysts, will come-up with efficient way to implement the decision, which will take place without political involvement.
• Interest group competition – this model considers policy development as a continual incremental process with ongoing negotiation between different interests. Policy making and its implementation is determined by favourable treatment in legislative, executive and judicial processes. So the policy process is considered more political and the analyst provides information about the efficiency of each choice decision makers identify. Analysts are excluded from partisan or special interests politics.
• Ideological conflict – this model suggests that ideology plays important role in the political process when issue relates to social aspects. Ideological issues are widely applied to efficiency oriented analysis of public policy issues and the policy analyst is a proponent of ideology supporting rationality and efficiency.
2.3.5 Hajer’s Model

Political context of policy analysis should have three defining elements (Hajer, 2003): (i) Polity (political order); (ii) Knowledge (though as it is for politics this should not be political but scientific); and (iii) Intervention (problem-oriented, considering events which lead to meaningful policy interventions).

2.3.6 Stewart’s Model

Another method of policy analysis is systems analysis (Stewart, 2001). This model gives a perspective from which to understand the relationship between policy content and process. Assessing the problem comprehensively, accepting it as a system, considering communication possibilities across the system, and considering all possible players and organisations enable a realistic analysis: appreciating the difficulties with influencing and provide opportunities for lateral thinking. This approach helps to build a systemic model to assist decision-making; helps generate analytical and implementation strategy leading to the development of policy recommendations; and allows policy makers to build on existing communications and linkages.

2.3.7 Sprechmann and Pelton’s Model

The thesis will use Sprechmann and Pelton’s model to analyse HIV policies in Russia, as this model comprehensively considers the role of the stakeholders and their participation in policy making process. The model also considers the complex environment which influences the stakeholders’ decisions and their actions. Figure 1 builds on the framework developed by Sprechmann and Pelton (Sprechmann & Pelton, 2001) and provides a lens through which to view the analysis of Russian HIV/AIDS policy. The figure will also provide the thematic basis for the analysis of the data from the stakeholder survey, and will provide a starting point to develop an advocacy model suitable for the Russian context.
Figure 1: A Framework for Policy Analysis

**Policy Analysis**

- Identification of the policy causes or policy issues
  - What is the problem?
  - Which policy causes the problem?
  - Who is affected?
  - Where the problem occurred?
  - How the policy emerged or has failed to emerge?
  - When and under which circumstances were policies approved or blocked?
  - Who proposed, opposed, supported policies?
  - When the last change was made?

- Identification of key actors and institutions making decisions, process of influence policies and their interests
  - Who makes decisions about policy?
  - Who is influential in the decision making?
  - What are there own interests in the policy?
  - What resources are available?
  - What is the perception and attitude towards the policy?
  - What are main concerns?

- Analysing the policy environment
  - How participatory is the policy decision making process?
  - What are the communication channels?
  - Where and by whom the decisions are made?
  - How much propriety is given to the policy?
  - What relevant policies exist?
  - What are possible political changes and how will they affect the policy?

- Summarising policies and possible impact
  - What are the possible direct and indirect causes of the problem?
  - What policies lead to the problem?
  - What are the circumstances supporting the policy decisions causing the problem?

- Identification of options for policy change
  - What policy changes could have positive impact on the problem?
  - What are the options and which are the best ones to give results?
  - Which policies will get wider support or face opposition?
  - Who or which groups should initiate the change?
a) Identification of the policy causes or policy issues. A policy issues could arise due to an absence of policy, an adverse or inadequate policy, improper enforcement of a policy. There are several ways of identifying the “policy issue”. These include, field experience, observation, in-depth examination of laws, review of documents, and through interviews of key decision makers. These methods are not mutually exclusive and often used in combination. To have a complete picture of the problem it is important to relate the policy issue to the people affected by the problem.

b) Identification of key actors and institutions making decisions, how they influence policies, and their interests. To successfully develop an advocacy strategy it is important to identify policy makers and analyse their interests and attitudes towards the policy. Policy mapping, force-field analysis, mapping the level of influence and interest of stakeholders, are useful methods to help understand stakeholders.

c) Analysing the policy environment. For successful initiation of change, an analysis of the policy environment (e.g. whether it is receptive for change) is important. The policy environment includes the social norms, history, taboos, and economic constraints. The scope for change is a state of the policy environment and an indicator of whether a policy change would be successful or not. Here the focus of analysis is on:

- The distribution of political power among key actors, policy makers and those who are affected by their decisions.
- Understanding the relationship between formal and informal policy making and the level of political openness.
- Understanding the social, political and environment context of policy, e.g. rules, restrictions and circumstances under which the policy operates.
- Gathering information to understand the extent to which the policy issue is publicly discussed.

d) Summarising policy findings. A good way of summarising the result of analysis is through problem tree analysis, which helps to visualise and synthesise findings. The main four steps in this are:

- Problem identification.
- Identification of direct causes of the problem.
- Identification of indirect behavioural, environmental, structural causes of the problem.
• Identification of the causes that lead to behaviours.

e) Identification of options for policy change. Policy analysis provides options for policy change and explores possible impact of changes on the problem, hence identifying which of the options could lead to the desired result. It is also important to assess whether the desired policy change could be achieved through advocacy. Cost-benefit considerations and approaches to change also inform the choice of an option. In relation to advocacy, a number of questions need to be considered:

• Is there any risk in initiating advocacy?
• Is the timing right?
• How urgent is the desired impact? Can the advocacy achieve the desired impact?
• Are there alternatives to resolve the problem?

To summarise, the role of policy analysis is not only to find best solution to the problem and propose suggestion for change, but also provide an opportunity for lobbying and negotiating to ‘push’ the idea across to key stakeholders for acceptance and implementation. Once the idea has been accepted by the government the policy could be adapted to ensure alignment with the context within which the policy will be introduced. In addition, institutional structures may need to be modified for effective implementation of the policy and performance of the institutions affected by the policy.

2.4 Policy Implementation

Although for almost 50 years political scientists deeply engaged in debates surrounding policy analysis and policy process, policy implementation was more or less ignored, until Pressman and Wildavsky highlighted the issue of ‘implementation gap’ (Pressman & Wildavsky, 1984). Since then, scholars have developed approaches/frameworks and models to describe aspects of policy implementation, but the complexity of the subject matter means none of models satisfactorily capture the process in its entirety (Younis, 1990).

Models of public policy implementation developed deal with different aspects of the policy process, for example: Who makes policies and for what? How the decisions are made and by whom? What are the implementation and success criteria? Who is
practicing power, influencing the process of change? What is the context of change?

Last but not least, prioritisation and financing in policy issues (Abbott, Shaw, & Elston, 2004; Almeida & Bascolo, 2006; Armstrong, Winder, & Wallis, 2006; Glenngard & Maina, 2007; Hanks, 2007; Negro, 1984; Pressman & Wildavsky, 1984). These analytical approaches, which are widely used have now been institutionalised, have become the "conventional wisdom" (Saetren, 2005). Policies and their implementation, especially related to health, are not only made and affected by policy-makers, but also health professionals and the public. So the success of policies depends highly on the local circumstances, and the extent to which these are acceptable to the populations affected by these policies (Almeida & Bascolo, 2006).

### 2.4.1 Models of Policy Implementation Process

There is an implicit assumption that once policies have been formulated, they will be implemented (Smith, 1973; Younis, 1990). There are certain political and organisational conditions for such assumed success. Grindle and Thomas argue "outcomes of policy change are not just successful or unsuccessful implementation, but a range of possible outcomes" (Grindle, 1989; Grindle & Thomas, 1991). Younis (1990) citing Williams emphasises the difficulty in predicting whether implementation of policies will succeed or fail, as in the majority of cases it is impossible to locate the reason for failure; whether the reason of failure is the bad ideas, or that the ideas were good, but the execution was poor (Younis, 1990). Kerr (1976) citing Bunker suggests a 'Federalistic' framework for policy execution, where, he argues, there are territorial and vertical layers of bureaucracy (federal; state or regional, and local jurisdictions) and functional divisions (the administrative and operating bureaucracies that are directly charged with policy execution and program management; political leadership consisting of elected officials in both legislative and executive positions; organisations and individuals providing rational-analytic input, elites in active constancy). Based on this differentiation he develops a scheme presenting a mixture of descriptive and normative elements to test the hypothesis "policy implementation requires a diversity of functional and territorial dispersed resources and capacities" and for successful policy implementation, and to aggregate effect, it is vital that there is effective performance within each level and functional division. Kerr argues "the execution of complex
programs requires vertical coordination and the integration of multiple functional inputs" (Kerr, 1976).

Policy implementation could be seen as transactions and tensions generated between and within forces in society, involving idealised policies, implementing organisations, target groups, and environmental factors (see the box 2)(Grin, 1996; Smith, 1973b). The result of these tensions could, or could not, meet the outcome expectations of the policy makers. These tensions and transactions could be crystallised into institutional routines and in a form of feedback, be addressed to policy makers who in turn will support or reject implementation of the policies. So whether policies meet desired outcomes or not will depend on whether these policies are a result of demands and pressures by interest parties. Smith (1973) suggests that the incremental policies are much more easy to implement rather than those are ambitious non-incremental.

**Box 2: A Model of the Policy Implementation Process**

The *idealised policy* is defined as an interaction of idealised patterns of interaction and consists of four variables: the formal policy, the type of policy, the programme and the images of the policy. The *target group* is defined as those who pressurise the government to adopt new patterns of interaction. The *implementing organisation* is defined as a responsible body for implementation of the policy and could be a unit of the government bureaucracy. The environmental factors are those which can influence or be influenced during policy implementation.

Source: *Smith, 1973*
Hogwood and Gunn (1984) discuss the contribution of social sciences to policy implementation and suggest four main approaches in understanding the policy implementation (Hogwood & Gunn, 1984):

- Structural – consideration of appropriate structures for implementation.
- Procedural and managerial – development of appropriate processes and procedures (including managerial) to incorporate relevant techniques for implementation.
- Behavioural – human behaviour and attitudes (acceptance or resistance) towards implementation.
- Political – which includes, but is not limited to, party politics, as well as practicing power and influence between and within organisations involved in policy implementation.

The literature does not adequately discuss an important aspect related to policy implementation: the willingness of the policy makers to implement their own policies. If the Russian authorities implemented their own policies this would reveal policy gaps and problems with these policies. Policies which are implemented should be assessed and evaluated (Smith, 1973). One could consider that, the results of these evaluations would oblige the policy makers to address emerging issues and incorporate further changes into policies. But, if policies are not implemented, they will be seen as ideals, allowing policy makers to hide themselves behind “financial problems and lack of resources and capacities” as excuses, leading the public to think that the problem is in implementation rather than the quality of policies. So by avoiding policy implementation policy authorities are resolving ex ante potential problems they could face: the constant tension and pressure by the public to increase the threshold of the quality of their decisions.

Policy implementation requires certain level of institutional capacity to execute organisational change (Bunker, 1972). When enforcing implementation of their policies authorities have to address capacity constraints in implementing organisations that will be under pressure to introduce change and deliver results. Furthermore, the organisations, groups and individuals involved in policy implementation will be subject to social and political pressure.
To analyse these interactions, Bunker citing Gergen has proposed a three-dimensional relationship between issue salience, power resource and agreements**, to predict directions of preferred change, for optimisation of resource use and to ascertain the probability of implementation (Bunker, 1972).

2.4.2 Successful Implementation of Policy

Whether a policy is successful or not depends on its implementation. If a policy cannot be implemented it will not be a successful policy (Kerr, 1976). The “quality” of the policy depends whether it is operational and how the policy ideas could be translated into effective and collective action. This operationalisation is dependent on “aggregate patterns, of specific, local administrative actions as well as legislative provisions, programme guidelines and judicial decisions” (Bunker, 1972). Policy success is assessed in various ways. Giacchino and Kakabadse distinguish between process-oriented and people-oriented factors which influence success (Giacchino & Kakabadse, 2003). Khan identifies nine factors influencing policy success: project planning; implementation approach; creating an awareness and sense of urgency for change; publishing success stories; creation of powerful group of ‘champions’ of change; networking and teambuilding; anchoring changes in the organisations’ culture; project management structure, and selecting ‘right’ project team (Khan et al., 2000). O’Toole drawing on a review of over 300 implementation-related articles, concludes that policy characteristics, resources, implementation actors, attitudes and preconceptions of implementing personnel, alignment of clients and timing as important factors which influence policy success (O’Toole, 2004; Struyk, 2007).

Hogwood and Gunn (1984), incorporating ideas of Hood, Pressmand and Wildavsky, identify ten following preconditions of successful implementation of policy (Hogwood & Gunn, 1984; Pressman & Wildavsky, 1984; Younis, 1990):

** issue salience refers to an importance of an actor and amount of attention to the issue required from the particular actor; power resources refers to the number and potency of political resources (power, economic benefits, patronage, prestige, etc.) the actor has available; agreement refers to mapping the position of an actor towards a positive advocate of the policy to be executed.
• Control of external restraints to the implementing agency.
• Availability of adequate time and resources for the entire implementation, as well as the availability of the combination of resource necessary for each stage of implementation.
• Policy is developed based on valid theory of cause and effect, and also considered intervening links in this linear causation.
• There is a single implementing agency, which has no dependence in implementation from other agencies, or at least that interaction is minimal.
• Clear understanding of the objectives to be achieved and tasks to be performed.
• Perfect communication and co-ordination of activities within subjects of implementing agency and between implementing agencies involved in the process.
• Authorities are entitled to demand and obtain obedience.

The suggested preconditions look ideal but in practice rarely realised. They may be achievable when implementing small-scale projects, but when implementing large-scale public policies, it is require multisectoral responses, engagement of multiple organisations, coordination of inputs, and horizontal and vertical management of activities. As regards HIV policies, none of these preconditions exist in Russia.

Younis summarised implications of successful implementation of policy developed by Ham and Hill, which are as follows (Younis, 1990):
- The nature of policy
- The implementation structure
- The prevention of outside interference
- Control over implementing actors.

Policy implementation could fail for several reasons (Kerr, 1976; Younis, 1990):
• The frequency of occurrence of a problem, in many places simultaneously, and the implementing agency being unable to handle this problem.
• The set conditions are not facilitating the implementing agency to take actions.
• The policy does not address the purpose and is considered an instrumental failure.
• If the policies are normatively not justified, though being implemented.
2.4.3 Policy Implementation in the Russian Federation

Struyk (2007) has applied the ‘conventional wisdom’ of policy implementation to analyse the experience of programme implementation in Russia. He assessed the factors associated with successful programme implementation in the transition economy of Russia. He suggested nine factors were important when analysing success of programme implementation in the Russian context, namely: degree of local leadership and its consistency; characteristics of the program: clarity of goals, procedures and organisation; availability of resources; number of implementing actors; attitude of implementing personnel; alignments of clients; opportunity for learning among implementers; and past experience with similar program; local environment (Struyk, 2007). In the Russian context, he identified political support and local leadership to be the most important factors influencing implementation (Table 1).

Table 1: Factors Influencing Success of Programme Implementation in the Russian Federation

<table>
<thead>
<tr>
<th>Factor</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Degree of local leadership and its consistency</td>
<td>Extremely important</td>
</tr>
<tr>
<td>Characteristics of the policy being implemented: efficiency; clarity; consistency; flexibility</td>
<td>Some influence but flexibility is also important</td>
</tr>
<tr>
<td>Availability of resources</td>
<td>Local government resources were consistently available; so hard to determine pattern</td>
</tr>
<tr>
<td>Number of implementing actors</td>
<td>No association found</td>
</tr>
<tr>
<td>Attitude of implementing personnel</td>
<td>Important</td>
</tr>
<tr>
<td>Alignments of clients</td>
<td>Implementers did a good job in this area consistently; so hard to identify the role</td>
</tr>
<tr>
<td>Opportunity for learning among implementers</td>
<td>No clear association found</td>
</tr>
<tr>
<td>Past experience with similar programmes</td>
<td>Positive association found; reduces risk, generates support</td>
</tr>
<tr>
<td>Local environment</td>
<td>Seems to be important but probably works through other factors</td>
</tr>
</tbody>
</table>

Source: Struyk, 2007
2.5 Application of Different Theories to the Health Care System

Politics critically influence health affairs (Lindblom, 1968; Thomas, 2005). Health policy is a product of political processes when it deals with problems, agendas and decisions, but becomes a more technical process once policies are formulated and implemented (USAID, 2000). Walt suggests that health policy involves low policies, distributive or regulatory policies and the policy process is pluralist (Walt, 1994). Lewis describes health policy as “a complex network of continuing interactions between actors who use structures and arguments to articulate their ideas about health”. In that sense, influence is an important factor in the health policy process. The medically trained academicians, health bureaucrats and public teaching hospitals are considered as influential agents in this process (Lewis, 2005). Though Lewis emphasises a significant role of medical professionals as a powerful political elite in setting the health policy agenda, he does not elaborate the governmental setting within which the decision-making and problem prioritisation process occurs. In the case of Russia, authority and power is highly centralised and the decision-making controlled by the Federal authority (Marsh, 2000). Moreover, health care system issues are not considered as a priority in comparison with defence or business development, as reflected in the Federal resources allocated to these areas. In this context the opinions of health care professionals are less influential than Lewis may suggest. Moreover, the decisions within health sector are not made according to needs or evidence (such as epidemiological information), but based on political judgements and resource availability within the sector. If health professionals created coalitions to voice their concerns in a more organised approach, they may have more influence but even then, it is doubtful if their views will be seriously entertained by the government. But as senior health professionals in the health system are appointed by the government, they have little choice but to support government decisions to stay in their positions.

Frenk argues that health policy operates at four levels: i) systematic (deals with main features that shape the health system overall, like the nature of health care institutions, the relationship between the private and public sectors, and relationships with organisations in other sectors); ii) programmatic (identifies health care priorities, the nature of health care programmes, and resource allocation); iii) organisational (efficient and effective use or resources, quality assurance within the system); iv) instrumental
One way to analyse health policy is to explore how policies emerge and are developed. Some authors (Pettigrew et al., 1992; Walt, 1994) attempted to apply different theories and models developed for decision-making in policy process to explain and analyse these phenomena in the health care sector. The Public sector orientation model stresses the high quality and consumer responsive services. Public organisation theory discusses interconnection of structure, behaviour and management within the public sector. Although acknowledging differences between the specifics of private and public organisations, there are also common elements presented in health care system management. These issues are discussed by Pettigrew who identifies three important issues in relation to analysing public policies: i) generic issues such as human resource management; ii) common context, such as changes in national political economy, which is reflected in restructuring; iii) common managerial and organisational processes and competencies, such as strategy development, networking and political skills. All these three elements are pragmatic way for building the capacity to manage change (Pettigrew et al., 1992).

Filmer identifies three factors which influence the impact of health policies (Filmer, 1998):

- anticipated efficacy of public sector under existing institutional arrangements;
- underlying justification of public intervention;
- how responsive individuals’ decisions are to public actions.

Rutten et al (2003) referring to Wright (1976) suggests the concept of logic of events stating that human action could be explained by wants, abilities, duties and opportunities. Rutten applies this notion to policy making and develops a model which proposes that ‘personal wants’ are subordinate to political goals, policy makers’ individual abilities are part of organisational resources, personal duties are subordinate to institutional obligations and opportunities are related to political context and political support. The ‘logic of events concept’ is applicable to health-related behaviour of the population and to health policy action of policymakers. Thus behavioural change could be achieved through concrete goals, sufficient resources and public support and policy implementation could be achieved through personal commitment and organisational capacity. Policy
implementation changed behaviour for a number of public health issues, such as smoking, and screening for breast cancer, for which there were sufficient evidence to promote health promotion policies. But policy making is not a rational process. Concrete policy action is determined by personal wants of the policy makers, but will also be a reflection of the interests of organisations and individuals implementing these policies. In the same way, “abilities” in the context of policy are not different actors’ individual abilities but reflect organisational capacity and the available resources of the entities involved. Health policy will lead to specific obligations and institutional arrangements in the health system and the community. These also will increase or decrease public awareness, population participation and mass media interests. Collectively these will define the favourability or hostility of the context for the policy. So likely chances of implementation and policy impact could be analysed by investigating these determinants that will influence policy execution (Rutten et al., 2003).

Incrementalism is visible in nearly every area of public health policy. The source of incrementalism is the institutional design of the political system itself and the bounded rationality when considering problems and solutions, as there is always lack of information, resources and time to respond to problems. Consequently, instead of system-wide reforms, programmes and policies with limited scope are developed, to reach consensus and minimise uncertainty and instability. Often, to avoid conflicts over values and beliefs and political deadlock, policies are directed at achieving short-term outputs, rather than long-term outcomes (Thomas, 2005). Bounded rationality, which links human choice and organisational procedures and policy processes, helps predict organisational and policy outcomes of collective behaviour (Jones, 2002; Ryan, 2001). Bounded rationality emphasises four principles:

i. Intended rationality – which states that though people are goal oriented, they fail to achieve their goals because of the interaction of their behaviour and the complex environment. Behaviour could be logical (rational choice), illogical (lacks of ends-means thinking) and non-logical (intervention of sentiments and residues into logical thinking). Rationality could be thick (motivated by self interests and is capable of strong predictions about individual behaviour and collective choice) and thin (process focused and assumed maximizing behaviour regardless the goal). Simon (1957) suggests that human behaviour is not determined by rationality, but that irrational and non-rational elements ‘bound’ the rationality.
ii. Adaptation – though human thoughts are adaptive and basically rational, most of human behaviour directed by the nature of the task environment.

iii. Uncertainty – its defined human psychology of difficulties in working out probabilities, risk assessment, and making inferences with uncertainty involvement.

iv. Trade-off – it suggests that an individuals in organisations from alternatives choose (through lexicographic strategy or elimination by aspects) the one which give them maximum benefit.

Bounded rationality theory combines human choice and organisational behaviour. *Behavioural theory of human choice* determined by long-term memory; short-term memory; emotions set priorities; preparation search trade-off and identification. The main aspects of *behavioural theory of organisation* are organisational memory; agenda setting; parallel processing; serial processing; emotional contagion and identification. There are commonalities and there is a causal relationship between organisational and individual decision-making. *Bounded rationality* and *behavioural choice* help to predict policy outcomes where organisational outputs will be disjointed and episodic (Jones, 2002).

Based on the *management by objectives approach* (set of directed efforts to identify individual steps and targets necessary to achieve common goals), health care services use targets to influence policy implementation. In this process government often provide leadership, guidance and strategic directions for the health sector by monitoring and setting health targets. Most often, given the recent globalisation the targets are set internationally (such as Millennium Development Goals (MDGs)) and the role of international donor organisations in setting and achieving these targets is substantial (Cassels, 1995). In relation to management by objectives, McGinnis (1990) has adopted an approach widely used in business and health. This is a cyclical process, which starts with definition of strategic goals, based on which objectives are identified, followed by implementation and monitoring of objectives, and then by evaluation to ascertain achievements to establish new objectives for implementation (Green, 1997; McGinnis, 1990; Van Herten & Gunning-Schepers, 2000). This targeted process works as a motivation and guide for policy makers, directing them to think rationally when establishing health policies and use targets as a tool for policy improvement.
Many countries have positive experience of using health targets to develop rational and transparent health policies (Herten, 2000; Van Herten & Gunning-Schepers, 2000). Implementation of policies to meet set targets requires leadership (Box 3), community empowerment, authority and the capacity to act, reliable information systems, adequate resources, administrative skills. Health targets can be used to develop evidence-based health policies that are consistent and coherent, but achieving them will require effective management of political processes and stakeholders commitment (Van Herten & Gunning-Schepers, 2000).

**Box 3: Benefits of Health Targets for Health Policy Development**

- It's a process of needs assessment and identification of targets and a process focusing on high priority area; while setting the targets, in a proper analysis of population health all aspects and perspectives are assessed.
- It makes policy more focused and consistent within health programmes and increase recognition of affected areas in health policy.
- It stimulates debate and facilitates identification of the best solution to problems.
- It helps to built awareness and support of policy makers, professionals and public, making the implementation process efficient.
- It facilitates improvement of management analysing strategies, timetables and resource allocation to programmes.
- It provides benchmarks for progress measurement and improved accountability, through monitoring and evaluation of implementation as well as impact of health gain activities.
- It identifies required data and reveals discrepancies to be eliminated.
- It could lead to political promises and commitments.
- It provides follow-up point for accountability to citizens.
- Finally and perhaps most importantly, provides a strategic vision of future health policy.

But to establish and implement management by objectives approach when dealing with communicable diseases, there is a need for well-established epidemiological data collection and surveillance systems to identify targets key parameters and establish
scientific (evidence-based rather than opinion-based) objectives. In the case of Russia, epidemiological data are not complete and when available not used to guide policy. But even when, under international pressure, targets are set, because of lack of leadership, limited political commitment, and scarce resources these targets are not met or for political reasons outcome data are adjusted to record that targets are met.

Werhane, who has applied stakeholder theory to health care organisations, suggests methods for prioritising stakeholders by their importance in the system. In this analysis (for financial stability and quality of services) the most important stakeholders are patients, followed by health care professionals, with patients having a privileged status (Werhane, 2000). Obviously, this is not the case in Russia, as neither patients nor professionals have priority in the system.

2.6 Problem Definition

Policies are developed to resolve problems. Thus, problem definition is critical before developing policies. Problems are identified and defined by humans who try and make sense of complex and often troubling contexts. As human behaviour is subjective and influenced by prior experience and interpretation, problem definition and representation of a situation cannot be objective. Further, the context within which the problem is defined is important, as this not only determines the decision makers’ perceptions and values, but also the pathways through which information passes and gets to policy makers for evaluation (Primm & Clark, 1996; Stone, 2006).

Stewart (2001) argue that the policy problem is complex and can not be understood separately from its solution, and suggest the use of system theory to rationalise problems and options to address these. The systems approach explores linkages between the components of the system (kinds of links; hierarchical or network-based, market-type transactions). One reason policies fail is misjudgement about the implications of changes in interconnected system, which is a product of either failure of structures and systems to built productive cooperation between actors, or politically considered choice. Another reason is failure of policy makers to consider causes and consequences of interventions.
Most cases of policy failures are encountered when there is a lack of accountability of policy makers to the public. Often policy failure occurs not because policy makers are ignorant or ill-informed, but because elites’ interests conflict with those of the public. But often, actions and decisions are made without prior understanding of probable negative consequences. For example, in Russia unsound policies were adopted when market-oriented liberal economic reforms were introduced, but public pressure on policy makers to be accountable for their decisions influenced subsequent policies to reduce distortions in equity. International agencies, extra-governmental actors, non-governmental organisations and multilateral organisations played an important role in promoting public understanding of the consequences of these policies (Ascher, 1999). So systems theory can be applied to policy making in two ways: i) system analysis of policy; to promotes an understanding of what happened while policy is made and ii) system analysis for policy; to help generate concepts, ideas and modes of action to resolve the policy problem (Stewart, 2001).

From the policy makers’ point of view, a problem relates to a condition that people find unacceptable thus want to change. Health issues become a political problem, when there are publicly shared needs and desires to be met. When this occurs, it is possible to mobilise social groups to attract attention of public officials to these concerns. The response of government depends on the process of health problem identification and definition of the problem. The latter is expressed as statistical indicators, scientific research or as evaluation results of existing programmes (Trostle et al., 2005). Statistical data and research analysis are not enough to put an issue on government agenda, but can be used for sensitisation, as decisions are made based on knowledge and social interaction. Only the expression of a socially credible threat could put the problem onto the government agenda (Thomas, 2005).

The government response to a problem, apart from perceived level of risk, depends on who is held responsible for the problems and the cause of the problems. Initiation of policy action is likely when harmful consequences are the product of intention rather than an accident. A problem is more likely to be addressed if it is a priority for the government, which is influenced by the affected population (Thomas, 2005). The likelihood and nature of government reaction determined the affected individuals’ popularity, occupational or social group (Thomas, 2005). But, defining a priority and
refining policy is not enough to address a problem. It also requires a change of institutions through which policies are implemented (Cassels, 1995). The economic and social impact of the problem on the country, international pressure, and available resources all interact in a complex way to support or hinder bringing of HIV/AIDS problem on the agenda.

### 2.7 Decision-making

Once the problem is defined, policy makers have to choose amongst options to resolve the problem. Thus they have to make decisions and exercise policy choice that involves uncertainty and risk (Grindle & Thomas, 1991). In some cases decision-making operates in problematic conditions. Simon suggests that a decision is a choice between alternatives, which supports achievement of goals or objectives within organisations (Jones, 2002; Simon, 1957). In a democratic society policy decisions are gradual processes, consisting of several steps: involving policy-makers and experts, cost-benefit analysis, public hearings and debates with mass media involvement. While decision makers consider different alternatives, apart from information they are also guided by their values. Decisions will suffer if values are poorly defined and emotions are involved (Wenstop, 2001).

Grindle describes the influence on decision-making as society-centred (through mobilization and concentration of efforts of groups, coalitions and networks), and state-centred (through identification of government officials who will accept and benefit from change and mobilizing their support) (Grindle & Thomas, 1991).

From 1945 to 1958 several models been developed of human choice examining the psychological processes of organisations, political and economic institutions, as individual or combination of several theories. Human behaviour in organisations fulfils three criteria: i) must not harm; ii) to allow to move between individual level and organisational processes in faultless manner; iii) should be efficient (Jones 2002). Simon (1957) linking organisations and behavioural theory developed *behavioural organisation theory*, which examines the role of organisational processes in determining organisational outputs. *Behavioural decision theory* examines the role of organisational processes in determining individuals’ outputs. Bounded rationality and the behavioural
theory of choice have both emerged from organisational theory (Jones, 2002). Neo-classical economic theory, which is based on assumptions of rationality and equilibrium, is concerned with prediction of optimal outcomes (Burns, 2000).

Cohen (1972) describes the idea of organised anarchies. When preferences are problematic and, organisations’ preferences are poorly defined and inconsistent they operate through loose collection of ideas instead of coherent structures. Preferences emerge from actions rather than actions resulting from preferences, technology is unclear and participants are fluid.

Another suggested model is the garbage can model. This model explains that decision-making is not aimed to resolve a problem well, but enables choice to be made from alternatives (Cohen et al., 1972; Lewis, 2005; March & Olsen, 1996). In this model, an organisation operates through trial-and-error learning from past experience, mistakes and by reflecting on what is practical and necessary. Participants vary depending on time of decisions. Organisational boundaries are not well defined and changeable. When investigating such anarchy using behavioural theories of organisation two areas should be considered: choices are made with absence of consistent, shared goals and problems are often resolved without determined negotiation (Jones, 2002; March & Olsen, 1996; Simon, 1957). To use nominative theory to understand organisational anarchy additional concepts of intelligent decision-making, attention and revised theory of management are required (Cohen et al., 1972). The garbage can model suggests that problems solutions and participants move from one choice opportunity to another in a ways that the nature of choice, time required for solution and the problems depends on the relatively complicated intermesh of elements, like available choice, mix of problems in organisation at the time, solutions considered and external demand on decision makers (Cohen et al., 1972). Four basic variables are considered in garbage can theory: choice, problems, solutions and participants. To connect suggested variables key behavioural assumptions are related to: i) additivity of energy requirements; ii) way the energy is allocated to choice; iii) way the problem attached to choice. Elements of organisational structure influence the outcome of a garbage can decision process in three different ways: i) time (when the choice become available for the problem solving); ii) resources (allocation of energy of participants to supply decisions); iii) interconnection (linkages of variables). Organisational features contribute to the
process in terms of managerial planning, individual and collective learning and imitation.

Organisations are vehicles to solve well-defined problems or structures, to resolve conflicts through negotiation, and provide set of procedures helping participants to interpret their actions. *Theory of organisational decision-making* involves interplay amongst generation of problems within organisation, the operation of personnel, solutions made and the opportunities for choice (Simon, 1957).

Common's *theory of economic organisation* (1934) based on building blocks of decision-making, utility functions, production functions, property rights and sovereignty, and suggests three challenges to overcome scarcity: resolving conflict, dealing with interdependency and creating civic order. Mentioned challenges could be addressed through collective action creating system of government, who develop rules to guide individual actions. Common's theory is based on bounded decision-making, when human behaviour is purposive and directed by passion (extreme emotion leading to inconsistent and irrational decision-making), ignorance (imperfect information) and stupidity (limited cognitive ability). As a rule, human decision-making takes place in an environment of uncertainty, when future events and probabilities are indeterminate (Kaufman, 2003). Parallel to political government possession, groups and organisations possess measure of sovereignty and try to create and enforce their own rules (Kaufman, 2003). This could work if there is a democracy in the country and possible to have parallel opinions and goals.

Analogical reasoning plays a prominent role in decision-making. Political scientists accept analogical reasoning as a fact of political life in elite decision-making, whereas psychological studies consider it as a persistent tendency in human problem solving behaviour. A country’s past foreign and domestic policies provide good analogies to understand the policy makers’ approach to decision-making (Houghton, 1998). I will argue this is relevant if the same elite, political party or social class are still governing the country, thus their decisions are driven by the same ideology and directed to achieve similar objectives.

Houghton (1998) referring to Jervis (1976) demonstrates how analogies could lead policy makers to misinterpret situations thus respectively choosing wrong decision to
address an issue. Houghton referring to Khong (1991) suggests that analogies could be used for diagnosis and assist policy makers to: i) understand the situation; ii) assess the stakes involved; iii) provide prescriptions; iv) predicting the results of their actions; v) evaluating their moral rightness; vi) warning about effect of certain decision (Houghton, 1998). I would suggest analogies could be used by advocacy agencies as a tool of influence when building their campaign to gain power or stake.

Reasoning that draws on analogies alone is not always suitable for decision-making; it is possible to use historical experience to motivate and encourage policy makers. If in most cases there is motivation among policy makers to use analogical reasoning, it is encouraged to use this technique in situations when: i) there is a shortage of time for response; ii) dealing with lack of information and unclear evidence; iii) there is a high risk uncertainty; iv) previous experience was recent and easy to recall; v) public opinion regarding the issue already presume the action, vi) whether the decision-making is episodic or continuous (Houghton, 1998). I will add to this list in a case of ‘chain’ policies. Some decisions are a reflection of or a result of past policies or historical decisions. These past policies and decisions predetermine the direction of future related policies: removing any levers to influence or change these future policies. For example, if a government developed polices to encourage use of generic drugs instead of branded ones, if market mechanisms do not work efficiently (as is the case in Russia) generics producers may need to be supported to ensure adequate and consistent supplies to meet demand, while physicians change their prescribing behaviours to met policy objectives. Hence a set of interrelated policies are established, creating a trend path which restricts possibilities of deviating from it, unless the new policies or decisions are themselves interlinked to create a ‘chain’ of decisions or policies. Hence, where a trend path is established and a series of interrelated polices already exist, isolated and interconnected new policies will be ineffective in changing system behaviour, as these are unlikely to influence have a knock-on effect all the previous policies. A systems approach (Atun et al., 2005) is then needed to free policies from path dependency. HIV/AIDS control is particularly suitable for systems approach. Isolated and unisectoral policies will have limited effect on the epidemic, as effective control measures will require simultaneous intervention and policies for managing IDUs, STIs, CSW, and tuberculosis. Further policies will be needed beyond the health sector: requiring multisectoral approaches, with involvement of the social and education sectors, the ministry of interior affairs and the penitentiary system (for effective control of TB and HIV in the prisons).
Hansberger argues that, when making policies, policy makers use history to justify and promote preferred action and are more concerned about their image than critically learning from the past experience, especially as regards public policy and legitimacy issues. Policies are path-dependent and usually follow incremental pattern, but actors, such as governments, could disrupt this trend path and change policy direction especially if these policies are built or initiated by civil society actors (Hansberger, 2003). But one could argue that such changes in trajectory of policies are more likely to occur in democracies with strong civil society and participatory decision-making but would be more challenging in settings such as Russia where democracy is young, civil society weak, and participatory decision-making not the norm.

Health impact assessment (HIA) is increasingly used as a tool to aid public policy decisions (Scott-Samuel & O'Keefe, 2007) as it provides an objective means of assessing social, health and environmental impact of policies. HIA encourages public participation in policies, affirming human rights through participation and accountability, and by providing an evidence-base for policy decisions improves the quality of decision-making, while promoting equity.

2.7.1. Decision-making in Russia

Odom, discussing decision making by the Russian military policy, argues that the "decision makers are limited by inadequate information about the nature of the problem and its possible solutions.... and decision makers usually accept the first satisfactory decision that they uncover,...and the solution based on coalitions between actors" (Odom, 1998). Further he states that the determining factor for decisions is the political system, which "makes government decisions not by a single rational choice but by the pulling and hauling that is politics"(Allison, 1971).

Indeed, politics determines all developments in Russia with decision-making centralised in the Kremlin as it was in Soviet times (and it will be like this until there is democracy in the country). Democracy will facilitate the civil society development allowing it to act as a counterbalance to the government challenging its decisions and pressurising it
to develop sound policies to tackle problems, rather hide them using the levers of power.

Mendelson (2001) analysing Western NGOs’ assistance in the development of democracy in Russia suggests that although this assistance helped specific groups of local activists to build institutions associated with democracy, they are fragile and function poorly and their decisions heavily rely on decisions by the leaders of the country. Richter (2000) suggested the aim of building civil society in Russia via outside assistance was unrealistic from the outset and such support has not been very effective. The ideas and methods that the Western organisations imported to Russia related to a bottom-up, client based approach, grounded in consultations with national and regional political activists. However, the results of an assessment of the influence of democratic assistance in Russia between 1995 and 2000 found that it had little to no effect on the senior political leadership of the country. Moreover, Mendelson (2001) suggests that from 1990 “the harassment of political and social activists has expanded in Russia, threatening its fragile democratic institutions. Russian federal authorities have increasingly pushed back advances in civil liberties and human rights. The state has targeted the independent media outlets in particular, but there have been numerous cases of environmentalists, human rights activists, and even students and academics-Russian but also American and European- being intimidated, interrogated, trailed, jailed, robbed, accused of treason, beaten, and run out of the country, all by the federal authorities” (Mendelson, 2001).

Moreover, the recent introduction new legislation regulating NGO activities in Russia, curtailed many of the NGOs’ tax advantages, and was reflected by a campaign of harassment of environmental organisations challenging federal policies. As a result, US and European foreign assistance to Russian NGOs had declined substantially (Richter, 2000). This action deteriorates already weak civil society, which Richter argues could have been the source of democracy in Russia, as they could work to enforce accountability. Unfortunately this could only happen if local civil organisations had access to resources independently from the state, whereas now their only funding sources are tiny contributions from foreign organisations and governmental funding. In order to access governmental and sometimes even international funding there has to be connections to governmental officials (Richter, 2000), which will also assure their participation in decision-making but with the condition that their decisions should be in
line to the government "recommendations". Without this alignment their funding could be cut.

Considering that the "democracy" practiced in Russia, includes any opinion not in line with government decisions been prosecuted, it would be hard to advocate values opposing national policy. "Abuse has begun to creep back in, and we're seeing more cases", said Lyubov Vinogradva, executive of the Independent Psychiatric Association of Russia describing the fate of anti-government activists, who being diagnosed with different mental health conditions are referred to psychiatric institutions in order to isolate them from the public, despite them completely health; "it is not on a mass scale like in Soviet times, but it's worrying" (Finn, 2006).

Although Russia welcomes democracy, allowing the creation of political parties in the country and country leaders engaged into elections, "norms related to retaining power-not furthering the cause of democracy- were most salient. Whatever positive impact democracy assistance had at the grassroots level, it was obscured, even threatened, by the actions of the leadership". The Kremlin remains the powerful player, and controls the decisions to be made (Mendelson, 2001).

Discussing democracy and decision-making in Russia, Timoshenko (2007) suggests that state power is monopolized and is under the control of the Kremlin; the latter emasculating the parliament, curtailing political opposition, took control of the mass media as an essential step towards revitalising centralised power (Timashenko, 2007; RIA Novosti, 2008). The same source, referring to a study conducted by the Moscow Centre for the Study of Elites, states that 26% of the current government (departmental heads of the president's administration, cabinet ministers, parliamentary deputies, heads of federal units, and heads of regional executive and legislative branches) served at the same time in the KGB (Committee of State Security) or one of its successor agencies. Kostyukov (2003) and Petrov (2005) suggest that 70% of presidential staff, which comprises Russian elite, hails from military and security organizations. Another study exploring the Russian elite under Putin's government (Rivera, 2005) suggests that the government positions were mostly held by those with a background in the "power agencies" (Federal Security Service, Foreign Intelligence Service, Ministry of Internal Affairs and Ministry of Defence), "who have a substantial and pernicious influence on
contemporary Russian policy making”. They also suggest that another powerful set of actors in decision-making are the representatives of business professionals, who are a new but growing part of the elite involved in all sectors of Russian policy. Kryshtanovskaya and White (2003) refer to the policy under Putin as a “well-ordered police state”. Referring to Mosca (1939), a classic elite theorist, who suggested that the elite is a group of individuals in the leadership positions, the Russian elite “was quickly transformed into a ‘militocracy’” (Rivera, 2005).

2.8 Power and its Functions

The policy process is influenced by the way power in society is perceived and practiced (Brown, 2004; Hill, 1997; Lewis, 2005). Power is a ‘disposition’ concept and rooted in political theory (Kadushin, 1968). Parsons (1967) defined power as “…generalized capacity to secure the performance…and as specific mechanism operating to bring about changes in the action of other units, individual or collective, in the process of social interaction” (Lukes, 1974; Parsons, 1967). Parsons argued that power depends on institutionalisation of authority and is perceived as a standard for commitments or an obligation for effective collective action. Power is exercised to affect others and is a matter of individual’s conscious action. Power is usually exercised by citizens when they have choice and full information to compare data to support a claim for a particular situation (Parsons, 1967).

Power can also be considered as the capacity to work through certain mechanisms to reach an aimed outcome—to create equilibrium for protecting the interests of certain groups. Power itself is a discrete notion. There should be subjects towards whom the power could be exercised, and subjects to influence (to achieve a policy objective), and those who are ‘anti-power’ to be managed (such as advocacy or coalition groups). In each society, and in each setting, there are different mechanisms to exercise power. Each organisation also has its own mechanisms of power. As social systems are composed of multiple and interacting units, the way power is exercised in such systems will be influenced by the make up of the social system and the environment (broader context) within which a social system is situated. Within Russia there are several organisational levels each with own mechanisms of power: for example the Duma (the parliament influenced by the electorate, influential individuals such as oligarchs, and
State organisations, businessmen), the Ministry of Health (where the power structures are influenced by position, salary levels, career options), the Government (which controls most of the resources in the country and exerts political, economic, and military power), the Presidential ‘Apparatus’ (which exerts power on the government and State functions in general), and the external donors (who try and exert political power through a number of different means, such as providing credits, grants, budget support, or technical support for local programmes).

Coerciveness is a central attribute of power, and also a defining characteristic of the State (Nicholson, 2002). In every human institution there is an ordered system of power, an integral part of the organisation’s ‘power structure’, which often is a mirror image of the organisation’s stratification (Bachrach & Baratz, 1962). In most countries political power is highly correlated with income, social class and size of organisations (Sabatier, 1988). Distribution of power amongst different groups and competition amongst these to gain power helps assure power is not concentrated in few hands (Lewis, 2005).

Power and power relations can be examined in a number of ways. Dahl (1958) defining the nature of power argues “power involves a relationship between political actors…and power must be studied in cases where there are differences of preferences between actors” (Dahl, 1958). Here actors are defined as individuals, groups or other human aggregates. In conflicts of key political issues those who have power in the political system influence the final decision. Hence, Dahl and pluralists argue, power is expressed when there is a key decision to be made also when there is an observable conflict of interests amongst various groups. However, this pluralists’ view of power is one-dimensional (Dahl, 1958; Lukes, 1974), as power is seemingly tied to issues, (which can be brief or continual and provoke coalitions to act consent) and focus not on the sources of the power, but how it is exercised (Bachrach & Baratz, 1962). In doing so, this view fails to consider adequately the political system within which policies are made and the manner in which the political agenda is controlled.

Bachrach and Baratz who explore power through a pluralistic lens and identify the ‘non-decision-making’ nature of power: non-decision aimed at suppressing conflict and preventing issues to emerge in the political agenda (Arts, 2004; Bachrach & Baratz, 1962; Lewis, 2005; Lukes, 1974). Non-decision can be achieved, they argue, by: i) the use of force, preventing demands to bring an issue into the political process; ii) using
power to undermine the importance of an issue and to deter debate on the issue, by; iii) using rules and procedures to deflect unwelcome challenges; and iv) reshaping the existing rules and procedures to block challenges. This is a two-dimensional view of power, as it considers how power can be used to exert control over the political process, and keep potential issues out of the political agenda. However, although Bachrach and Baratz (1962) address key shortcomings of the one-dimensional view of power, they do not adequately take into account of the sociological perspectives of decision-making and non-decision-making, in particular latent conflicts within a society.

Lukes (1974), who considers earlier approaches as being too individualistic and criticises the behavioural focus of power and the idea of exercising power in a presence of conflict adds a third, a sociological, dimension to power to explain how people’s preferences are shaped and how expressions are avoided. (Bachrach & Baratz, 1962; Clegg, 1989; Lukes, 1974). This three-dimensional view allows exploration of sociological and not just individual processes to explain why political issues emerge or are prevented from entering the political arena. Power can be exercised through inaction rather than action, as though the decision not to act may be unconscious, it is a decision and power may be exercised by collective groups or institutions not just individuals. Clegg argues that one dimensional-view of power is a liberal concept of interests, the two-dimensional view is a reformist concept and the tree-dimensional view a radical concept (Clegg, 1989).

Schneider and Ingram (1993), consider more widely the social context within which power exists, and suggest a framework for analysing the extent to which social construction of target populations shapes the policy agenda and policy design (see Figure 2). They categorise the population into four groups arguing that the advantaged groups are treated favourably as regards policies (Schneider & Ingram, 1993; Thomas, 2005).
 Applying this framework to HIV/AIDS, transition from a concentrated to a generalised epidemic will mean increased risk for the general population, including the advantaged groups could lead to stronger political commitment by governments to combat the epidemic. During concentrated epidemics policymakers do not feel pressurised to develop robust responses to control the epidemic, as HIV/AIDS is perceived to be a 'problem' of marginal groups in the society, namely, the IDUs and CSWs (Court, 2004). Similar behaviour is observed with public health problems related to tobacco control, breast cancer, and firearms, where policy inertia can be explained by the fact that these problems affect the disadvantaged more frequently than advantaged population groups (Thomas, 2005). This argument can be extended to HIV/AIDS control in Russia, where there is low commitment to developing or implementing effective policies for controlling the epidemic (Atun et al., 2005), as the population affected by HIV are considered by many as "deviants". But, if the HIV epidemic were to spread amongst "advantaged" high-ranking officials of society, one could argue that the government will more likely to mobilise resources and develop adequate response to combat the epidemic.

Kadushin (1968) developed the concept of "social circle" to resolve conceptual problems in studies of the 'elite' in relation to power (Kadushin, 1968). These ideas are further developed by Lewis (2005) who is concerned with sources of power and explores how the structure of society benefits key groups uses a 'structural interest perspective', to analyse power of elites. Using this analytical approach, he argues that the elite's power is based on their professional position (Lewis, 2005). This power can
be further extended if the professionals have a strong position in government, i.e. in policy making or decision-making processes, and the extent to which other elite groups, such as business leaders or political authorities, are interested in issue and their relative influence in government and decision-making (Grindle & Thomas, 1991; Lewis, 2005). Professionals can be a source of significant power, as they are able to use professional knowledge and data to inform the population and coalitions about a problem and its magnitude, and can create a favourable environment for a particular viewpoint. The extent of this power will be influenced by the political context of the country: i.e. whether it is democratic, authoritarian or totalitarian.

2.8.1 Classifications and Applications of Power

Kadushin classifies power as a pyramid structure (where the elites are at the top and are closely responsive one to another), functional (where the elite form cohesive circles), coalitional (where separate elite circles cooperate on purpose) and amorphous (when it is difficult to identify a specific power circle) (Kadushin, 1968). Power is also defined as formal and informal. Sources of power can be physical (military), intellectual (information for decision-making), positional (authority, donor), economic (money, business), charisma, and knowledge (Smith, 1993). Power can be explicit (easy to define and its action is transparent, where the actors are known) and implicit (actors either unknown, or ‘hidden’ behind ‘false’ actors and outcomes of their actions difficult to predict, as moves are hidden and often a combination of sophisticated set of activities).

A social circle can be a network of indirect interactions through third party, a network with common (e.g. political or cultural) interests or sometimes a circle is not formal as there are no clear leaders, defined goals, established rules, distinct criteria of membership. Based on their interest the circles could be cultural, utilitarian, power and influence, integrative (Kadushin, 1968).

Power could be expressed by having resources (dispositional), achieving outcomes (relational), in controlling organisation, its resources and rules (organisational), having knowledge, deliberation (discursive), conflict oriented (transitive), social integration and collective outcomes (intransitive), acting agent or structures. Hence, power could be considered as organisational and discursive capacity of agencies, which, through
competition or in coalition achieve outcomes in social practices. Clegg (1989) suggests three highly interdependent routes of power: episodic (related to agency, causal mechanisms and outcomes), dispositional (social integration, discourses, organisational rules of the game) and facilitative (system integration, domination in society). Arts and Van Tatenhove (2004) draw on Clegg to develop a three-layered model of power and policy (Box 4). In this model the power is not restricted to mobilisation of resources or achievements of outcomes, but also to dispositional and structural phenomena. They propose studying and analysing power at three interconnected levels: policy innovation (rational power), policy arrangements (dispositional power) and political modernisation (structural power).

**Box 4: Three Layer Model of Power and Policy**

First layer refers to the notion that power always constituted and exerted in social relationship. The main elements of the first layer are actors, resources, outcomes and interactions. Second layer shapes the agency capacity to act by rules and resources. It defines each agent’s action and autonomy or dependency position within organisation and distribution of allocative and authoritative relations. The third layer shapes the nature and conduct of actors in micro-societal structures, in individuals and collective organisations.

<table>
<thead>
<tr>
<th>Type of power</th>
<th>Focus</th>
<th>Policy concept</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rational (transitive and intransitive)</td>
<td>Achievement of policy outcomes by agents in interaction</td>
<td>Policy innovation</td>
</tr>
<tr>
<td>Dispositional</td>
<td>Positioning of agents in arrangements mediated by rules and resources</td>
<td>Policy arrangement</td>
</tr>
<tr>
<td>Structural</td>
<td>Structuring of arrangements mediated by orders of signification, domination and legitimisation</td>
<td>Policy modernisation</td>
</tr>
</tbody>
</table>

Source: Arts and Van Tatenhove, 2004

Notion of power is closely related to politics. The political process is about shaping, distribution and exercise of power. Political processes influence the policy process. Social construction of societal problems, knowledge and risks influence decision-
making and policy formation (Arts, 2004). When policy analysis informs politics there is an investigation of different possibilities and reasons for preferences and a particular option is chosen. Alternatively, when politics is given priority above policy analysis, policy developed reflects the way control, influence or power is exercised (Lindblom, 1968; Thomas, 2005).

Arts and Van Tatenhove (2004) describe a policy arrangement approach, where policy decisions and policy making processes within policy arrangements (agents, resources, rules and discourses) result from an interplay of contextual processes (namely structural, political and social change) political modernisation and policy innovation. They emphasises that (i) multi-actor policy processes are entrenched in institutions; (ii) globalisation and other structural development are expressed in concrete policy practices; (iii) in policy making there is a role distribution between actors holding power; and (iv) change and continuity processes in organisations.

Application and exercise of power will be influenced by the degree and nature of resistance to a particular issue or policy. The sources of resistance may be internal —as state organisations or the elite work to maintain the status quo or the existing equilibrium— or external, from groups (who will be affected by the proposed policies). Coalitions or advocacy groups play an important role in shaping external resistance to policies.

2.8.2 Influence and Networks

There is a difference between power and influence. Influence is the communication of values and provides a framework within which outcomes occur. It is a mechanism for persuasion (Kadushin, 1968; Parsons, 1967).

Lasswell and Kaplan suggest that power is participation in decision-making, whereas influence is “having value position potential” (Lasswell & Kaplan, 1963). Both concepts are connected with the elite. Elite could be statistical (these group of people are few but manage to get most of the value), functional (this type occupy positions enabling them to transmit opinions) and structural (these are people having status in
politics monopolise role of community through securing power and rules) (Kadushin, 1968).

Earlier studies suggest that the elite is the ruling class and occupy strategic commanding posts within the social structure (Kadushin, 1968; Mills, 1956). But the elite are not always visible or in ruling positions and could be ‘hidden’ but influence policies and decisions (e.g. businessmen, financial dealers, influential criminals) by occupying both a functional and a structural role. As circumstances require, the elite change their degree of visibility and develop ‘new mechanisms to operate’.

There is increasing interest in the concept of networks (policy and social) and their role in influencing policies. There is a difference in networks as a conceptual model (theoretical concept exploring interconnectedness) and networks as a form of coordination and governance (analytical tool for measuring interconnections). Analysis of policy networks (coalitions, corporatist institutions or professional monopolies) use functional approaches to understand the way interest groups control the policy process through formal and informal connections. The social network approach focuses on interpersonal, single or multiple relationships, which could be different in terms of direction, content, intensity and strength (Lewis, 2005). Networks have gained importance in policy studies, as an extension of political-bureaucratic relationships and as an alternative to markets and hierarchies (Atkinson & Coleman, 1992; Stewart, 2001) and have proved useful especially when classifying and comparing sub-systems in terms of their stability, inclusiveness and centrality.

Public policy choice is affected by policy networks and regulatory regimes (Cashore & Vertinski, 2000) and the system of governance influence the way an organisation responds to different external pressures. The literature describes five types of policy networks, shown in box 5.

With client-pluralist and concertation networks operating in legal/non-discretionary regulatory style, the organisation will influence policy choice and legal problems will be resolved via statutory or regulatory change. With concertation network, business dominated networks may support change and introduce limited change as a response to external pressures, especially if there is a threat of increasing regulations or if there is a possibility of change in policy networks. Under pressure-pluralist and corporatist
networks organisations most likely will compromise under economic pressure and innovation is less likely, because the environmental and social pressures make policy change uncertain. Organisation is active under pressure-pluralist network as a response to pressure from economic, governmental and social stakeholders. Under pressure-pluralist or corporatist policy networks, there will be compromise to pressure from social interests. State directed networks will be dependent on the direction of the State, and will less respond to pressure from non-governmental groups (Cashore & Vertinski, 2000).

**Box 5: Types of Policy Networks**

**Pressure-pluralism** – groups independently vie for attention of the state; the state is autonomous and network groups are policy advocates, rather than participants.

**Clientele-pluralism** – groups independently vie for attention of the state; the state has little autonomy from organized interests and the relationships are bureaucratic, agency dependant. In addition, policy participants support business interests and have ability to veto policy change, whereas organized interests are supported by policy advocates.

**Corporatist** – groups exist where there is a high level of state autonomy and decision-making is centralised and controlled. Groups participate in the formulation and implementation of policies and business, labour, environmental groups and societal interests are considered in decision making aiming to achieve consensus.

**Concertation** – this case presumed individual interests in policy making and firms and business associations cooperate with government in a choice of policy but state remains autonomous from business interests.

**State-directed** – networks operate in an environment where state officials control the policy making process and impose solutions. Networks are not accepted as policy participants, but act as policy advocates.

2.9 Policy Change and Innovation

Policy change presumes strategic innovation introduced by power. This process results in re-institutionalisation based on structural power (Arts, 2004). Innovation occurs in
niches: locations for learning processes, where the rules are not yet crystallised and are less clear, so there is less structuration of activities. In regimes, rules become stable and they have a more structuring effect. Stronger structuration of activities occurs in landscapes. These are locations beyond the direct influence of actors, thus cannot be changed (Geels, 2004).

Structuration is a synthesis between the role of agents and the structures in a society. The process of structuration (i.e. institutional definition) consists of four parts: interaction of similar organisations, domination and patterns of coalitions with emergence of inter-organisational structures, increase in information, development of awareness within organisations. Social structures and policies could remain in equilibrium until some external events (such as the introduction of new technologies or environmental change) cause a shift, creating opportunities for new social construction and resulting in policy change that inscribes the changed construction and lends it legitimacy (DeLeon, 2005; DiMaggio & Powell, 1983; Schneider & Ingram, 2004). As a response to the environmental change the organisation has to innovate to improve performance. As social construction can initiate policy change, policy change can also effect changes in construction (Cashore & Vertinski, 2000; DeLeon, 2005; DiMaggio & Powell, 1983; Schneider & Ingram, 2004). Environmental changes will affect the established equilibrium. Organisations either change to adapt to the new environment or become extinct. The elite which guide and control the social system will try to oppose change. This may work in the short run, after a period of time, to keep power, the elite will be forced to introduce some change: often incremental change. Otherwise there will be a change of the elite. This incremental change is a ‘safe move’ for the elite and while not affecting the equilibrium, could create a vision of concern and sympathy to public concerns.

Transaction from one system to another occurs because of the tension of activities and between certain rules, which allow actors to differently interpret rules and regimes. The source of such tension could be pressure on the regime and internal restructuring, internal technical problems, negative externalities, change in user preferences, or competition between organisations. If the regime is stable, novelties are stuck in niches, but once tensions occur in activities of social groups, the opportunity is created for a novel break through. Another possibility of change is through gradual transformation consist of multiple innovations, resulting increasing problems in regime, which asks for
alternative technologies search. The latter is a gradual process and could take time till one of the options become dominant, stabilising in new socio-technical regime (Geels, 2004).

Change involves actions, reactions and interactions of different parties involved in the process (Pettigrew et al., 1992). Policy change or development is a cumulative, not a linear process; it is an on-going process because the environment is dynamic. Adoption of one or a set of policies lead to changes, but a new set of problems emerge, or new interest groups form, influencing the balance of power and creating a need for further policy development. But policy development requires time, and needs substantial financial and human resources (AIDSCAP, 2005; Philpott et al., 2005). The power struggles among groups and institutions, which have different resources, beliefs, systems and structures, within a dynamic socio-economic environment drives policy change (Sabatier, 1988). The objectives of these communities/social groups reflect their own needs and agendas rather than the needs of the wider society (Burns, 2000). Hence, the policy change influenced by the interaction of these groups is a blend of their interests.

Social, political and economic forces are the drivers for policy innovation. But not each policy innovation resulted with change, as basic legal norms are quite resistant to change (Sabatier, 1988). Change occurs when controlling governmental power opens a “window of opportunity” resulted abrupt shift in problem perception (Geels, 2004; Thomas, 2005). To clarify, policy innovation results with policy change, when in policy process advocates manage to bring together the problem and preferred solution, with consideration of political leaders’ priorities, organized interests and public opinion (Thomas, 2005).

Sabatier referring to Heclo (1988) suggests that policy change is a result of: i) political, social and economic change; ii) strategic interaction of people within policy community for power and development of more knowledge to address policy problem (Sabatier, 1988). Using Heclo’s insights, Sabatier developed a framework for policy change based on three premises: i) understanding the process of policy change; ii) interaction of actors from different institutions interested in policy issues; iii) set of value priorities and causal assumptions about how to implement them. The basic argument here is that policy-oriented learning is important in policy change, which can modify coalition’s
belief system. However, the crucial factor leading to policy change is the results of perturbations in external factors (e.g. macro-economic conditions, new governing coalitions) (Sabatier, 1988).

There are three dichotomies for differentiation of change processes (Kim, 2002):

- formal vs. informal;
- revolutionary vs. evolutionary;
- regressive vs. progressive.

Though it could seem, that change contradict stability and equilibrium towards which the system works, researchers suggest that stability and change are not mutually exclusive processes and can coexist simultaneously. In a changing environment stability can be maintained if there is change to reflect new circumstances. Organisations change behaviour, on the other hand institutions are the outcome of actions of individual members of the organisation (Kim, 2002). So one of the opportunities for change is actions initiated by the members of the organisation as a response to their organisation behaviour, and on the other hand, the organisation itself changes its behaviour trying to reflect change of the environment.

Before initiation of policy development, or change, certain issues should be considered. First, it is important to assess whether the policy development or change can be a solution to the problem. In some cases other interventions are required to tackle the problem, like better management, training or administration, or changes in programme content or operations. In the field of HIV/AIDS, the AIDS Control and Prevention (AIDSCAP) project developed a checklist (see box 6 below) helping to evaluate whether it is worthwhile or not to initiate policy development or a policy change (AIDSCAP, 2005).

It should be considered that it is rare that in adjusted system a single change occur. Even if such a single change is possible, it still has its consequences in terms of causing a series of changes to reach equilibrium of the system. Thus to address this issue a contextual form is useful. There are several principles to be considered while using such an approach:

- change should be studied in the context of interconnected levels of analysis;
- understand the change past, present and future;
• explore interrelation of change and action;
• take into consideration the causation of the change and acknowledge that its neither a linear nor a singular process, but the product of a variety and a mixture of causes of change, which occur at certain periods of time and under certain circumstances.

Box 6: Policy Development and Change Checklist

Develop or change the policy
• In a case when the issue relates to the country or organisation or large segment of the population.
• Conditions indicate a need for organisational guidance on tolerable behaviour.
• If there is no steady way to deal with the issue and each time it occurs different responses are used to resolve it.
• In a case of unequal distribution of resources.
• As a response to the change of the situation requiring special consideration.
• If the issue requires greater attention resulting in real benefit.

Do not develop or change the policy
• In a case of the absence of sufficient capacity of the organisation or of coalition time and resources required for the development of the policy.
• In a case where the developed policy will not be implemented and enforced for certain reasons.
• If there are certain circumstances indicating negative feedback to the proposed policy change.
• If the existing policies cover the issue sufficiently.
• Impact of the change will be insignificant.
• Better administration or management of the problem could resolve it successfully.
• If there is not enough information available or it is not strong enough to persuade development or change the policy.

To summarise, change should be explored in a three-dimensional model: content, process and context. I will also add to this list outcome of the change. In addition, there is an importance to highlight the significance of management style in use, strategies and tactics applied, as well as structural, political and cultural features of
particular locales. The literature describes the process of managing change, conditions when change occur, stimulating and impeding factors for change, and once the change has occurred, adaptation and stabilization of change, as a product of innovation.

Context for change could be receptive (favourably associated with forward movement) and non-receptive (features associated with blocks on change). Here the author refers only to positive change, assuming that it is forward moving, whereas I argue that change is not always forward moving; sometimes it is a mechanism of adaptation, which fails to suggest a solution, but provides a 'cosmetic resolution' to the problem for the time-being.

To stimulate change of practice in health care it is not enough to introduce and ratify policy, unless it addresses the organisational, professional and social context within which the policy will be implemented, which may block or facilitate the process (Watt, 2005). Also the implementation of a policy requires support in terms of resources, economic structures, social institutions and political processes. I will add to this list behavioural change support by the citizens, apart from providers and policy makers, the consumers are invaluable part of the process. During the process of development/change of policy, the policy makers should consider providers experience and knowledge. On the other hand policy makers and providers are accountable for policy making and also implementation to consumers, who need to be informed and be prepared to the change. This could exist only in a case of strong social movement in the country, democratic participatory decision-making and democracy within the country, which obviously not a case for Russia.

2.9.1. Mechanisms of Change

Quinn and Cameron (1988), referring to Hernes and Dahrendorf suggested that a theory of change in social structure should meet the following four criteria: i) properties of individual motives and collective structure, linking structure and action which are main bases for any organisational change; ii) explain the source of change within and outside of social structure; iii) explain stability and change; iv) include time as historical accounting system (Quinn & Cameron, 1988).
Heintz (1988), referring to Sabatier, suggests a conceptual framework (see box 7 below) to desirable policy change, focusing on the relationship between the context of analysis and the role of analysis in the political process (Heintz & Jenkins-Smith, 1988; Sabatier, 1988). It is based on three elements of policy change: i) the interaction of opposing advocacy coalitions; ii) the analysis of factors explaining policy change; iii) the belief systems of opposing coalitions. The interactions of coalitions through bargaining, negotiating and compromise, as well as in working out subjective political values (progressive model) or ideological conflicts (ideological model), are continual and leads to incremental policy change. This framework explains factors associated with policy change initiation in the policy arena and policy evolution, which is the result of policy learning based on analytical debate; analytical tractability of key issues, the nature of the forum in which the debate occurs, the level and intensity of conflict over beliefs.

**Box 7: Conceptual Framework for Policy Change**

<table>
<thead>
<tr>
<th>His framework for policy change suggests that policy analysis:</th>
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<tbody>
<tr>
<td>• usually come-up with several opinions and suggestions;</td>
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<tr>
<td>• rarely determines the outcome of a policy debate;</td>
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<tr>
<td>• unlikely to impose public preferences onto decision makers;</td>
</tr>
<tr>
<td>• can stimulate learning among policy subsystem members;</td>
</tr>
<tr>
<td>• advocates positions in policy process.</td>
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A basic model of organisational change is described by Burns (Burns, 2000; Kim, 2002). They analysed the institutional approach in "management accounting change" and described contribution of habits, rules and routines in the process of change (Burns, 2000; Hill, 1997). Institutional principals are encoded in established rules to be followed by individuals while acting. Geels identified several types of rules (Geels, 2004) presented in box 8 below. Rules are linked to the system: private (regulates personality activities) and social (structures and regulates social transactions).
**Box 8: Types of Rules**

<table>
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<tr>
<th>Regulative</th>
<th>are explicit and formal to constrain behaviour and regulate interaction.</th>
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<tbody>
<tr>
<td>Normative</td>
<td>present values, norms, expectations, duties, rights and responsibilities.</td>
</tr>
<tr>
<td>Cognitive</td>
<td>represent the nature of reality and the frames through which meaning and sense is made.</td>
</tr>
</tbody>
</table>

Rules are performed by habits of individuals in organisation. After a certain period of time habits become routines. The relationship between action and institution is regulated through organisational routines. To understand the relationship between actors and structure, Burns and Flame developed a *theory of social rule system* (Burns & Flam, 1987; Geels, 2004; Giddens, 1984; Sabatier, 1988). Actors interact within the constraints and opportunities of the structure, at the same time they restructure the system within which they act. Motivated by self-interests, aiming to control resources social action influence and change private rules of the system. This process affects the actors (actor structuring), and ruling system (social learning). Factors, which structure actors, social action and system development, may change over time impacting social rule system causing internal restructuring.

Burns and Scapens model of social rules describes relationship between actors and structures. They suggest that routines are the collective habits of individuals. When rules are not clear, misunderstood or are inappropriate to circumstances, there are deviations from habits during performance, which after several repetitions, over some period of time, formulating new routines. The institution formalizes the established routines by reflecting them in rules, thus initiating change. The actors who encode routines, thus initiating the change of rules could be motivated by curiosity, which itself generates creativity and novelty (Burns, 2000; Kim, 2002).

When rules are very precise and the management system has strict control, there is no space for deviation or innovation as well as any accidental change in routine. So rules remain formulated by the management who dictates the direction of change in accordance of its own scheme. Thus, there is a two-way relationship between rules and routines.
After a period of time, being disassociated from historical circumstances, these established rules and routines are institutionalised by their transformation into normative behaviours and encoded into established rules and routines. The problem is that rules and routines are 'meaningful' whilst they are in their historical context. Once cut off from its formation pathway, rules become 'mechanistic' reproduction and as a result require change in routine reflected in change of rules (Kim, 2002). Another argument although suggest that unclear rules are source of change, will add that habits of individuals and training, as well as approach to their tasks (creative or instructive), even while following rules and routines could result in different outcomes. In this model it is considered that the actors establishing rules and reflecting institutional principals are considered to have the same values and agenda as actors who initiate change in routine. In such a case the initiated change will be smoothly transformed into rules and the performance of the routine will be within the “frames” of the rules. So there will be coherent organisational performance.

Moreover, individuals as well have their objectives and hidden agendas, (e.g. to climb a carrier ladder by performing exceptional) could perform tasks differently and be a source of change i.e. initiate shift from rules and conceptualised in routines. So, if there is a difference in the agenda and the values of established rules could challenge values of the actors performing routine, thus they will jeopardize the performance within rules and do their best to ‘accommodate’ their routine in accordance to their values. The actors establishing routines will try through sanctions and dismissals to control the situation and keep the performance of actors within rules. This antagonistic relationship could be resolved in favour of the actors who have sufficient power. Better off are those actors or groups who gain more resources through introduction (or improvement) of new technologies. As a result, policy makers develop new rules to regulate the process, to which actors react by changing behaviour (Geels, 2004). On the other hand information could play an important role to encourage policy change through affecting the balance, as can mobilise more actors making them active if they have appropriate information. So could be useful to identify latent interests to use actors by providing them information to act (Sabatier, 1988).

Another option is that the power will intervene from outside the system, e.g. external source for change, which could be international organisation, innovation, the
introduction of advance technology, government crises, etc. Furthermore, while reproducing routine, actors could initiate change consciously (there is enough resources or evidence to question existing rules and routines) or unconsciously (poor management and monitoring of rules and routines, or unclear statement as well as gaps in rules and routines while actors perform).

So the process of institutionalization and encoding is an ongoing process, unless there is power to impose the establishment of routines. In addition, rules could emerge from established routines. In all cases a new practice emerges initiating change as a result of combination of random, systematic and inertial forces. This is the evolutionary pathway, whereas there is a revolutionary, in other words, radical change of existing routine causing a fundamental challenge to institutions, which is a reflection of major external change. Even in such cases the change will be influenced by existing routines and institutions and still the process will be path-dependent. In conclusion, to understand change requires understanding of context of the organisation, its routines and institutions, habits of members and the assumptions which determine activities (Burns, 2000). I will add in a case of opposition to change or inter/intra organisational challenges, the change should be explored in its environment, context, concepts, actors (explicit and hidden) and political agenda. The latter been supported by literature, suggesting that the role of legitimacy is important while explaining organisational structures and working practices (Kim, 2002).

2.9.2. Theories of Change

The literature describes several concepts analysing the process of relationship between actors and their contribution to the process of change.

2.9.2.1. Neo-institutional Theory

Neo-institutional theory examines the role of formal institutions, conventions and values and assumes that organisation responses are determined by the external environment. Institutionalization is considered as a process of social construction, resulting
individuals acceptance of social reality of values and rules. Whereas, an organisation's institutionalization depends on the source of external pressure, but can compromise, avoid or manipulate depends on the type of the pressure and range of responses and strategies. The degree of resistance to pressure depends on the cause, constituents, content, control and context of the external pressure (Cashore & Vertinski, 2000). The last statement is questionable, as it is depends how strong is the organisation role in the country in terms of financial stability and income, as well as their power among stakeholders. When organisation is powerful it can act as a source of pressure and could "direct" the government decisions, or at least can "resist" the government and other stakeholders. On the other hand, being powerful, the organisation could "shape" the environment to its benefits and "convenience".

2.9.2.2. **Stakeholder Theory**

This thesis will use stakeholder theory of change which better describes change in Russia and consider not only environment and structures participating in the process of change but also central part of change consider stakeholders and main body creating the environment for change.

Stakeholder theory assumed that an organisation operates in a network of relationships, which can't be explained through logic and simple cause and effect predictions. Stakeholder theory suggests that the organisation has a relationship with several groups and to gain and maintain their support it has to consider and balance their interests and this could be achieved by using instrumental and nominative implications trying to address their interests (Evan & Freeman, 1993; Jones & Wicks, 1999; Reynolds et al., 2006). Stakeholder theory concludes that stakeholders relationships are based on reciprocal accountability, prioritised by organisational mission; roles and role obligations; organisational culture and climate; professional interests and obligations; social expectations, as well as evaluation criteria for organisations (Werhane, 2000).

The normative cores of stakeholder theory are: i) the purpose of the organisation; ii) the relationship between the organisation and stakeholders; iii) interrelationships among stakeholders (Freeman, 1984; Werhane, 2000). The proponents of a theory of
Stakeholder identification and prominence suggest that stakeholders possess any of three relationship attributes: power, legitimacy and urgency (Mitchell, et al., 1997).

Stakeholders provisionally could be divided into economic, state and social. It is important to understand the conditions under which different stakeholders have influence (Cashore & Vertinski, 2000), as well as the mechanisms of interaction between stakeholders. The influence of individual stakeholders on the organisation could be identified by social network analysis. This technique aimed to identify the multiple, interdependent stakeholder demands and predict the respond of the organisation to the simultaneous influence of multiple stakeholders when trying to undertake large scale change (Rowley, 2006). External pressure could be conceptualise in four sets of stakeholders (Cashore & Vertinski, 2000):

- the state as an actor - state officials and state agencies;
- the state as a legal order - regulation and court rulings;
- economic interests - shareholders, customers and suppliers;
- social interests - environmental groups, the media and organized labour.

Some scholars argue that the stakeholder theory is centred towards managers (Donaldson & Preston, 1995; Reynolds et al., 2006), as they are supposed to respond the interests of all stakeholders involved in establishment of organisational structures, general policies and in occasional decision-making. Stakeholder theory helps to understand organisations and organisational accountability and suggests that the organisation and its stakeholders combine in a moral community directed by moral principals’ fairness and social justice, while making decisions. In other words, the managers should balance stakeholder interests; e.g. assess weight, address the competing claims and distribute the scarce resources among organisation stakeholders. This process could be cognitive or administrative, directed towards resolution of conflict between different stakeholders needs and requests (Reynolds et al., 2006). In contradiction to this theory, I’ll argue that in the reality there is an issue how to distribute resources, which in most cases are scarce or indivisible. In this case the manager should decide the ‘level of importance’ of the stakeholder for the organisation, which is basically consideration of the stakeholder influence, power, contribution to the organisation (financial and intellectual), amount of holding stakes, as well as consequences of “not keeping them happy”.
Stakeholder theory is a managerial theory and focuses on ethical imperatives and fails to account the influence of incentive structures on managers’ behaviour. It should instruct and explain positive actions within organisations aiming to meet various stakeholders’ interests. The challenge is how to address the issues of prioritization and decision-making in a way to be able to keep balance between stakeholders and preventing domination, or the intrusion of one group upon the legitimate interests of another (Barker, 1996; Elms, 2002; Freeman, 1984). Stakeholders’ characteristics are different and they are different: in power of their influence, legitimacy in relationship to organisation, urgency of their claim of resources (Werhane, 2000).

**Power of Influence** relates to access to resources and utility, coercive-legislative and regulative, normative- associations and code of ethics. Powerful actors can influence the process of adoption of norms, but in a case of uncertainty and conflicting interests of stakeholders the preference goes to institutional goals, as institutional pressure is stronger than stakeholders power (Brandes et al., 2005). This notion is questionable; as it is depends the “stake” of the institution in policy making arena. Moreover, some stakeholders who are not “backed-up” by any institution could hold power being influential either financially or through other mechanisms. Some stakeholders could be authorities of the institution at the same time and be the ones who may establish institutions goals and rules.

**Legitimacy in relationship** relates to legally mandate and socially accepted and expected relationship or structures. Managers hold information important for decision-making. The literature suggests that a manager tries to reduce information asymmetry between stakeholders (Brandes et al., 2005). I would suggest that at the same time information is a convenient tool for managers to use and manipulate with stakeholders. And as institutional owners are not the same, obviously managers could distribute information to stakeholders according to their interests and objectives. But this one-sided, selective information will never give the stakeholders opportunity to see the complete picture, and thus make objective judgements, but will direct them into judging in the way that manager would prefer. My argument could be supported by Freeman’s (1984) neoclassical economic model of rational choice theory, which assumed that human beings act preliminary from their own interests, and as Bryder argues is a base for political psychology (Bryder, 2004).
Urgency of claim of resources suggests that the manager will face a difficulty while trying to assess stakeholders’ claim on the resource. To conceptualise and measure the validity of stakeholder claim, Mitchell (1997) suggested that the manager should be guided by saliency (extent to which stakeholder is powerful, legitimate, urgency of claim). I would add whether the decision will ‘harm or reward’ the manager and keep him longer in a current position.

While being guided by saliency, managers will be faced with the issue of ownership. Stakeholder theory suggests the notion of balancing stakeholder interests across the system (within-decision and across-decision) and it’s presumed that the manager shouldn’t give any priority to particular stakeholder (Reynolds et al., 2006). I would suggest that already mentioned ‘assets’ make some stakeholder more favourable and valuable than others, creating a gradation in attitude of manager. The saliency could work in business setting where all stakeholders have the same goal within the organisation, i.e. profit. Whereas transferring the theory into policy area, where different stakeholders have different goals and ambitions, as well as the resources are scarce, there is a constant competition for power and resources and each stakeholder will try to ‘pull the blanket’ to his side while competing for resources to meet their objectives. Also it is important the issue of resources distribution: who needs it mostly and for what. In biology, in a battle for scarce food resources or territory, survival is better in those who accommodated to external environmental conditions and developed enhanced hunting skills, or have better camouflage or developed other protecting mechanisms (poison, thorn, etc.) (Reynolds et al., 2006). Transferring this biological concept into policy arena could be stated that in a case of limited resources, better-off will be those stakeholders who have stronger power to survive competition between stakeholders, or their objectives are consistent to country goals. Another option is that the organisation has enough flexibility to get adjusted to change required to be able to respond to new environment change. Last but not least, the manager will try to manipulate and manoeuvre to keep everyone happy if not actually at least prospectively. So there could not be any slight possibility that manager be non-biased.
Organisational theory suggests that structural changes in organisation are less driven by competition or efficiency, but, more determined by processes that make organisations similar, which are effected by the state and the professions (DiMaggio & Powell, 1983).

The organisation itself is deep-rooted in its social, cultural, political and historical context. Apart from the necessity of the presence of policies facilitating the change, the organisations capacity to undergo change as well as perform in new circumstances is important. It is interplay of ideas about context of change, (inner i.e. ongoing strategy, structure, culture, and management; and outer i.e. economic, political and social context) process of change and the content of change. The process should be supported by regulating relationships between these three components and legitimacy supporting the change. There are two sides of the process: initiation of change and management of change. The literature suggests different models of management within the organisational theory (Perry & Rainey, 1988; Pettigrew et al., 1992), which are presented in below box 9.

**Box 9: Models of Management in Organisational Theory**

- **Highly formalistic** model suggests that the manager is considered as an institutional decision maker, with complex tasks, operating through personal contacts and little information due to the hectic pace.

- **Public management approach** model is oriented to mechanistic approach.

- **Public sector orientation** model is oriented to strong culture stressing high quality and consumer-responsive services

- **Public organisation** model is oriented towards public needs and interests.

Important aspects for building change in organisational theory to be considered are: i) analysis of health care setting; ii) questions of performance iii) the ability to manage long-term change; iv) the impact of political economy on organisations; v) nature of leadership (Pettigrew et al., 1992).
2.9.2.4. Management Theory

The paradigm of management theory itself had undergone change over a period of time. Reductionism developed the idea of a division of labour, the idea of tasks, interchangeability of parts, standard procedures, quality control, cost accounting, time and motion studies, and organisational figures. Taylor integrated these ideas with concepts of the scientific methods and suggested coherent management philosophy bringing analytical logic to management. He suggested to: i) develop a science for individual worker; ii) train and develop the worker; iii) cooperate with others; iv) divide work and responsibilities between labour and management. Work tasks are divided into basic skills and difference between performance eliminated through training and standards. The equilibrium of the system is maintained through organisational control (budget, performance review, audits and standards).

If policy institution is to be accepted as an organisation, the framework of complex adaptive systems (CAS) could be applied to understand the nature of change. The theory of complex adaptive system is based on four paradigms of management: system theory, contingency theory, population ecology and information processing (Dooley, 1997; Morgan, 1997). The management theory components are presented in box 10.

CAS is a multilevel and multidisciplinary representation of the reality as system understood through complexity of patterns, which describes potential evolutions of the system. The system gains its equilibrium through environmental adaptation and self-organisation. Control and order are a result of development rather than hierarchy (Dooley, 1997). There are different managerial applications of complexity theory. One is the theory of autopoiesis suggesting that the structural change occurs through self-renewal. Another is system dynamics, which uses simple differential equations to model large-scale systems like ‘surprising behaviour’. Another theory is dissipative systems theory, where crises could lead the system to be far-from-equilibrium, opening and opportunity for creative new solutions. One more theory is chaotic dynamics, which presents change as a result of hypersensitive disturbance of a system followed after long-term stability or incremental change. In all models CAS evolves according to two key principals: order is a result of development and the state of the system is irreversible and difficult to predict.
Box 10: Development and Components of Management Theory

*System theory (organic)* describes a system as automated control mechanism aimed to maintain the system’s behaviour as inconsistent to desired goal. Using this theory the organisations are seen as an ‘organisms’, which are responding to the change of the environment and contingences through change as an adjustment mechanism. The nature of such change could be strategic, tactical or cultural.

*Contingency theory* suggests that the organisation organises its functions according to nature of the environment in which it operates, aiming at better integration through differentiation and specialization as a result of change.

*Population ecology theory (organizmic)* suggests that the organisations with inferior structures die over resource-constrained competition, whereas variation occurring at random or in a planned fashion brings beneficial options. In a case this change is over sighted by institutional control and retained via standardization internal interpretive scheme change occurs. This view suggests hereditary perspective on organisational behaviour to be transmitted vertically back and forward or horizontally. By this theory the change in organisation is a diffusion and adoption of technical and managerial innovations, supported by the environment.

*Information processing theory (cognitive)* explored the parallel between human and organisational decision making and suggests that organisations as humans are limited in their information processing capacities. Thus decisions are made within incomplete information, exploring not all alternatives, and not necessarily developing cause and effect judgement. This is basically influenced by bounded rationality theory. Under this theory the organisation can act in such environment, either through reducing its need for information, or through increasing its capacity for information acquisition, storage and retrieval.
2.9.3. Change in the Health Care System

After getting familiar with wide variety of theories describing the process of change this heading tries to describe some theories to explain organisational transition approach resulting contextualist analysis of the change in health care system.

Bureaucratic theory views health care organisation as professionalized bureaucracies and assumes strong resistance to innovation and radical change, which makes the system highly incremental in nature. Any strategic change should be achieved through a continuous, evolving and consensus building approach and change will take place through successive, limited and negotiated shifts. Though being a dominant approach to explain decision-making in health care systems, it is not an adequate explanation of discontinuity of events.

Diffusion-based models of change consider readiness to perceive the communication process as a convergent process. It accepts that organisational innovation processes could be in a form of individual innovation adoption of decisions. This model fails to present effectively the top-down pressure for restructuring of processes.

Institutional theory presumes organisational structures change in response to institutional norms aimed at addressing structural arrangements of more modern, professional or accredited processes.

The Contingency theoretic approach is based on comparative analysis of formal organisational structures and the external environments in which they operated. In health care, value-based predictors, or ‘behavioural elite’ of strategic decision makers, have greater power compared to structures. This model does not consider adequately the social, cultural and historical settings of organisations.

Management of strategic change in health care could be achieved in different ways: i) highly top-down, rational and formal; ii) series of actions converge into patterns and legitimized by senior management; iii) combination of deliberation and control with flexibility and organisational learning.

Organisational Culture and Cultural change where the organisational culture is accepted as the background shaper of a belief system. This theory considered
underdeveloped historically, and has little concern about nature of issues and the way the organisations evolve through time.

The organisational life cycle and organisation transition perspectives model argues that different organisational processes are characterised by distinct organisational stages consisting of: birth, early development, maturity, decline and death. This theory seems to explain the best the development of organisations in health care system through time.

Population ecology model suggests that strong internal pressures on structure, which is a result of internal arrangements and influence of the environment, hindered the ability of organisation to achieve change. This model fits best in conditions when the environment is unstable, e.g. presence of a large number of small organisations and the presence of high degree of competition, which is not the particularity of health care systems.

When trying to apply any of these theories it is important to distinguish between core and peripheral changes. Core organisational changes respond to the ecological view, whereas the peripheral changes are reflected by adaptation views. Difference between adaptation and selection-based models might occur because of: i) effects of institutional changes on birth/death rates in organisation; ii) role of legitimacy of population dynamics, and the process of acquisition of institutional support on reduction of pressures on organisations; iii) effects of population increase/decrease on internal dynamics within organisations.

2.9.4. Change of HIV/AIDS Policy

The HIV epidemic could be considered a crisis. Thus, to respond to the epidemic adequately, the health care system should have undergone revolutionary change. Whereas, the response, as has been shown by Pettigrew (Pettigrew et al., 1992) while analysing the National Health Services (NHS) response to HIV, developed in an evolutionary way over the decades. It was initiated by health personnel who transferred their habits into routines. These routines were then more recently institutionalised into rules, forcing the health system institutions to undergo change, developing adequate
structures enabling them to respond to the epidemic. The reason for the slow response was mainly that the epidemic was not perceived as a crises. Moreover, the problem has been ‘diluted’ in the many other problems of the country, thus it was less prioritised.

Pettigrew (1992), analysing the literature states that “the environment, more than the person makes the biggest difference to the level of innovative managerial activity”. He defines the environment as integrated (problem solving, team-orientation, cooperative approach, strong mechanisms for idea generation and exchange, goal orientation) or segmented (compartmentalized problem-sensing and problem-solving, preoccupation with hierarchy and rules, inhibit entrepreneurial spirit) features of the structure and culture of firms. I will argue that people as individuals or groups create the environment based on certain considerations and goals, and furthermore try to preserve that environment from such ‘stress’ like change and innovation till it responds to their needs. So campaigning, lobbying, coalition-building and information sharing, developing reward and recognition systems, accompanied by championship are essential for innovation, which are features of people rather than environment, though still requires support from environment.

Using an example of strategic service change in NHS (Pettigrew et al., 1992), a linked set of conditions (see figure 3) were determined which supports change (box 11 presents explanations of factors promoting change). This change is possible when there are supporting conditions, which are: i) factors represent a pattern of association rather than a simple or linear causation, and could be accepted as a series of loops but not as a causal path between dependant and independent variables; ii) notion of receptivity and non-receptivity could be accepted as dynamic but not static concept; iii) continued processes and reversible and uncertain in their outcomes and implications.
The epidemic of HIV/AIDS revealed unusual problems, characterised by an exceptionally high degree of variability, complexity and uncertainty, causing pressure on health care system which required continuing rather than episodic organisational change. Pettigrew analysed NHS response to epidemic based on case studies, trying to test how the response was formulated and understand impeding and enabling factors to change (Pettigrew et al., 1992). Main assumptions were: i) social movement organisations (SMO) can act as catalysts for change, containing a large cultural and instrumental component, with common goals, through bringing new values and commitments to formal organisational settings; ii) a crucial aspect of change is
leadership, provided by senior members of the organisations (who can win influence and have boundary-spanning networks into social services and voluntary sector) or general management (created to provide a clearer focus for driving through change and be able to cope with continuing rapid change); iii) clinicians having power and prestige could act as 'product champions' in health care innovation being able to work effectively in a non-programmed environment, and due to their ability to deal with variety of groups serving different goals but having crucial contribution to success for change.

**Box 11: Factors Promoting Change**

**Factor 1: Quality and coherence of policy** – should consider several important aspects: i) analytical and process; ii) policy and managerial; iii) major role of data in substantiating a solid case; iv) strong testing of initial thoughts to ensure a strategic framework, consider questions of coherence between goals, feasible and complemented the service strategy with parallel functional strategies; v) broad rather vague vision.

**Factor 2: Key people leading change** – Change is highly sensitive to its context and to the leadership availabilities of key people in critical posts. These officials who are supposed to assure continuity of change and lead, in a pluralist and delicate way, based on team-building using diverse constituencies and complementary skills.

**Factor 3: Environmental pressure** – Inadequate environmental barrier is a key factor draining energy out of major change processes, whereas environmental pressure can lead to movement, if the pressures are skillfully applied. This is practically true for financial pressure is put depends on the existing distribution of power, history and assumptions, as far as financial crises are threat to the organisation, rather than an opportunity for radical reconfiguration, though in some cases could accelerate the process of rationalization.

**Factor 4: Supportive organisational culture** – Culture is defined here as deep-seated assumptions and values, officially exposed ideologies or patterns of behaviour. These could manifest as invisible barriers for change causing inertia in organisations or positively challenge to achieve success.
Factor 5: Effective managerial-clinical relations – A powerful block on change could be clinicians, if they become an opposition. Needs assessment could help to build trust, honest and effective atmosphere for change. Clinicians could facilitate between medical communities as a whole and can identify, foster and encourage change. Opportunities for training and education, commitment and energy-raising, trust-building, bargaining and deal-making, as well as for marrying top-down and bottom-up concerns.

Factor 6: Cooperative inter-organisation networks – Development and management of inter-organisational networks facilitate communication across agencies and are effective tool in both informal and purposeful communication facilitating change. They provide opportunities for training and education, commitment and energy-raising, trust-building, bargaining and deal-making, as well as for marrying top-down and bottom-up concerns.

Factor 7: Simplicity and clarity of goals and priorities – This factor influence the rate and pace of change. It is useful to divide the change agenda into set of key priorities and persistently and patiently pursue objectives over a long period. It should be considered that the change of long-range objectives requires behaviour adaptation and depends on networks of widely dispersed units, thus making change difficult and burdensome to implement.

Factor 8: Change agenda and its locale – Locale could inhibit or accelerate change as it influence on power balance between manager and unions. So it’s useful to learn about possible obstacles (political culture, workforce, unions activities) to change prior of initiation of the change.

By acknowledging that the managerial processing of strategic issues and accordingly response could be different in crisis and non-crises situations, also been acknowledged that even response to crisis itself could be different depending acceptance of crisis-as-threat (increased cartelization and formalization, breakdown of integrated structures, erosion of information channels, exiting of key human resources, loss of trust and loyalty to organisation, etc.), or crisis-as-opportunity (continuing pressure from pioneers, formation of advocacy groups, high energy and commitment, strong integration mechanisms, etc.).
In both cases, the organisational response was shaped on pre-existing shared cognitions and emotions and the key management challenge was not just to implement change, but also to develop the organisation’s capacity to cope with change and become an organisation which is capable to learning, and generating change rather than just reacting to it. To process HIV/AIDS issues and retain control over the epidemic, organisational developments could involve but were not restricted to the development of lateral forms of communication, use of facilitators to develop capacity, construction of benign organisational niches to adopt innovation and development of strong organisational culture to reward risk takers.

Analysis of case studies indicated that the NHS was either unwilling or unable to act prescriptively in shaping the service system, managers and members played marginal role, SMOs were weak, and the champions were clinicians. Generally the response to epidemic could be characterised in three phases: short-term phase as crisis-as-panic, medium term phase crisis-as-energizer and phase of crisis aftermath leading to withdrawal and burn-out. Resistance to change existed because of entrenched attitudes and beliefs rather than superficial behaviour patterns, requiring considerable time and effort to conceptualise the change (Pettigrew et al., 1992).

2.10 Evidence Based Policy Making

In most cases policies are developed without a robust evidence base. Advocacy agencies use available evidence very selectively in accordance with their interests. Policies should reflect local priorities and international evidence, which could be used in a way that reflects the country context and the local capacity to implement these practices. However, in practice, international donors often ignore these principles and promote policies, which are irrelevant and ineffective for the country (Court, 2004).

Decision-making in health care should be systematic, drawing on scientific evidence rather than ideology or expert opinion. The process should also ensure active participation of healthcare providers, policy makers, patients or patient advocates. Health policies should be systematic and logical, reliable and valid, practical and
feasible, and last but not least clear and understandable for experts and non-professionals (Lohr et al., 1998). When developing policies, policymakers, purchasers, payers and patients should be concerned with four sets of issues:

- costs and access to care and decisions about coverage and reimbursement of services;
- quality of care and related to it issues of patient satisfaction, accountability;
- public and professional education of care policies and science;
- priority setting in research.

Research provides evidence for policy making, but use of research is patchy. Lindquist identifies four different roles for research in the policy process (Lindquist, 2001):

- routine – in this type of policy process the role of research influence on policy makers is insignificant, as policy makers repeat previous decisions.
- incremental – policy makers deal with issues selectively and use research evidence ad hoc and disjointed manner.
- fundamental – in this case policy makers rethink their approaches, so research data could be useful tool.
- emergent – this refer to cases when policy makers should deal with new policy issues, so itself there is not much that research can provide.

Policymakers can use the research to (NatCen, 2006):

- help to assess their decisions evaluating the implementation of existing policies;
- develop evidence base for developing new policy areas;
- understand dynamics of policy and the attitudes of the public and stakeholders;
- evaluate policy impact and stakeholder engagement.

Earlier models have envisaged the link between research and policy to be a linear process. However, the research and policy in development (RAPID) framework (see figure 4 below) developed by the Overseas Development Institute (ODI) to assess research and policy links highlights four areas of interaction (Barnett & Whiteside, 2006; Court, 2004). The approach considers research-policy link to be a dynamic and complex two-way process where research and policy spheres and interacting and have impact on policy makers decisions (Court, 2004). This model was developed to address the gap
between research and policy for HIV/AIDS (Philpott et al., 2005). Detailed description of each component and its role in policy-making is discussed in box 12.

![Figure 4: The RAPID Framework: Context, Evidence and Links](image)

External Influences
International factors, economic and cultural influences; etc

The Context – political structures/processes, institutional pressures, prevailing concepts, policy streams and windows, etc

Links – between policy makers and other stakeholders, relationship, voice trust, networks, the media and other intermediaries, etc

The Evidence – credibility, methods, relevance, use, how the message is packaged and communicated, etc

Source: ODI

Policy makers often use research to push their own agenda and interpret research findings to support decisions already made.

Research is more likely to be used to inform policy in democratic societies where the government is accountable to the electorate and where decisions are made through participatory consensus, and where organisations exist to oppose decisions. In highly centralised structures, such as the prevailing structure in Russia, neither the specialists nor the public organisations have adequate capacity to participate in the decision-making process. Instead, the Government exerts strong control over their actions. As a result, these organisations are not able to mount opposition to influence or change government decisions. In Russia, some NGOs receive their funding from the government, and are likely to promote government views, rather than those of the public,
who trust these NGOs to play a balancing role. Other NGOs will promote their own agenda and may place organisational interests above those of the public.

**Box 12: Components of the RAPID Framework**

- **Context** – Research and policy are political processes, starting from agenda setting ending up with the policy implementation. So one of the most important aspects of political context is the degree of freedom, openness and competition among stakeholders within the system. Though context factors are the most difficult to change, still small amendments could have major impact.

- **Evidence** – Policy is lacking high quality and relevant data to ground the decision-making. Local research capacity use could address the issue. There is a gap on operational relevance of the research. Quite often in main policy arenas are highly politicized thus surveillance, prevention, care and treatment, impact mitigation is controlled by policy makers, and lacking evidence and unreliable.

- **Links** – Grassroots movements and community-based groups could affect drastically the policy response by persuading policy makers to put on their agenda the issue and also develop effective solutions. Non-governmental agencies, community, NGOs, network coalitions and faith organisations play far more active role than government in response to epidemic, so public action and private sector participation could create massive campaign to develop effective response.

- **External influences in HIV response in countries could affect the issue become on the policy agenda, – external donors and international research agencies involved so the research should be relevant and targeted to the country specifics and the findings should be widely disseminated and promoted to use for further policy development.**

As for the external influences, most donor agencies are political organisations. Thus, their primary agenda will be political. Most of these agencies use available funds to pay for their own consultancy fees rather than develop local capacity or to effectively target local needs. Further, these agencies recommend technical solutions that are not adjusted
to the country context. Hence, often this shortcoming in design leads to failure of projects supported by international agencies. Moreover, prevailing approaches used by donors increase a country's dependence on foreign assistance and reduces country commitment and contribution to local problems. In some cases, donor assistance leads to reductions in local financing in areas supported with external funds and severely impact on chances of sustainability.

2.11 International Policy Development to Respond to the HIV/AIDS Epidemic

As with the epidemic, the policy responses to HIV/AIDS have also evolved. Though the first AIDS case was diagnosed in the early 1980s, it took almost ten years to develop a comprehensive global response. Stover and Johnston, who analysed the response to HIV in developing countries, describe this response in four phases (Stover & Johnston, 1999). In the first phase, the medical response, countries tried to treat the disease as a medical problem through blood screening, organising safe medical practice and establishing surveillance and research systems. In the second phase, the public health response, governments tried to incorporate public health activities, such as condom promotion, counselling and mass media campaigns, to resolve the problem. In the third phase, the multisectoral response, international organisations began to stress the disease impact on social life and economic development of the countries, calling for different sectors and disciplines to be involved and collaborate to create a comprehensive and integrated response to epidemic. In the fourth phase, characterised by treatment and prevention, efforts focused on the promotion of preventive activities, with increased concern for ethical and resource issues associated with the introduction of new treatments and more active prevention options.

The mechanisms adopted by countries to confront and mitigate the impact of the HIV/AIDS epidemic differ, and include polices (26%), strategic plans (21%), legislation and laws on HIV/AIDS (18%), as well as national programmes, plans, guidelines, declarations on commitments, epidemic updates, codes of practice, best practice collections, treatment guidelines, monitoring and evaluation support documents (see Figure 5). While some countries have adopted several mechanisms and implemented a combination of these, others developed policies sequentially as the epidemic evolved.
In some, the response was delayed and inadequate. These policy responses (by policy responses is referred to documents entitled policy, but also any officially accepted regulatory framework/s in a country aimed at regulating and addressing the HIV epidemic), which reflected the knowledge gained about the development and influence of the epidemic on the society, aimed to regulate the response to the epidemic.

Currently, three policy issues are of particular importance for HIV/AIDS:

- Provision of HIV treatment to all in need (HAART and other necessary medication, obstetric and reproductive health services, treatment of mental health and substance abuse issues, case management services, HIV prevention services, primary and necessary specialty services).
- Provision of prevention services to the general population (counselling and testing, small group counselling interventions, community level interventions delivered by peer-opinion leaders).
- Provision of prevention services to PLWHA (to ensure services appropriately targeted, customised and client-oriented to PLWHA, and to prevent transmission to seronegative partners).

**Figure 5: HIV/AIDS National Strategic Frameworks Developed by UNAIDS Member Countries as of 2004 (N=220)**
2.12 Modern Trends in Health Policy

Although countries develop their own public health policies, globally, some general trends are noticeable (Baggott, 2000):

- Increasing international influence on local public health policies: international agreements and initiatives across a range of public health issues have created new frameworks within which national policies are developed. Though those initiatives provide useful guidance, there are instances when harmonisation has weakened domestic regulations and ignored key targets.
- Increasingly important role played by the media: by sensitising the public to public health issues and by supporting campaigns of pressure groups.
- But in spite of improved responses, the campaigning by pressure groups to promote public health, are still relatively weak in comparison to the commercial lobbies, as the public health lobby is fragmented and limited to single-issue groups, environmental-pressure groups and professional organisations. Joined-up working and campaigning by these groups to mobilise government, public and parliamentary support would yield better results.
- Concern that public health is still dominated by the health professions and efforts directed towards care and cure rather than prevention: the prevention efforts are targeted at clinical prevention and not public health, which in many countries has low prestige amongst the medical specialties. Consequently, multisectoral public health and prevention efforts are lacking with policies that have inadequate consideration of socio-economic and environmental factors influencing health.
- Policy networks, which influence public health responses, remain relatively closed: greater public accountability and involvement is needed. Policy networks are underdeveloped and could be strengthened through improved communication, sharing of information, greater openness and wider consultations with interested public health stakeholders to engage them more effectively in decision-making in policy sector.

Major public health challenges can affect the support for governing coalitions and influence degree and nature of support by different parties towards policy changes (Heintz & Jenkins-Smith, 1988).
2.13 Policy Concept Adopted by the Thesis

In this thesis policy will be defined as 'an organised chain of actions, or inactions, of the government or decision-making power to address issues of concern and mitigate problems as they develop.' These actions or inactions could take the form of a written document, legislative act, strategy or statement, order or decree, or be an unwritten physical action.

While acknowledging that scholars differentiate policy and policy implementation, this distinction will be considered from a different viewpoint. Policy here will be defined not as documents, stating intentions, but as concrete actions of the government. Though many scholars refer to this action as a policy implementation, in the Russian context, where documents are used as political declarations and where no mechanisms exist to create the necessary accountability to enforce the implementation of the policies articulated in policy documents, the definition used in the thesis is appropriate. Many written policies are 'appeasement' policies, aimed at convincing the international community that the policies adopted are in-line with international agreements. Hence, the 'true policy' is not what the government states should be done but what the government actually does: the 'intended' policy. It is the intended policy which is explored in this thesis.

The policy process in Russia can be suitably explored through the elitist theory, which argues that policy choice and change is determined by certain social classes/institutions, represented in policy making by holders of authoritative positions, with the government ensuring the continuing dominance of those classes/institutions.

In Russia, ideology and propaganda plays an important role in the formulation of public policies. A well-defined ideological discourse can improve the quality of policy making by providing an orientation when clarifying priorities: by helping to 'steer' through information overloads, and by linking separately developed policies. (Bryder, 2004) But in the Russian context, where there is a relative lack of democracy, the only way to influence the elite is through crises, such as HIV/AIDS, by lobbying the elite to alert them to the dangers of HIV/AIDS and pressurising them to act, whilst also finding compromises to address the issue.
This thesis will use stakeholder theory of change, which provides a useful lens to examine the change process in Russia. This lens enables exploration of not only the environment and structures participating in the process of change but also the stakeholders themselves, who are the key to creating the change. Stakeholder analysis is used to understand the Russian HIV/AIDS policies: both the 'appeasement' policies (as articulated in official documents) and 'intended' policies (what has been implemented). The adopted policies are appeasement policies and are declarative: not realistic in their aims and guided by political correctness rather than feasible solutions to the problem. While acknowledging irrationality in policymaking, the policies developed in Russia to address HIV are realistic and implementable, taking into account of the resources and capacity in the country and the socio-political situation.

The analysis draws on change theories to take into account the differences in the influence and thus power of the stakeholders in the decision-making process. In Russia where the decision-making is state-centred, the government is the most influential stakeholder, with strong powers to influence policy. To date, in Russia, society-centred influence has been weak, as the civil society is disorganised and poorly developed. The social construction of the target populations shapes the policy agenda and policy design (Schneider & Ingram, 1993). Hence, when the HIV/AIDS epidemic begins to impact on the general population, the government is more likely to show stronger political commitment and take more drastic actions to combat the epidemic. The role of specialists in providing the evidence on the spread of the epidemic to the general population and through them to the governing elite will be critical to policy-makers initiating action.

Exploration of the concepts and theories as well as main notions related to policy, its formation and analysis, decision-making process and mechanisms of change, should be complimented by an analysis of how change is initiated and by whom. This explored in the next chapter, which focuses on advocacy; a process of influence to shift the power and initiate policy change.
Chapter 3: Advocacy

Advocacy underwent development over decades having different applications and purposes, as well as, actors and outcomes. The literature suggests several words associated with advocacy (defending, sensitizing, change, persuasion, exposure, communication, providing a solution, influence, intervening, decision-making, selling and idea, lobbying, attracting attention) and different understandings depends on the countries structure, civil society level of development and freedom, outcomes of advocacy and its objectives. Consequently, advocacy campaigns and its strategies could be different based on specific subject to be influenced and changed.

3.1 Historical Roots of Advocacy

Advocacy dates back to the earliest times in history, as early as 2200 BCE, when the ancient Egyptian pharaohs recognised the need for "communicating truthfully, addressing an audiences interests, and acting in a manner consistent with what is being said" (Smith, 2004). In 1,800 BCE the rulers in Mesopotamia, the earliest cradle of civilisation, produced "policy guidelines" on farming and irrigation to increase the harvest. Much later, Aristotle developed the art of effective speaking, discourse, rhetoric, and persuasive communication by using compelling and ethical arguments to offer verbal proofs for ideas. In the classical Mediterranean world Syracuse, Cicero and Fabius developed confrontational and ethical aspects of persuasive speaking. In the mid-first century BCE, Caesar posted the first public newsletter to keep citizenry informed.

Further development of the government-public relations related to religion. Peter and Paul used persuasive techniques (speeches, staged events, letters and oral teaching) to increase interest in the new religious movement Christianity. Tarsus used strategy of interpretation and audience segmentation to interpret gospels. Other religions also used the strategies and tactics of public relations. The prophet Mohammed deliberated about problems facing his public. Further the strategies of interpretation and audience segmentation were used to appeal to the interests and needs of different audiences by writing different versions of the same event and "developing messages for different target audience".
In the Middle Ages communication tactics, including writing, public speaking, word of mouth, slogans and symbols were used to influence the public opinion and to attract thousands of volunteers for Christian Crusades. In 1215, Langton used the tactics of lobbying and government relations to peruse recognition of rights of barons and the church in England (Meeting at Runnymede: The Story of King John and Magna Carta, 2006; Powicke, 1929). In 1351, Wycliffe developed a campaign using illegal street lectures, pamphlets and books to win over the common people (Cloud, 2000). Loyola further developed public relations strategies: such as appeals to both positive and negative values, third-party endorsements, orchestration of the message, use of popular spokespersons, as well as public relations tactics such as speeches, letters, books and pamphlets (St. Ignatius Loyola, 2006). In the 20th century, with the de-Europeanization of church government, public relations further evolved, more effectively using the strategy of segmenting the audience and developing messages approach based on the wants, interests and needs of each particular segment.

Colonisation of the America encouraged the development of new methods in public relations, with unreasonable exaggerations so called “promotion”, to attract settlers and financial backers to these new lands.

In their review of the recent history of public relations, Grunig and Hunt present four stages of development (Grunig & Hunt, 1984):

- The Publicity era (1800s), which focused on dissemination and getting attention through one-way communication with little research on the issue: a tactic now used in entertainment, sports and marketing.
- The Information era (early 1900s), which focused on honest and accurate information dissemination through one-way communication based on readable and comprehensive research: a tactic often used by governments, NGOs and business organisations.
- The Advocacy era (mid 1900s), which focused on modification of attitudes, and influencing behaviour, through a two-way communication, based on in-depth research of attitudes and opinions: a tactic developed during the Second World War for propaganda, brainwashing and social manipulation and now widely employed by competitive business organisations, causes and movements. This tactic is also used in political public relations, and in cause-
related promotions (for example promoting citizen support for military campaigns, and generating public support for health, safety and welfare).

- The Relationship era (late 1900s and beyond), which focused on creating mutual understanding and conflict resolution by using two-way communication. This approach draws heavily on public research to understand perceptions and values related to issues. It is a core function of the management and leadership of an organisation, and not just a communication activity. This approach is widely used in business regulation, government public relations, NGOs and social movements.

### 3.2 Definitions of Advocacy

Advocacy is commonly associated with a number of words, such as defending, sensitizing, change, persuasion, exposure, communication, providing a solution, influence, intervening, decision-making, selling and idea, lobbying, attracting attention (CEDPA, 2003). Forms of advocacy have changed over time from traditional directive approaches to more contemporary consumer-centric and empowering approaches (Nursing Centre, 2004).

Advocacy is an organised effort to influence decision makers with the goals of developing, establishing or changing the use of power (AIDSCAP, 2005; The World Bank, 2001b; WHO, UNAIDS, & UNODC, 2004). It is often also called lobbying or campaigning. It is one approach used to influence policy and initiate change (Bane, 2001).

Lobbying to influence public policy is an effective form of advocacy for groups of citizens who are disempowered in society (EBSCOhost, 2003; Weafer, 2003). It is therefore helpful to understand the sources of power for individuals and groups in a society, which include (Weafer, 2003):

- decision-making power;
- access to information and resources;
- range of options to chose from;
- assertiveness;
- having optimism with respect to the possibility of change;
• critical thinking: learning and conditioning;
• learning about group controlling skills;
• feeling support of coalition of individuals;
• human rights knowledge;
• effecting change for individuals and community;
• persuasive skills, competency and ability to act;
• negotiating abilities;
• knowledge of issues and experience;
• previous successful experience.

Advocacy is much more than dissemination of information or education. Information and education equip individuals and a community with knowledge about a topic, an issue or services. Advocacy goes beyond this to secure support for a cause or an issue and influence the interested parties to act in favourable way with respect to an issue. “Advocacy is the act or process of supporting a cause or issue and the advocacy campaign is a set of actions in support of a cause or issue” (CEDPA, 2003). The literature widely describes how advocacy can be used to influence decision-makers to change policies (AIDSCAP, 2005; AMICAALL, 2005; International Planned Parenthood Federation, 2001; WHO, 2005a). Policy makers could also use advocacy to promote their decisions and initiate successful implementation of policies by citizens and professionals.

Advocacy is a means for persuading influential people to change, rather than information, education and communication (IEC) and community mobilization, which relate to activities with the general public or a specific group of people (The International HIV/AIDS Alliance, 2002). Advocacy is a strategy used by NGOs, activists and policy makers to influence policies. “Advocacy is the deliberation process of influencing those who make policy decisions. Advocacy is about creation or reform of policies, but also about effective implementation and enforcement of policies” (Sprechmann & Pelton, 2001).

McKee describes public health advocacy as a strategic use of the media to move forward public policy initiatives, change policies and laws in the presence of strong opposition (McKee, 2005). Though he suggests that advocacy is not directed at behavioural change, it can be argued, that a change of policy requires a change of
attitudes and behaviour, not only by policy makers, the public or professionals, but also by advocates themselves. This is because knowledge is one of the underpinning factors of human behaviour and in-depth learning of the subject to be changed, suggests new approaches to resolve the problem. The latter is possible only through change/adaptation of human behaviour to new circumstances.

In the health sector, advocacy is widely used for patient empowerment. The primary role of an advocate is to inform patients about key issues and give adequate information about possible options related to an issue, then provide support to patient in relation to their decisions. This type of support differs from the support provided by a lawyer, who, as an advocate, actually presents the client’s case and either pleads for justice, or defends the client from accusation. In the patient advocate role, when the patient makes a decision, the advocate abides by it and defends the patient’s right to make a particular decision. The role of the advocate comprises only two functions: to inform and to support (Teasdale, 1990; Wolfensberger, 1972), but support does not mean ‘fighting battles instead of the patient’ (Teasdale, 1990).

The Centre for Development and Population Activities (CEDPA) has analysed how different organisations define advocacy (see box 13). (CEDPA, 2003) The definition and understanding of advocacy differed in each country and for each organisation: influenced by the level of human development, the socio-cultural traditions, extent of democracy, the nature of the civil society organisations and the levels of individual freedom.

Understanding and definition of advocacy influences the way it is practiced. In the health literature (esp. mental health) advocacy is seen as an effective support to an affected population; used to recognise their needs, to voice their problems and to protect their human rights. The thesis defines advocacy as an organised set of activities that places issues on the policy agenda to initiate a shift in policies to generate solutions to address a problem. Advocacy can be used by the civil society to persuade policy makers to resolve an issue, or be used by a government to encourage the public and specialists to adopt and implement policies.
Box 13. Definitions of Advocacy

"Advocacy is a process that involves a series of political actions conducted by organized citizens to transform power relationship. The purpose of the advocacy is to achieve specific policy changes that benefit the population involved in this process. Effective advocacy is conducted according to a strategic plan and within a reasonable time frame”.

The Arias Foundation for Peace and Human Progress

"Advocacy is speaking up, drawing a community’s attention to an important issue, and directing decision-making towards a solution”.

CEDPA

"Advocacy is defined as the promotion of a cause or the influencing of policy, funding streams or other politically determined activity”.

Advocacy For Youth

"India- Advocacy is an organized, systematic, intentional process of influencing matters of public interest and changing power relations to improve the lives of the disenfranchised.

Latin America- Advocacy is a process of social transformation aimed at shaping the direction of public participation, policies, and programs to benefit the marginalized, uphold human rights, and safeguard the environment.

Africa- Advocacy begins pro-poor, reflecting core values such as equity, justice and mutual respect, and focusing on empowering the poor and being accountable to them”.

Institute for Development Research

"Advocacy consists of deferent strategies aimed at influencing decision-making at the local, provincial, national, and international levels. Effective advocacy requires sharp understanding and analysis of concrete problems, and a coherent proposal for a solution”.

InterAction

"Advocacy is a process to bring about change in the policies, laws and practices of influential individuals, groups and institutions”.

International HIV/AIDS Alliance, Zimbabwe, July 2001 workshop

"Advocacy is an ongoing process aiming at change of attitudes, actions, policies and laws by influencing people and organisations with power, systems and structures at different levels for the betterment of people affected by the issue”.

India HIV/AIDS Alliance, India, November 2002 workshop

"Advocacy is an action directed at changing the policies, positions and programmes of any type of institution”.

Support for Analysis and Research in Africa (SARA) Project, Training guide
There is a difference between advocacy and leadership. Advocates pursue specific agendas as regards policy change, whereas leaders (ideally) should explore and consider all possibilities to resolve an issue. Advocacy can be used as a strategy by the leadership on some issues.

3.3 The Aims and Goals of Advocacy

The aim of advocacy is to influence authorities to provide leadership, political support and commitment by (i) building support for a cause that requires policy action, (ii) influencing others to gain support, and (iii) trying to influence the policy and legislation that affect a cause (AIDSCAP 2005; CEDPA 2003). By forming a groups, partnerships and alliances advocacy creates a critical mass and stronger effort beyond what one organisation can achieve alone (CEDPA, 2003; CEHRC, 2004).

In Europe, organisations engaged in advocacy have four central goals (Moreslli, 2000; NDA, 2003):

- to provide information and training programmes;
- to provide practical help for those who seek it;
- to campaign for legislative and structural change;
- to encourage research in the area.

Advocacy provides means for speaking on behalf of the voiceless (representation); encouraging others to speak on an issue (mobilization); and supporting the voiceless to speak for themselves (empowerment) (The World Bank, 2001a; EBSCOhost, 2003; Hurlbut, 2003):

Policy analysis and policy advocacy differ. While policy analysis aims to reveal all possible alternatives available to decision makers, policy advocacy aims to narrow the range of alternatives available and promote a particular option for policy makers (Pielke, 2004; Pollack, 2006). But policy analysis is needed to identify policy options and to focus on the range of options that best serve a particular cause. Similarly, if policy makers better understand policy options favoured by different constituencies through their advocates more optimal solutions can be developed to address a problem.
3.4 Types of Advocacy

Advocacy can be direct (asking policy makers to take action) and indirect (trying to influence public opinion) (Sprechmann & Pelton, 2001). The public health literature (Morrell, 1992; NDA, 2003; NHS, 2002; Teasdale, 1990; Weafer, 2003) (Cambridgechire County Council, 2004; NHS, 2002) identifies several types of advocacy, including:

- Self-advocacy – Motivating individuals and helping them to present their own concerns, needs and interests.
- Collective Advocacy – Uniting individuals of different backgrounds in campaigns to fight for their rights as a group of citizens.
- Independent or Citizen advocacy – Supportive activity by groups of independent, trained volunteers working on behalf of people, presenting their needs and concerns (for their future, health condition, etc.)
- Peer advocacy – This type involves a provision of support for individuals by those who have experienced similar difficulties and problems.
- Family advocacy – This type is generally initiated by the family members of affected groups, who bring strong and effective arguments to support the individuals.
- Professional advocacy – Campaigns conducted by a professional group, who have expert knowledge of a particular case.
- Public policy advocacy – This is an effort to influence public policy through persuasive communication.

These different types of advocacy are not mutually exclusive and can overlap (Weafer, 2003). In patient advocacy, alignment between ethical standards and incentive structures is critically important (Elms, 2002). The incentive structures, such as governmental laws, institutional standards and requirements, public support and professional ethics are essential determinants of successful patient advocacy and initiation of any advocacy activity in general.

Advocacy could be reactive and proactive. Advocacy may be necessary because a problem emerges and requires action, or because a problem exists and has been neglected. Reactive advocacy is the response to address this problem. Alternatively, if a
problem is anticipated advocacy is used to prepare the future, by ‘setting the agenda’, and creating a positive environment aimed at prevention of the problem before it happens. This is proactive advocacy.

3.5 Advocacy Models

Multipartite advocacy model defines various roles a person or entity could play in advocacy activities, to realise the greatest impact for their efforts. The main components of multipartite advocacy model are: lay advocacy (informal persuasive actions practiced outside of the system, seeking a social and/or a political outcome); legal advocacy (formal authoritarian actions implemented by outside of a formal regulatory service system, aiming at a legislative and legal outcome); protective advocacy (consists of formal and authoritarian actions aimed at the enforcement of regulations and codes) and professional advocacy (consisting of informal and persuasive actions assuring availability of services) (Creating Change Through Advocacy, 2004).

The State Education Action Team (SEAT) in USA has developed an advocacy model consisting of seven steps (ASHA, 2004):

- analysing the state’s potential for advocacy success;
- developing state action plan;
- developing roles for advocacy partners;
- establishing grassroots network;
- creating a media plan;
- developing communication strategies between advocacy partners;
- considering key strategies from targeted state.

Figure 6 presents a widely accepted model for HIV/AIDS advocacy (HIV/AIDS Advocacy Model, 2006), but consider only the prevention and care of HIV/AIDS without suggesting any options for treatment and counselling.
Figure 6: HIV/AIDS Advocacy Model

Self-selected stakeholders → Community planning groups → Advocacy for prevention interventions → Funding of prevention programs → Prevention resources

Self-selected stakeholders → Community planning groups → Advocacy for care interventions → Funding of prevention programs → Case management services

Regional Level

Community Level

Individual Level

Source: http://www.msu.edu/user/lounsbu1/w14fig2.html
This thesis will suggest a wider use of advocacy, as presented in Figure 7, for use in every stage of HIV prevention, control and care. The figure illustrates in detail activities to be initiated and issues to be addressed before initiation of advocacy, during the advocacy campaign and after completion the planned activities. This division of stages is not static, as the process is continuous and requires constant evaluation of implemented activities and adjustment to policy environment and changing priorities. This scheme is also useful for policy-makers to assess the process of implementation of their policies and advocate their decisions to populations to encourage implementation of their policies.

3.6 Advocacy Implementation

Advocacy could be implemented either through different forms of partnership, or through direct involvement in service provision (Weafer, 2003). Advocacy activities should be planned and an advocacy strategy developed before implementation. An “advocacy strategy” should consider the following questions:

- What we want to change through our influence?
- Who will make the change?
- How the change could be made?
- When the change could be made?

Advocacy activities can take many different forms – for example, they can be written, spoken, sung or acted. They can also vary in the time they take, from one hour to more than several years. Advocacy could be conducted individually, when there is enough capacity, or with others in a group, creating networks and coalitions (Creating Change Through Advocacy, 2004; The International HIV/AIDS Alliance, 2002).

Before initiation of advocacy activities, several issues could be considered. Initially, information should be gathered about current policies and political positions related to the issue. Initiation should be followed by risk assessment and resource-mapping. The next stage should emphasise building strategic relationships to strengthen influence. Credibility of the advocates should be developed to encourage chances of being heard. Mass media involvement in this stage is crucial. Efforts at this stage should aim to link
advocacy to the priorities of the country. And finally, a focus should be maintained on the issue creating persistent action (Sprechmann & Pelton, 2001).

Public opinion plays a major role in implementation of advocacy and persuading policy makers, as the policy makers are elected representatives of their constituents (American Association of Critical Care, 2006).

### 3.7 Precondition for Successful Advocacy

Views of the critical factors for a successful advocacy campaign differ, based on the subject of advocacy, country policies, political and socio-economic conditions influencing advocacy groups’ activities, agendas of advocacy networks and coalitions’ power of influence.

A successful advocacy strategy should consider (The World Bank, 2001):

- **Policy** – aimed at influencing or reforming the existing policies and laws, formatting responses, shifting budgets and funding, or developing new projects or programmes.

- **Process** – aims to influence and change the process of decision-making, by educating leaders, policy makers and others involved stakeholders about the issue.

- **Civil society** – aimed at increasing peoples’ involvement in their own governance by creating participatory, accountable, and transparent decision-making structures.

To develop effective advocacy strategies, advocacy groups involved in a campaign should: i) have knowledge of the political/economic environment; ii) have shared views about the change; iii) be skilled at solving complex problems; iv) make decisions collectively and effectively; v) be willing to express their interests; vi) hold public officials accountable (The World Bank, 2001).

Before initiating an advocacy campaign, a number of steps should be taken to increase the chances of the success, namely: helping to generate ideas; understanding and
minimising risk; increasing the likelihood of being understood; providing a number of strategic choices.

The critical steps and actions for successful advocacy, as suggested by Sprechmann and Pelton (Sprechmann & Pelton, 2001; Bane, 2001; International Planned Parenthood Federation, 2001; The International HIV/AIDS Alliance, 2002) have been modified to develop an HIV/AIDS model for Russia (see Figure 7). These steps will increase chances of successfully implementing an advocacy strategy as they will (Silvera & Kapasi, 2000; Sprechmann & Pelton, 2001):

- provide more information about where to go for ideas, how to find partners, how important decisions are made;
- help provide a better understanding of the political environment and minimise the risk of not achieving policy change;
- increase the likelihood that the ideas fit community priorities;
- help build relationships in the preparation stage and increase the number of strategic choices which can pay significant dividends during implementation.

Information is crucial in organisation of advocacy activities. The advocacy process starts with the collection of information, to make it accessible; discussing choices; facilitating decision-making by individuals and monitoring outcomes (Digital Governance, 2004; Weafer, 2003). Advocacy uses information to influence established policy rules. Kubler emphasises the importance of social movement theory in this process (Wälti & Kübler, 2003). Information could be used for several purposes (Sabatier, 1988; USAID, 1995) for example:

- to expand resources in policy debate to protect their values and interests;
- to alert people about potential threat to their interests and values, that issue could cause;
- to support and justify a developed position regarding the issue;
- to complement their power and convince other actors possibility of alternative approach.

Good advocacy is the secret to success in positive change (Coates & David, 2002; Faciszewski & Krueger, 2004; ICASO, 2001; International Planned Parenthood Federation, 2001; Weafer, 2003; WHO, 2005a; WHO, UNAIDS, & UNODC, 2004). There are six steps to successful advocacy:
1. Define the target audience:
   - certain community, NGO;
   - leaders, health care professionals, researchers, academics;
   - local government or policy makers, politicians;

2. Find the facts to support what to say:
Information is the cornerstone of advocacy, which helps to build a persuasive and powerful argument. The message presented should vary with the audience. The main considerations are:
   - choose and use advocacy type appropriate for the issue;
   - develop information based on credible research;
   - stress the magnitude of the problem and define affected vulnerable groups;
   - propose solutions and justify them;
   - develop the message focused on the audience.

3. Package the message, suggesting how to say it. This is important as it will help reach the audience:
   - should have the right topic to be listened to;
   - the message should be clear and brief, focused on few issues, supported with few strong facts;
   - the messages should be strong but not sensational being able to grab the attention of the audience;
   - should be evidence based and contain research information to contribute updated knowledge, when there is already some understanding of the issue;
   - use simple language acceptable to the audience;
   - contribute visual materials to make message clear and memorable.

4. Work with the media to sell the message:
   - choose appropriate timing so as not to clash with other important events;
   - organise press conferences and distribute press release to sensitisise journalists about the issue;
   - involve celebrities and authorities;
   - publications should have the appropriate formats like: news releases, feature stories, letters to the editor, etc.

5. Mobilize others to organize the moves:
   Loud message is difficult to ignore. To create loud message investigation should be one for finding more partners and involving/attracting them to the issues.
   - assure equal access to advocacy and involve the affected population;
• guaranteed funding and support;
• provide ongoing supervision and support to safeguard themselves and people they represent;

6. Assure leadership and management of the process:
• assure information access as an important prerequisite for advocacy;
• work independent from service providers and officials;
• organize pre-campaign education and training for advocates (paid and volunteer);
• educate health care providers and policy makers;
• good record management system assuring confidentiality and continuity;
• commitment to review and evaluate activities to assure effectiveness and accountability;
• well established complaint system to assess feedback and address it;
• operation on macro-level initiating policy structural change rather than ‘patching’ approach.

The most powerful advocacy is by the people affected by the problem or issue. It is very important to receive the permission of the people affected by the problem and seek their support and direct involvement. This legitimises the advocacy activities and helps build coalitions.

3.8 Advocacy as a Tool for Policy Change

Interest groups, which are influential in lobbying legislators and administrative agencies, can initiate legislation change, stimulate grassroots political activities and participate in election campaigns. Interest groups influence the policy process as they have (Thomas, 2005):
• credible information on social conditions, policy options and possible impacts;
• access to and interactions with policy makers;
• a geographically representative membership;
• ownership of priority issues within and between groups;
• capacity in terms of resources (staff size and expertise) and electoral resources (campaign funds and political intelligence);
• a strategic niche in policy arena and recognition of leadership.
Another powerful tool for advocacy is population opinion polls, which affect the actions of policy makers. According to public opinion surveys (initiated by the California Centre for Health Improvement (CCHI) between 1995 and 2001) on the role of polls and policy analysis 90% of informants believed that polls affected the actions of policy makers and 92% believed that policy analysis affected policy decisions. Public opinion and policy analysis undertaken by independent bodies not involved in policy decisions help establish visibility and frame issues without determining outcomes (Greenwald & et al., 2003). Advocates influence policies if they have access to the decision-making. The policy process determines whether the advocates have the ability to build alliances with policymakers (Malloy, 1999; Sedelmeier, 2002). The media is a powerful tool that could be mobilised to influence the policy process (Anderson, 2000; Wallack et al., 1993).

It is rare that a single interest group will have enough capacity to initiate a policy shift. Thus, in most cases, groups with the same interests and objectives form coalitions to gain more power (Thomas, 2005). In coalitions, debates on policy issues are motivated by different ideologies, material interests, information on the causes of the problem and the potential consequences of different policy options (Heintz & Jenkins-Smith, 1988). Sabatier suggests that advocacy coalitions could be a powerful tool for policy change, as they come together based on common fundamental values, causal assumptions and perceptions of the problem (Sabatier, 1988). The beliefs of advocacy coalitions determine the direction of their actions while initiating policy change, whereas available resources (financial, specialists, supporters and legal authorities) determine the actual actions. So resource availability will determine whether the beliefs will be translated into authoritative policy decision or not. Whether the beliefs of coalitions are reflected or not in policies, the coalitions need to translate their beliefs into governmental programmes (Sabatier, 1988; USAID, 2001) and use these proposals to gather support for policy change. To obtain necessary resources, coalitions need to have power; enough stakes in an organisation (stakeholder theory) or the authority to change rules (institutional theory).

The elite have a vested interest in maintaining the established current equilibrium. In response to pressure from coalitions to change the established balance the elite will try to keep the balance by introducing minor changes. Otherwise they risk losing their
positions. The elites can also increase the resources they have available, such as popular support or financial backing, to resist the pressure for change. Alternatively, the pressure for change could come externally rather than from coalitions: for example environmental change of changing socio-economic conditions, the interaction with other systems. However, these external pressures can be controlled by the elite, and be used by them to suppress formation of advocacy coalitions (Sabatier, 1988).

Policy research is a powerful tool for advocacy. Interest groups can use research results as evidence to influence debates and policy. Research on perceptions, values and ways of thinking on an issue are particularly useful to inform public debates and to influence decision-making (Bane, 2001).

Policies are not made only by parliaments, church councils or governments, but are often a result of group efforts, which tends to encourage, persuade or pressurise the policy makers to act. Programme managers technical specialists, analysts, planners, advisors, coalitions/alliances, media, communities and policy makers can all influence decisions (AIDSCAP, 2005) and should be targeted by advocacy groups to initiate change.

3.9 Advocacy in HIV/AIDS

Advocacy in HIV/AIDS must be based on factual information that draws on current studies, recent scientific developments, baseline data and situational analyses. HIV/AIDS advocacy work should focus on (CEDPA, 2003):

- creating awareness of the magnitude and the seriousness of the problem;
- diminishing discriminatory practices;
- removing policy and other barriers to prevention, care and treatment activities
- campaigning for effective and sustainable action

Advocacy in HIV/AIDS can be particularly useful in (CEDPA, 2003; Shanti, 2004; UNFPA/UNAIDS, 2005):

- outreach and engagement – functioning as navigators;
• needs assessment – evaluating need for medical care, medication, food, shelter, clothing, transportation, substance use information, mental health needs, benefits, and other related requirements;
• information and referral – provide information about, or referrals to, agencies that address needs;
• medical and medication assistance – assist the patient in adhering to complicated schedules for medications, accompanying them to medical appointments and advocating for them with medical providers;
• emotional support – provide peer counselling, including harm reduction strategies for substance users;
• practical support – support in day to day activities, like shopping, housework, etc.;
• publishing a newsletter on HIV/AIDS;
• encouraging resource mobilisation and donations to STI/HIV/AIDS programmes and research;
• networking with colleagues involved in the response to AIDS;
• involving the mass media in HIV/AIDS campaigns;
• supporting campaigns for increased availability of antiviral treatment;
• promoting good policies and practices;
• promoting knowledge on HIV/AIDS to the population in general and to target groups in particular;
• organizing fund raising for PLWHA;
• reducing stigmatization of HIV/AIDS affected people;
• upholding the human rights of HIV positive people;
• strengthening solidarity between NGOs and PLWHA;
• involving PLWHA in prevention, education and advocacy.

Advocacy campaigns for HIV/AIDS should emphasise human rights and gender issues. Sexual subordination of women makes them more vulnerable to infection than men. In many societies women have low social status, are subject of sexual violence and unable to negotiate for safe sex. A partial solution to the problem is in changing men’s attitudes on these issues. Another important aspect of advocacy is the involvement of the HIV positive people and other affected populations in policy design and planning and implementation of AIDS-related work. PLWHA can play a significant role in education and prevention activities.
An example of best practice could be the enforcement of 100% condom use in Thailand averting two million infections and saving $US 6 billion. In Cambodia, a more significant group for transmission are sex workers and so-called indirect sex workers “beer girls”, among whom condom distribution is organised. In Indonesia, peer groups and counsellors advocate condom use among transvestite sex workers. Thailand and India targeted sex workers, truckers, labourers and fishermen through advocacy work and cooperation with restaurant owners and brothel keepers. In Thailand advocacy efforts to senior military and defence ministry brought cooperation with air force personnel. In Mauritius and Kenya advocacy succeeded through workplace motivators organising talks, training of trainers and posters production in factories and workshops. In Thailand AIDS awareness became a policy of companies and 3,500 new employees per year underwent AIDS awareness training. In Botswana advocacy campaign is established through awareness and work with schools, education authorities, school management, as well as with students and parents. In Turkey advocacy directed to policy and decision-makers to develop practical and humanitarian responses, through mobilising parliamentarians and civil servants to recognize and take actions against HIV/AIDS making prevention a national duty. In Myanmar advocacy directed to district authorities and religious leaders through training raises awareness among the general public. In Central American countries Honduras, Nicaragua, El Salvador, Guatemala and Panama advocacy strengthened the collaboration among parliamentarians through increasing their knowledge, awareness, understanding and commitment to HIV/AIDS issues. In 1996, because of the pressure from the civil society, the government of Brazil passed a law of universal free access to ART. As a result of the policy change savings totalling US$360 million accrued in 2001 simply through the decline in hospitalizations. Zambia created a special association of media workers to strengthen media participation in HIV/AIDS awareness. Burkina Faso and Cote d’Ivoire established a national “solidarity fund” to support HIV/AIDS affected population. In Tanzania the Gender Network Programme and the Women Lawyers Association created a coalition to promote gender and human rights with respect to HIV/AIDS.
The advocacy work should be developed specifically for each target group, taking into account main modes of infection transmission and the particular behaviours of each target group. For example advocacy for female condom use among sex workers, especially in countries where clients refuse condom use; advocacy for introduction of sex education in schools; implementation of IEC programmes in the armed forces, prisons and clients of sex workers (truckers, fisherman, labourers, etc.); and, introduction of on-the-job education in firms and private companies (International Planned Parenthood Federation, 2001).

Advocacy is a critical element of strategies to improve institutional and community responses to HIV. It is also a tool for promoting commitment of the leadership. Advocacy can target different groups through different messages on particular policies. The literature (ACCESS, 2002; Teasdale, 1990; The World Bank, 2004) describes (see box 14) examples of successful advocacy campaigns, some of which targeted specific risk-groups and policy makers. The successful HIV/AIDS advocacy activities were those which were targeted at harnessing commitment of leaders, reinforcing interventions to effectively respond to the epidemic, mobilising resources, adaptation of legal frameworks, establishment of a positive policy environment, improving national coordination and governance, increasing population awareness, improving professional knowledge and influencing cultural norms and religious belief.

3.10 Notions of Advocacy in the Russian Context

There is not much published about advocacy in Russia, and also advocacy of HIV/AIDS in Russia. Conducting detailed review of literature, very few works had been found in Russian and English literature. This limited portfolio of publications discussed below. Because there are such limited empirical studies and theoretical discourses of subject matter in the context of Russia, I broaden my analysis and explored advocacy in different aspects. First, I have explored advocacy in legal context, second I have explored advocacy in relation to health sector in general, and then explored advocacy in relation to HIV/AIDS specifically.

In a very restricted sense I propose to look at legal advocacy. Advocates (legal) have practiced in Russia since 1864, after Tzar Alexander II carried out legal reform. In the
beginning of the 20th century Russian advocacy became politicised, which made it less popular among the general public. After the Revolution, Lenin liquidated the practice of advocacy in Russia. This practice was re-established and regulated under the legislation of 1979-80 and has operated without the traditions and rules of ethics. Since 2002 many bills been adopted to regulate the practice of advocacy in Russia (Sharov, 2006).

Zhumagaliev (2003) claims “advocacy is a strange thing in Russia”. He suggests that there is no equivalent term in Russian and also there seems no equivalent concept: people relied on authorities to resolve their problems “Czar/Party/Secretary/Boss/President is fair, he just doesn’t know about my trouble...”. Though nowadays this mentality is not common, still there has been little change to the practice of relying on authorities.

The literature claims that advocacy networks in Russia do operate, focusing on the issues of women’s rights, environmental degradation, political party formation, free trade unions and independent media (Mendelson, 2001). My own literature search of organisations working on advocacy in Russia gave poor results, but is consistent with what literature describes: one organisation works in cancer area (Cancer Patient Advocacy group in Russia), one established by UNAIDS to support private business (Centre for International Private Enterprise), one advocacy group deals with disability issues (All Russian Society of Disabled People), an environmental organisation (Global Forest Watch) a Harm Reduction Network and an Organisation of Human Rights. Despite the international agencies running several programmes (IREX, UNAIDS and WB) for strengthening civil society in Russia, it is obvious that sustainability of the programme was not achieved and the organisations stopped operating once the foreign programme closed and the funding was withdrawn (Reuters, 2008; Centre for International Private Enterprise, 2004; Disability World, 2000; Bijl and Frost, 2000; Russian Harm Reduction Network, 2008; IREX, 2008).

HIV advocacy is even less familiar to the population, despite the rapid growing disease prevalence in Russia. One-on-one lobbying does not work and I argue that the only way of moving issues forward is to get together organisations working in the HIV/AIDS field. Further the author claims “when there is no history of advocacy or culture in your own country to draw on, you have to look elsewhere for guidance”. The problem in this
case will be to adjust the learnt notions to the cultural values and beliefs of local population, and to the political and socio-economic environment of the country, in order to be successful (Zhumagaliev, 2003).

Searching the database of organisations working on advocacy about HIV/AIDS in Russia I found only four local organisations (apart from UNAIDS, MSF and TPAA, who operate with foreign funding and management), two of these work with drug users and one works in broadcasting, where HIV is part of their advocacy, with only one working directly with PLWHA. Their activities are limited to information dissemination and psychological support of the affected population and restricted in policy influence and/or participation in policy making process. In order to participate in policy advocacy the organisations should be independent from government, whereas the facts suggest that “the impact of advocacy groups that lobby to influence legislation has been disappointing”. Richter (2000) suggests that the reason is the fact that even the state Duma has little power and the government is reluctant to implement legislation because of lack of accountability and pressure by public.

3.11 Advocacy Model Adopted by the Thesis

This thesis suggests use of advocacy to initiate policy change. The thesis defines advocacy, as an organised set of activities that places issues on the policy agenda to initiate a shift in policies to generate solutions to address a problem. Advocacy can target policy makers to encourage resolution of an issue. A government can also use advocacy to target the public and specialists to ensure implementation of policy decisions. In both instances there is an active interaction between the stakeholders.

The thesis draws on Sprechmann and Pelton (Sprechmann & Pelton, 2001) and modified to develop an advocacy model for HIV/AIDS in the Russian Federation (see Figure 7).

This chapter has discussed theories related to advocacy and the preconditions for successful advocacy campaigns to initiate policy change. Before applying these notions to Russia, it is important to analyse the epidemic in Russia to ensure advocacy activities developed are appropriate to the context.
**Figure 7: Advocacy Scheme**

4. Revision and redirection of the advocacy strategy
   - Assess the appropriateness of initially established objectives
   - Redefine key messages
   - Reschedule of the activities
5. Adjustment along with political climate
6. Discussion of the revisions within coalition
7. Revision of the advocacy tactics
8. Defining new challenges to influence for increasing the impact
9. Assuring continuity through developing long-term goals, keeping coalitions together and updating arguments

1. Conducting monitoring and evaluation of the intervention
   - Focus monitoring on tracking the progress on outputs, activities and inputs
   - Involve in monitoring stakeholders to accelerate the change
   - Focus evaluation on impact and effects
   - Compare data with the baseline data
   - Assure consistency with outlined assessment indicators developed in logframe
2. Conducting analysis of the findings
3. Drawing conclusions about the intervention
4. Defining area of subject for adjustment

- Analysing policies and political institutions
  - Understanding the political environment
  - Understanding community concerns
2. Assessing risk
  - Making informed judgements
  - Determining positive and negative effects
3. Building strategic relations
  - Establishing connections with policy makers
  - Networking with other organisations
  - Involve affected populations
4. Establishing credibility
  - Building up expertise to establish credibility with policy makers
  - Building up relations with communities to establish credibility with the public
5. Linking advocacy to country development strategy
  - Making connections between policy issues and other work of the organisation
6. Maintaining Focus
  - Developing short list of policy priorities

- Analysing policies
  - Identify policy issues
  - Identify key actors and institutions
  - Analyse the policy environment
  - Summarise policy findings
  - Identify options for policy change
2. Outlining an advocacy strategy
  - Select the policy issue
  - Select target audience (primary and secondary)
  - Set a SMART policy goal
  - Identify allies
  - Identify opponents
3. Finalising advocacy strategy
  - Select an advocacy role (confrontational; collaborative; public; private)
  - Identify key message
  - Define advocacy activities
4. Framing a plan
  - Set a timeline
  - Prepare a budget
  - Prepare a logframe
  - Mapping political solution
  - Plan for monitoring and evaluation
Chapter 4: Epidemiology of HIV/AIDS in the Russian Federation

This chapter presents the context in which the HIV/AIDS epidemic has developed in the Russian Federation. The chapter explores the country characteristics, socio-economic and political conditions, the health system structure and the resources targeted at HIV.

4.1 Country Profile

The Russian Federation is the largest country in the world, covers 17,075,200 sq. km in the Eastern Europe and North Asia. Of this 16,995,800 sq km is land and 79,400 sq km water. About 10% of the land is swampland and about 45% is covered by forests. The irrigated land covers 46,630 sq km and the arable land is 7.33% (Russian Federation, 2005; Library of Congress 2005). The Russia administratively divided into 21 autonomous republics, 49 oblasts (provinces), 6 krams (territories), 10 autonomous okrugs (regions) and 1 autonomous oblast. Moscow and Saint Petersburg cities have separate status at oblast level (A Country Study: Russia, 2005; The World Factbook: Russia, 2005; Library of Congress, 2005).

The population density is 8.5 persons per sq. km. 71% of population are in the 15-64 year old age group. The majority of Russia population (81.5%) are Russians. The main religions are Russian Orthodox Christianity and Islam (Russian Federation, 2005). The country's main demographic statistics are presented in table 2 below.

The Russian Federation was established in December 25, 1991 after the dissolution of the Soviet Union. In 1992, Russia underwent series of economic reforms to address the severe downturn in the socio-economic environment (Russian Federation, 2005; Tragakes & Lessof, 2003). Inequities widened while life expectancy fell. To address these problems, in 1993 the country voted for an economic programme that amounted to shock-therapy. The collapse of the Russian Rouble in 1997 led to a further financial crisis and political upheaval. The economic situation was exacerbated by the war with Chechnya.
Table 2: Country Main Demographic Statistics

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Data Estimate</th>
<th>Year</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population (thousands)</td>
<td>142,754</td>
<td>2006</td>
<td>UN population division database</td>
</tr>
<tr>
<td>Annual population growth rate (%)</td>
<td>-0.2</td>
<td>1990-2005</td>
<td>UNICEF database</td>
</tr>
<tr>
<td>Urban population (%)</td>
<td>73</td>
<td>2005</td>
<td>UNICEF database</td>
</tr>
<tr>
<td>Average annual growth rate of urban population</td>
<td>-0.4</td>
<td>2000-2005</td>
<td>Goskomstat database</td>
</tr>
<tr>
<td>Crude birth rate (birth per 1,000 pop.)</td>
<td>10.2</td>
<td>2005</td>
<td>Goskomstat database</td>
</tr>
<tr>
<td>Crude death rate (deaths per 1,000 pop.)</td>
<td>16.1</td>
<td>2005</td>
<td>Goskomstat database</td>
</tr>
<tr>
<td>Net migration rate (per 1,000 pop)</td>
<td>0.9</td>
<td>2005</td>
<td><a href="http://www.cia.gov">www.cia.gov</a></td>
</tr>
<tr>
<td>Maternal mortality rate (per 100,000 live births)</td>
<td>67</td>
<td>2005</td>
<td>WHO (WHR 2005)/UNICEF</td>
</tr>
<tr>
<td>Life expectancy at birth</td>
<td>65.3</td>
<td>2005</td>
<td>WHO (WHR 2005)</td>
</tr>
<tr>
<td>Total fertility rate</td>
<td>1.4</td>
<td>2005</td>
<td>UNICEF database</td>
</tr>
<tr>
<td>Infant mortality rate (per 1,000 live births)</td>
<td>11</td>
<td>2005</td>
<td>UNICEF database</td>
</tr>
<tr>
<td>Under 5 mortality rate (per 1,000 live births)</td>
<td>18</td>
<td>2005</td>
<td>UNICEF database</td>
</tr>
<tr>
<td>Literacy rate</td>
<td>99%</td>
<td>2005</td>
<td>UNICEF database</td>
</tr>
</tbody>
</table>

The economy began to recover in early 2000 supported by strong oil price and the introduction of structural reforms. In the last five years, the gross domestic product (GDP) has grown each year by 5-9% (Russian Economic Report, 2005; The World Factbook: Russia, 2005). In this period the real fixed capital investments increased more than 10%, while the real personal income increased over 12%. The international financial position has also substantially improved, allowing Russia to increase its foreign reserves from US$12 billion to over US$80 billion. But the banking system remains weak. Corruption and widespread lack of trust in business and government institutions creates a poor business climate (Russian Economic Report, 2005b; The World Factbook: Russia, 2005).

Since the 1993 constitution, Russia has had a democratic, federative form of government, divided into executive, legislative and judicial branches. The President is elected for a four-year term and sets the domestic and foreign policies. The Prime
Minister administers policy according to the constitution, laws and presidential decrees (Library of Congress, 2005). In 2000 V. Putin became a president. He moved centralised power to Moscow by limiting the power of regional governments (Library of Congress, 2005). He has also curbed the power of oligarchs, a group of wealthy businessmen who benefited from rapid and disorganised privatisation of Russian State assets. These actions brought political stability. Putin was re-elected in 2004 in elections described by Western observers as “less than democratic”. This has coincided with further erosion of the country’s nascent democratic institutions and weakening of civil society organisations (An Introduction to Russia, 2005; Russian Federation, 2005; Library of Congress, 2005). In upcoming year of 2008 Russia will face presidential elections, which will determine directions of country’s further development for next four years.

### 4.2 The Russian Health System

The organisational structure of the Health System of Russia is presented in the Figure 8 below. Since independence, Russian officials initiated reforms to improve delivery of the healthcare services. Several new programmes were introduced, namely the State Family Medicine programme, the General Practice programme, and the Mandatory Health Insurance Scheme. These efforts aimed to improve primary medical care services but improvement has been slow. In spite of the attempts to improve the system efficiency and effectiveness, the Russian Health System remains rooted in the Semashko Model: characterised by centralised planning and administration and inefficient service provision, which negatively influences the quality, sustainability and accessibility of the system. There is an excess capacity in terms of infrastructure and human resources, but the available resources are unevenly distributed through the country. The inpatient care, emergency care and the diagnostic services are overstaffed. There is no adequate referral system. The remuneration of the health personnel is poor. This adversely affects service provision, which is inadequate to meet population needs and of poor quality. The education, training and retraining of the health workforce remains a challenging area for improvement (Floyd & et al., 2006; McDaid et al., 2006; McKee et al., 2005; McKee & Nolte, 2004; National Intelligence Council, 2000; Rozenfeld, 2005; The World Bank, 2005c; Tkatchenko et al., 2000).
The financing of the health system is fragmented and decentralised. Over 85% of funds are raised and allocated at the regional level from revenues and payroll tax. The funding is inadequate (currently at 3% of the GDP) and provided in multiple streams, each stream earmarked for different purposes and different sets of providers. (McKee et al., 2005; McKee & Nolte, 2004; The World Bank, 2005c; Tkatchenko et al., 2000).

Figure 8: The Organisational Structure of The Health System of The Russian Federation (Tragakes & Lessof, 2003)
Following the Soviet Union's collapse, in 1991, the Russian population's health status has declined precipitously. Dramatic falls were registered in birth rate and were accompanied by the increase of mortality rates, resulted in negative population growth. Life expectancy became among the lowest in Europe. The major cause of death is cardiovascular diseases, which is the highest in European Region. The maternal mortality rate is one of the highest in Europe. Alcohol use is responsible for most premature mortality. Tobacco consumption is about 67%, which is one of the highest rates in the world. Child and adolescent health is very worrisome (Tragakes & Lessof, 2003).

Problems in Russian health care system have continued despite the large number of health care facilities and health care staff. Rosenfeld analysing the crises of Russian reforms suggested that problems are due to "a continued lack of funding, medical and technical equipment and supplies, and finally, to the ineffective organization of health care delivery services" (Rosenfeld, 1995). This all affects the quality of services, and service accessibility to population remains low. Though several attempts at reform programmes been proposed, in general they were "tactical approaches", and failed to address principal problems or the overall strategy and approach. Rosenfeld suggested that the Russian's health care problem is "rooted in the accepted political model of state-paternalistic social system development". This model is reflected in the attitude of the policy makers, who perceive the goal of population health protection as a secondary to protection of state priorities.

The main source of the information related to the organization of HIV care services are the regulatory documents on the Federal Aids Centre website. These are 5 normative documents describing the diagnosis, prevention (vulnerable groups and general population), epidemiologic control, care, treatment and social support and rehabilitation of HIV/AIDS and opportunistic infections (TB, Hepatitis, STIs). These normative documents describe in details activities of each department and also suggest the structures and activities to be implemented in regions and other federal subjects. It also suggests the structures in local settings and remote areas of the country. The document "recommends" structures to be developed in the regions and also functions to be carried out in line with the suggested document. Reviewing the authorship (totalling 19) of the document, all members were from the Federal level; there were 2 representatives from NGOs (one representing PLWHA) and 4 representatives from international agencies.
(UNAIDS and WHO). There was no any representation from regions, which indicates that the Regions' (and other federal subjects, like oblast, town, etc.) participation in any decision-making is very limited.

In reviewing those documents it should be admitted that they were in line with many international recommendations and strategies. The issue is whether the government, institutions, and public implement the proposed regulatory frameworks. This is a research topic that was beyond the scope of this thesis. I will simply describe the content of the documents, although my research findings contradict many normative acts described in these documents, indicating poor implementation.

The main document describes the structure, functions, funding and management of the HIV/AIDS Centre. The main functions of the Centre are coordination, organisation and implementation of prevention, epidemiologic control, diagnosis and treatment and other activities related to prevention of the spread of HIV/AIDS and related opportunistic infections. The Centre also responsible for organisation of the psychological and social support of HIV/AIDS infected individuals and their families, with consideration of their human rights, and addressing issues of stigma and discrimination. The Centre’s functions also include information dissemination to the general public and mass media, as well as technical support for organisations involved in diagnosis, prevention, care and treatment of HIV/AIDS patients. Another dimension of the Centre’s activities is development and organisation of distribution of the educational materials, and professional literature about HIV/AIDS and scientific investigation of the problem. The structure of the Centre is as follows:

An Organisational-medical department is responsible for organisation and coordination of activities in HIV/AIDS and its consequences. Particularly, this department is responsible for development and training of staff; collection and analysis of information about the organisation, prevention, diagnosis, treatment of HIV infected population and patients with opportunistic infections. This department is also responsible for organisation of conferences, seminars and initiations to help to overcome stigma and discrimination of patients and their families.

A Prevention department is responsible for organisation and implementation of preventive activities, information dissemination and education of general population and vulnerable groups.
An Epidemiologic department is responsible for collection, analysis and dissemination of statistical data related to HIV/AIDS, conducts epidemiologic research and information distribution of HIV infected contacts.

A Diagnostic department is responsible for laboratory-diagnostic investigation and clinical-laborator control over treatment and diagnostic activities. This department is organising and implements diagnostic activities related to HIV/AIDS and opportunistic infections.

A Clinical department is responsible for inpatient care and treatment of the HIV infected population and also provides palliative care.

A Medical-social and legal support department is responsible for organisation and implementation of activities directed towards social help of the HIV infected population, including activities towards decrease of discrimination, palliative care, care of orphans and other family members of the HIV affected population.

An Administrative support department is responsible for administration of the Centre.

Another document describes the process of referral and care of the patients. HIV infected patients are getting all types of treatment according to clinical recommendations, and they have all the rights in line with the Law of Russian Federation on population health protection and care. The HIV positive patients can receive medical care in any health organisation nearest to their habitation, and this are depends on the medical condition to be addressed. In a case of a sudden need of surgical, obstetric-gynaecological and other emergency interventions HIV patients could apply to any nearest medical organisation. Most of the HIV patients attend local “Centres of HIV/AIDS and other Infectious Diseases Prevention and Care” or TB, Narcological Dispensers or dermatological centres (this is where in Russia the STIs are treated). Centres have a database of HIV patients, where all information from medical institutions is provided. If the patient attends obstetric-gynaecological, dermatological, TB or drug use centres, they are asked to consent to HIV test, and if the result is positive the medical institution completes the form and the patient is referred to the local HIV/AIDS Centre for diagnosis of the stage of the disease and gets advise and consultation related to HIV. When there is a high concentration of patients in a certain area, it is recommended that there are HIV wards in the hospitals. Also patients with active, virulent TB forms are not referred to the HIV Centre, but treated locally, and for diagnosis and HAART recommendations, a doctor from HIV Centre visits the patient.
Those patients who are in Narcological dispensers and rehabilitation institutions, the
HIV Centre doctor visits and advises on the treatment and care schedule.

Walt (1994) argues that health policy is a “low issue” and the decision making power is
concentrated in hands of health professional. Another source suggests that health
professionals at least should be asked for their opinion while making decisions (Lewis,
2005). But in Russia one has to be “in close circles with the government to get leading
positions” in the institutions and in order to maintain a position, decisions should be in
line with the political interests of the country. Moreover, health professionals could be
advised about the services and activities provided by the health organisations and
institutions but the funding will actually determine which of the declared activities and
services will really be provided.

4.3 Development of the HIVAIDS Epidemic in the Russian Federation

Russia accounts for 70% of HIV infections in the ECA region (The World Bank, 2005b).
Among those infected, 80% are young people in the age group 15-29 years (Feshbach &
Galvin, 2005). The epidemic is driven by IDU and unsafe sex (Rhodes et al., 2002). But
a sharp increase was reported in MTCT from 125 to 3531 cases, from 1998 to 2003.
According to Vadim Pokrovski, the head of the Federal AIDS Centre of the Ministry of
Health and Social Development, in 2004, 50% of new cases were through heterosexual
transmission. But because of mis-categorisation there is disagreement on whether there
is a concentrated or a generalised epidemic (Feshbach & Galvin, 2005). Moreover,
statistical inconsistencies exist not only between local and international data sources,
but also between the country sources themselves. This is mostly because of the
underreporting and the use of different statistics, which conflict with UNAIDS and
WHO methods (Feshbach & Galvin, 2005).

The epidemic is spread unevenly across the country but has been detected in 88 of the
89 administrative territories. The high growth rate of the epidemic has been
accompanied by a negative population growth rate, which creates “...an explosive mix
with serious economic and social costs” (The World Bank, 2005b). Although the
growth of epidemic has slowed, the government response is weaker than what the epidemic warrants (Seltsovsky et al., 2004).

4.3.1 Evolution of HIV/AIDS in the Russian Federation

Under the Soviet law homosexual relationships and IDU were illegal. Government officials were confident that HIV/AIDS would never become a problem for the country (Kelly & Amirkhanian, 2003). The first case of HIV was registered in 1985 (TPAA, 2004), in a citizen who was purported to have contracted the virus in Africa. This was followed by 15 soldiers, who were infected through homosexual sex (Feshbach, 2005; Grisin & Wallander, 2002). In the following couple of years, the numbers of confirmed HIV cases remained low and concentrated among foreign students in Russia. This allowed the Russian press to mislead the public by labelling the epidemic as a “Western Problem” associated with a corrupt lifestyles (Goodwin et al., 2004; Grisin & Wallander, 2002). In 1986, almost 300 cases were discovered amongst children infected in medical settings in the Russian cities Elista, Volgograd, Krasnodar and Rostov-na-Donu (Frolov, 2003; Grisin & Wallander, 2002).

In 1989, then Soviet government developed the first “national programme” and established a national centre, seven regional centres and 82 territorial or local centres for HIV/AIDS activities (Medvedev, 1990). The main activity of these centres was surveillance of cases. Testing was considered as a prevention and control measure. Some categories, such as known drug users and men who have sex with men (MSM), people with STIs, “individuals having casual sex”, citizens who had returned from abroad, blood donors, pregnant women, recipients of blood products, soldiers and prisoners, were compulsory tested. The narrow specialisation of the medical services led to misdiagnoses of AIDS. The possibility that patients with other diseases could be coinfectected with HIV was not considered. Around 99 % of all registered HIV cases were identified in the period 1999-2003 (Tedstrom & Narkevich, 2004; TPAA, 2005a). The shortage of diagnostic equipment and a lack of medication meant that prophylaxis for opportunistic infections was rarely administered. There was little emphasis on prevention activities.
The vast territory and population diversity made HIV/AIDS prevention and education difficult. Prevention messages were mainly based on fear campaigns, which led to development of stigma. The situation was worsened by the political and economic instability, flourishing organised crime, poor health conditions and epidemics of other infectious diseases, which diverted attention from AIDS (Feshbach, 2005; Stachowiak, 1998).

Today Russia has one of the highest growth rates of HIV infection in the world (HIV/AIDS Explosion in Russia Triggers Research Boom, 2003; The World Bank, 2005c; The World Bank, 2002b; WHO, 2004). Even on the basis of officially registered cases, the epidemic is progressing with a new infection every 12 minutes (UNAIDS, 2003a; UNICEF, 2003). Since 1999, the most common mode of transmission in Russia has been IDU contacts, followed by sexual transmission and MTCT (EvroInfo, 2003; Wines, 2003).

It is difficult to predict how the HIV epidemic will evolve (Grassly & Garnett, 2005; Wall, 2003), as it depends many factors. Assuming that the prevalence rate among the general population is 1% (equivalent to a cumulative number of 1.2 million infected persons) in 2005, the cumulative number of infected could reach 2.3 million in 2010 and 5.4 million by 2020 (Atun et al., 2005; Rühl et al., 2002). These predictions assume spread amongst heterosexuals. According to US National Intelligence Council prediction by 2010 adult prevalence of HIV epidemic in Russia could reach 5-8 million (National Intelligence Council, 2002b; Tedstrom & Narkevich, 2004). Another source estimates that cumulative new cases could range 4-19 million and expected deaths 3-12 million by 2025 (Eberstadt, 2002; Grisin & Wallander, 2002; Kelling, 2003; The World Bank, 2005c; Wall, 2003). The latter projections might be considered an overestimate, as the prediction methods are not transparent enough to be validated. Though the predictions of HIV/AIDS infection numbers vary between local and international experts, all call for urgent mobilisation of all stakeholders, and resources to curb the epidemic (Butler, 2003; National Intelligence Council, 2002; Tedstrom, 2003; TPAA, 2004; UNAIDS, 2002b).

The HIV epidemic is considered 'low prevalence' or 'concentrated,' when cases are confined mainly to individuals who engage in high risk behaviours, such as men who have sex with men, people who inject drugs, prisoners, and sex workers. An epidemic is
considered 'concentrated' or 'medium prevalence' when less than one percent of the general population (or low risk groups like women in antenatal clinics) but more than five percent of any 'high risk' group are HIV-positive. When HIV prevalence among high-risk groups if five percent or more and one percent or more among low risk groups or general population, the epidemic considered 'high prevalence' or 'generalised' (Population foundation of India, 2003; UNICEF, 2008).

Referring to above definition and analysing the official statistics, the epidemic in Russia is low prevalence or concentrated as more than five percent IDU are infected and yet the prevalence among the population as a whole is less than one percent. The deception of a concentrated epidemic sends a message to policy makers that the problem is not great and that those infected are in stigmatised groups. This makes advocacy extremely difficult as politicians able to ignore HIV/AIDS as a problem.

However, there are number of countries which have had similar epidemic to Russia were successful respond were mounted with strong involvement of civil society groups participating in advocacy. By this meant countries South Asia: India, Cambodia and Viet Nam, which also had concentrated epidemic among CSW and where the bridging population shifted the epidemic to general one. In these countries multifaceted responses with advocacy component halt the incidence and prevalence of HIV/AIDS. These are brief discussed below.

In India, the epidemic is distributed unevenly “with pockets of high prevalence” as it is in Russia (UNAIDS, 2007). In India and Thailand the epidemic spreads from “high risk behaviour groups” (e.g. commercial sex workers) to a bridging population (married clients), who in turn infect their spouses. The spread to the general population reflected in the rising number of cases among pregnant women and their infants (between half and two thirds of male clients of sex workers are either married or have regular female partner) is the phenomenon that Russia is facing now (French, 2004; Epstein, 2007). In Orenburg, 64% of newly registers HIV cases in 2006 were attributed to sexual intercourse; prevalence of the epidemic in Saint Petersburg and Orenburg among pregnant women was one percent in 2006 (UNAIDS, 2007). ICL compared the predicted and observed HIV epidemic in Saint Petersburg, using an ordinary differential equation, compartmental mathematical model, which takes into account infection and sexual transmission with heterogeneous mixing partner. The research found that there
is a limited potential for heterosexual transmission, but there is a risk of heterosexual acquisition amongst partners of IDUs (Asghar et al., 2008 draft paper).

Pokrovski (2006) the director of the Federal AIDS Centre in his presentation suggested that there “are no signs of saturation of HIV in the IDU population in many of the Russian regions”. He also suggested that the risk of further intensive HIV transmission would be possible, especially in low affected areas. During the same presentation he suggested: “the percentage of new reported cases with identified main risk factor as sexual intercourse increased from eight in 1989 to 43 in 2005, but the total number of heterosexual transmission trends is increasing slowly” (Pokrovski, 2006). Further, he claimed that despite the increase of the heterosexual transmission there are insufficient data to confirm that “the second (heterosexual) high scale wave of the epidemic in Russia is already started”.

All above mentioned discussions are not considering one more important factor influencing the HIV/AIDS epidemic in Russia, which is TB. Using system dynamic simulation model of the transmission of drug sensitive tuberculosis, multidrug resistant tuberculosis (MDRTB) and HIV scholars (Atun et al., 2007) suggests that high coverage with HAART (75% or more) in combination with MDRTB cure (about 80%) rates is required to prevent deaths (almost 60%) from TB and HIV-associated TB, whereas HAART coverage and TB cure rates in Russia are far below the recommended thresholds.

Bearing in mind that there are inaccuracies in the statistics, precise predictions are impossible, but having a high concentrated epidemic among sex workers and IDUs the epidemic will likely spread to the bridge population. If the Russian government will not adopt more profound and “aggressive actions” to halted the epidemic based on a comparison with other countries, the epidemic could spread into general population.

Some countries experience of best practice in HIV awareness and prevention programmes encouraging safer paid sex could be considered. In Cambodia sex trafficking, exploitation, violence, drug use, party celebrations and sex tourism contributing to rapid spread of HIV. The government adopted a strategy of working with brothel owners and clients of sex workers called ‘100% Condom Use Programme’ (100% CUP). The objective of this programme was to reduce HIV transmission from
high HIV prevalence groups (sex workers) to low HIV prevalence group (housewives) through the bridging group (clients of sex workers). The evaluation of the implementation of the programme was encouraging indicating positive impact on HIV/STI prevention among sex workers (WHO and NCHADS 2001): the rates of new infections among sex workers decreased by half dropping from 43% in 1998 to 21% in 2003 (HIV and AIDS in Cambodia). Positive changes been reported also among the IDU population half of whom reported using condoms while buying sex and almost one third of whom reported using condom with their wives and girlfriends. As a result HIV prevalence has fallen nationally in 2006 (UNAIDS, 2007), which is an outcome of efforts lasting almost 16 years.

A positive experience of HIV prevention cases from Viet Nam, where the government displayed strong leadership (a multi-sectoral committee is chaired by the Deputy Prime Minister) and mobilised stakeholders from different sectors to combat the epidemic. Most of the sectoral ministries included HIV prevention in their work plans; labour Unions were involved in implementation of an “HIV at work places” awareness programme, the Women’s Union established Empathy Clubs for HIV patients and their families; Fatherland Front launched a campaign to promote positive leaving “cultured family and community”. All the above mentioned groups, as well as NGOs, and different faith organisations, were actively involved in the “policy development process; raising awareness of updated legislation; supporting ART services in health facilities; referring between and within health and social services; and last, but not least, they have been a key factor in fighting stigma and discrimination towards people and children living with HIV” (The Socialist Republic of Viet Nam, 2008).

4.3.2 Current Status of HIV/AIDS in the Russian Federation

According to AFEW, as of February 2007, there were 362,068 PLWHA living in Russia (AFEW, 2007). UNAIDS estimates puts this number at 940,000 at the end of 2005 (UNAIDS/WHO, 2006). AFEW estimates the number of deaths among the PLWHA by end of February 2007 to be 14,757 (AFEW, 2007).

The pattern of development of epidemic in Russia is presented in Figures 9 and 10 below (AFEW, 2007).
Figure 9: Official Registered HIV Cases in the Russian Federation from 1987-2007

![Graph showing Official Registered HIV Cases in the Russian Federation from 1987-2007.](image)


Figure 10: Number of Deaths from HIV/AIDS in the Russian Federation 1987-2007

![Graph showing Number of Deaths from HIV/AIDS in the Russian Federation 1987-2007.](image)

Sources: TPAA [http://www.tpaa.net/pdf/policybrief_eng.pdf]  
Although the data in Figure 9 indicates a decrease in the incidence, this is believed to be due to a decline in the numbers of persons tested in the period 2000-2003, which declined by 50% due to the introduction of a new Law on drug control, which deterred many IDUs to be tested. Given that 10% of the IDU population is infected, and this group comprised 70% of HIV infections, a decline in testing of this group will result in a lower number of recorded infections by 54.6% (Feshbach, 2005). However, this calculation assumes no repeat testing.

There is underreporting and mis-categorisation of HIV/AIDS deaths. Because of stigma relatives bribe physicians not to issue a death certificate identifying AIDS as a cause of death, but instead use cardiovascular diseases, pneumonia, viral hepatitis or cancer as a cause. Further, deaths from opportunistic infection associated with AIDS are not reported as AIDS deaths (Feshbach, 2005).

Russia’s top health officials believe that the numbers describing the epidemic are significantly under estimated and that the official registered HIV cases should be doubled and even maybe quadrupled to provide valid figures. They argue that the epidemic is still accelerating (HIV/AIDS Explosion in Russia Triggers Research Boom 2003; Amirkhanian et al., 2001; Gorbach et al., 2002; Kelly & Amirkhanian, 2003; The World Bank, 2002b). This underestimate could prevent recent growth in infection from being acknowledged. According to leading experts, there are an estimated 700,000-1.5 million PLWHA: 0.4-1.5% of total population (Global HIV News, 2003; Butler, 2003; Tedstrom & Narkevich, 2004; UNAIDS, 2002b). The epidemic is probably still in the early stages, but over the next five years there is likely to be a dramatic increase in the numbers of PLWHA needing treatment (Vinokur & Semenchenko, 2004). According to TPAA calculations, more than 70% of PLWHA are young men aged 15-39 years (Rühl et al., 2002; TPAA 2004) (see Figure 11 below), and 80% of PLWHA are in the age group 30-50 years (UNAIDS, 2006).
Currently, the epidemic is concentrated (76% new cases in 2003, were associated with IDUs). However, there is evidence suggesting that the epidemic has began to shift into general population (heterosexual transmission increased from 4.7% in 2001 to 17% in 2004) (Atun & Samyshkin, 2002; Tedstrom & Narkevich, 2004; The World Bank, 2005c; WHO, 2005b).

4.3.3 High Risk Groups

The populations especially vulnerable to HIV infection are the IDUs, CSWs, MSM, prisoners, TB patients, pregnant women, patients with STIs, adolescents, military personnel and migrants. The history of HIV acquisition by risk category is presented in Figure 12 below, which shows the dramatic transition from MSM to IDUs in 1997 and the subsequent growth in heterosexual acquisition (Facts About HIV/AIDS, 2005). The situation is exacerbated by the overlap between some, and sometimes, several groups (Kalichman et al., 2000). The development of the epidemic through transmission modes in Russia in 2004 is presented in Figure 12.
Russia is experiencing one of the fastest growing injecting drug use (IDU) associated HIV epidemics in the world (Hamers & Downs, 2003; Lowndes et al., 2003). There are estimated 1.5 to 3.5 million IDU in the country (Rühl et al., 2002; WHO, 2004): almost 1% of the population (Grisin & Wallander, 2002), but some sources put this figure at 3-4% (Seltsovsky et al., 2004). IDU is the major transmission mode and 70% of HIV cases are attributed to IDU (Dehne et al., 1999; Dehne & Kobyshcha, 1999; Lowndes et al., 2003; Platt, 2004; WHO, 2004). The most vulnerable group are the young people. The main factors responsible for HIV spread through IDU are interacting behaviour, environmental and structural, as well as enormous socio-political and economic changes experienced since 1990s. Drugs cheap and easy to access but needle exchange programmes are lacking as they are illegal (Grisin & Wallander, 2002).

The same factors are associated with the exponential increase in the number of CSW, who are held responsible for increased HIV. According to WHO, 5-15% of CSW are infected with HIV (WHO, 2004c). The situation is exacerbated because of the overlap between of the IDU and CSW population: 25-80% of female sex workers are estimated to be IDUs (Dehne & Kobyshcha, 1999; Lowndes et al., 2003; Platt, 1998). The CSW is a bridging population for HIV spread (The World Bank, 2002a). In 2003, 17% of new
HIV cases were through heterosexual contacts. Sexual intercourse is considered to be the predominant transmission mode of HIV/AIDS infection and STIs (Grisin & Wallander, 2002). High rates of STIs in Russia could lead to high HIV transmission. As STI infections increase the susceptibility to or infectiousness of HIV, HIV control would benefit from the detection and treatment of STIs. The common transmission mode of both diseases makes the target audience for interventions the same and the preventive mechanisms for HIV and STI could work for both diseases. Further, STI monitoring, as a second-generation surveillance, would help predict the development of HIV epidemic (WHO, 2005b).

Over the five year period 1998-2003, the number of mother-to-child transmission cases has increased by 14.7 times (Feshbach & Galvin, 2005). In 2003, almost 10% of the newborn children were exposed to HIV infection perinatally. In 2003, the number of MTCT cases increased from 125 to 3,531 cases (The World Bank, 2005b). Most of these children were abandoned by their HIV-infected mothers: almost 30% of the children were left in hospitals, 54% in state orphanages and only 17% in various "substitute families". As of mid-2003, 10 regions were responsible for 50-60% of all children born to HIV-infected mothers. (TPAA, 2005). The MTCT transmission level from treated women is 6.9-10% (Feshbach & Galvin, 2005; TPAA, 2005). There is a high rate of abortions among HIV positive women, because of unavailability of treatment, lack of information, stigma and uncertainty about the future (Feshbach & Galvin, 2005).

Another marginalised group vulnerable to HIV/AIDS is people in penal facilities (WHO, 2005b). The prevalence of HIV infection among prisoners is 2-4%. Some estimates the prevalence in this group to be 30 times higher than that in the general population (The World Bank, 2005c). Prevention activities and treatment of those infected with HIV is not a priority in Russian prisons. Moreover, as sex is prohibited the supply of condoms is restricted. For security reasons bleach for sterilisation of needles is also prohibited. At any given time, around 20-30% of IDUs are in prisons and the number of prisoners infected with HIV and tuberculosis is growing (National Intelligence Council, 2000). Most prison sentences are not permanent as Russia frequently implements amnesty programmes. Hence, this population poses a real threat to the general population. Almost 300,000 prisoners are released each year, of which 10% have active TB and MDRTB (Feshbach & Galvin, 2005).
Though the first cases of HIV/AIDS were registered amongst MSM, this group does not account for a large proportion of cases. This may be due to underreporting of some sex contacts because of the stigma (Hamers & Downs, 2003) and violence directed against this group. There are no outreach services for this group (WHO, 2005b).

The military personnel are also an affected group, but because HIV/AIDS in the military is a sensitive issue (as it relates to national security) access to statistics is restricted (Grisin & Wallander, 2002).

4.3.4 The HIV Epidemic in Altai Krai

Though not all below presented data are up-to-date, this is the most recently available data described in the literature. Altai krai is located on south-east of west-Siberia, bordering with Mongolia. Altai krai covers a territory of 168,000 sq. km. with a population density is 15.9 people per sq. km. There are 60 village regions with 1,639 villages, 12 cities and 15 micro-regions. Fifty two percent of population is concentrated in urban areas. The chemical industry, oil production and processing, and zoo-agriculture are the main economies of the krai. As of 1998, 2% of population was unemployed (Altai AIDS Centre, 1992; UNDP, 2000).

In 1998, the population was 2.673 million. Of these 52.8% were women and 58% were economically active. Altai krai is experiencing negative population growth. The number of orphans has doubled within five years. Only 10% of population above 16 years of age have higher education (Kurtikova, 2002).

In 1998, major causes of death were cardiovascular diseases (44%), followed by malignant disease and accidents. The infant mortality rate has declined to 14.6 per 1000 live births. Maternal mortality rate of 34.4 per 100 live births is low compared to the average for Russia (50.2). There was an increase in socially determined diseases, particularly TB compared to the Russian average; in 1998 the rate was 78.5 vs. 73.9 per 100 000 population. The STIs have also increased; in 1997, there were 343.2 for 100
000 population, 42% of which were 20-29 years old, 6.6% 14 years old and teenagers. The number of IDUs in the krai doubled within four years (UNDP, 2000).

The first case of HIV was registered in Altai krai in 1990. In the same year an HIV/AIDS centre was established. In 1991 mass serological screening was introduced; from 1991-1993 almost 56% of general population was screened, and 0.12% of the screened population was found to be positive. Because of low financial resources screening strategy has been changed to exclude migrants and surgical patients: allowing more targeted screening of vulnerable groups, including patients with clinical symptoms, donors, blood recipients, and patients with STI. In 1998, 18.5% of population was screened, whereas the proportion of screened from targeted groups was increased, including prisons, IDUs (Sultanov et al., 2000; UNDP, 2000). Screened target groups are presented in Figure 13 below.

Figure 13 shows no data for CSW and MSM, which indicates that these groups were missed out from the screening and no records were kept. There were 20 immunological laboratories for screening in Altai krai. Strict sanitary-epidemiological control was established in hairdressers, acupuncture services, blood transfusion services (UNDP, 2000).

Figure 13: Groups Screened for HIV/AIDS in 1998 in Altai Krai

![Figure 13: Groups Screened for HIV/AIDS in 1998 in Altai Krai](image)

Source: Situational Analysis: Report UNDP
As of March, 2007, there were 4,191 HIV/AIDS cases registered in Altai krai (Altai AIDS Centre, 2006; Federal AIDS Centre, 2006; UNDP, 2000), of which 70% were IDUs, 5.5% were infected through sexual contacts, 1.6% infected through MTCT (Altai AIDS Centre 2006; Federal AIDS Centre 2006b; UNDP 2000). The UNAIDS data indicated that HIV prevalence in Barnaul (the Capital City) ranged from 3.5-9% (UNAIDS, 2006; UNAIDS/WHO, 2006). But, regional data are difficult to find and there are discrepancies in data from different sources. Below Figure 14 presents the development of the epidemic in Altai krai.

**Figure 14: Dynamics of HIV/AIDS in Altai Krai 1990-2007**

![Graph showing the dynamics of HIV/AIDS cases in Altai krai from 1990 to 2007.](http://www.altaiyts.alt.ru)

Source: Altai AIDS Centre [http://www.altaids.alt.ru],
Federal AIDS Centre [http://hivrussia.org/index.php]

In 2002, HIV infected mothers delivered 41 children. The gender and age distribution of infected in Altai krai are presented in Figure 15. Seventy three percent of the HIV infected is male, 75% of the infected are young people aged 18-29 years. Sixty four percent of the HIV infected is unemployed (Altai AIDS Centre, 2006; UNDP, 2000).
Source: Altai AIDS Centre [http://www.alt aids.alt.ru]

Figure 16 presents HIV infection by transmission mode. There is an equal distribution (40% each) of infection through sexual contacts and drug use. The source of infection in 16% of the cases is unknown.

Source: UNDP report
Treatment of HIV infected (with timazid and interferon) is free of charge (the cost to government 18,300 Russian Rubles per year per patient). But, because of lack of financing from the federal budget triple-therapy is not provided. Opportunistic infections and treatment of patients with symptoms is financed from general health service budget. The HIV/AIDS Centre also provides psychological support before and after testing. Once diagnosed, the patients have a consultation with a physician, a psychotherapist and a psychiatrist. Afterwards, an epidemiological investigation is organised, followed by patient hospitalisation and registration for further follow-up (UNDP, 2000).

4.3.5 The HIV Epidemic in Volgograd Oblast

Though not all below presented data are up-to-date, this is the most recently available data. Volgograd oblast is located in the south-east of the European part of Russia. It covers a territory of 113,900 sq. km., of which 84% is agricultural. The oblast is rich with natural resources. The region is considered as one of the agricultural and industrial centres of Russia. There are 288 local and foreign private business organisations, 56 higher education and scientific institutions (Volgograd DATA, 1999).

As of 1999, the population of the region was 2.7 million, out of which the urban population was 74%; over one million inhabited in Volgograd. Under regional subordination there are 33 areas and 6 towns. Twenty five percent of the population was under 18 years old. The death rate was slightly less than the average in Russia. Consequently, life expectancy was longer than average: 61 for men and 63 for women. In 1996 the birth rate was 17.3 births for every 1000 women under 18 years old, which indicates early sexual relationships. The number of abortions among women of reproductive age was 57.2 for every 1000 in 1998, which was below the national average. There were 46 doctors to 10,000 people, which was equal to the national average. There was no shortage of medical personnel or hospital beds in the oblast (Volgograd DATA, 1999; UNDP, 1999).

There was a high level of migration into the region (in 1999 almost 25 thousand), accompanied with a brain drain. The crime level was slightly less than in Russia, though was raised compare to 1998. In a study conducted in October 1995,
unemployment among 16-29 years old, was 63.1%. In 1997 the level of unemployment among economically active population was 13%, which was higher from country average of 11%.

In 1998 the number of prosecuted drug users was 108.3 per 100 000 people, from which 7.2% were under-age, 72.5% were 18-30 years old; women were 10.7%, which according to militia (police) is increasing. In 1998, 55.7 people per 100 000 population had been registered with the health system for drug or psychotropic substance use, though according to the police data this number could be significantly higher (UNDP, 1999).

The first case of HIV in Volgograd was registered in 1987. As of end 2006, there were 5,008 HIV infected registered in Volgograd oblast (in 18 administrative centres). The UNAIDS estimates HIV prevalence in Volgograd was 3% of the population (UNAIDS, 2006; UNAIDS/WHO, 2006). The dynamics of the epidemic are presented in Figure 17, which shows a sharp increase in the number of cumulative of cases in the period 2001 to 2006.

Figure 17: HIV/AIDS Dynamics in Volgograd Oblast 1987-2006

[Graph showing the increase in HIV/AIDS cases from 1987 to 2006]

http://www.afew.org/english/statistics/HIVinRFregions.xls
The gender and age distribution of those infected is shown in Figure 18. As of 1999, 60.6% of HIV infected was men and 39.4% women. 43.3% of the infected is children under 15 years old (Federal AIDS Centre, 2006; UNDP, 1999).

![Figure 18: Gender Distribution of HIV/AIDS in Volgograd Oblast (1999)](image)

Source: UNDP Report

The largest group with HIV is children, who contracted HIV in 1998 from infected blood transfusions in the local children’s hospital. Of the 57 children infected in 1998, 25 had died from AIDS. The main barrier for donor blood control was lack of materials and technical equipment of the HIV laboratory. Most of the equipment including syringes was non-disposable and sterilised. Even disposable equipment often sterilised and has multiple uses (UNDP, 1999).

The proportion of PLWHA who are IDUs has grown. According to Ministry of Health and Social Development (MoH&SD), in 1999, over 90% of those infected were IDUs. HIV/AIDS infection by transmission modes is presented in Figure 19. The main function of the regional narcological dispensary (hospital) is diagnosis and treatment: there were no rehabilitation services, despite demand and an order to open such department. Unprotected sex is prevalent amongst CSW and the general population, especially amongst the youth (UNDP, 1999).
In 1999, children with HIV were hospitalised with adults, including IDUs, CSW and MSM. Stigma was widespread; social services provision was incomplete and poor (UNDP, 1999).

### 4.4 Russian Government Response to HIV/AIDS

The Russian government’s efforts to address the epidemic have been described by the World Bank as “weak and patchy” (The World Bank, 2005c; The World Bank, 2002b). The epidemic is driven mainly by IDUs, and in spite of the steep increase in this group, the incidence and prevalence in the general population levels are low. Hence, there is a lack of awareness among the government and public. Political advocacy is limited and when done not linked to evidence base (Gómez, 2005; Grisin & Wallander, 2002). To effectively tackle the epidemic, Russia requires political mobilisation, epidemiological and behavioural surveillance, effective prevention, care and treatment, as well as the removal of judicial constrains on effective actions (The World Bank, 2005c).

Despite the seeming universality of the law, its implementation is patchy as the translation of these laws into policies and actions is determined by contextual and health system factors in the country, which are unfavourable in Russia (Atun et al., 2005).
quality of counselling is inadequate, the health system does not use informed consent, and access to services is limited (WHO, 2004). Government funding for the implementation of laws and for HIV/AIDS control do not in line with the needs (Atun et al., 2005; Atun & Samyshkin, 2002; Tedstrom, 2003). Most actions still remain declarative (TPAA, 2005c).

In 2005, the Russian Government implemented several activities aimed at mobilisation and coordination of efforts to combat HIV/AIDS, namely:

- The Interagency Advisory Council on HIV/AIDS was established in April 2003. The Agency comprises government agencies and NGOs, including PLWHA. It aims to facilitate cooperation between government, civil society and international organisation activities directed at controlling the HIV epidemic.

- Drawing on international best practice, Russia established a Country Coordinating Mechanism (CCM) on HIV/AIDS and TB. The CCM has wide involvement of federal Ministry of Health and Social Affairs, federal Ministry of Justice, NGOs, bilateral and multilateral donors, Russian Orthodox Church and PLWHA. In April 2004, the CCM submitted a proposal to the Global Fund, to secure funds to improve treatment and care of marginalised and low-income PLWHA.

- In early 2004, the Russian State Duma established a “Deputies’ Working Group on the Prevention and Fight against AIDS”. This coalition will support the development and implementation of HIV/AIDS policies in Russia, expand public-private partnerships in the fight against AIDS, strengthen the federal expenditures for HIV, and promote collaboration of the Russian and international partners.

4.4.1 Health Care Response and Capacity

There is a well-developed health care infrastructure and staff capacity for provision of services (see table 3). The AIDS services are a specialised care provider network for HIV control. They include personnel consisting of infection specialists, epidemiologists, diagnosticians, psychiatrists and counsellors, as well as statisticians and social workers
(TPAA, 2004). The issue is not the infrastructure but the quality and efficiency of the services provided.

**Table 3: Health Care Infrastructure and Staff Capacity for HIV/AIDS Services Provision**

<table>
<thead>
<tr>
<th>Infrastructure/ Capacity</th>
<th>Number in Russia</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal AIDS Centre</td>
<td>1</td>
<td>Developed AIDS guidelines, normative directions and epidemiology. In addition provides HIV/AIDS prevention, testing and counselling, treatment, surveillance and laboratory monitoring</td>
</tr>
<tr>
<td>Okrug AIDS Centre</td>
<td>7</td>
<td>Responsible for interregional coverage for HIV/AIDS prevention, testing and counselling, treatment, surveillance and laboratory monitoring</td>
</tr>
<tr>
<td>Regional AIDS Centres</td>
<td>89</td>
<td>Provides HIV/AIDS prevention, testing and counselling, treatment, surveillance and laboratory monitoring</td>
</tr>
<tr>
<td>Municipal Centres</td>
<td>20</td>
<td>Provides HIV/AIDS prevention, testing and counselling, treatment, surveillance and laboratory monitoring</td>
</tr>
<tr>
<td>Laboratories</td>
<td>1000</td>
<td>Conduct routine serological surveillance</td>
</tr>
<tr>
<td>Infectious hospitals and disease units</td>
<td>100</td>
<td>Provide inpatient care for PLWHA</td>
</tr>
<tr>
<td>Hospitals</td>
<td>300</td>
<td>Provide inpatient care for PLWHA</td>
</tr>
<tr>
<td>NGOs</td>
<td>40</td>
<td>Providing HIV/AIDS services</td>
</tr>
<tr>
<td>Governmental staff (mix of professionals)</td>
<td>6700</td>
<td>Providing HIV/AIDS services, prevention, testing and counselling, treatment, surveillance and laboratory monitoring</td>
</tr>
<tr>
<td>HIV/AIDS specialist physicians</td>
<td>300</td>
<td>Providing HIV/AIDS services, prevention, testing and counselling, treatment, surveillance and laboratory monitoring</td>
</tr>
<tr>
<td>Infectious disease physicians</td>
<td>9000</td>
<td>Trained in HIV/AIDS treatment and care</td>
</tr>
</tbody>
</table>
4.4.2 Highly Active Antiretroviral Therapy (HAART)

HAART improves the quality and longevity of life for PLWHA: transforming HIV/AIDS from a fatal disease to a manageable chronic disease (WHO, 2004). The availability of the HAART also leads to increasing uptake of voluntary testing and counselling for HIV. HAART keeps CD4 count over 200, prolongs the functioning of the individual's immune system, preventing the onset of several opportunistic infections including bacterial pneumonia, pneumocystis carini pneumonia and tuberculosis (Feshbach & Galvin, 2005).

In Russia, the national guidelines developed for HAART are in line with WHO recommendations. In 2004, an estimated 15-56,000 citizens living with HIV/AIDS in Russia required HAART, but coverage was less than 5% (TPAA, 2004; Vinokur & Semenchenko, 2004; WHO, 2004). HAART is available only through limited number of federal and regional AIDS centres. In Russia, in 2004, there are 14 registered antiretroviral (ARV) drugs. Tenofovir, strongly recommended by WHO, was only registered in 2004. No generic drugs are registered. This makes HAART expensive. As of end of March 2004, first line therapy costs US$7,800-8,800 per patient per year, while the cost of second-line treatment was US$12,000-15,000 (WHO, 2004).

Federal AIDS Law guarantees free universal access to treatment and provision of medical care to PLWHA. The Law also stipulates State financing for measures aimed at constraining the spread of HIV. But the Law is not implemented because of:

- Lack of political commitment;
- Widespread stigma and discrimination against PLWHA;
- Insufficient financing of HIV/AIDS programmes;
- High price for ARV;
- Absence of the national guidelines on provision of treatment with ARV;
- Lack of capacity in the national medical procurement and distribution system (Vinokur & Semenchenko, 2004).

The donor community contribution covers the need of HAART by only 10% for a few years. This may help to address financing gaps for treatment in the short-term, it is not a sustainable solution. The Russian government needs to develop sustainable policies and demonstrate long-term commitment to address financing gaps. By 2009, Russia...
will need to provide HAART for 74,000 patients. With existing financial commitments, this can only be achieved with a price reduction from US$10-12,000 to US$500-800 per patient. Price reductions can be achieved if Russia follows international best practice for example:

- Organise centralised price negotiation with suppliers of ARV medicines
- Introduce pooled procurement;
- Procure generic medicines;
- Consider “Compulsory licensing” or “Government Use”, as provided by TRIPS Agreement;
- Exempt ARV medicines from tariffs, duties and taxes;
- Scale up domestic production of ARV medicines.

Apart from price decreases and organising a constant supply of HAART, Russia needs to address weaknesses in the drug distribution networks, set up health care and delivery structures for HAART, educate and train medical personnel, and scale-up social and psychological support services to address the HIV/AIDS patients’ needs (Vinokur & Semenchenko, 2004).

4.4.3 HIV/AIDS Legislation In the Russian Federation

In the Soviet period there was no national programme to regulate HIV/AIDS activities, but Russia, as a part of USSR, responded to its first registered HIV-positive case with a decree in August 1987 “On Measures for Prophylaxis Against Infection with the AIDS Virus”. This legislative act “reflected only the interests of society and had a restrictive (and repressive) effect on citizens’ rights” (Polubinskaya, 2004). In 1990, in response to the emerging epidemic, the USSR adopted the Law “On Prophylaxis of AIDS Disease.” This Law defined the rights to social and medical care; free transportation to medical facilities; free outpatient medication; access to pensions for those infected through medical instruments and also included provisions to prevent discrimination of PLWHA. In 1993, the government of the Russian Federation developed “Federal Programme for the prevention of the Spread of AIDS in Russia from 1993-1995” (Bobrik & Twigg, 2007). The main activities of this programme were directed towards HIV/AIDS prevention; improvement of the capacity for diagnosis; treatment and follow-up of
infected patients; activities to provide social and legal support of PLWHA; activities to improve surveillance systems; increase scientific capacity for HIV/AIDS research; and information and education of public and medical personnel. In 1995, Russia adopted a Federal Law “On Prevention of Spread in the Russian Federation of Disease Caused by Human Immunodeficiency Virus (HIV infection)” (Polubinskaya 2004). This Law, which built on the Federal Programme adopted in 1993, and which was renewed in 2002, defined basic State activities to combat the epidemic, including a wide range of legal guarantees and social protection related to HIV/AIDS, such as the provision of anonymous and confidential testing and counselling, providing HIV positive people free access to health care and social welfare services, along with universal access to Anti Retroviral Treatment (ART) (WHO, 2004). In the period 1996-2001 the Law on HIV/AIDS Prevention was implemented through the Federal Anti-HIV/AIDS Programme.

In addition, based on the Federal Laws, 69 of the regions developed regional HIV prevention programmes (Davis & Dickinson 2004; Rodrigez 2002). In 2001, Russia signed the UNGASS Declaration of Commitment to HIV/AIDS, committing Russia to “ensure the development and implementation of multi-sectoral national strategies and financing plans for combating HIV/AIDS”. Later, in 2002, Russia and other countries of the Commonwealth Independent States (CIS), signed a declaration (Moscow Declaration on “Urgent Response to the HIV/AIDS epidemics in the Commonwealth of Independent States”) stating the importance of dealing with the AIDS problems (Polubinskaya, 2004).

In May 2003, in his annual address to the Federal Assembly, the Russian President V. Putin emphasised the negative influence of HIV/AIDS on the country’s demography.

Currently in Russia, HIV/AIDS is regulated through the Federal “Targeted Programme for Prevention and Control of Social Diseases for 2002-2007”, which includes an HIV/AIDS sub-programme. UNAIDS is attempting to develop a National AIDS policy framework for Russia, with a strategy for implementing the “Three ones” approach (one HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners; one National AIDS Coordinating Authority, with a broad based multi-sector mandate; one agreed country level Monitoring and Evaluation System (UNAIDS, 2004)). To achieve this, UNAIDS is providing support to build capacity in federal level
governmental institutions and to establish a monitoring and evaluation system for HIV/AIDS.

All the laws and programmes adopted in Russia to control HIV/AIDS are in line with international legal requirements, recommendations developed by international agencies and intergovernmental declarations. However, these laws and programmes have not been properly implemented (Bobrik & Twigg, 2007; TPAA, 2005). Moreover, HIV control has confronted another problem: namely the Federal Law on Narcotics and Psychoactive Substances, adopted in 1998 and which declared illegal the use of all drugs without prescription of physicians. This law directly challenged needle and syringe exchanged programmes, making them illegal and hindering harm reduction programmes for IDUs. This law was amended in 2002, introducing the concept of “average minimum doses”, with severe punishments for those found with amounts beyond this amount (Bobrik & Twigg, 2007).

But there is a shift in the attitudes of senior officials recently. In May 2006 Russia hosted a major conference on HIV/AIDS in Eastern Europe and Central Asia, with wide representation of international donors, local officials, NGOs and representatives of the scientific community. In February 2006, the Russian State Duma held hearings on HIV and its adverse impact on the Russian society (Bobrik & Twigg, 2007). In July 2006, while hosting G8 meeting president Putin declared HIV/AIDS as a priority. Whether these actions mark a change of attitudes towards HIV/AIDS epidemic or amount to “appeasing” policy manoeuvres will be apparent in time.

### 4.4.4 HIV/AIDS Funding in the Russian Federation

The extent of Government commitment to the HIV problem is reflected in the amount of funding for HIV control (McPherson, 2003; UNAIDS, 2004d). The World Bank views Russia’s allocation to HIV/AIDS to be “disproportionately modest” (The World Bank, 2005). The planned budget for the Federal Programme 1993-1995, was US$20.35 million, but only 42% of this budget was executed. The federal anti-AIDS programme is funded from the budget of the MoH&SD and implemented by the federal, territorial and regional AIDS centres (The World Bank, 2002a). According to the Russian health authorities, US$97 million was needed over five years to implement the Federal law
provisions: with US$26 million was to be allocated from the Federal Budget and almost US$70 million provided from regional budgets (Tedstrom & Narkevich, 2004). The contribution of each region varies, depending on the economic conditions in the region, HIV/AIDS prevalence rates and the level of NGOs and foreign donors’ contribution to HIV related activities. The average annual contribution in a region is US$350-550,000, but in some locations (such as Tatarstan Republic, Krasnoyarski krai, Moscow, Saint Petersburg) this figure can reach US$1.4-1.8 million per annum. Poor financial allocation reflects not the resource availability but the level of importance and priority given to the issue (Tedstrom & Narkevich, 2004). The shortfall in financing for HIV has been partly met by around 100 NGOs which operate in Russia and which receive funding from bilateral and multilateral donors.

The programme budget for 2002-2007 is US$252 million: but, by 2005, only US$40 million of this sum was executed (Bobrik & Twigg, 2007). The budget allocated to HIV/AIDS programme in 2003 was US$5.6 million (Seltsovsky et al., 2004). In 2004, the combined federal and regional budget for HIV/AIDS was about US$19 million. By 2006, the funding needed for the treatment of HIV infected patients alone was estimated at US$280 million (Tedstrom & Narkevich, 2004).

On average, at federal level, Russia allocates approximately US$5 million a year to HIV/AIDS (Grisin & Wallander, 2002; Tedstrom & Narkevich, 2004), against an estimated need of US$19 million per annum. This budget shortfall is met by donor agencies, which, in 2004, contributed US$13 million, almost three times more than the federal budget. There are a number of donor-funded projects and loans to support HIV-control activities (Seltsovsky et al., 2004; Tedstrom & Narkevich, 2004), these include:

- The World Bank loan totalling US$286.18 million, signed in 2003. The loan was meant to support the federal programme for prevention and control of social diseases, including an AIDS component and was directed at supporting capacity building, surveillance, programme development and prevention and care interventions, totalling US$48 million. The allocation from regions will be total to US$15 million for programme implementation.
- The Global Fund to Fight AIDS, Tuberculosis and Malaria, signed in 2003, to fund HIV prevention, advocacy, care and support over five years. The programme funded by US$89 million grant is implemented by five NGOs in 10 regions.
• British Government programmes totalling UK£8 million (US$16 million) of grants provided to the Russian regional HIV/AIDS programmes.
• The International Labour Organisation (ILO) programme for HIV prevention for the period 2004-2007, funded by a US$1 million grant.
• The Netherlands Government project with total funding of over €1 million.
• The Swedish International development Agency (SIDA), funding of US$2 million (between 2002-2007) to establish HIV prevention project among prisoners in some Russian regions.
• EC Technical Assistance to CIS (TACIS) programmes (2003-06) totalling €5 million.

The recent economic growth in Russia means that if HIV is seen as a priority, Russia could contribute far greater sums from its federal budget surplus, from the Central Bank state golden currency reserves (more than US$80 billion), stabilisation funds (almost US$20 billion for 2005), and income from the use of natural resources (US$40-45 billion annually) (Seltsovsky et al., 2004).

In April 2006, President Putin promised to provide to regions matching funds from federal resources totalling US$175 million in 2006 and US$285 million in 2007 to fight HIV/AIDS (Bobrik & Twigg, 2007). It remains to be seen if these promises are kept.

4.5 The Impact of HIV/AIDS in the Russian Federation

The HIV/AIDS pandemic has led to untold human suffering with severe social and economic consequences for the affected individuals, communities and countries (Barnett et al., 1996; Barnett & Whiteside, 2000; Gerber & Mendelson, 2005). HIV, through its impact on young people, places a burden on labour markets and families and creates serious social, economic and security problems for the countries affected by the epidemic. Russia will face these problems unless decisive steps are taken by the government to address HIV (Vinokur & Semenchenco, 2004). HIV/AIDS now affects all Russian regions, but 70% of the epidemic is concentrated in the 10 most developed and populated regions (TPAA, 2004; TPAA, 2005b).
HIV/AIDS has both macroeconomic and microeconomic consequences and could have a major effect on the Russian economy through (TPAA, 2005a):

- Negative influence of the labour force;
- Direct and indirect costs for firms;
- Diversion of state resources to HIV;
- Lowered of productivity and reduction in gross domestic product (GDP).

HIV/AIDS has a high prevalence amongst young adults. Most new cases of HIV infected are male aged 18-25. This could decrease the pool of potential military recruits and impact on the country defence capability (Feshbach & Galvin, 2005). Demographers estimate that by 2020, Russia will have a shortage of 600-700,000 conscripts. HIV will also affect the higher education and the labour force in the country (Grisin & Wallander, 2002). HIV will also affect the economy. According to scenarios developed by the WB by 2010 HIV/AIDS epidemic will lead to a decline in the GDP by 4.15% and by 2020 the decline could reach 10% (The World Bank, 2005c; The World Bank, 2005b; TPAA, 2004). A more recent study conducted by Imperial College London found the burden of the epidemic on the Russian economy to be insignificant because of the low prevalence and minimal allocation of resources to HIV/AIDS activities. HIV epidemic will increase direct costs to firms because of costs of illness and low productivity, but as the cost of medical services is currently low, and costs absorbed by the health system and social insurance these are currently insignificant (Samyshkin et al., 2005).

Economic costs have been estimated at US$1.2 billion by the end 2008, above and beyond the necessary investments for treatment and prevention (Rühl et al., 2002; TPAA, 2004).

HIV could also reduce the quality-adjusted labour supply because of a decline in the absolute numbers of workers because of deaths and a decline of workers' productivity affected by disease (Rühl et al., 2002; The World Bank, 2005c).

The socio economic characteristics of the country is presented in table 4.
### Table 4: Socio-economic Characteristics of the Russian Federation

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Data Estimate</th>
<th>Year</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross National Income, ppp, per capita (Int.$)</td>
<td>4460</td>
<td>2005</td>
<td>WHO (WHR 2005)</td>
</tr>
<tr>
<td>Gross Domestic Product per capita (US$)</td>
<td>11,100</td>
<td>2005</td>
<td><a href="http://www.infoplease.com">www.infoplease.com</a></td>
</tr>
<tr>
<td>Gross Domestic Product per capita % growth</td>
<td>6.4</td>
<td>2001-2005</td>
<td>The World Bank</td>
</tr>
<tr>
<td>Gross Domestic Product % to health and social services</td>
<td>3.1</td>
<td>2005</td>
<td>International Monetary Fund</td>
</tr>
<tr>
<td>Real Growth rate</td>
<td>7.3%</td>
<td>2005</td>
<td><a href="http://www.infoplease.com">www.infoplease.com</a></td>
</tr>
<tr>
<td>Inflation</td>
<td>12.7%</td>
<td>2005</td>
<td>The World Bank</td>
</tr>
<tr>
<td>Unemployment (included considerable unemployment)</td>
<td>8.6</td>
<td>2005</td>
<td>The World Bank</td>
</tr>
<tr>
<td>Export (in % of nominal GDP)</td>
<td>35.1 (241,219 million US$)</td>
<td>2005</td>
<td>International Monetary Fund</td>
</tr>
<tr>
<td>Import (in % of nominal GDP)</td>
<td>21.6 (98,577 million US$)</td>
<td>2005</td>
<td>International Monetary Fund</td>
</tr>
<tr>
<td>Reserves of Foreign Exchange and Gold (US$)</td>
<td>251.1 billion</td>
<td>2006</td>
<td>International Monetary Fund</td>
</tr>
<tr>
<td>Investment (as a % of GDP)</td>
<td>20.9</td>
<td>2005</td>
<td><a href="http://www.cia.gov">www.cia.gov</a></td>
</tr>
<tr>
<td>Public Debt (as a % of GDP)</td>
<td>28.2</td>
<td>2004</td>
<td><a href="http://www.cia.gov">www.cia.gov</a></td>
</tr>
<tr>
<td>Domestic Debt (in rubles)</td>
<td>875 billion</td>
<td>2005</td>
<td>International Monetary Fund</td>
</tr>
<tr>
<td>External Debt (US$)</td>
<td>258.4 billion</td>
<td>2005</td>
<td>International Monetary Fund</td>
</tr>
<tr>
<td>Income per capita</td>
<td>7938</td>
<td>2005</td>
<td>International Monetary Fund</td>
</tr>
<tr>
<td>Human development index</td>
<td>0.797</td>
<td>2005</td>
<td>UNDP</td>
</tr>
<tr>
<td>Total expenditure on health as a % of GDP</td>
<td>6.4</td>
<td>2005</td>
<td>WHO</td>
</tr>
<tr>
<td>Government budget spent on health care (%)</td>
<td>9.5</td>
<td>2005</td>
<td>WHO</td>
</tr>
<tr>
<td>Per capita total expenditure on health (Int. $)</td>
<td>551</td>
<td>2003</td>
<td>WHO</td>
</tr>
<tr>
<td>General government expenditure on health as % of total expenditure on health</td>
<td>64.3</td>
<td>2005</td>
<td>WHO</td>
</tr>
</tbody>
</table>
Another consequence for the economy could be decline of effective labour supply. The latter has double effect: decline in absolute numbers resulted deaths and decline of workers' productivity resulted affected by disease. The epidemic will have dual effect on the latter: a decline in the absolute numbers of workers due to death and a decline in productivity amongst workers affected by the disease. In addition, opportunistic diseases could cause temporary disability and costs of the supporting services that are necessary for care will increase the economic burden increased by the disease and have negative indirect effect. All of the above do not include implications of the disease for the peers of infected population.

But given that the Russian economy is highly dependent on extractive industries and not labour-intensive, the affects are more likely to be at microeconomic level, affecting firms, households and individuals (Wall, 2003).

Tedstrom and Narkevich (2004) forecasted the following possible consequences of HIV:

- A reduction of the labour productivity and corporate competitiveness affecting the progress in growth of GDP.
- An increase in poverty within the country, as a result of the less income generation amongst the HIV/AIDS affected population.
- A decrease in the number of military servants, due to an increase in the affected young male population.
- A demographic crisis, because of the low birth rate and the reduction in life expectancy resulting from premature deaths among young adults and infants.
- A decrease in social welfare and an increase in the pension burden for society resulting from decrease in the proportion of population available to employ and an increase in the proportion affected by the disease.
- Hindrance of socio-economic development because of the high cost of public health expenses.
- An increase of death rate caused by HIV/AIDS and other opportunistic infections, which develop in parallel to the infection.
- A weakening of the health of the country’s population.
- An increase in the social security burden because of the increasing number of orphans.
- Aggravation of social tensions caused by the stigma and discrimination against the affected population.
A range of actions could address the emerging problems (Tedstrom & Narkevich, 2004; WHO, 2004) including: better coordination between different sectors; improved coordination within the health sector; development of outreach for the marginalised and difficult to reach populations (IDU, CSW); community support and reduction of stigma against PLWHA, IDU, CSW, TB patients to increase utilisation of services; increase support for adherence; increase in HAART coverage; improved management and retraining for effective use of the existing HIV/AIDS workforce; improved surveillance and development of second-generation surveillance. Many of these activities are inadequately implemented in Russia.

This chapter gave an overview of the context of the epidemic in Russia. HIV/AIDS epidemic in Russia is in early stages of development and there is still a window of opportunity to mobilise key stakeholders, such as the government, health professionals and civil society representatives to combat the epidemic. It is these stakeholders that will determine how Russia responds to the epidemic. Hence their views and perceptions are critically important. This has been explored in the research that underpins this thesis. The next chapter presents the methodology, which is followed by the stakeholder analysis.
Chapter 5: METHODS

Research used secondary data review and analysis combined with primary research that used qualitative methods of inquiry. Primary research used structured interviews to ascertain stakeholders' views and perceptions on HIV. Theoretical (purposive) sampling with snowballing was used to identify respondents for research. Research was conducted in three regions, research sites for the study, and included 153 face-to-face interviews carried out by local researchers from Volgograd, Barnaul and Moscow. The interviews were transcribed verbatim, coded and analysed. The thematic and domain analysis was used for data interpretation informed by the framework (see Figure 1) developed for policy analysis in Russia.

5.1 Secondary Data Review and Analysis

Secondary data was used to extract and analyse statistics related to the epidemic and to obtain general country information (DISC, 2003; Partnership & Household Livelihood Security Unit, 1998). The main sources of secondary data were official statistics, technical reports, scholarly journals, scientific papers, on-line Web sites, literature review articles and reference books. Secondary data analysis helped to acquire more information and explanations about the problem and its solutions (Gilbert, 2007; Kiecolt & Laura, 1985) and provided valuable information for primary research (Partnership & Household Livelihood Security Unit, 1998; 969 Research Methods: Secondary data Analysis, 2007).

This process was extensive and very time consuming, as local, federal and international data were poor and difficult to locate. When available there were substantial discrepancies in data from different sources. As a researcher, I experienced all the disadvantages of secondary data described in the literature: data availability, quality of data, outdated data and problem of quality control.

Secondary data analysis was conducted at the outset and when writing the thesis. Statistical data were revisited several times to update the figures and numbers and use the latest data upon availability.
5.1.1 Literature Review

A literature review was conducted between November 2003 to May 2006, to develop a good understanding of the theory and empirical body of knowledge. The main source of literature was the Imperial College London and London School of Economics libraries. The electronic catalogues of the US Congress library and British libraries were used. A review of key databases, websites, and journals (main ones presented in box 15) was performed in a systematic fashion. Key words (and different combinations of key words) were used with key terms to obtain initial list of publications. The abstracts of these publications were screened to identify relevant articles. These were obtained from libraries and reviewed in detail. A cascading of references was used to yield further publications not captured in the search. In addition, key books relevant to the topics (policy and related studies and theories, qualitative research) were studied. The search was conducted among Russian and English language publications.

Box 15: Systematic Literature Search Strategy

| Databases- | PubMed, Bids, MetaLib |
| Search Engines- | Yahoo, Google Scholar |
| Journals- | Health Planning and Policy, BMJ, AIDS, Reproductive Health and STD, Social Science and Medicine, Journal of Social Policy, Health Policy, Lancet, Public Administration |
| Key Words- | HIV/AIDS; Russia HIV/AIDS/epidemic/development; advocacy definitions/campaign/model; IDU; decision making; power; policy definition/change/process/analysis/theories; |
| Year | 1980-2006 |
| Search results number of articles identified | 21,304 |
| Total number of main articles reviewed | 753 |

The literature review yielded theoretical and conceptual frameworks that could be used to guide the interpretation of findings, to develop more precise problem statement, and for validation of the findings (Marshall & Rossman, 1995; Strauss & Corbin, 1990).
5.1.2 Documentary Analysis

The documentary analysis provides additional information about the subject; traces the historical development of the event and explains the factors underpinning the issues under investigation. Archival data, records of organisations, protocols, meeting minutes and formal policy statements provide supplementary information and also allow checking of data gathered through interviews (Green & Thorogood, 2004; Holloway & Wheeler, 1996; Marshall & Rossman, 1995). The analysis of documents is an unobtrusive method of the data collection.

A local researcher was used to collect all documents relating to policies, laws and regulations on HIV/AIDS. The documentary analysis provided additional information about the policy process; traced the historical development of HIV and provided information to explain key factors underpinning the issues under investigation. Analysis of the HIV/AIDS regulatory framework in Russia was conducted to understand the current policy framework used to guide Russian decision-makers.

5.2 Justification for the Choice of Qualitative Research Method

Quantitative research approaches enable measurement of responses (e.g. how many and how often), whereas qualitative approaches explore why and how certain phenomena occur. Quantitative research provides essential evidence, whereas the qualitative discovers the process. Determining essential causal pathway requires a greater understanding of events and the relationship between them. There was a need to look deeply at the processes and to understand the respondents' point of view, rather than the frequency of the response. Thus, the qualitative method was found appropriate in implementing data collection (Crabtree & Miller, 1992; Denzin & Lincoln, 1994; Jones, 1995).

Qualitative research is an essential component in health and health services research (Black et al., 1998; Green & Thorogood, 2004; Pope & Mays, 2000). It enables access to areas, such as health beliefs, which cannot be readily ascertained by quantitative research. Qualitative research compliments quantitative research (Pope & Mays, 1995; Savage, 2000; Strauss & Corbin, 1990). Qualitative research aims to understand
phenomena in a natural setting based on respondents’ knowledge, experiences, and views (Pope & Mays, 2000). The research tries to identify the behaviour of people and understand the underlying meaning of the experiences, attitudes, and beliefs they describe. The reasoning inherent in qualitative research is inductive rather than deductive (Bryman & Burgess, 1994). Box 16 below presents some applications of qualitative research.

**Box 16: The Range of Use of Qualitative Research**

- Early exploration for idea generation and direct experience of a target population
- Explain, understand and illuminate quantitative behavioural and attitude data
- Understand the reason for behaviour or attitude shifts
- Help develop communication strategies, concepts and treatments
- Obtain information from small, “elite” samples
- Clusters of behaviour on an individual basis
- Problem identification and definition
- Identify information needs of potential target segments
- Pilot quantitative study: exploration, hypothesis development, language

Qualitative methods are particularly valuable when describing and understanding a situation or behaviour (Berg, 1998; Bryman & Burgess, 1994; Murphy & Dingwall, 2003), and commonly used to explore health reform and policy formation process (Britten et al., 1995; Pollitt et al., 1990; Savage, 2000).

My research objective was to explore in depth the HIV policy processes in Russia and to understand stakeholder views on HIV. Thus, qualitative method was appropriate to achieve my research objectives (Crabtree & Miller, 1992; Denzin & Lincoln, 1994; Jones, 1995).
5.3 Qualitative Analysis of Stakeholders: Key Informant Interviews

Short time scales shape the direction of research for applied policy analysis. Limited time means that research is usually carried out by a team of researchers and involved individual interviews, observations or group discussions, complimented by documentary analysis and desk research (Bryman & Burgess, 1994). The current study used in-depth interviews conducted by teams of local researchers.

Strauss and Corbin (1990) suggest several types of qualitative research: grounded theory, ethnography, the phenomenological approach, life histories and conversational analysis. For this study the ethnography type was used for data collection, as there was not much information available related to the subject under research and thus required detailed understanding of the issue. Marshall suggests the following fundamental methods for qualitative research: participation in setting, direct observation, case study, in-depth interviewing and documentary analysis (Holloway & Wheeler, 1996; Marshall & Rossman, 1995). From the above methods the study adopted in-depth interviewing and documentary analysis for information collection, based on consideration of the topic under investigation and inappropriateness of using other methods to cover issues related to this particular research. There are several specialised forms of in-depth interviewing: ethnographic, phenomenological, elite and focus group. For the study elite interviewing was used, as the research interest was in the policy process, which in Russia is the output of the elite. The elite are well-informed, influential the prominent individuals within organisation or the community and were selected based on their experience in the relevant area (Green & Thorogood, 2004). The advantage of elite interviewing is that valuable information can be obtained on personal and organisational views on financial, legal, structural, and policy issues and future plans (Marshall & Rossman, 1995). This is particular information that the study was interested in. The disadvantage of elite interviewing is that they are difficult to access, could readily influence the interview process by taking the lead and have their own agenda, so the interviewer should be well trained in interview techniques. In this research the key informants were the elite group of policy makers and HIV/AIDS stakeholders who were selected based on their experience (Green & Thorogood, 2004).
The stakeholder analysis was conducted using the qualitative research technique - structured interviews to ascertain the views of the key stakeholders (Patton, 1987), and to understand their attitudes, values, motivations and beliefs (Aday, 1989).

In qualitative research the main source of information is informants. Informants are people who can easily contact the interviewer, who understand the need for the information that is sought, and who are glad to share their opinion with the interviewer (Bernard, 1995). In having an appropriate understanding of the culture and language and in making contacts with the defined population the informant’s role is very important. In this study context, informants are people with direct experience of the HIV/AIDS problem being investigated (Weller & Romney, 2002). The stakeholder analysis was conducted among the current stakeholders actively involved in HIV/AIDS issues in Russia and among the potential stakeholders who are currently not involved, but could play significant role in resolving challenges suggested by HIV/AIDS. The latter group were a valuable source of information for understanding the policy development process (starting from main influences, decision-making, drafting, discussions, adoption, enforcement and implementation), the policy gaps and possible ways of overcoming potential bottlenecks in policy development.

5.4 Sampling Frame

The literature suggests two categories of sampling, which can be grouped according to the theory underpinning the process: probability and non-probability (Bernard, 1995). Together these categories involve seven major kinds of samples: quota, purposive, snowball and hap-hazard for the non-probability samples and simple or systematic random, stratified random and cluster in the case of probability samples. The latter samples are representative of larger populations and increase the study external validity. **Probability** sampling requires a sampling frame (i.e. a list of population under study) from which individuals can be chosen for the study. In the absence of a list, **non-probability** sampling is used. The disadvantage of the technique is that it gives low external validity to the study. The research used purposive sample of informants (Bernard, 1995) from the list of organisations provided in the initial interviews and thereafter sampled by nominations. A list of potential informants/inter-sectoral
Committee members was obtained from the study regions. The lists of NGOs and private sector organisations provided by the regional authorities were incomplete. Many of the identified organisations were either not functioning or dissolved. Therefore, non-probability sampling was used. The respondents at the first stage of interviews were asked to nominate further respondents, i.e. snowball sampling or nominations.

5.4.1 Location of Study

The interviews were conducted among the stakeholders at three levels: Federal (Moscow), Oblast (Volgograd) and Krai (Altai). The research sites were identified by the UK DFID, who funded the research, and the Russian Government.

The selection of the research sites was based on convenient sampling. The research was a part of the “Knowledge for Action on HIV/AIDS in Russian Federation” programme, which was funded by DFID, and the DFID and Russian Co-partners determined the choice of the sites. Unfortunately, none of the project related documents justified the choice, but they represented three different administrative levels: Federal, Regional and Oblast. Geographically, the sites were located in the eastern part of the country. The economic, demographic and socio-economic parameters (see details in Chapter 4) for all sites were different, so was the experience of working with international donors and dealing with the issues related to HIV/AIDS. Altai Krai had longer experience of working with international agencies, and was more open to discussions and suggestions. The communication with local authorities was more informal and efficient. Whereas Volgograd was more centrally structured and the bureaucratic apparatus maintained control of daily activities, hindering progress in implementation of the project. On the other hand on some issues (e.g. harm reduction) Altai had some negative experience, and was sceptical about certain ideas (e.g syringe exchange and issues related to human rights of drug users), whereas Volgorad stakeholders where more open to suggestions as they had no prior opinions on many of the initiatives. On both sides the local researches were very skilled and knowledgeable making, the research implementation professional helping to maintain the quality of the research.
5.4.2 **Sample Size**

Having no features available pointed out the need for non-probability sampling, it was not possible to calculate the sample size prior to data collection. This is the reason that the study used purposeful or judgmental sampling. During all four stages, in total 153 interviews were completed: 66 in Volgograd oblast, 65 in Altai krai and 22 at the Federal level. The sample size was determined when all nominated stakeholders been interviewed and no new information was emerging, indicating a saturation point in interviews. This was true for each of the target regions: Altai krai, Volgograd oblast and on Federal level.

5.4.3 **Sampling Strategy**

To identify the HIV/AIDS stakeholders, the regions provided lists of the HIV/AIDS Committee members, who were then all interviewed during the first stage of the study. So purposeful or judgmental non-probability sampling was used for the first stage data collection. This is because we deliberately choose the respondents according to their position in decision-making (Pope & Mays, 1995). For the other three stages a non-probability snowball sampling approach was employed. This is widely used in the study of social networks (Dey, 1993). It is also useful in studies of difficult-to-find populations. In snowball sampling several key individuals are interviewed and asked to name others who would be likely candidates for the research. This is an effective way to build an exhaustive sampling frame.

For stage one of the data collection, the key informants were the inter-sectoral HIV/AIDS Committee members, who were asked to provide information for data collection in stages two, three and four. For stage one we asked the Committee members to nominate (i) government officials involved in HIV/AIDS issues in Russia but who were not Committee members, and (ii) those who are not involved in HIV/AIDS issues, but could be in the future, and where the contribution could be valuable. The interviewees in the first stage were also asked to list the NGOs and private sector organisations currently cooperating with them, as well as those that were not cooperating but could contribute to HIV/AIDS issues. The nominated governmental organisations, NGOs and private sector organisations were used to create a list of
interviewees for the next stages of interviews. The lists were sent to the regions and discussed with local counterparts to secure their agreement.

In regions, the data were collected in four stages, totalling 131 interviews:

**Stage 1 (S1)** – interviews were conducted with members of the HIV/AIDS Intersectoral Committee. A total of 33 interviews were conducted (n=13 in Altai and n=20 in Volgograd).

**Stage 2 (S2)** – interviews were conducted with the representatives of governmental organisations not involved in the inter-sectoral Committee work, but who were important (or potentially important) stakeholders to be involved in HIV/AIDS issues. A total of 52 interviews were conducted (n=27 in Altai and n=25 in Volgograd).

**Stage 3 (S3)** – interviews were conducted with representatives of the NGOs involved, or could be involved to combat HIV/AIDS. A total of 27 interviews were conducted (n=14 in Altai and n=13 in Volgograd).

**Stage 4 (S4)** – interviews were conducted with the representatives of the business community (industrial units and factories) who could be involved in HIV/AIDS issues. A total of 19 interviews were conducted (n=11 in Altai and n=8 in Volgograd).

Twenty two interviews were conducted at the Federal level. The respondents were members of the HIV/AIDS Advisory Council, consisting of high-ranking government officials representing different sectors, PLWHA, and NGOs. Details of all the interviewed stakeholders are presented in box 17 below.

The research response rate was 97%; one interview was interrupted because of the interviewee’s health condition and four respondents (two in Altai and two in Federal level) refused to participate citing a shortage of time as their reason to decline.
Box 17: Characteristics of the Stakeholders Interviewed

<table>
<thead>
<tr>
<th>Characteristics of Interviewed Stakeholders</th>
<th>Altai Krai</th>
<th>Volgograd Region</th>
<th>Federal Level</th>
<th>Number of Interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directors and managers working at local or federal government administration</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Intersectoral Committee members</td>
<td>14</td>
<td>18</td>
<td></td>
<td>32</td>
</tr>
<tr>
<td>Administrative department head/deputy heads</td>
<td>16</td>
<td>15</td>
<td>7</td>
<td>38</td>
</tr>
<tr>
<td>Clinical institution heads</td>
<td>4</td>
<td>5</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Academic/Research institution authorities heads and leading specialists</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>NGO heads</td>
<td>15</td>
<td>13</td>
<td>8</td>
<td>36</td>
</tr>
<tr>
<td>Private Sector directors/leading specialists</td>
<td>11</td>
<td>8</td>
<td></td>
<td>19</td>
</tr>
<tr>
<td>TOTAL</td>
<td>65</td>
<td>66</td>
<td>22</td>
<td>153</td>
</tr>
</tbody>
</table>

5.4.4 Inclusion and Exclusion Criteria

I developed the inclusion criteria which were: the elite and other stakeholders involved in planning and delivering of HIV/AIDS programmes and who were in a position to provide information relevant to research questions, share with their ideas and opinions regarding the relevant topic. Exclusion criteria were those stakeholders who previously occupied senior positions and been nominated by HIV/AIDS intersectoral Committee members for interview, but who currently were not working on HIV/AIDS arena.

5.5 Ethical Approval

Ethical approval for the research was obtained from the London Riverside Ethical Committee (see Appendix A). Though there were no sensitive questions asked of the population under investigation, ethical issues were discussed with the researchers during
the training. I sensitised researchers to minimise the influence on the respondents' judgement by their attitude, by the wording of questions and using the probing techniques. Based on the ethical approval, I developed an introduction sheet for research participants (Appendix B) to provide awareness and a consent form (see Appendix C) to be signed by each respondent before the start of the interview. With the interviewees' agreement the interviews were tape-recorded and field notes taken.

5.6 Data Collection

The data collection was conducted in the period from February-June 2004 in Volgograd and Altai and March-May 2005 in Moscow, by sociologists from Moscow Public Health institute, Altai State University and Volgograd State Medical University. I trained the data collectors in London in qualitative research theory and methods and also conducted a one-day seminar before they started data collection in regions.

5.6.1 Data Collection Instrument

The qualitative interviews generate valuable insights from the respondents about the complexity of the issues and range of the attitude, values and behaviours (Bauman & Greenberg, 1992; Maanen, 1979). To achieve a better understanding of informants' experiences from their point of view, ethnographic interviews were conducted with key informants who met the stated criteria (Bernard, 1995). An instrument for data collection was chosen from known in-depth unstructured, structured in-depth, focused, psychological-clinical and ethnographic interviews (available upon request). The technique chosen was unstructured and nondirective which allows us to understand people's interactions, behaviours and beliefs in their personal and cultural context, allowing us to gain insights about HIV/AIDS issues. The main characteristics of ethnographic qualitative interview are (Bauman & Greenberg, 1992):

- They permit some flexibility to interviewer to choose the topic and questions
- All responses are open-ended
- Information is provided from the respondent's point of view.
There is a high degree of rapport between interviewer and respondent, which encourage self-disclosure.

It identifies factors, situations, concepts and interpretations unknown to researcher.

For conducting interviews an initial draft instrument was provided by the project "output leader" Dr. Tkatchenko. However, this questionnaire required extensive adaptation to provide a structured ethnographic field guide, which I undertook. Preliminary contact with informants was done either by phone or directly by the sociologists and a detailed time-schedule for interviews was developed. If the contact was done by phone the time and day was arranged for conducting the interview.

The data collection instrument was developed in November-December 2003 and pre-tested twice for stages one and two in November 2003 and January 2004 respectively. Data collection instruments for the stages three and four were developed and pre-tested in March 2004 and for Federal respondents in February 2005. The instrument for Federal data collection was adjusted in February 2005, because not all questions were appropriate for the entire country. The field guide included topics and example questions to be covered in the in-depth interviews. The questions were descriptive (grand-tour, experience and example), structural (verification and cover-team), contrast (direct contrast and contrast-verification) and filter. The questions covered the following themes: (i) the role of different players in the area of HIV/AIDS; (ii) cooperation and co-ordination of activities; (iii) perception of the HIV situation; (iv) policy documents and interventions; (v) level of funding for HIV-related activities; (vi) information and communication. All stages covered the same themes, with minor differences reflecting the particular group of respondents. The differences were based on the work that the stage respondents were involved in.

I also developed an introductory statement explaining the purpose and objectives of the research, which was read by the interviewers prior to interviews. Before starting the interview two copies of the consent form (one for interviewer and one for interviewee) was presented to the informants, and after an agreement to participate and signing, the interviews were conducted. Each interview was conducted for approximately one hour and 45 minutes. With the consent of the interviewees, the interviews were tape recorded and the interviewers took field-notes during the interviews, used reflexivity, which had
further been incorporated for data validation (Green & Thorogood, 2004; Murphy & Dingwall, 2003; Pope & Mays, 2000). Interviewers took notes on each interviewee questionnaire. Based on the field notes, tables of comments were created for each stage of the interviews. During the analysis questionnaires and tapes were compiled for cross-check analysis of available responses. Interviews were conducted in Russian.

I trained and encouraged the researchers to use probing, repetition, directives and iteration for some questions to get more complete responses and clarification of answers. Probing is a technique used to deepen the responses, increase the richness of data and to find the cues from the interviewee about the level of the response (Bowling, 1997; Patton, 1987). Patton describes different types of probes based on the information desired to obtain: detailed oriented (asking questions to understand particular details), elaboration probes (encourage the respondent to talk more about the subject), and clarification probes (tries to understand the depth of the information provided). The interviewers were advices to use all above-mentioned types of probing as appropriate.

I developed enumerative codes to blind the interviews to assure the anonymity of interviewees in relation to answers. The codes were shared with researchers in regions and the purpose and the logic behind it were explained.

5.6.2 Data Management and Analysis

The purpose of qualitative analysis is to find patterns in the data and ideas which will help to explain the existence of those patterns (Bertrand, 1996). The collected data are random bits of messages. The transfer of these messages into information could be achieved through data analysis by organising it into categories and understanding the systematic relationship to the entire culture. The analysis is a systematic examination of phenomena aimed at determining its constituent parts, identifying relationships amongst the parts and the relationship to a whole (Basit, 2003; Spradley, 1979). It is a process of "bringing order, structure and meaning to the mass of collected data" (Marshall & Rossman, 1995). Seidel suggested three parts of the qualitative data analysis (Coffey & Atkinson, 1996; Seidel, 2005): noticing things, collecting instances of these things, thinking about these things.
Each phenomenon could be analysed in numerous ways. This study adopted ethnographic analysis. The five-step ethnographic analysis method described by Spradley was used (Spradley, 1979): After defining the problem and collecting the data, the analyses of data were conducted and ethnographic hypotheses were formulated. The results are thoroughly analysed and discussed. From four available types of ethnographic analysis (domain, taxonomic, componential and thematic), I conducted domain and thematic analysis. Codes were analysed by grouping and analytical outputs aggregated into emerging themes and further grouped into sub-themes allowing further categorisation of the data.

5.6.2.1 Data Transcription

Transcription is a process of writing the interview from tape and notes. The data was transcribed using taped interviews and through incorporating field-notes. Transcription conducted during the period July-December, 2004 by four researchers from Volgograd and Barnaul. Federal data was transcribed during May-June, 2005 by two researchers. I requested that researchers swap the tapes between them, to assure that the researcher who interviewed the respondent did not transcribe the same interview. I randomly cross-checked selected transcripts with the questionnaires and incorporated some corrections/adjustments. Further, to assure the quality randomly several transcripts were compared to tapes.

5.6.2.2 Data Coding

Code is a process of research data conceptualisation through use of an abbreviation or symbol applied to a segment of words (sentence or paragraph) to classify and clarify segments into meaningful and relevant categories (Bowling, 1997; Miles & Huberman, 1994; Pope & Mays, 2000). The indexing/coding is the application of the codes to the transcript during which the data is broken down, conceptualized and put back together in a new way, helping to build theories from data (Basit, 2003; Strauss & Corbin, 1990). Although attaching codes to data and generating concepts have an important function in reviewing the meaning in data, Coffey and Atkinson suggests that coding is a part of the process of analysis but not analysis itself. The coding links data fragments to a
particular idea or concept and reflects analytic ideas, but is not considered as an analytic work of developing conceptual scheme. The main goal of coding is “to facilitate the retrieval of data segments categorized under the same code”. It is a process of indexing the data (Coffey & Atkinson, 1996).

From the available numerical, mnemonic and words type codes, for this study I developed and implemented a “words” type of code. Before coding initiation, I conducted two days training in Moscow with researchers from the regions. I designed a multistage coding process to assure the quality of coding. Firstly, I developed the coding framework after reading several transcripts. In addition, without sharing the developed codes, I requested regional researchers (along with myself) develop their own coding framework independently, based on the agreed upon five transcripts. Once the three (mine and two researchers) coding framework were drafted, they were discussed and codes agreed between researchers. These agreed first level codes were used to index three more transcripts with and develop two level codes. We all discussed and compared our coded transcripts assuring that we all use same approach to coding. I also requested that in each site 2 researchers coded the same transcripts and discussed and agreed a final version for each interview. Afterwards, I finalised the two level coding framework and provided researchers with a protocol for guidance. The two-level coding framework was used to code transcripts in Microsoft (MS) Word software. A total of 67 (17 first level and 50 second level) codes were developed for data analysis (see Appendix D).

In parallel, I attempted to conduct the analysis using NVivo software. After coding almost 11 transcripts the problems of a bi-lingual (Russian transcript and English coding) system, occurred; which I’ve tried to resolve by contacting the software developers in Australia. It appeared that the programme was not constructed to work in two languages. A potential solution would have been to translate the entire transcript into English, but in that case the specific meanings of the key words will be lost. On the other hand it would have been extremely time consuming with small benefit. Unfortunately, after several attempts they admitted that the system failed to overcome the problems identified and I found it inappropriate to use the software for further data processing and undertook analysis using MS Word.
The coding of transcripts was done in MS Word by regional researchers, on each transcript; afterwards the separate file was created for each code. I randomly checked 10% of the files as part of quality assurance. However while conducting analysis, I have recoded some information.

5.6.2.3 Domain Analysis

The domains were culturally defined groups of people who share common sets of perceptions, beliefs and values (Coffey & Atkinson, 1996; Spradley, 1979). From common domains used such as location, concept, materials and people, this study found it appropriate to choose the people domain for analysis. Each domain is structured into the following elements: cover term, included term, semantic relationship and boundary. The cover term is a name for the category of cultural knowledge. The included term is the folk term, which belongs to the category of knowledge. Each domain can have two or more included terms. The other element of the domain is the semantic relationship, which links a cover term to all included terms in the set. Finally each domain has a boundary, which goes unrecognised until the informant provides a clear cut-off. The domains are presented in Appendix E.

5.6.2.4 Thematic Analysis

I conducted thematic analysis using a framework described in the literature (Bryman & Burgess, 1994; Silverman, 2000):

- Familiarisation with the material to gain an overview of the richness, depth and diversity of the data and also to begin the process of abstraction and conceptualisation through listening to the tapes, reading the transcripts and studying observational notes. The transcripts of the interviews were read and general ideas were drawn out.
- Identification of the thematic framework, attempting to identify the key issues, concepts and themes according to which the data will be examined and referenced, through rereading the reports, putting in sub-headings and dividing
into thematic categories. Based on the main expressed themes of discussion, the codes for each theme were developed.

- Indexing of the thematic framework for application systematically to the data in its textual form through breaking into paragraphs, cutting into phrases and coding. On each transcript the appropriate code was inserted into the text.

- Figuring of the data, which are lifted from their original context and rearranged according to the appropriate thematic references through chopping, extraction, categorization, putting headings and subheadings, quantification and clipping. The indexed paragraphs were extracted from transcripts and a separate file was constructed for each theme, expressing the general ideas and explanations.

- Mapping and interpretation by putting together the main characteristics of the data and mapping, interpreting the data set as a whole. The data sets were constructed and read for interpretation, explaining trend, thoughts, ideas, and events.

5.6.2.5 Theoretical Frameworks of the Thesis

The analysis was inductive and iterative but theoretically informed. It used the analytical model developed by Sprechmann and Pelton and modified for the study (see Figure 1, chapter 2). This model provides a lens through which to view policy making as regards HIV/AIDS in the Russian context. The model enables exploration of the stakeholders' role and participation in policy making process, but simultaneously considers the complex environment which influences stakeholders' decisions and their actions. The data from the stakeholder survey was built into the Figure 1 and used to understand the Russian HIV/AIDS policy. Based on this the advocacy model was then be developed. This combined by thematic and domain analysis described above. The thesis also used stakeholder theory of policy making to understand relationships between stakeholders and the process of power influence in the policy making process in Russia.

The elite is the ruling class who occupy strategic had commanding posts within the social structure (Kadushin, 1968; Mills, 1956). As it has been mentioned in the Chapter 2, elitist theory believes that policy choice, and change, is determined by certain social
classes/institutions, which are represented in policy making positions, with the state ensuring the continued dominance of those classes/institutions. This theoretical perspective illuminates well the policy process in Russia, as decision-making is highly concentrated at the level of Federal authorities.

Though Walt (1994) suggests that the issues of high policies (economic, national security issues) are decided through the elite, whereas low policy issues (domestic, social issues) are decided through pluralism, this view applies only to democratic society, where the government is open to legitimate influence by an opposition which keeps the government accountable. Further, the author claims that health policies due to interventions from various groups, could shift from low policies to high policies (Walt, 1994). As HIV/AIDS influenced many aspects of a countries development, up to threatening country security, is discussed in the Chapter 4 (heading 4.5), policies related the HIV/AIDS could be considered as high policy and thus under the control of the elite.

Bachrach and Baratz, (1962) differentiate policy issues into the categories important and un-important and suggest that approaches to address them should differ accordingly. The argument made have will be that there are no unimportant issues (and accordingly no single action), but each important issue consists of a chain of less important issues and actions to resolve these less important issues develop the attitudes, which in turn determine the way important issues are resolved. So as not to ‘lose’ their influence and ‘weaken’ their positions policy makers should ‘keep their hand on the pulse’ of events and constantly exert their power. As the people who deal with less important issues are appointed by officials in higher positions, dealing with important issues (to ‘please’ those who ‘trusted’ them), ‘a chain’ which serves the same goal is established. However, even low policies have their elites who determine the direction of policy development. In most cases this elite is highly dependant in its decisions on the elite making high policies, especially as the high policy making elite decides on resource allocation.

Zimmerman (2002) conducted a survey during 1991-2000, exploring the Russian elite, particularly their participation and contribution to the formation of Russian foreign policy. In his findings he suggests that there is a domination of the elite in the policy process and that the elite “controls over the rank and file are contingent”. Moreover
discussing democratic achievements the author claims that Russia is "pro-democratic" and "democratising" (but not "democratised" yet) and is "partly free" as the country is "consolidating" rather than being "consolidated". I would suggest that he assessed the country by comparison with the Soviet period in the 1970s, rather than assessing its democracy by developing certain absolute criteria and matching developments to those criteria. In the same book the author referring to a Freedom House (a NGO who published annual assessments of the level of freedom in various countries since 1972 evaluating certain behavioural indicators) report, claimed that in Russia long-term prospects for democracy are problematic, scoring 4.5 for 1999/2000 (unfree is 5.5 and above and free is 2.5 and below), which is a direct result of Russia's authoritarian past. The lack of democracy in the past reflects the problem of the masses: "mass publics have been able to link their preferences and the preferences of leaders", i.e. the views of the two coincide (Zimmerman, 2000).

Russia uses analogical reasoning in decision-making (applying Houghton's (1998) theory discussed in Chapter 2), which determines the political line in elite decision-making. A country's past foreign and domestic policies provide good analogies to understand the policy makers' approach to decision-making, so the Soviet influence still determines the behaviour and approaches to issues of the elite. I will argue that this is relevant, if the same elite (which is the case for Russia), political party or social class are still governing the country, thus their decisions are driven by the same ideology and directed to achieve similar objectives.

In Russia, ideology and propaganda play an important role in the formulation of public policies. A well-defined ideological discourse can improve the quality of policy making by providing an orientation when clarifying priorities: by helping to 'steer' through information overloads, and by linking separately developed policies (Bryder, 2004). But in the Russian context, where there is a relative lack of democracy, once a problem like arises the only way to influence the elite is if it can be argued that there is a crisis, as is the case of HIV/AIDS. And then by lobbying the elite to alert them the dangers of HIV/AIDS and pressurising them to act, whilst also finding compromises to be made when addressing the issue should occur. This was the consideration taken into account in developing advocacy model to influence the elite. However, it should be noted that these attempts applying external pressure can be controlled by the elite, and used by
them to suppress the formation of advocacy coalitions as discussed in the Chapter 2 (Sabatier, 1988).

Though acknowledging Lewis (2005) claim that the medically trained academicians, health bureaucrats and public teaching hospitals are considered as influential agents in the health policy process, he does not elaborate on the governmental setting within which the decision-making and problem prioritisation process occurs. In the case of Russia, with poor democracy and passive civil society participation in the policy process, the authority and power is highly centralised and the decision-making controlled by the Federal authority (Marsh, 2000). Moreover, health care system issues are not considered a priority in comparison with defence or business development, as reflected in the Federal resources allocated to these areas. In this context the opinions of health care professionals are less influential than Lewis may suggest. Moreover, the decisions within the health sector are not made according to needs or evidence (such as epidemiological information), but based on political judgements and resource availability within the sector. If health professionals created coalitions to voice their concerns in a more organised approach, they may have more influence, but even then, it is doubtful if their views will be seriously entertained by the government. But as senior health professionals in the health system are appointed by the government, they have little choice but to support government decisions to be able to stay in their positions.

In order to learn about Russian policy in the area of HIV/AIDS the elite involved in the HIV/AIDS related policy process would be the best informant group to be interviewed. This exercise will not only help to understand the rational behind the decision making and the policy process, but also clarify “the face of the elite”; i.e. who involved in policy making in the health area in general and the area of HIV/AIDS in particular. Obviously, our main contacts were officials who claimed to be involved in HIV/AIDS policy making, and are in charge of implementation of the policy; i.e. Intersectoral HIV/AIDS committee members, which are suppose to be the health associated elite.

5.6.2.6 Data Presentation

The presentation of the qualitative data is a key factor in understanding and interpreting the content of information. The data could be presented using quotes, matrices and
tables, causal flow figures, ethnographic decision models, taxonomies, diagrams and multi-dimensional scaling. The findings of this study are presented through quotes and tables. Lofland describes two “sins” of presenting the qualitative data using quotes (Lofland, 1971):

- When the material seems too simple, there is a trend to present straightforward things in a more complicated manner aiming to increase the scientific value.
- “Gun-shy theory”, which suggests presentation of the quotes from respondents and tends to avoid suggesting and developing any ideas about the information gained.

The data collection, transcription and coding was performed in Russian and for data presentation I translated quotes into English. Bearing in mind the above mentioned sins, and to be precise in translation, as well as to avoid personal interpretation I translated the quotes verbatim. Many of the respondents presented their ideas in poorly formatted sentences so the meaning suffered slightly during translation.

5.6.3 Data Representativeness, Reliability and Validity

In small-scale qualitative studies the issue of the representativeness, reliability and validity of findings becomes important for arguments, primarily because the qualitative research conclusions are not easily applied to the other groups (Borman et al., 1986). Dey defined the validity as “one which can be defended as a sound because it is well-grounded conceptually and empirically”. There is a paradox in the grounding of the theory, that well-grounded theory which can be done solely through themes emerging from the data or can be generated from initial themes, which are refined and attained by the data (Dey, 1993; Jackson & Trochim, 2005). Qualitative research deals with an exploration of unknown phenomenon and in most cases has no satisfactory consistent measure or comparison for material obtained. To overcome this problem Day suggests the need to demonstrate whether the themes are grounded, by exploring the identified concepts and the connections in the data. This can be achieved by comparison of the criteria used while categorising and linking the data, noting and discussing the borderline, extreme, deviant or negative, as well as straightforward or typical examples.
Other techniques for data validation are respondent validation and triangulation (Black et al., 1998). It is also important to consider notable exceptions, to present a thorough review of examples, identify patterns and using cross-check analysis (Bryman & Burgess, 1994).

Morse suggests that in qualitative research, problems with respect to reliability and validity could occur in any stage: during construction of the measurement instrument (questionnaire), sampling, data collection, coding, and data analysis (Mays & Pope, 1995; Morse, 1991). Following the literature (Green & Thorogood, 2004; Morse, 1991; Pope & Mays, 2000; Silverman, 2000; Strauss & Corbin, 1990) I considered the issue of the data validity and reliability during the design stage of the research. Constant errors connected with the measurement instrument known as “social desirability” and “acquiescent response set” were reduced through the use of open ended, “grand tour”, contrast and inclusive questions, as well as suggesting multiple choice answers (providing also cards with answers) to avoid pointing out the correct answer. On the other hand, some elements of social norms could be eliminated from the answers, but I found this sort of information valuable, as explains predetermined decisions behind the choice. Also the measurement instrument was piloted twice to avoid misunderstanding of the questions and to make the language jargon-free. Though in qualitative research when using non-probability sampling the internal validity is not a goal, we still tried to achieve validity through interviewing all current stakeholders in the Intersectoral Committee, and respondents nominated by this group including the known potential and desired stakeholders i.e. a complete sample of the population of interest. In the interview the respondents’ answers indicated that we had reached saturation. Pragmatic validation of data was achieved through triangulation, using informal key informant discussions and documentary analysis. Reliability and validity in data collection, coding and analysis was attempted through training of interviewers adding to their professional experience. The coding was done and compared by three researchers (two in regions and finally checked by myself) and during analysis random errors were eliminated using questionnaires, field-notes tape and transcripts. The quality of transcripts was assured through randomly checking 10% of transcripts and comparing them with tapes.
5.7 Limitations of the Study

The study has several limitations which are general, related to the qualitative method and specific, related to the study.

5.7.1. General Limitations

One of the limitations of the study is that the chosen non probability sampling technique gives low external validity. Moreover, the data are not generalisable: one of the limitations of qualitative research.

The other shortfall is that being in authority, not all respondents expressed their opinion frankly; they presented what the official response should be and what is correct from a political point of view. This is a problem with interviewing of the elite. This limitation been addressed through triangulation, with some officials, un-official discussions were held related to HIV/AIDS policy formation on different convenient occasions. The other approach is to assess and check some results by looking at practice, rather than just being directed by the answers of the respondents. It should be considered that the study was about HIV/AIDS, which is likely to cause some biases with respondents being pre-oriented to provide “correct” socially and politically desirable answers.

Having a large sample size of 153 qualitative interviews, caused difficulty in tabulations of results. Conclusions are based on the most frequent occurring answers; whereas divergent single responses could also contain valuable information. Answers were grouped and categorised into sub-themes trying to minimise the “losses” of opinions.

5.7.2. Specific Limitations

Because the aim of this thesis was developed concomitantly with implementing the project after it had been designed in the funding application stage, there is a possibility that during the policy analysis or advocacy model development the need for certain additional data could arise. In such cases, the gap closed using material available from the literature.
The interviewers did not always follow the given instructions accurately, despite receiving the training and despite written protocols having been provided. During the data collection, transcription and coding examples of underperformance identified are as follows:

- Though the initial design of the questionnaire was semi-structured and the interviewers were trained and encouraged to ask additional questions to clarify and find out more information regarding the subject, in almost all cases the interviewers stuck to the questionnaire, and only in few cases used probing techniques. As a result, the questionnaire became structured. Since there was sufficient material for analysis, this has not prevented the completion of the research.

- The coding to blind the transcripts was poorly done in Altai, which was overcome by asking researchers to develop a table with appropriate notes. The Federal level researcher failed to blind the transcripts at all, breaching confidentiality. Again a table was developed to blind the responses during the analysis. These problems have not affected the research, as access to the original data is denied to anyone and the developed tables used in analysis blinding the relationship between the subjects and the answers.

- In some cases, inaccuracies occurred in coding of transcripts. Despite the interviewers been trained and the agreement to code by themes, the researchers still for convenience coded by questions. This shortfall has been overcome; the analysis was conducted only after reading the transcripts and re-coding the document, and subsequently comparing the results for the analysis with the different coding. Additionally, questionnaires with answers are used to recheck the replies.

- Trying to present the results quantitatively it was found, that the total number of respondents differs from the total number of the interviews. Knowing that we had 97% response rate, relevant answers have been checked with the completed questionnaires and quantitative data has not been used.

- While support results with citations, in attempt to choose best citation which will conclude general ideas of many respondents, some respondents been quoted more often then others. This was just because some respondents' answers in terms of language had been constructed more accurately.

- Citations been chosen based on common occurring answers; outrageous reply; rare information that haven't been suggested before but could support the
judgments, which best could explain or support the opinion. However, the
discussions been based more on commonly occurring opinions, thus some
though interesting but rare ideas left unrepresented in discussions.

- Though acknowledging that social science and qualitative research requires
that translation of the citations should be as close as to the original and thus
should be translated verbatim, some respondents presented their thoughts
fragmented. Moreover not always sentences were linguistically correctly built.
Whereas presenting quotations I have tried to present the meaning in correct
grammar, though without intervening into content.

The other main limitations were the lack of time available to federal respondents and
many federal level questions being focused on specifics that are not relevant because the
situation varies across Russia, which is large and heterogeneous. To deal with this
limitation of time and generalisation in restricted questionnaire dealing with the
appropriate level, focusing on key issues was developed.

An important limitation of the research was that for secondary data analysis it was not
always possible to obtain the up-to-date statistical data. Several thorough attempts to
find recent data failed and thus the thesis presents the ‘available’ rather than ‘desirable’
data. It should be stated that the issue of data availability is a major problem in any
research related to Russia.

The project sites were not been selected by the researcher or the project management
but were chosen by the funding agency (DFID) in collaboration with the Russian
Government. This left a gap in information about the rationale of the choice. This fact
limits the representativeness of the data. On the other hand, with the existing funding
and within the suggested timeframe, it would have not been possible to organise a
project to cover the entire country. Similarly, it would have been difficult to find sites
representing the country, as Russia covers a huge territory and the country has many
differences between regions. This shortcoming did not affect the research findings, as
being a qualitative study there was no intention to generalise the findings and
recommendations as representable.

Another shortfall of the research was that the informing group was limited to elite. This
decision was driven by the purpose of the research, and the elite was the group of the
informants having the best knowledge and ability to provide information. Nevertheless, it would have been interesting to obtain more information from the affected population and the general public. It also needs to be acknowledged that in Russia religious organisations are influential in the development of public opinion, and that there was no respondent involved in the research to discuss the religious organisations opinion and approach to HIV/AIDS issues.

From the beginning of the research following conducting the literature review, it was obvious that the decision-making in Russia was centralised at the federal level and that the authorities/elite involved in decision-making are not the health professionals, our access was limited to the health elite. Still, importantly, we should analyse the findings to learn who are the main decision makers. The only way of addressing this issue was to interview 2 Duma representatives at the federal level, and also in the regions we interviewed some health officials who are in the local administration. Though there is no doubt that additional primary sources of information would have been useful, still it is clear that the local authorities decisions are determined by senior colleagues at the federal level, which was confirmed in the research findings. Unfortunately, we had limited access and couldn’t reach the ‘upper’ elite, which is one of the shortfalls of dealing with the elite described in the literature.

A shortage of time and availability of resources prevented an exploration of advocacy process in Russia. It would have been useful to establish contacts with a few organisations working on advocacy, even if not in health area, and learn about their activities and also the challenges they are facing. This shortfall was addressed with a literature review of the advocacy activities in Russia and as there is a little activity there would be little experience and knowledge to access.

It would have been useful to learn the actual process of HIV patient’s diagnosis, care and treatment, also the monitoring process, but because of ethical considerations it would have not been possible to organise the shadowing of any patient, whereas the information gained from organisations will describe the protocol rather how it has been done in reality. So the process and organisation of services was reviewed using information described in the literature and regulatory documents of the Federal AIDS Centre.
For information purposes all regulatory documents were collected and collated with the help of a consultant, it would have been useful if a legal specialist had been able to conduct an analysis of these legal documents to reveal legislative faults and mismatch between the clauses and within/between the documents. Though the research had insufficient funding to conduct such activity, the issue was addressed by analysing the review of the documents existing in the literature.

Although acknowledging the importance of conducting a literature review of Russian language literature related to HIV/AIDS, the thesis does not describe the findings of the review. It should be mentioned that the information related to the policy and other aspects touched on in the thesis have been incorporated but this was a small part of the full review. The majority of the articles were scientific, and clinical discussions related to HIV/AIDS were left out from the thesis because they were not related to the thesis aims.

After getting familiarised with the research aims and objectives, theoretical framework of the thesis, main theoretical concepts related to policy and advocacy, as well as methods used for research data collection, next further chapters present findings of the research, analysis and discussions of results.
Chapter 6: RESULTS

To identify the behaviour of stakeholders and understand the underlying meaning of the experiences, attitudes, and beliefs they describe, 153 stakeholders were interviewed. Interviewees were current and potential stakeholders of HIV/AIDS issues: HIV/AIDS Intersectoral Committee members, authorities from governmental organisations, NGO and private sector representatives. Results of the research are presented in accordance with the questionnaire structure and coding of transcripts. Codes were analysed by grouping gained information into emerging themes and further grouped into sub-themes allowing further categorization of the data. In addition to main ideas summarising respondents’ thoughts, citations are quoted and tables are presented to support main findings.

6.1 General Problems at Regional Level

To identify the regional priorities, the respondents were asked to nominate three general problems in the region (without ranking). To understand the rationale behind their choice the respondents were also asked to provide their reasoning to clarify their answers. Despite the respondents having been asked separately to nominate general problems and health problems, most of the answers overlapped; under general problems for their region the respondents mentioned health problems and in nominating region health problems the respondents also raised some general problems (Gevorgyan et al., 2005b).

Volgograd respondents identified 189 issues (some mentioned less than three, or more than three problems) and Altai respondents 181 general problems, which were grouped into five sub-code categories: political, economic, social, health and ecological. Many problems like poverty, migration, crime, equality between city and village, organisation of population leisure time, or education could be grouped under more then one (economic/social/political) category, as they are cross cutting issues with multiple influences impacting the problems. The decision to put an answer under a certain category was based on the given explanations by the respondents.
The respondents in both regions gave prime importance to social problems (crime, lack of social welfare, protection of the population, poor housing conditions, poverty, lack of population leisure time and etc.). Thirty six percent of Volgograd and 35% of Altai respondents mentioned social factors as a cause of many problems in their regions.

According to respondents the second most common major problem for Altai was economic and for Volgograd health. Some Altai respondents suggested that country is lacking leadership. As a matter of fact, the interviews were conducted shortly after the elections of the regional administration.

"Government and the authorities left peoples survival up to destiny, ...so what other problem is there?"

A2-14, page 1

Volgograd respondents mentioned health (service organisation issues, health facilities, medical conditions, certain diseases like diabetes, hepatitis, and tuberculosis) as a main priority among general problems of the region, considering good health as a cornerstone on which to build the country's future.

"I am deeply convinced that the power of the government depends on the population health, I am deeply convinced that the health of the nation, the health of each individual is a strategic objective of the government in general”.

VI-13, page 1

Most respondents gave priority to particular health issues like infectious diseases, drug use, tuberculosis, or alcoholism. Out of 189 nominations in Volgograd and 181 nominations in Altai HIV/AIDS issues (HIV infection, HIV prevention, AIDS, etc) were mentioned as a general problem for the region 12 and five times respectively.

"Because HIV/AIDS infection spreads in geometrical progression. And affects youth, school-children, e.g. our generation, it means we are cut-off from our future”.

V1-7, page 1

The economic problems like closure of the factories, debt payment and unemployment were mentioned as being important for both regions. Under the economic category are grouped financing issues (namely underfunding, financial problems, insufficient
financial recourses, a limited federal budget). The issue of finance, whether in terms of financing the region, the health care system in particular, or remuneration of physicians in general, or the low-income of population, was perceived to be the determining issue for the respondents. They re-emphasised it during entire interview, even when answering other questions. Other certain problems like education, or drug use were explained through financial problems.

"... finance determines the welfare of each person, and social adaptation in the society depends upon this welfare. Consequently finance determines whether leisure time will be spent on getting a shot somewhere to forget yourself [i.e. drug use], or on spiritual development. To have quality time you need money, you need the ability to buy, need an adequate salary."

During the interviews, a problem concerning those both regions was the issue of youths; their health and education, organisation of their leisure time, drug use and alcoholism among teenagers and youth, crime. The growing anxiety about the future generation was connected with the future development of the country.

6.2 Health Problems

To find out health priorities that the region face, the respondents were asked to nominate three health problems most important for the region (without ranking). To understand the rationale behind their choice, the respondents were asked to explain their answers.

The health problems were sub-coded under organisational and medical problems, drawn from the answers. With respect to health problems, 46% in Volgograd, 58% in Altai and 39% of Federal respondents’ nominated health system organisation. The respondents concern was poor quality of the services provided, financial problems, poor organisation and mismanagement of the health care system, and poor conditions of health facilities. In addition, the inadequate remuneration of health providers, drug and medical supply shortages and quality control of provided services were mentioned. Some answers (unhealthy lifestyle, ecological problems, etc.) were difficult to place under medical or organisational categories, but a decision was made to put them under organisational
problems, based on the explanations given by the respondents. Twelve percent of Altai respondents nominated ecological problems for their region. This is because Altai is located near Semipalatinsk Nuclear Polygon. Often the respondents criticised health care reforms and the way the system was run and managed. Specifically, many times, the populations' poor access to health care services was emphasised, because of unaffordable fees (official and unofficial):

"If a grandmother came, who is 70 years old, nobody will even talk to her, because she won't be able to pay.... Everything is to be paid for and costs are too high, so not everyone can afford".

Talking about medical problems, some answers were very concrete and the respondents mentioned specific diseases like: "behavioural diseases"- drug use, alcohol use and smoking; tuberculosis, HIV/AIDS, cardio-vascular diseases, and reproductive health problems which were the most frequent occurring answers. Some respondents nominated a certain broad category: the maternal or child health or population health. Federal respondents gave highest priority to HIV/AIDS from all health problem (15%) of the time; Altai respondents gave priority to HIV/AIDS (7%) among medical health nominations; whereas in Volgograd, infection got 8% of health nominations, leaving the priority to behavioural diseases (alcohol, drug use and smoking).

6.3 Priorities

Though results indicate that HIV/AIDS was not one of the top priorities for any of the regions involved in the study, whilst asking respondents to categorise HIV/AIDS problem and choose one from set of five suggested answers (one of the most important problems; important problem; not that important problem; not important at all; difficult to answer), 99% of Volgograd and 82% of Altai respondents considered the HIV/AIDS issues as one of the most important or important problems for the region.

Federal respondents acknowledged the importance of the issue based on epidemiological statistics, suggested that statistical data indicated that the country still has more urgent priorities to address. Sixty eight percent of these respondents disagreed
that HIV was a priority for the country. Moreover, they mentioned that even among health issues, HIV is still not an outstanding issue, but at the same time respondents acknowledged the “big potential” of the issue. Some Altai and Federal respondents also acknowledged that they are lacking “real information” about the epidemic to assess it objectively.

"Meanwhile, according to statistics, still [HIV/AIDS] is in line with several problems..., but the potential is immeasurably high compared to other problems”.

The respondents were also asked to name organisations which define the priorities for their region. Almost all respondents put the obligation on both the Federal and local Administrations.

“I think not media, not health authorities, and not even the Committees, but the administration should decide, show main directions.”

Among the organisations that decide priorities, most of the respondents mentioned government and President, the Oblast Duma (parliament) and different regional Committees. A few Altai respondents emphasised the importance of developing population attitude towards the issue, which could influence the authorities’ decision-making process and will help to advance the problem among country priorities.

To understand the rationale behind the choice of priorities the respondents were asked to try to explain/clarify their answers. Most mentioned that “their experience allows them to think so” or just it is “their perception of things”; for regional respondents rarely the explanation was “the statistical data evidenced”. Federal respondents mostly back-up their choices by statistics and data. Very often the choice was determined by the President or another high authorities speech or report. Whether the respondents were talking about the general or health related problems, the issue of lack of information and population awareness was emphasised, and considered as a determining factor for decision-making in prioritisation of the problems.

“I don’t know why it is so, but we are lacking information...We are afraid of ‘talking’ in figures and numbers”.

V3-6, page 2
Apart from the fact that the lack of information was considered as one of problems, it was also mentioned that the information provided by the mass media was of poor quality.

6.4 HIV/AIDS Knowledge

To measure respondents knowledge of HIV/AIDS related issues, several questions were asked about their attitude to some suggested statements, describing the main principles underlying, consequences and main directions of the repose to HIV/AIDS.

6.4.1 Main Principles

Below table 5 presents the distribution of results of main understanding principles related to HIV/AIDS:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Volgograd</th>
<th></th>
<th>Altai</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Agree</td>
<td>Disagree</td>
<td>Difficult to answer</td>
<td>Agree</td>
</tr>
<tr>
<td>The problem of HIV/AIDS epidemic in Russia is exaggerated</td>
<td>3</td>
<td>86</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>HIV/AIDS is problem of risk groups (IDU, CSW, etc.)</td>
<td>8</td>
<td>89</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>HIV/AIDS could negatively influence the economic growth of Russia</td>
<td>70</td>
<td>18</td>
<td>12</td>
<td>65</td>
</tr>
<tr>
<td>Its worth talking and writing about HIV/AIDS as much as possible</td>
<td>91</td>
<td>1</td>
<td>8</td>
<td>84</td>
</tr>
<tr>
<td>HIV/AIDS is a medical problem and should be solved only within health care system</td>
<td>1</td>
<td>98</td>
<td>1</td>
<td>8</td>
</tr>
</tbody>
</table>

The table shows the percentage of respondents answering the specific suggested option for each region
As the table above demonstrates, the vast majority in both regions disagreed that the problem is exaggerated in Russia and supported the idea of talking and writing about HIV/AIDS as much as possible. Though majority in both regions agreed that HIV/AIDS could negatively impact the Russian economy, still 18% of respondents in Volgograd and 24% in Altai disagree with such statement. It was interesting that almost all respondents in both regions disagreed that HIV/AIDS is a medical problem and only health care system could resolve it. Vast majority of respondents disagreed that HIV/AIDS is a problem of risk groups. It is worth mentioning that there was no difference in answers between domains (Committee members, governmental organisations, NGOs and the private sector representatives).

**6.4.2 Consequences of the Epidemic**

To learn about the respondents' understanding of the possible consequences of the epidemic, they were asked to choose the three problems which could have the most significant influence on the development of their region from a range of suggested options. Suggested options cover different level of impact of the epidemic: direct impact on demography; which its turn will affect economy and increase poverty by causing political instability. Table 6 presents the distribution of results.

**Table 6: Respondents Understanding of Consequences on the Region**

<table>
<thead>
<tr>
<th>Development (in %)</th>
<th>Altai</th>
<th>Volgograd</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decrease of population growth rate</td>
<td>20</td>
<td>24</td>
</tr>
<tr>
<td>Increase of premature death rate</td>
<td>26</td>
<td>13</td>
</tr>
<tr>
<td>Decrease of number of productive population</td>
<td>21</td>
<td>22</td>
</tr>
<tr>
<td>Increase of orphans</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Decrease of GDP</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Increase of poverty</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Increase of government expenditure on health care system</td>
<td>17</td>
<td>16</td>
</tr>
<tr>
<td>Political instability</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

The table shows the percentage of respondents answering the specific suggested option for each region.
These set of questions were asked to learn about stakeholders’ understanding of the depth of epidemic impact. A major impact could be through the decrease in population. Deaths related to HIV/AIDS could affect the GDP and increase the poverty. The latter itself could cause political instability in the country.

Both regions mainly choose consequences having direct impact on demography of the country. The main three most often mentioned problems for Altai respondents were: increase of premature death rate, decrease of number of productive population and decrease of population growth rate. Volgograd respondents basically mentioned the same main threats for their region. As can be seen from the table 6, the main threats are considered to be a decrease of population growth rate. Results of domain analysis repeated the pattern in Volgograd but there was a slight different pattern in Altai: most respondents from NGOs think that HIV/AIDS mostly will affect the region development through increase of health care expenditure.

Federal respondents were asked to describe the possible consequences of the epidemic for the country. Almost all respondents expressed concern about future of the younger generation. Most of respondents divided consequences into economic and demographic. Under economic consequences respondents mentioned a decrease in the number of productive people in the population and a shortage of specialists/qualified workforce, a decrease in the country income and an increase in financial allocations to health (for diagnosis and treatment of HIV/AIDS). Under demographic consequences respondents mentioned an increase in the premature death rate, a decrease in the reproductive population, and population aging. Two respondents mentioned a decrease in military recruits and associated negative impact on the country defence. One of respondents mentioned as a consequence discrimination against PLWHA and “decrease of the country reputation, as incapable to combat the epidemic”.

6.4.3 Actions Towards HIV/AIDS

To understand attitude towards the main actions available to combat the epidemic, the respondents were asked to choose from 5 possible options (strongly support; tend to
support rather than not; tend not to support rather than support; strongly do not support
and difficult to answer) best describing their attitude towards suggested actions.

The majority of Volgograd respondents do not support the idea to decrease number of
HIV/AIDS tested. Though the majority of Altai respondents agreed, there was a
significant number of respondents who answered positively to this question. In
particular NGO respondents from Altai argued that the number of tests should be
decreased. In Volgograd, opinions about an increase in harm reduction programmes for
drug users were split almost equally between those who support the action and those
who do not. Altai respondents from almost all domains supported the idea of expansion
of harm reduction programmes. The exception was respondents from governmental
organisations, whose opinions were split equally. The introduction of sex education in
schools was supported as an idea almost unanimously in both regions. In Volgograd,
the statement on the free distribution of condoms to CSWs was welcomed by
Committee members, but by government organisations, whereas NGOs and private
sector representatives’ opinions were split. In Altai, this idea reserved support from
amongst Committee members, NGOs and private sector representatives, but been
rejected those from governmental organisations.

Almost all respondents in both regions supported statement of providing free treatment
to PLWHA, with small exemption among government organisations in Altai. The issue
of distribution of condoms in prisons was difficult to answer for most of governmental
organisations’ representatives, but mostly received support from Committee members,
NGOs and private sector representatives in Volgograd. The same opinion prevailed in
Altai, but government representatives’ opinion on the issue was split almost into half,
with small preference towards support. The last three statements on prevention
activities among military recruits, financing of programmes for psycho-social support
for PLWHA and their families and financing of programmes for human rights activities
of PLWHA were supported and welcomed by almost all respondents in both regions.
6.4.4 Main Problems to Combat Epidemic

To find out main barriers to combat HIV/AIDS, respondents were asked to share their opinions about what, according to them, hindered their actions to combat the epidemic in their region. Since there was no particular trend or difference between regions and within domains this information is presented at an aggregated level. Respondents from both of the regions and from the federal level suggested common problems.

The main problem that almost all respondents in both regions mentioned as a major barrier to development of an efficient response to the epidemic was lack of information about the epidemic amongst the population, though some (especially Federal respondents) mentioned that this was also true amongst government officials and specialists.

"...because we don't know what we are combating with".

V3-13, page 15

Respondents expressed concern that the lack of information created misconception of the problem and people become reluctant to acknowledge the issue. It was especially emphasised that the government should take leadership and support the population, PLWHA and their families. With respect to the latter stigma was mentioned as one of the barriers for effective response to the epidemic. In addition, a few federal respondents emphasised lack of unawareness of the issue amongst the population, which develops stigma, creating barriers for the organisations to conduct activities and also causing an additional burden to social services. In particular, the intolerant attitude of the population towards PLWHA and their relatives was mentioned. A most sensitive issue is the destiny of children (orphaned and within families) who are stigmatised at educational institutions both by classmates and their classmates parents. Other parents pressurise the authorities to isolate children affected by HIV/AIDS in separate institutions.

"...because as usual we think it will bypass us, and it never will happen to us".

V2-6, page 11

Another concern related to information was that it is not in a form acceptable to the population, especially youth.
"We need awareness...and the approach should be differentiated with consideration of age specifics: for children, teenagers, youth and population in general".

Many respondents emphasised a lack of awareness about HIV/AIDS amongst vulnerable populations and risk groups who, mostly because of poverty, have no access to mass media and received no information about the epidemic. Many respondents in the regions also mentioned the role of mass media in information distribution (positive or negative). The latter was mentioned because of poor quality of social advertisement propagated with a "dual message". Some respondents expressed concern that programmes about CSW, could be misinterpreted by youth as an "easy income" and point youth to "adventurous activity".

The other major barrier to combating epidemic identified by respondents was insufficient financing of services: health care in general, and HIV/AIDS activities particular. In addition, population poverty and financial well being was mentioned as a problem. Respondents suggested that income influence on the quality of time spent on leisure. Lack of finances also had an influenced organisation leisure time by youth, employment of youths to prevent them from engaging in risky behaviour development.

Respondents mentioned their concern regarding poor preventive activities amongst the general population and the high risk groups, to avert spread of epidemic. They mentioned information distribution, harm reduction programmes among drug users, condom distribution to CSWs and also provision of access to condoms for the general population.

Importance was also attached to laws and legislation that had been development with the aim of prevention of drug use. This was emphasised especially in Volgograd, as the region is on transit route for drug distribution from middle Asian countries to other regions of Russia. Most respondents related the HIV problem to risky behaviour and thought that activities should be directed towards drug users.

"Most consider that this is a problem of drug users and prostitutes, and this is how our population think actions needed".
One of most important concerns that arose in interviews was the ideological development of youth, their development of values and principles in relation to sex, drug use, and healthy lifestyle in general. The main concern was related to negative values development.

A few of respondents thought that medical personnel need to be trained to update and improve their quality, and that medical equipment sterilization should be strictly implemented. It was also suggested that those pieces of equipment, which are supposed to be disposable, shouldn’t have been sterilised to deal with shortage of supply.

A couple of respondents mentioned the control of MTCT as a barrier to control the epidemic, suggesting MTCT as a priority intervention for prevention. Some respondents in regions expressed dissatisfaction with the role of Intersectoral Committee and the quality of their work. The poor coordination and organisation of activities by the government was also emphasised. The latter was blamed on their “not being transparent” about the problems. However, the Federal respondents also expressed the same concern, and suggested that poor coordination within and between organisations leads to duplication of activities and ineffective use of resources. The Government approach to epidemic was described as “non-systematic” and “fragmented”. It was interesting, that majority of federal respondents themselves mentioned insufficient political support, suggesting that it is a major issue hindering the development and implementation of interventions.

"There is a lack of political will; once resolving this everything will be functional".

F3, page 5

A couple of respondents from both regions thought that the epidemic monitoring system was “poor and patchy” and that diagnosis and screening was not organised properly.

"...we haven’t tried to combat the problem yet...".

V2-28, page 9
Some believed that the government should give priority to the problem and start action towards developing public opinion. The majority of respondents in both regions mentioned the importance of developing public opinion about HIV/AIDS and that ideological support could facilitate the process.

"One of the problems is that there is no wide propaganda about the issue".

In response to the question about how their organisation contributes to combating the epidemic and what activities they are involved in or organize, most of the respondents, especially from governmental organisations and the private sector, mentioned that they are not involved at all in any activities. Only a couple of NGOs mentioned that they work with risk groups or prisons but their activities are highly dependent on scarce resources and is not on regular bases. Intersectoral Committee members even were poorly engaged in collaboration, prevention or any other activities and just few mentioned that they provide information or work with youth.

6.5 Attitude to HIV/AIDS

To understand the attitude of the population and the authorities to HIV/AIDS respondents were asked to share their opinion about how seriously population and authorities perceive the problem to be, their understanding of its magnitude and the threats of the epidemic.

6.5.1 Attitude of Authorities

Vast majority of federal respondents suggested that even the authorities who are supposed to have enough information about the magnitude of the problem and supposed to be responsible and to lead population regarding the issue, do not themselves assess
the situation as serious: “government hasn’t woken up from sleep”. Only a few replied that authorities know and understand the situation, but those authorities were high officials working in the health system. Two respondents suggested that although it was slow there had been a slight improvement and that things were moving ahead.

“Last three years this problem started to be approached more seriously, especially last two years, ...its due to initiation of propaganda to ‘push’ the issue forward, also due to involvement of international organisations to make the case sound loud”.

F1, page 2

One of the most telling indicators in the evaluation of whether the problem is accepted as serious or not is the funding provided by authorities for the activities of HIV/AIDS programmes. So in most respondents’ opinion any positive attitude is not supported by the actions.

“The level of acceptance of the problem is low and the problem is not considered seriously by decision makers and it is expressed by financing, which is totally in adequate to situation”.

F3, page 3

Some respondents even prescribed that there was a need for “political will” to handle the problem.

Regional respondents’ opinions were different between domains. The opinions of respondents from the Intersectoral Committee in both regions were split almost equally; still there were some respondents who mentioned that more should be done to increase the volume of activities.

“They don’t think about that problem, they think only when they get grants”.

V1-13, page 5

In both regions, the opinions of those from governmental organisations, was split into half, but in Volgograd most respondents think that their authorities have a serious attitude. Still some respondents explained their opinion, suggesting that the attitude is more declarative and is not supported by action or adequate funding. As to financing, some think that lack of financing is not allowing a serious approach, whereas some
think there is no serious approach in the funding in place and that is why financial allocations are inadequate. Many mentioned that there is lack of a systematic approach towards the issue. Two respondents criticised the Intersectoral Committee’s work.

"The problem is accepted seriously, but not professionally".

V2-7, page 4

Those from government organisations in Altai mostly thought that that problem was not taken seriously by the government.

"It's time to develop governmental policy towards the epidemic and decide actions of each organisation and structure. At this stage we should be concerned with this and accept the epidemic as a threat to national security of Russia".

A2-8, page 3

The majority of NGOs, with few exemptions, and private sector representatives think that government attitude is not serious:

"Everything is ending up as declaration, as a moral support, but when it comes to resources, there is shortage for prevention, treatment, diagnosis...even for preventive activities the government is not allocating finances".

A3-6, page 2

6.5.2 Attitude of Population

Almost all federal respondents accepted that the population attitude towards the issues "is far from being serious". Many respondents put the blame on a lack of information about the problem of HIV/AIDS amongst population.

"...people talk about PLWHA as about aliens among us...they don't understand that the problem is so close and that anyone could be involved in it. ...Of course I don't suggest to threat people, but a shock therapy needed to make people to understand...there is a need for information to explain people the issue more clearly".

F4, page 3
The same was true in the regions. All Intersectoral Committee members accepted that the population does not take the problem serious and for the same reason that there was lack of information. A few respondents blamed themselves; others mostly speak abstractly, without mentioning who is responsible for this:

"If government authorities don’t know about it, then population couldn’t know about it...thus there is not a serious attitude, because of absence of thorough developed governmental policy towards that issue, there is a lack of governmental propaganda about that issue”.

Again, in both regions, the vast majority of respondents from governmental organisations think that the population is not taking the problem seriously and suggested that it was because of a lack of information. Some respondents from this domain in Volgograd, had a different perspective and thought that acceptance of the problem depends on population education level and age. They also suggested that young population is not taking the problem seriously, even if they have information about the issue, whereas vulnerable groups (drug users, CSW) and those with low incomes (engaged in manual activities in factories and in agriculture) do not have enough information or lacking information at all to assess the situation objectively.

"I believe some of population takes it more serious than it is in administrative structures, but it depends on the populations education, and age configuration...if we’ll talk in percentages then only 20% understand the problem”.

Respondents admitted that quite a lot effort should be contributed for prevention and information dissemination to explain to the population about possible threats and to increase the populations’ awareness. A couple of respondents even blamed the government for knowing the main reasons (most blamed the drug use) for epidemic spread but adopting a passive attitude to resolve the problem. They claimed that the government authorities are “unwilling” to act to prevent the advancement of the issue and the legislative system is weak to support any action.

Many respondents think that the government should be more proactive in its propaganda and involve the mass media in their information dissemination, explaining
the situation more comprehensively using differential approaches to cover different target groups. Many mentioned the importance of the role of social advertisement in increasing population awareness.

The majority (with few exceptions) of NGOs and private sector representatives think that the populations’ attitude towards the issue is not serious.

6.5.3 Organisations Shaping the Attitude Towards HIV/AIDS

The vast majority of all respondents think that health organisations determine attitudes towards HIV/AIDS. This is because respondents believe that the main responsibilities (for diagnosis, treatment, prevention and mostly information dissemination) should be carried by the medical organisations. The medical organisations mentioned were health Committees, the HIV/AIDS Centre and Sanitary-epidemiological organisations. There is also a perception that medical organisations should inform the country’s authorities about the problem that they can develop laws and legislation about activities to combat the epidemic. The country authorities mentioned were the heads of the local administration. On a federal level they said that the responsibility should be born by the Ministry of Health and Social Development, the Government and Duma, few mentioned the President.

Many respondents believed financing to be a determining factor in the ability to combat the epidemic, and thus the preventing attitude towards the epidemic they think is also determined by organisations which allocate funding.

As the most affected population is considered to be drug users and CSWs, many respondents replied that interior affairs organisations should support combating HIV/AIDS by their activities and relevant laws to prevent drug distribution and control in the country.

Respondents considered youth to be the main vulnerable population and suggested that Committees of youth and education departments should also been involved. Most of respondents mentioned that the mass media creates an attitude and so far they have played this role poorly.
A couple of respondents named specific people, like the main infectionist (head epidemiologist) of the region, or authority from city administration, few mentioned specific NGOs.

6.5.4 Vulnerability

To understand attitudes about HIV/AIDS issues and particularly the possible reaction when the epidemic develops and to measure understanding of the possible consequences of the epidemic, the respondents were asked to assess whether their employees were vulnerable to epidemic and how the epidemic could affect their work.

Most of respondents think about vulnerability only in terms of their professional responsibilities and those organisations that do not have direct contact with the HIV infected population, blood, screening or treatment think that they are not vulnerable.

"Extremely non-vulnerable. Our employees are intellectually very developed people and will not allow themselves to be infected".

Intersectoral Committee members in Volgograd think that they are vulnerable as most of them either have direct contacts or work with vulnerable population. More than half of Intersectoral Committee members in Altai think they are not vulnerable to epidemic as they have good knowledge; just there is a possibility of professional risk.

Whereas the opinions of those from government organisations was split in both regions as they think that without dealing with the HIV infected population directly they are safe, only a few in Volgograd but many in Altai mentioned that it could happen to everyone, and they all are vulnerable as a whole population.
In both regions, NGO and private sector representatives mostly think that their employees are not vulnerable to the epidemic. Mostly they think that strong moral values and discipline will prevent their employees from infection.

As to epidemic consequences, most of respondents again thought about their work, and Intersectoral Committee members suggested their workload would increase and also there will be an increase in financial expenditure. Some respondents thought that HIV will affect the country economically, socially and psychologically; a few mentioned military recruits’ pool will decrease and some mentioned that the country’s productive workforce would decrease and affect development. A couple of people thought that the number of people with disabilities will increase. Some private sector representatives suggested that they “have strict discipline which will protect their employees”.

It is worth mentioning that in both regions respondents from all domains displayed stigmatising attitudes, when asked about their vulnerability and how it could affect their organisation. As a response, many respondents were touching wood, immediately declaring that their employees are not drug users and connecting the problem with behaviour rather than probability.

“If someone from our organisation will get infected, I think it will affect our entire organisation, we will be paralysed, as the populations’ attitude towards it is negative. There will be conflict and they can’t coexist in the same work place”.

V2-18, page 3

“...if the employee is suspected of drug use [this was not mentioned, but was respondent’s immediate assumption that this would be the mode of transmission] we will try to eliminate that person in all means without any further investigation or analysis, as we don’t need such sick workers, neither in our organisation nor among our staff.”

A2-1, page 6
6.6 Intersectoral Committee

To learn about the activities that Intersectoral HIV/AIDS Committee is involved in and also to understand the perception of governmental organisations, NGOs and private sector about the work of the Committee, respondents were asked a set of questions (a set for Committee members and slightly adjusted version for governmental organisations, NGOs and private sector) regarding the content of the Committee work and their contribution to regional HIV/AIDS programme development and financing, and the procedures for suggestions of changes to the regional programme. Respondents were also asked to share their perspective on whether they found the Committee’s work efficient.

There was an explicit difference in respondents’ perceptions between domains. Obviously, Intersectoral Committee members’ knowledge of their own work as well as their participation in the development of regional programmes was better, though still there was no homogeneity, even within this same domain. It should be accepted that these people perhaps were biased, as the discussion was related to their own work. Those few from governmental organisations, who had been exposed to the Committee work had some slight knowledge, otherwise, there was poor understanding of Committee activities. Knowledge significantly decreased amongst NGO representatives, and only one or two from NGOs who had been exposed to HIV/AIDS activities had some knowledge. At the extreme, there was no evidence of any knowledge amongst the private sector respondents, who claimed not to have any knowledge of the Committee’s activities, and also had never heard of their existence. A respondent in Altai suggested that they are a council not a Committee.

6.6.1 Main Objectives of the Intersectoral HIV/AIDS Committee

Most of the respondents of Intersectoral Committee in Altai managed to describe the Committee objectives, how decisions are made, and described main functions. Only four respondents failed to describe their mission, out of which two, were not though Committee members but participate in Committee work periodically, replacing their organisation representative. All Volgograd respondents were clear about their functions and responsibilities.
In Altai the most prevailing answer regarding the objectives was “coordination of activities between different Committee member organisations”. Many respondents referred that their objective is to: “combine resources in resolving the issues”, “develop complex approach to problem”, some suggested activity to raise the awareness of HIV within the population: “make people know about the problem”.

“The problem is that our governmental structures are disconnected either by legislation or by financing, thus we have different objectives... but we have common aspects to work on...There should be integrated approach which should combat not the disease but the sick people, and from this point of view there are many common aspects between different organisations. So in Committee we have to work on the same direction and help each other in activities whether its prevention or treatment, etc. ”

Altai respondents perceived their role as more as comprehensive and broad, suggesting their participation in many activities; diagnosis, treatment and resolving social aspects of epidemic, whereas from Volgograd respondents the most prevailing answers were “coordination of preventive activities”. Though most of these respondents suggested that the Committee serve a function of coordination, they connected their activities with prevention. In Volgograd another common answer was that the Committee role was to “convey message to population”, few respondents suggested that they “define strategic directions”, or “control the epidemic”. Only three respondents suggested that, apart from prevention, they are involved in treatment and rehabilitation of PLWHA and their families. A respondent in Volgograd thought that the Committee was supposed to “combat drug use, prostitution and problems of homosexuality”.

The majority of respondents from other domains (governmental organisations, NGOs and the private sector) either suggested that they don’t know the objectives of the Committee, or just guessed at an answer based on the name of the Committee “to coordinate activities”. Suggested answers were accompanied by “I think”, “presumably”, and “could guess”. Among other guesses were: to provide information; to develop methodologies for prevention and treatment, and to analyse the situation.
6.6.2 Committee Activities

Respondents were asked to describe the main functions that the Intersectoral HIV/AIDS Committee has, how the agenda and the schedule of meetings was agreed, how often they had met in 2003, the role of Committee in the formulation of the regional HIV/AIDS programme and their organisations' contribution to the development of that programme, as well as their perception of, how influential their organisation is in the Committee's work. Respondents were also asked to suggest three themes that were the topics of the Committee discussions that they remember and to suggest possible changes to the HIV/AIDS programme that they think could improve the response to the epidemic. Last but not least, respondents were approached to suggest which organisations they think should be involved in this Committee work.

In both regions all respondents who were member of Intersectoral HIV/AIDS Committee were aware that there is a decree about the creation of the Committee, which also describes regulations of its activities. In Altai the vice-governor is the chair of the Committee. In Volgograd the Committee is chaired by the deputy head of Administration. In both regions the Committee was representation from the different Ministries analogues within the region for the Committees of health, education, social protection, youth and sport, 'narcologic (drug) dispensar', ‘Gossanepidnadzor’ (hygiene/epidemiological services), interior affairs, etc. Two Volgograd respondents suggested that there is a media representative as an observer at meetings (not as member).

At the end of each year, members of the Committee suggest themes for the meetings of the coming year. The list of suggested themes is summarised and the draft of the annual plan/agenda of meetings is completed by the HIV/AIDS Centre and presented to the Chair for confirmation. In this way the agenda for meetings is decided a year in advance. Afterwards, each meeting has designated people who make presentations about the particular issue; usually those who suggested the theme, or those who are involved in it. After presentation there is a discussion, followed by resolutions for actions. The meetings' minutes are distributed to participants 2-3 days following the meeting. These procedures were described by most respondents in both regions. Two respondents in Altai suggested that the head of the Committee decides on the agenda, and who will present on the issue. In Volgograd, though, almost half of respondents
suggested that the themes/agenda for the meetings are decided on and the presentations are done mainly by medical services representatives: health Committee, HIV/AIDS Centre, chief head epidemiologist, etc.

In both regions most respondents suggested that the Committee develops the regional HIV/AIDS programme, and though it suggests what the financial requirements are, has no participation in financial allocation and no control over any financial issues, stating: "we can't intervene". A small fraction of respondents in Volgograd suggested that they participated in financial allocations. Some respondents suggested that Duma and Administration decides financial allocations. A couple of respondents suggested that Committee of finance participated in the process.

"Committee discusses the programme and suggests the amounts required for the implementation of activities, but it is in the authorities power how much to allocate".

VI-3, page 17

There were discrepancies in both regions in answers regarding the number and frequency of meetings. Despite in both regions the most frequent answer suggesting that the meetings took place quarterly, there were three respondents in Altai and three respondents in Volgograd who claimed that there were meetings on monthly bases in 2003. Others suggested that there were two, three, five, six and seven meetings during 2003.

Intersectoral Committee members were asked to name 3 issues discussed during the meetings that they could recall. Most of respondents failed to nominate three issues. Very few suggested more than three issues, with a few suggesting none. In Volgograd preventive activities were strongly highlighted; some referred to general preventive activities, whereas many were more specific, suggesting prevention among particular groups: youth, pregnant women, drug users, CSWs. Though in Altai several respondents also mentioned prevention, it was not as emphasised as it was in Volgograd. Actually, in Altai no one issue was as a theme from Committee meeting. Among other answers were: drug users’ screening, social rehabilitation of PLWHA (twice), three respondents mentioned vertical transmission, information dissemination, customs/drug issues, prison and diagnosis issues. Also a respondent suggested the future of children born to HIV positive mothers who left in the hospitals. Four respondents in Volgograd recalled discussions on epidemic status in general, two respondents talked about work
with the press. Among rare answers in Volgograd were: financial issues, organisation of ‘youth friendly’ centres, propaganda issues, work with PLWHA. Two respondents in Volgograd and one respondent in Altai suggested discussions of United Nations (UN) project.

In general there was a lack of information about the Committee and its’ activities among governmental organisations, NGOs and private sector respondents. In Volgograd three members of governmental organisations and two representatives of NGOs claimed that they received minutes of Committee meetings. Out of these five respondents only one from a governmental organisation was not a member of the Committee itself. In Altai one member of a governmental organisation and three NGO representatives claim to be members of the Committee, whereas one NGO representative suggested that they do not received any document and work is “fragmented” and poorly organized. The rest of the respondents in both regions do not get any information about the Committee’s work and activities, unless something appears in the mass media, which was also claimed to be “rare”. Those few respondents who do get information suggested that they get minutes of meetings after each one.

Almost all Committee respondents in both regions suggested that their organisations are powerful enough to influence the Committee decisions and they found their role important in Committee work. Many suggested that there is “equality” and there is no pressure from any particular organisation. Some respondents suggested that health professionals and the chair have more influence. In both regions almost all respondents suggested that there are enough members of the Committee and that they don’t see any necessity to increase the membership.

6.6.3 Efficiency of the Committee

Almost all Committee members in both regions evaluated the performance of the Committee as efficient. A few complained about insufficient financing.

“Efficient, just the efficiency decreases because these programmes are not financed. Otherwise, people in principle know what should be done, how it should be done and are ready to act”.

V1-14, page 12
Four respondents in Altai and three respondents in Volgograd assessed their work as inefficient. A respondent suggested that the epidemic’s escalation is the evidence for their lack of efficiency. Three Volgograd respondents found difficult to answer the question.

"I think we are not efficient enough. On the level of working groups there is some intersectoral relationship, communication, and information exchange. The Committee itself should pay attention to the efficiency and effectiveness of its work and should take actions to improve its work".

VI-18, page 11

In contrast, almost all respondents from governmental organisations, NGOs and the private sector in both regions failed to describe Committee activities and to assess the efficiency of the Committee’s work. Many respondents suggested they do not know, some attempted to guess: it should be efficient, as it exists; whereas many suggested that it could not be efficient as they has never heard about it. Two respondents suggested that some time is required to be able to assess the efficiency and that the efficiency should be measured based on achievements.

"It's important to have control...necessary control of implementation of decided activities. So alongside with coordination there should be accountability through mass media informing population about faced problems, solutions to them and adopted actions".

A2-18, page 5

A governmental organisation respondent from Altai, who was a member of the Committee, suggested that it’s difficult to judge about the efficiency of their work.

"It's difficult for me to suggest how efficient we are 5, 10, 20 or 100 percent...but I can say, it could be worse, if such a Committee didn't exist".

A2-16, page 9

6.7 HIV/AIDS Programme

To learn whether respondents are familiar with the programme targeted at HIV/AIDS in general, a number of questions were asked. It is of interest to learn of the main stakeholders who developed the programme and the level of their participation and
contribution in this process. It was useful to learn the procedures for the programme development as well as how amendments and changes are made; also to learn respondents’ views about possible changes they think should be introduced to make the programme more comprehensive and assure a better response to the problem.

As can be seen from the table 7, in both regions only Intersectoral Committee members (80% in Altai and 68% in Volgogorad) are familiar with the HIV/AIDS programme. Still there were some members who were not familiar with the programme; in spite of the fact that they work on the Committee. A few members of Intersectoral Committee who were not familiar with the programme suggested that they “heard about the programme during Committee meetings”, some suggested that “they were never seen or heard about it at all”. As to other respondents from other domains, prevailing majority in both regions were unfamiliar with the programme and the knowledge drastically decreased respectively among domains of government organisations, NGOs and private sector representatives.

Table 7: Familiarity With the HIV/AIDS Programme (in %)

| Options | Altai | | | | Volgograd | | | |
|---------|------|------| | | |------|------|------|
|         | S1   | S2   | S3   | S4   | S1   | S2   | S3   | S4   |
| Yes     | 80   | 29   | 9    | 68   | 20   | 25   |
| No      | 20   | 71   | 91   | 100  | 32   | 80   | 75   | 100  |

The table shows the percentage of respondents answering the specific suggested option for each region and over the 4 survey stages.

*- where n in Sn refers to the recruitment of respondents

It was useful to learn about participation of respondents or their organisation in the development of the programme. All respondents who claimed familiarity with programme, suggested that they participated by contributing to its development. In addition, a few respondents who claimed that they were not familiar with the programme still suggested that their organisation contributed to its development. Thus, it is not always the specialist who worked on the issue that is a member of the Committee. Contribution to development of the programme by governmental
organisations in Volgograd was minimal; only two replied positively regarding their contribution. Whereas, in Altai all respondents of government organisations that positively responded that they are familiar with the programme also suggested that they contributed to its development. Participation in development of the programme was poor according to NGOs (only three) and private sector (none) representatives in Volgograd. In Altai, neither NGOs nor private sector had any contribution to programme development.

"NGOs practically are not involved in the process of development, so they will be unaware of the programme content, as they have never seen it. If there are some who know about it, it is just because they work with the AIDS Centre".

A3-6, page 8

Private sector representatives suggested that they had never been contacted by any organisation and that they have no information about the programme. A respondent from Altai suggested that it would be useful if the programme were to be disseminated through the mass media, as it is important and useful to learn about.

Respondents were also asked to nominate other organisations who according to their knowledge participated and contributed to the development of the programme. Almost all participants nominated the health Committee, because they think that this organisation holds ownership and is perceived that it should be responsible for the programme.

"This programme is perceived as exclusively a medical issue...we've tried to develop complex programmes, but those programmes haven't been ratified because sectors are financed from different budgets, some from regional some from federal, so organisations can't cooperation because of difference in their financing sources".

V1-3, page 18

Other organisations that the respondents mentioned should be responsible for the programme were the regional Administration and the regional Duma; Committees (or their analogues) of education, youth, drug control, interior affairs, family, social, sports, finance and economy; AIDS Centre; Gossanepidnadzor.
6.7.1 Programme Development Process

Based on the replies of respondents, it seems that in Volgograd the process of programme development is more participatory than in Altai. Volgograd respondents were more aware of procedures of programme development and also who participated in the process and also suggested that, despite the process of making change or amendments to existing programme being difficult and highly scrutinized, but it is still possible. The main problem recognized was financial; more exactly the mechanism of financing. Many Altai respondents were pessimistic about the participatory development of the programme, discounting the possibility of consideration of advice or opinions during the development process or any changes thereafter. Many Altai respondents mentioned that the programme was developed behind the scenes, though to be fair, some answered that the development of the programme by the Committee had been an entirely transparent process. Some suggested that despite having been asked to express their opinions, they had been ignored.

"I strongly doubt that the opinions of the intersectorl HIV/AIDS Committee were considered, because the Committee were faced with a done deal of the ready programme.”

A1-5, page 8

In Volgograd respondents mostly knew the process of development of the programme and agreed that either they have been contacted by health Committee to present their suggestions, or had been directly actively involved in development of the programme. A respondent from governmental organisation suggested that they had been contacted by the Administration and given the task of developing some aspects of the programme. The frustration was about the deadline imposed which must they had a lack of time to complete the task properly, conducting a research and using evidences to develop suggestions. Instead the organisation had been asked to sign a pre-prepared document that authorities suggested. The organisation refused to sign the document and eventually conducted research and came up with suggestions, though none had been accepted.

Respondents were asked to describe the process of programme development. As Altai respondents suggested, although they developed their own regional programme, they had been guided by the federal programme and had simply adjusted it to their region. It
was learned from responses that in Altai the Intersectoral HIV/AIDS Committee appointed working groups, which initiated consultations. Working groups collect suggestions from Committee members, summarised suggestions into a draft document, which was then discussed during Intersectoral HIV/AID Committee meetings. Once changes had agreed, it went for ratification to the local Administration who decides on the budget allocation. Once the new programme is ratified by the administration it becomes a legal document and is not subject to change. The major problem is that the agreed upon budget was not allocated and thus the programme activities are not implemented.

Respondents were also asked to share their knowledge about the consultation about financial allocations to the activities, and how participatory this process is. Only a few respondents were able to describe this and their answers were contradictory.

"This question is bypassed regularly, as a matter of fact, I never heard it to be discussed. Till now it's a big mystery for me. We spent what is given".

A1-1, page 19

6.7.2 Process of Change to the Programme

From the responses in Altai it has already been ascertained that there is no a system in place for change (at least this is the opinion of most respondents), whereas, in Volgograd respondents were more knowledgeable and many were able to describe the process of change. Nevertheless, in both regions it was suggested that the process is much scrutinized and that it takes a long time to introduce a change, with finance identified as the main obstacle to the change. Suggested changes should undergo the same pathway as the initial development of the programme and as Administration ratifies the programme changes also should undergo Administrative approval. The regions usually lack fund and by the time any change is introduced the entire regional budget is already allocated and approved. According to the rules, any change, which is supposed to be supported by financing, should have this reallocated from other sources, so that each change generated a series of changes in the administrations activities leading to intense scrutiny.
From replies from a few Altai respondents it was learned, that the regional Administration, once a year circulates a document to organisations that participated in programme development requesting that they come up with suggestions (if any) for changes to existing programme. Each organisation should agree with counterparts their suggestions before replying to Administration. Further, the organisation which suggests the change, should justify their point to members of the Duma and Administration. As a respondent said, they will be ‘interrogated’ as to why they need that change and where the money should be found for it. Then if they manage to ‘survive’ and the majority are convinced only then will the change be accepted and a relevant amendment introduced.

Volgograd respondents suggested that there is a formal procedure for change supported by the law. The latter suggests that any amendment should undergo wider discussions, with participation of civic society and general population. So relevant organisations should develop and discuss suggestions with the public and present changes to Administration and Duma for ratification in May (this is time when the Administration initiates discussions for the coming years programme). Discussions are initiated by the HIV/AIDS regional centre, which starts the process and summarises changes to the existing document, agrees changes with other Committees, finalizes the document and presents it to the Administration and Duma for ratification. Changes became active only once the old programme expires. Respondents suggested that because of these both the public and especially the Administration and Duma members should have comprehensive knowledge and information about the issue and be able to understand the problem and judge the changes objectively. A few Volgograd respondents described the process of change as being very democratic, but also a very long process.

A respondent from a governmental organisation suggested that they “struggled” for seven months but failed to amend a particular change, because of financing mechanisms. The respondent explained the failure, which was due to several organisations being supposed to be involved in implementation, whereas some are financed from federal (Federal Service of Security, Government Unit Interior Affairs, Drug Control Committee, Prosecutors Office), some from local budget and those who are funded from federal budget can not participate in activities, which are funded by a local Administration.
To learn about what the respondents would change in the current programme if they could, they were asked to identify areas that could useful be included in the existing programme. Mostly, respondents were happy with the programme and did not come up with any suggestions. The most frequent reply in both regions was that they would be happy if the current activities were fully financed as had been agreed and they would then be able to implement the agreed programme. Another common suggestion was for an expansion of preventive activities and for the involvement of the mass media in information dissemination and a strengthening of "information package" in general. To support preventive activities some respondents suggested closer work with the general population, some suggested an increase in youth and school children awareness activities. Others suggested organising activities for risk groups. It was suggested that it would be useful to include an assessment of implementation and monitoring of the programme. Some respondents suggested that propaganda is needed to increase the population’s awareness about developing a healthy lifestyle. A few suggested that the programme should describe the process of the cooperation with NGOs and private sector. Two of respondents suggested that the programme should assure an update of the equipment for blood services, diagnostic centres and treatment facilities. Two respondents suggested that programme should address aspects of social rehabilitation and other social issues, like housing, benefits to PLWHA. One respondent from Altai suggested that they lack normative documents regarding implementation and that the programme should consider creating them. It was suggested that the heads of coordinating bodies before commencing in their positions should undergo compulsory training in foreign countries to learn how to combat the epidemic successfully.

6.8 Perceptions of Partnership

To understand the process of cooperation between different sectors and each organisation’s role in combating the HIV/AIDS, the respondents were asked to define their perception of the functions of: governmental organisations, NGOs, private sector and donor organisations. In general there was no difference between understanding of the role in both regions and among representatives from different domains.

The overwhelming majority of respondents perceive the Government’s role as being responsible for policy, provision of laws, financing and in providing ideological support.
A few Federal respondents also thought, that the government should “provide control” and do most of the decision-making. Some respondents think the Government should also provide prevention, diagnosis and treatment; but some saw NGOs leading these last activities. In addition, Federal respondents mentioned the importance of increasing the quality of the NGOs’ staff. They also added to the list of government responsibilities the role of drug distribution, research/scientific work and work with Media.

“Government should assure financing and general directions of activities, should assist with legislation and legislative acts of course, acting as the host of the issue”.

V3-1, page 8

NGOs should work closely with population providing information; work with marginalized populations, conduct harm reduction and other preventive activities, as they “could gain access to those groups”. At the same time Federal respondents blamed the NGOs for “not always having competent qualified staff” and for poor quality performance.

“I think that governmental organisations should deal with global issues, those that NGOs won’t be able to resolve. As for NGOs, they should support the government, though often it happens visa versa, and NGOs are involved in more responsibilities. It’s only because the risk groups contact the NGOs, whereas the governmental organisations they don’t, as they are afraid of consequences”.

V2-24, page 8

The majority of respondents perceived the role of private sector as sponsorship activities and in the provision of financial resources. A few mentioned that the private sector should finance social advertisements and support sports clubs. Federal respondents and Altai participants suggested that the private sector could provide jobs for PLWHA and could conduct preventive activities among their staff. On the one hand, it could help to break the stigma, on the other it will provide support to affected families.

“...the help should be in terms of financial support and of course creating jobs and employing PLWHA”.

A1-9, page 7

Federal respondents blamed the private sector for being inactive in response to the epidemic and in ignoring the magnitude of the epidemic, as well as in not considering
its impact on private sector development. It was also mentioned that the private sector could be more active in the development of the drug industry and could financially contribute to research.

"Unfortunately, private sector does not understand how serious the situation is and the possible dangers of HIV/AIDS especially for business".  

F2, page 4

The International Donor Community role was defined in financial means, mobilization and input, in the provision of technical assistance “as a motivator of ideas” and sharing of experience through exchange programmes, provision of voluntary services and in helping to conduct social marketing. Some respondents from Altai also mentioned the mobilization of policy makers; a few mentioned also lobbying the government. A couple of Federal respondents suggested that donors could provide drugs.

"I suggest, firstly, those organisations [meaning international organisations] should collect and summarize the experience. Secondly, to disseminate these experience. And thirdly, some how coordinate implementation of programmes, of course without violating the country’s sovereignty".  

A2-8, page 6

6.8.1 Primary Responsibility for the Epidemic

The research tried to learn respondents’ opinion about who bears responsibility for tackling the epidemic. Most respondents in both regions believed that primary responsibility for HIV/AIDS resides with medical organisations: the Ministry of health and AIDS centre. Some respondents also mentioned the ministry of Interior Affairs, education organisations, and family and youth organisations. Several respondents thought that it is a responsibility of each citizen. In addition to the above, some federal respondents believed AIDS as a broader issue and that the responsibility goes beyond medical specialists.

"It’s a complex issue, intersectoral. Responsible for it are the government, as well as civil society."  

F10, page 1
Many mentioned the President and the Government should take a lead and that “it's not enough to declare, its time to act”.

6.9 Problems with Interorganisational Cooperation

To identify problems in cooperation between different organisations, the respondents were asked to nominate the problems hindering cooperation. Most of the responses were common in all sites and among domains.

There were several respondents in both regions that found there are no problems in cooperation between the government and NGOs. Meanwhile, most respondents found that there are problems in cooperation within governmental organisations, as well as between governmental organisations and NGOs. The main reason was poor coordination of activities among stakeholders and different sectors. Federal respondents also mentioned duplication of activities, whereas certain activities remained uncovered. There was also hope that the newly created (May 2004) (MOH&SD) Coordination Advisory group would help to resolve the problems, though at the same time it was noted that the body lacked the authority to act.

"Today in Russia there is an absence of worked-out ideology for partnership between different organisations, sectors, NGOs, private sector, and any other organisations, e.g. there is no ideology."

F1, page 3

A couple of Federal respondents and some government and NGO respondents in both regions, highlighted the absence of trust between government and the NGOs, and also between different NGOs, which is the biggest challenge, as it creates an unhealthy environment for cooperation.

"Governmental organisations do not take NGOs seriously".

V1-16, page 9

"The government do not need NGOs...They perfectly understand if we start raising issues and create a wave, no one will benefit. That is why we are
separated, as weaker NGOs are better for government. It's a principle of divide to control”.

A federal respondent also classified the relationship between NGOs as “competition and a hunt for money”. Most respondents mentioned lack of information about each organisation activity; difference in perception of the role and possible contribution of each sector representative to combat the problem; some see the problem in laws and the regulatory framework. The different approaches to implementation of activities and management of tasks were also mentioned, as well as differences in the technical skills and abilities, which caused conflict.

“Governmental organisations are hindering the process...they are often working not for the common goal.”

In addition to these common problems, some specific problems were described as typical in the coordination between governmental organisations and NGOs, such as absence of the structures for coordination of activities and the division of responsibilities, though in the Ministry there is such department. Governmental organisations announced they lack data and information about the NGOs operating in the HIV/AIDS area, whereas the NGOs found that the government is not providing adequate information and financial resources to NGOs for their operation. Some also mentioned financing and economic conditions as a hindrance to better cooperation. A few mentioned the absence of related laws to guide coordination of activities.

6.10 HIV/AIDS Activities

To learn in which particular HIV/AIDS related activities respondents are involved in and to understand the main directions of each organisation (Committee, government, NGOs and private sector), respondents were asked to describe activities that they are involved in, and how they contribute to combat HIV/AIDS within their organisation, particularly for the general population and for PLWHA. Overall it seems that not much is done in any of these directions.
6.10.1 Activities within their Organisation

In both regions, most of respondents from the Intersectoral Committee confirmed their contribution to combat HIV/AIDS, but mostly as their direct job responsibility (treatment, diagnosis, equipment sterilization, donor blood control, scientific contribution). Most respondents described their participation as attendance at meetings to discuss HIV/AIDS. Some suggested that they keep statistical information; others make arrangements and administer the implementation of decisions. A few suggested that they create laws and regulations and control the activities of others: “just controlling”. Those respondents, who suggested that they are not involved in any activities, witnessed that there are specialised organisations to run certain activities as a part of their job and were surprised that they are expected to contribute to the response HIV/AIDS. A few respondents suggested that they work with the mass media providing information for dissemination. A couple of respondents suggested that they are involved in international projects. A few respondents mentioned the imperfection of laws and lack of financing as an obstacle for initiation of activities.

“Many legal documents are not supported by byelaws which hinders their implementation”.

AI-7, page 6

In both regions, participation of governmental organisation in AIDS activities could be assessed as negligible as almost all mentioned they are not involved in any activities. Most common answer were based their job description.

“Our organisation responsibilities do not involve any activity neither for prevention, there is no ideological work about HIV/AIDS, no information collection and we are not involved in any way”.

V2-4, page 5

Mostly they believed their staff to be “intelligent enough” and suggested that they do not need to initiate any activities within their own organisation. Most of NGOs and private sector organisations followed this trend and suggested no activities within their work place. A few respondents from the private sector and suggested that they initiated preventive seminars, inviting representatives from health institutions to give one off talk and inform their employees about threats and possible prevention. A couple of
respondents of organisations involved in service industry suggested that their employees are undergoing testing from time to time, which is a responsibility of the government laws.

6.10.2 Activities for the Population

It was suggested that little is provided for population by the governmental organisations, NGOs and the private sector to combat the epidemic. Those few respondents who replied positively, were mostly from the Intersectoral Committee and some NGOs (in both regions), who are involved in preventive activities (publishing posters and brochures, work with youth). Activities mainly involve seminars and talks in schools, colleges and higher education institutions.

"I think the main problem is, that we don't do anything systematically. There is no support, as far as I know...there are some few activities like psychological counselling perhaps some organisations provide as a part of planned activities, but I haven't heard anything about an organized big programme as a part of a campaign. I think its worth to think about it".

A3-3, page 4

Only one organisation from the Intersectoral Committee mentioned that they are involved in work with vulnerable populations and another one was working with prisons. A few NGOs work with vulnerable populations; some provide information alone i.e. where to apply for screening or get information, others provide more comprehensive services, like condom distribution, harm reduction programmes, counselling of vulnerable population and training of volunteers. One works with sports organisations for youth and provides talks about the threats of risky behaviour and possible prevention. Overall, the majority suggested that they are not involved nor do they initiate any activities for the population.

6.10.3 Activities for People Living With HIV/AIDS

While asking the question regarding activities provided for PLWHA, the immediate reaction of many respondents was: "we don't have them among us".
"We don’t have it so far [meaning HIV/AIDS]...to be said, this question is not bothering us yet...If there will be some cases, then only then will we start to think of doing something...so far this problem is bypassing us, and I think there is no need to bother, this problem is not related to us".

A4-6, page 4

Most respondents in all domains and in both regions provide very little, or nothing at all, for PLWHA. Intersectoral Committee members because of their responsibilities are involve in the provision of the modest social package to PLWHA and their families. Those respondents mentioned the problems they face with financing and stigma, from society that they have to overcome to provide their activities.

"...We had huge difficulty in accommodating that child [got infected in hospital and both parents and orphanages refused from the child]. He was almost 7-8 years old and several years he used to live in the hospital...neither school nor the orphanage wanted to accept him. Though I believe it is a fault of the society".

V2-10, page 6

Most mentioned activities which are part of their job description: distribution of pensions, social benefits, placing infected children in schools or with orphanages. A few NGOs mentioned that they know and work with PLWHA, only once they get financing from governmental organisations. Whilst private sector representatives replied that they are not involved in any activities, some did suggest readiness to sponsor or provide financial contributions either to activities or for providing social support upon request.

6.11 HIV/AIDS Prevention

To learn about preventive activities available in Russia, respondents were asked to describe what activities their organisation is providing for their employees, and general population to prevent new cases of HIV/AIDS infection, as well as for people who are already infected. Also respondents were asked to share their attitude towards expansion of preventive activities.
6.11.1 Preventive Activities for their Employees

More than half of the Intersectoral Committee respondents claimed that they do not provide preventive activities for their employees. Most of those respondents considered that their employees work in the area and have enough knowledge to perform their tasks and not get infected themselves. Also they mentioned that their employees are intelligent enough to learn more if need so in that sense, they do not consider that they need to expand preventive activities related to their staff in the future.

"We do not have any preventive activity, as we don't think its an actual issue".

A1-1, page 10

Another suggested reason was that there is no “set up system”, and the Committee should react to situations once they occur and develop their activities to resolve issues.

"Of course there is a need to expand [meant prevention activities], but we are in a situation when the priorities constantly change, and despite it becomes an important issue, we should be dynamic and react to any occurring situation”.

V1-3, page 9

Very few of the Committee respondents, who do not provide activities, feel that they need to do more for prevention, a couple mentioned that “it’s vital”. Those respondents, who replied that they do not provide preventive activities for their employees, suggest that still, as a part of the health and safety for their job there are certain guidelines that all employees are suppose to follow (i.e. sterilize equipment, wear gloves while working with patients, etc.). A few suggested they don’t require preventive activities as their employees’ “moral values are strong”; they are above age of 50; they don’t work directly with “clients” or “we don’t have such people”; “there are no drug users among my employees”.

"...we don’t have risk groups among our employees, there are none”.

V4-9, page 5

One of respondents from Altai suggested that some work required psychological support for their staff, as on a day-to-day basis they are exposed to emotional stress, and nothing is provided at workplace for stress relief. One respondent, as a preventive activity, mentioned investment in improvement of diagnostic equipment and updating of technologies at their workplace.
Almost all respondents from government organisations (except three in Altai and two in Volgograd) also replied that they do not provide any preventive activities among their employees. Many respondents in Altai were genuinely surprised that they were expected to do so.

"Our people are well educated, have higher education, they all are capable to explore the problem themselves".

A2-9, page 4

A few respondents in Altai considered the issue important and expressed readiness to implement any suggested activity. A few mentioned that because of their job, their employees undergo screening once a year. A couple of respondents mentioned that once they have been invited to give a lecture to discuss the issue with their staff. Though in Volgograd the governmental organisations were more open to increase prevention activities for their employees, some just don’t think it is supposed to be done at the workplace and during work hours.

"...we need it, but don’t think we should waist our time and distract employees from their work".

V2-19, page 4

Though in both regions only a few NGO representatives mentioned that they provide preventive activities for their employees, in Altai they were open to idea that it was necessary and they would like to expand the activities, whereas in Volgograd more then half considered there is no such a need. Private sector representatives in both regions were lacking any activities (with a few exceptions), but were keen to educate their employees. One respondent suggested that current forms of preventive activities exhausted them and new initiatives and new forms of activity were required to catch the attention of the population and schoolchildren. In Altai a respondent described organizing a competition among students of different professions to develop new initiatives and innovative approaches for preventive activities (economists suggested insurance mechanisms, film faculty students came up with social advertisement, etc.).

For those who provide preventive activities among their staff it was mostly in the form of updating from time to time their existing knowledge through seminars and lectures, additionally a few mentioned participation international in conferences and symposiums.
A few respondents also suggested that they were involved in the creation of normative documents and allocate financial resources to prevention, they also participated in meetings. One NGO representative suggested that they provide free condoms to their employees. Only two private sector respondents suggested they once had a lecture at work.

One of the key issues emerging from the discussions was that of financing. The respondents complained that though prevention was suppose to be one of the important aspects of combating the epidemic, even if it is supported by laws, because of lack of financing activities already are envisaged being ignored. Actually, lack of financing was the reason for decreasing the number of people being screened, especially in Volgograd, where only pregnant women and blood donors are currently subject to screening; even the number of screened children has decreased. The respondents claimed that there are no finances for other activities such as: publication, health visits for lecturing, and for promotion of other preventive activities. The same problem faced NGOs, who claimed that they are unable to plan their activities, and have to organize their activities only once they manage to obtain some tiny amount of funding.

6.11.2 Preventive Activities for the General Population

More then half of respondents from the Intersectoral Committee in both regions suggested that they do not provide any preventive activities for their populations. Some who replied that they do some work with the population, described activities like treatment and diagnosis, which were basically part of their daily job description. The majority of preventive activities directed at youth and teenagers were in seminars and lectures provided at schools, colleges and few higher education institutions. A few work in collaboration with youth Committee and organize information dissemination through games and during sports events. It was also mentioned the training for teachers, school nurses and psychologists had been provided. Concomitantly, many of the same respondents expressed concern that these activities were not provided on a systematic base and have a very fragmented character.

"Compared with 2 years ago, there is a positive shift, but to say that population gets social, legal, psychological and medical support, then no".
In both regions, almost all government organisation representatives rejected the suggestion that they are involved in preventive activities for the population.

There were a few NGOs working with vulnerable groups, providing condoms, or suggesting to them places where they can access them. The existence of a phone trust-line for the population was also mentioned. A limited number of other activities included brochure distribution and one respondent mentioned a syringe exchange. One NGO works with a school only if they are invited. The private sector was not involved in any activities at all.

As a preventive activity, a respondent from Volgograd mentioned screening of military recruits in order

"to not allow any means that it [meaning HIV/AIDS] gets into the army".

6.11.3 Preventive Activities for PLWHA

Almost all respondents from the Intersectoral Committee with couple of exemption replied that they are not doing anything for PLWHA and "they don't know them". A few mentioned that they participate in development of privileges for affected population and their families. One mentioned that they are involved in social support.

No one from government organisations, NGOs or the private sector replied in the positive to this question. In Volgograd, an NGO was planning to organize a concert for HIV/AIDS.

6.11.4 Desired Activities for HIV/AIDS

Respondents were also asked to come up with suggestions as to which area of prevention could be improved if there was a possibility of reallocating scarce resources.
One of the priorities that was frequently mentioned was close collaboration with mass media to increase the populations’ awareness and the safety of donor blood.

One respondent suggested that current resources are not used rationally and suggested that the qualification requirements for specialists should be improved, which will increase efficiency of activities and will help to utilize resources effectively. A few respondents suggested that testing should be improved and be targeted only towards risk group populations. A few suggested just to improve preventive activities generally, which they think will assure savings from contribution to treatment.

In both regions youth was at focus and as a preventive activity organisation of youth leisure time aiming “to cut them from streets” was mentioned. Increase in population awareness and the creation of public opinion through propaganda, aiming for the “population to understand the issue and confront it rather than accept” was also emphasised. In Volgograd the creation of an HIV/AIDS hospital and the expansion of epidemiological services was prioritised. In both regions respondents gave weight to the quality of staff and the quality of information to mass media by health personnel. Additionally, the quality of information, in terms of its accessibility and acceptability for the population was mentioned.

6.12 Harm Reduction

In Russia drug users are the most HIV/AIDS affected population, therefore respondents were asked a set of questions regarding harm reduction programmes, particularly relating to their attitude towards harm reduction programmes, what could be done to support the expansion of such programmes, and who is influencing the attitudes towards harm reduction activities in Russia.

Below table 8 presents distribution of answers related to expansion of harm reduction programmes in Russia.
### Table 8: Respondents' Opinions about the Expansion of Harm Reduction Programs

<table>
<thead>
<tr>
<th>Suggested Options</th>
<th>Volgograd</th>
<th>Altai</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$S_1^*$ $S_2$ $S_3$ $S_4$</td>
<td>$S_1$ $S_2$ $S_3$ $S_4$</td>
</tr>
<tr>
<td>Agree (%)</td>
<td>65 48 27 67</td>
<td>90 56 75 90</td>
</tr>
<tr>
<td>Disagree (%)</td>
<td>15 32 73 22</td>
<td>10 36 17 10</td>
</tr>
<tr>
<td>Difficult to answer (%)</td>
<td>20 20 11 8</td>
<td>8 8</td>
</tr>
</tbody>
</table>

*The table shows the percentage of respondents answering the specific suggested option for each region and over the 4 survey stages*

*- where n in $S_n$ refers to the recruitment of respondents*

Overall, the majority of respondents in Altai and most respondents in Volgograd (exception were NGO representatives from Volgograd) agreed that there is a need for expansion of harm reduction activities in their regions.

In Volgograd, implementation of programme had just started and respondents were enthusiastic about expansion, whereas many respondents from Altai, witnessed previous negative experiences and suggested that they should consider mistakes, while expanding the programme.

Respondents form federal level, though generally agreed that there is a need to support drug users, at in the same time expressed concerns regarding professional ethics, and the way these programmes are implemented in Russia. Some respondents suggested that the existing programmes are enough, and there is no need for expansion.

All respondents suggested that there is poor understanding of harm reduction programmes among the general population and the decision-making authorities, a few also mentioned that this was also the case among medical personnel.

"There is contradiction in understanding of those programmes, and often syringe exchange is interpreted as drug use promotion".

F3, page 5

Some respondents mentioned that there is confusion between harm reduction, substitute treatment and syringe exchange programmes among programme implementators.
themselves blaming them for the lack of progress in developing programmes. In Russia, the harm reduction concept misunderstood and become equal to syringe exchange, which is just part of big concept and includes information dissemination, counselling, psychological, legal and medical support, outreach services, as well as treatment of drug addicts. Some respondents concerned about the quality of staff working in programmes and the efficiency of their work, suggesting that their coverage is only 3-5%, and that they are not located near to location of the target groups. So respondents suggested that programmes should be adjusted to “Russian reality” and “Russian mentality”.

“...because they [the programmes] are against the national mentality and the Russian approach to things”.

Another reservation tending non-support comes from previous negative experiences of programme implementation. Respondents mentioned that the staff was not experienced and professional enough to run the programme that they disliked the management and the way the programme had been implemented. One Altai respondent mentioned that the programme had been initially implemented by an international NGO and had then taken over by the local staff. They blamed the programme for discrediting itself, as staff became involved in political and human rights activities, earning negative attitude from the local authorities.

Many respondent stigmatised drug users and suggested that government should not “waste” its scarce resources on drug users. They argued that drugs are very expensive and if drug users have money to purchase drugs they should also pay for their syringes.

### 6.12.1 Supporting Factors

To understand what could support harm reduction programmes and their implementation, respondents were asked to nominate reasons for the slow development of programmes all over Russia.

Almost all respondents suggested that assessment and evaluation of existing programmes could gain support for programme implementation as well as expansion.
One common answer was that there is a “poor understanding of the problem”. There should be some evidence of efficiency based not only on international but also local experience.

“Perhaps we are missing convincing arguments and proof of economic efficiency of these programmes. ...we need to be shown why it is good and how much these programmes decrease drug use among IDU population and prevent HIV/AIDS development. I haven’t seen convincing data. And perhaps there is no enough information among people who make strategic decisions”.

F3, page 7

Respondents suggested that assessment of programmes will provide the evidence helping in advocating and lobbying for the programmes and getting support of the government, which respondents considered crucial for any further existence of programmes. In addition, they argued that it would give strong evidence, helping to influence public opinion, another hindrance for programme implementation, as majority of the population and officials consider syringe exchange and harm reduction in general as an encouragement of drug use in the country.

“Its very difficult to convince organisations, country legislative and implementing power about the importance of this programmes. If we will have information about efficiency then, sorry, but there won’t be any Gosnarcocontrol or Duma arguing about inefficiency of such programmes”.

V1-4, page 13

To underline the importance of public support, respondents also emphasised the existence of profound stigma towards drug users, which is a reason for neglecting the issue. Respondents considered that the reason for stigma is the lack of information about the programme and its benefits, which could influence and change attitude towards the programme. Also some mentioned that involvement of religious organisations could help in influencing public opinion.

“The root is general attitude towards drug users and distribution of syringes is basically interpreted as a support of drug use”.

A2-6, page 8

Another reason for poor implementation was financing and other competing proprieties within the country. Many respondents argued on the bases of social justice that
finances should be directed to other important issues and other health conditions which required more attention.

“No, first let's make sure that other part of population has enough medical supply, they have enough disposable syringes, then think about those, who sorry but suffer from their own head. First priority is they then drug users. Why they should get free of charge syringes, if grandmothers have to pay for theirs?”

A2-14, page 12

Some respondents suggested that support for the programme expansion could be gained through political support, developing a federal programme on drug use prevention, laws and legislative acts supporting implementation of programmes. To prevent limiting the programme activities just to syringe exchange, it was mentioned that it would be important to develop instructions describing necessary activities to be included in the programme. To convince the policy makers and get political support it would help if there was more proactive lobbying about the efficiency and benefits of the programme by the NGOs who are involved in programme implementation. Federal respondents suggested that the political environment is created at the federal level and support was required on “as high as possible” level.

“advocacy could contribute to the process, some legal mechanisms developed on the federal level are required which will regulate the process. We need some normative documents to avoid experimentation. As of today, all documents are declarative and suggest recommendations. There is no legal support and we are unaware what are further consequences. We don’t know the opinions of the public, religious organisations or Gosnarkokontrol [drug control department] regarding the issues. They should be informed and educated about the programme, there should be experience exchange with foreign colleagues”.

V1-18, page 15

Almost all respondents suggested more information about the programme should be disseminated through mass media, emphasizing its benefits, results and also problems. Propaganda could help to develop a positive public opinion and a supportive environment for programme implementation, which could also influence government officials leading them to prioritise the issue.
A few suggested that distribution of syringes could support the implementation of the programme, as because of lack of financing there are no syringes for harm reduction programme implementation (i.e. that international organisations could provide syringes and support the programme expansion).

Some respondents also mentioned that as the government is not involved in implementation, the role of NGOs is important, so the number of NGOs working in the area should be expanded.

Many respondents in both region suggested that one of the major problems is the access to drug users. The designated vans or separate entries to clinics can attract attention and hence drug users avoid using programme services as this breech their confidentiality. The population stigmatises drug users, and such entries and vans disclose their status, this discourages drug users. Some respondents suggested that legalization of activities and provision of harm reduction services within medical institutions is the best solution to increase access. They suggest that drug users should be registered with services and properly use provided services.

"They know that their first visit to syringe exchange station, not only will disclose their status of HIV positive but also everyone will know that he is also a drug addict."

Some respondents suggested that properly targeted legislation will bring more drug users to clinics, and not only for harm reduction, but also they could be offered social rehabilitation to divert them from drug use. It was also suggested that it would help to have information about how long the patient is a drug user and those who are ‘beginners’ should be involved in other activities like treatment or supported by job placement, to prevent them in becoming “steady drug users”. Those who are longer-term users, medically it is obvious that they won’t be able to be treated and they need to be involved in syringe exchange programmes. As respondents mentioned, there is no option of methadone treatment, as it is considered illegal in Russia.

Some suggested that schools and colleges should be involved in education towards a healthy lifestyle to avoid drug use problems in the future. Some suggested also that there should be education of drug users so that they do not reuse syringes as part of
"drug use culture" according to which they should share injecting equipment even despite availability of syringes and clear acknowledgement of possible dangers of such activities.

A couple of respondents in Altai mentioned that there is no political support because there is a criminal element connected with the drug business, which is very profitable and that the government has its share in it; harm reduction programmes could affect the demand and decrease their profit.

6.12.2 Supporting Organisations

Many respondents nominated religious organisations, media and medical specialist as the main organisations creating public opinion.

Additionally importance was given to governmental support in terms of legislation, financing, federal programme development and development of relevant structures for implementation. In particular, federal support was mentioned by almost all respondents. The President and Duma were first mentioned, followed by local and municipal administration, as well as ministries of health, drug control, and interior affairs.

"President has advisors and structures who consult on HIV/AIDS. If they will not at least criticize but be neutral, this will untied our hands and allow us to act".

F5, page 6

An important role was ascribed to medical specialists, who are supposed to work with the mass media and help to develop relevant materials for public distribution, to develop understanding of issues and create a positive environment for programme implementation. Some mentioned education specialists as well, emphasising the importance of information to prevent drug use development being distributed through schools and other educational institutions. A few mentioned Domuprav (the organisation responsible for utility services in Russia), as they are responsible for monitoring the use of vacant spaces in buildings (in Russia most drug users are clustered in basements of buildings to use drugs).
A few respondents mentioned that the involvement of celebrities could be a powerful tool in information dissemination, social advertisement or influencing public opinion.

6.13 Sex Education

To find out the stakeholders' attitude to one of the preventive activities, e.g. sex education, the respondents asked a group of questions related to sex education. Firstly they were asked to define their attitude towards the introduction of sex education into the school curricula. It is worth noting that the answers were very consistent and there were no substantial differences in respondents' attitude between the regions and stakeholder domains. Almost all respondents in regions (90% in Altai and 85% in Volgograd) and 100% in Federal level expressed the view that the school curriculum should involve sex education (see table 9 below).

Table 9: Sex Education Introduction At Schools (in %)

<table>
<thead>
<tr>
<th>Answers</th>
<th>Altai</th>
<th>Volgograd</th>
<th>Federal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>S1</td>
<td>S2</td>
<td>S3</td>
</tr>
<tr>
<td>Support</td>
<td>92</td>
<td>93</td>
<td>86</td>
</tr>
<tr>
<td>Not Support</td>
<td>8</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>Difficult to answer</td>
<td>2</td>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>

*The table shows the percentage of respondents answering the specific suggested option for each region and over the 4 survey stages.
*-* where n in Sn refers to the recruitment of respondents

To clarify the issue the respondents were asked to share with the interviewer their understanding of why in many regions of Russia the introduction of sex education in schools curricula faced opposition. Though all respondents mentioned the importance of sex education for child development and further participation in social life there were certain concerns expressed by those who support the curricula introduction and those
who oppose to it. The concerns are grouped by content and presented below (Gevorgyan et al. 2005a).

6.13.1 Starting Age for Sex Education

Respondents’ opinion on the appropriate age to start sex education varied. Some suggested children should be informed about sex-related issues at the age of five as “kids’ learning is completed by the age of eight”, while others suggested starting sex education in kindergarten when children become curious about their birth. Some argued that the best age was 12-14 years, as this was the average age when young people began their sexual life. Many respondents mentioned the need for different information at each age and grade, and emphasised the need to consider cultural and regional differences.

“...should be taught starting from 1st grade, kindergarten, 10th and 11th grades, e.g. with age consideration, and also with consideration of the territory, I mean Moscow and Jewish youth are different, and we talk about remote areas as well, they are different and kids are different, so information shouldn’t cause harm somewhere, somehow. So these should be considered”.

A1-1, page 26

Some respondents stated that girls and boys should be taught separately in different groups.

6.13.2 Reasons for Opposition

Taboo, conservatism, traditions, shame, complexes, and “closed theme” were the words respondents used to describe the public’s views on sex education and sexual issues.

“All these issues had been banned, and we learned about that (about sex) through trial and error”.

A2-10, page 8
Those opposed the introduction of sex education in schools suggested this should be done by the family, by parents, who better protected their children’s interests.

One of the reasons for opposition to sex-education programmes was because they were “rude” or “not ethically designed”. Several respondents opposed to sex education believed such programmes advocated an early initiation of sexual activity. A common fear about sex education expressed by a large number of the interviewees could be generalised in one citation.

"...because they [the programmes] are not thoroughly worked out or piloted and do not consider the parents’ opinions, which are very important. And also there is strong stereotype developed among us and it is very difficult to get rid off as it became psychological. Everybody said that in our country there is no sex, and this theme is closed for us, it was taboo and for our generation it is still”.

A3-3, page 13

Many respondents stated that parents, public organisations and in particular faith-based organisations (predominant part of respondents) opposed the introduction of sex education in schools, because:

"they are in contradiction to the morale norms of our society, against our mentality, in general, against orthodox traditions”.

V2-7, page 19

Those not opposed to sex-education tried to explain why there would be opposition to the sex education curricula, often using a phrase to describe the attitudes to sexual issues:

"Because this issue in Russia traditionally is “closed”. There is no sex in Russia, as we used to say. But it does exist, and it is “not-educated” and it causes a huge harm, unrecoverable one”.

A1-1, page 17

Several respondents mentioned that the teachers themselves constrained the introduction and implementation of sex-education curricula, as most of the schoolteachers were from an older generation and not ready or able to discuss sexual issues.
6.13.3 Teaching

As regards sex education, many respondents identified the central issues were the quality of curricula, methodological guidelines and the professionalism of the teachers. Those who supported the introduction of sex education at schools suggested it should be done by professionals and well-trained specialists. Several respondents emphasised the importance of education methods and the way the message is delivered. Those respondents who opposed the introduction of sex-education reasoned that staff were not trained to teach this sensitive issue and were inadequately prepared to discuss ethical issues.

The respondents were further asked to comment on factors that would encourage inclusion of sex education into school curricula. Many of the respondents suggested that establishing the right foundations was a necessary precondition for successful introduction. Parents should be educated. Legal and social conditions should be created before the curricula were introduced. The preparatory work before implementation should be conducted among the public to generate a positive attitude, e.g. some mentioned the importance of the “formation of public opinion”. Many suggested that “propaganda” for a healthy lifestyle could be used to shape public opinion to support the curricula's implementation at a later stage. Some of the respondents suggested that the curricula should be widely discussed among parents, specialists and the population to get public support.

"more sustainable, more active position of the public organisations...it is firstly propaganda, about its importance".

V2-4, page 13

There were a couple of suggestions to rename the curricula, because they think the word “sex” causes negative associations.

Some of the respondents even tried to describe the content of the curricula in order it could satisfy public requirements, children’s interests and obtain parents’ approval and support.

"...[which type of curricula] will parents’ like and will satisfy the needs of those who grow and learn, what should be developed by us and you [mean locals and foreign organisations]. At the same time it should give information and satisfy
the hunger, but at the same time be ethical.... I think you should go to school and ask children. Still there is a kids’ group who are outspoken and will tell you what they want to learn about. And at the same time may be worth to ask parents what they will want their children to be taught about.”

A1-3, page 15

It was suggested that curricula’s success depended on the support of the policy makers, faith-based organisations, communities, and the mass media, as they considered the issue sensitive. They noted the need for a group approach. Respondents in regions suggested that sex education should be initiated with federal support, smoothly and gradually, when all interested parties were ready for it.

“I am deeply convinced that particularly upbringing issues need delicacy, there should be evolutionary approach rather than revolutionary”.

V2-7, page 19

6.13.4 Responsible Organisation for Sex Education Introduction

The respondents were asked to name organisations at federal, regional and municipal levels, responsible for sex education and for forming attitudes towards sex. Many favoured involving health organisations (using nurses, ‘sexopathologists’ and psychologists) in curriculum development and implementation. General consensus favoured this issue to be decided at Federal Government level (i.e it should be “normal ideological policy”) and curriculum development and implementation be supported by law.

“I think information needs to be distributed not only to children but also to those people who make policy, give money for that”.

V1-5, page 15

The Duma (parliament), the Government Administration, Youth Committee, the Committee on family issues, Ministry of Interior affairs, NGOs, young teachers, pedagogical universities, youth organisations, systems of social protection and sociologists were identified as having an important role in children’s sex education. Federal respondents suggested that government policy could support implementation of sex education initiatives.
"The President annually made speech to the public, which we all read very thoroughly trying to find words ‘AIDS’ or ‘sex education’. If there will be those words in even just one sentence, even in a context of the country’s demography, or talk about reproductive health, about the importance of sex education, about AIDS, I think, our job will go forward".

F14, page 2

Many respondents noted the importance of involving faith-based organisations and the mass media to raise public awareness and to advocate the curricula.

"Again, it’s information...it should be taught by examples on TV, it’s more influential and memorable, when they are showing sick kids, people will look and think about it, otherwise it won’t be possible to remember...mass media and TV again”.

V4-2, page 12

Last but not least, it was mentioned that for curricula implementation, adequate financial resources should be allocated, for the purchase of educational materials.

6.14 People Living with HIV/AIDS

To understand the stakeholders’ attitude towards PLWHA, respondents were asked to name the NGOs representing PLWHA in their region, whether they thought PLWHA should be involved in the HIV/AIDS Intersectoral Committee’s work, whether the HIV positive population should receive HAART free of charge (paid by the government) and, if not, what categories of people should receive HAART.

In both regions, the vast majority of the respondents failed to name any NGOs representing PLWHA, suggesting that there were none or they were unaware of their existence.

Almost all interviewees supported the involvement of PLWHA in the legislation development process, so long as, some noted, their health allowed it and they had adequate knowledge to make a contribution. Many suggested that the HIV Committees would benefit from contribution of PLWHA “who know those problems best if not the
infected themselves”. Those who opposed suggested that laws and legislation should be developed by professionals.

All federal respondents and the majority in both regions agreed that the government should provide HAART to PLWHA. Nevertheless, many of the respondents from regions highlighted the scarcity of resources and emphasised the importance of other priorities in Russia, suggesting that those infected through medical equipment and blood transfusion should have free treatment, whereas those infected because of behavioural choices should pay/co-pay for their treatment.

"Firstly should be treated those who got infected not because of their fault. Those who got infected in medical institutions, doctors, who were infected due their job, yes those, should be treated. Whereas those who practiced a depraved sexual life, consumed alcohol and drugs and got infected because of that, then I won’t say there should be support, I won’t say 100% support”.

There was suggestion that those with low-income and the vulnerable groups should receive free treatment, whereas those who could afford to pay should pay for their treatment. A few suggested that international donor organisations could provide financial contribution towards free treatment of all PLWHA.

Those against universal coverage argued that treatment was expensive and the country had scarce financial resources for people “destined to death”.

"You know, when you are seeing hungry children, when the budget is not enough to treat really sick people, who are disable, old and you have to chose between those two, then I will chose exactly those people, who got the trouble not because of their fault.”

"How many people are dieing from TB, cancer, HIV/AIDS...if we put all these on our budget, then the entire country would work only to cover polyclinics expenses”.

A1-2, page 20

V1-9, page 11

A1-1, page 28
Finally, when asked who should decide on increasing financing to provide universal coverage with HAART, almost all identified the Federal Government, the President and the Duma. Some mentioned the health system and international organisations could influence this decision, the latter through financial contributions. Most of the respondents mentioned adequate financing and the law were necessary to support introduction of universal coverage and the mass media could raise awareness and create a supportive environment.

6.15 HIV/AIDS Financing

The health system in Russia has insufficient funds for general health activities and in particular for HIV/AIDS activities. The respondents were asked a set of questions on the level of financing, decisions on resource allocations for HIV/AIDS activities, ways of increasing financing and reallocation of existing finances to increase preventive activities. The respondents were also asked to identify priority areas for investment if funding declined or increased.

Almost 82% of federal respondents, the vast majority of Altai respondents and the majority in Volgograd suggested that financing for HIV/AIDS was “not much” or “extremely poor” (see table 10 below).

<table>
<thead>
<tr>
<th>Suggested Options</th>
<th>Federal Level</th>
<th>Altai S1</th>
<th>Altai S2</th>
<th>Altai S3</th>
<th>Altai S4</th>
<th>Volgograd S1</th>
<th>Volgograd S2</th>
<th>Volgograd S3</th>
<th>Volgograd S4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very significant</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Significant enough</td>
<td>18</td>
<td>8</td>
<td>4</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not much</td>
<td>32</td>
<td>42</td>
<td>39</td>
<td>42</td>
<td></td>
<td>30</td>
<td>50</td>
<td>25</td>
<td>10</td>
</tr>
<tr>
<td>Extremely poor</td>
<td>50</td>
<td>50</td>
<td>35</td>
<td>42</td>
<td>72</td>
<td>60</td>
<td>25</td>
<td>42</td>
<td>45</td>
</tr>
<tr>
<td>Don’t know</td>
<td>22</td>
<td>8</td>
<td>28</td>
<td>10</td>
<td>25</td>
<td>10</td>
<td>25</td>
<td>25</td>
<td>25</td>
</tr>
</tbody>
</table>

The table shows the percentage of respondents answering the specific suggested option for each region and over the 4 survey stages.

* - where n in Sn refers to the recruitment of respondents
In both regions, there was poor understanding of the mechanisms for distributing finances, who was responsible for allocating funds and (for health services and HIV/AIDS activities) and how decisions were made. Many respondents had never contributed to resource allocation process and lacked any knowledge of the process. Many began their comments with "I think", "perhaps", "according to logic", "I am not a specialist, but it could be", etc. Even Intersectoral Committee members found it difficult to describe the process. Many respondents in Altai complained that there was no transparency on the way the decisions were made and resources allocated: a process, they noted, "remains a mystery".

"It's a big mystery for me. I would suggest that our budget organisations are not transparent enough".

Those respondents not involved in healthcare activities but worked within the system, noted that in both regions an annual plan of activities was prepared and submitted to the local administration for support, but the finances allocated were far less than requested and not in line with proposed activities.

A few respondents who managed to describe the process suggested that Federal level financing to the regions was distributed by Moscow, but the regional administration, in particular the deputy governor (who was responsible for social issues) distributed resources between different sectors. The Regional Finance Committee also participated in this process. No one identified the criteria used for decision-making or the rationale behind choices. Some respondents from Altai suggested that the decision-making was "subjective", led by two-three people without discussions with specialists, occurred "behind the screen" and influenced by the decision makers' "grace to the sector". Once the allocation for health was confirmed, the Regional Committee decided allocations between different programmes, including HIV/AIDS activities (a few provided contrasting views on whether the members of the HIV/AIDS Intersectoral Committee and the HIV/AIDS Centre participated in this process). This process is strictly under the control of the deputy governor who decides how much should be allocated to HIV/AIDS and the entire process subjective:
“The amount HIV/AIDS will get depends the attitude of these people to HIV/AIDS and their knowledge of the issues.”

It was argued that the people involved in allocation decisions had technical but not humanities education, thus there was a poor understanding of social problems. As a result, priority was always given to production and industry. Volgograd respondents were more positive about the process for distribution of finances for HIV/AIDS activities, suggesting that the coordination Committee decided on the activities which should be financed and presented these to the Administration for approval.

The Committee of Health, the Committee of Finance, the administration, the Regional Committee, the regional administration, the department of economics, and the Regional Duma were also identified as organisations which took part in financing decisions.

6.15.2 Options for Increasing Financing

Most respondents suggested that the private sector could be an additional financial source, providing support through sponsorship, but information dissemination should be increased to raise their awareness and participation. A few respondents suggested that concerts could be organised to raise funds. A respondent from Volgograd suggested that as a result, they would become more eager to support and contribute to any organised activities.

“Eventually if the government has no money, there is a need to apply to wealthy people asking for help, or spend money on finding money...also could be organized some funds collection on TV, or something like that”.

“A4-3, page10

“Perhaps we should walk with begging hand and ask help from oligarchs, who could sponsor some articles of the HIV/AIDS programme like treatment or tests purchase...”

V1-3, page 22
Many respondents suggested Russia faced financial difficulties and noted that increased financing for HIV/AIDS would lead to reduced funding for other areas.

"You know that existing resources are so tiny, that if reallocate from one to another, still won’t make sense and the other will suffer as well".

VI-10, page 30

The only way to increase finances, many suggested, was through economic development and increase in GDP. A few federal respondents suggested involving insurance companies, while in Volgograd a respondent suggested involving the territorial compulsory medical insurance fund. An increase in general taxes or taxes on gambling and private business were also proposed.

A few regional respondents suggested that the only way to get a solution was by “pushing the issue”.

"...it should be done on Federal level in Ministry, in Government. More precisely, there should be people knowing the problem perfectly and be able to push the issue. Federal people have no idea about the situation in regions and they are not interested what happening in regions... In the Duma though there are people who know about HIV/AIDS, they are just a few, the rest of the parliament’s members mainly have a technical education and are from industry sector”.

Al-1, page 20

"Health system is financed with ‘the principle of leftovers’ and its difficult to reach reallocation”.

VI-14, page 18

In both regions there was hope for out of budget contributions. Almost one half of federal respondents suggested that additional funding should come from government sources.

Efficient use of existing financial allocations could release funds but many (even Intersectoral Committee members) had no idea where funds were allocated. Many suggested that scarce resources should be allocated only to those organisations which have sufficient quality to provide services or, as one suggested, allocated on a
competitive basis to best programmes. One of Intersectoral Committee member suggested that there is a general allocation to the Committee and but poor understanding of what the Committee was supposed to do, or coordinate its decisions.

Some respondents from the federal level, the NGO and the private sector also mentioned an increase international investments and the involvement of local donor organisations.

6.15.3 Options for Decreased Financing

To learn about preferences on how finances should be used and the priority activities for HIV/AIDS in the regions, respondents were asked to decide how they would use scarce resources if existing funding levels declined.

Many respondents were scared by such a hypothesis and suggested “there was no possible way to finance less”, “it will be a catastrophe”, and such a hypothesis was “…not serious”.

The Altai respondents considered screening and diagnosis to be the main priorities. Many respondents suggested testing in general, some testing specific categories, which were: children, pregnant women, risk groups: CSW, IDUs, military recruits, prisoners and PLWHA contacts. Some respondents suggested that priority should be given to screening of children and pregnant women. In contrast, some respondents suggested a decrease in the numbers tested and instead of mass screening more targeted approaches. The motivation for this suggestion was that the country lacked means for treating PLWHA. Also a few mentioned screening of contacts of PLWHA. In Volgograd some respondents from governmental organisation, NGO and the private sector were in agreement. Almost all federal respondents and a majority of Intersectoral Committee members identified prevention as the priority. Many respondents prioritised preventive activities for the youth, teenagers and schoolchildren.

"Preventive activities, as those who got infected are already sick, whereas it is important to prevent that less people become sick".

V2-24, page 14
The second priority was treatment. First priority was given to pregnant women and children. Others suggested prioritising those who were infected accidentally or when it was “not because of their fault”.

A couple of respondents in Altai, and many respondents in Volgograd suggested that scarce financial resources should be directed towards the dissemination of information and work with the population as part of prevention. They suggested that information dissemination would have a longer-term and larger impact. In particular, the NGO and the private sector representatives, and a couple of federal respondents, suggested that propaganda targeting the youth and the general population could have the widest impact.

One respondent in Altai suggested that they should close the AIDS Centre, as they considered this institution to be a waste of resources. They explained that there were few people who were aware of their status. The majority, being unaware of their condition, attended other general health institutions for medical help. Even those who knew their positive status bypassed the AIDS centre as the Centre disclosed their status.

6.15.4 Options for Additional Financing

To explore their views on the future directions for HIV/AIDS activities, the respondents were asked to consider which activities they would expand or start if they had additional financing.

Almost all respondents suggested that additional funding should be directed to preventive activities amongst the general population, but a few also proposed professional staff working with HIV/AIDS patients, prevention of vertical transmission, school programmes involving sex education and training of volunteers to work with vulnerable groups (such as IDUs, CSW and prisoners).

Work in schools and with children were identified as important preventive measures. Some respondents in both regions, and a few federal respondents suggested implementation of harm reduction programmes (only a few mentioning syringe exchange) and expansion of condom distribution activities.
Some respondents identified rehabilitation of PLWHA and targeted social benefits (such as food rations) for this group. A few respondents mentioned that as PLWHA were considered to be "society bugs", so additional financing should be directed towards improvement of societal attitudes. They suggested an increase in publications about stigma and related issues, with wider participation of sociologists and psychologists. One respondent suggested conducting a social survey to explore the attitudes of the population towards HIV/AIDS issues and PLWHA. Also was mentioned the psychological rehabilitation of PLWHA and their family members. One respondent in Volgograd suggested that they distribute food rations to PLWHA.

Many respondents suggested information dissemination, media involvement and the development of social advertisement as important part of preventive activities. Some respondents suggested activities directed towards the improvement and expansion of information distribution, by creating information offices or centres, and by developing printed educational materials. A few respondents suggested an increase NGO activities and more involvement of civil society.

Another group of respondents suggested increase coverage of treatment, purchase of medical supplies and improved technological supply and updating of medical equipment. A few respondents mentioned training and retraining of medical personnel and increased investment in research for HIV/AIDS to improve diagnosis and treatment.

Many respondents mentioned that propaganda is one of the important activities to implement if additional resources were available. In Volgograd propaganda was identified as an important part of prevention, and suggested this as a priority even if resources were scarce.
6.16 Information

One of the sections of questionnaire was constructed to understand issues related to information: its availability, channels for communication, sources of information, the exchange process, available pieces of information related to HIV/AIDS, how stakeholders use the available information and whom they transfer information to and finally, which sources they consider reliable.

Most of the respondents identified lack of available information as a problem. Linked to information unavailability was the poor use of existing information. Some federal level representatives mentioned that the problem was not in the amount of information, but in the use of information: as precisely captured by one of federal respondent:

"There is a wrong opinion that in Russia, there is less information about AIDS compared to other any European country. Visa versa, we have huge amount of information about it, more than any European country. Another issue is to what extend we use these resources".

The respondents assessed their awareness of HIV/AIDS issues and the available information as being better in Altai than in Volgograd (see table 11). Almost half of the respondents from Volgograd and 30% from Altai described the existing information as 'not much' and only 38% in Altai and 17% in Volgograd found the available information 'adequate enough'. Almost all the Federal respondents evaluated their information as being 'enough'.

<table>
<thead>
<tr>
<th>Options</th>
<th>Volgograd</th>
<th>Altai</th>
</tr>
</thead>
<tbody>
<tr>
<td>Too much</td>
<td>1.5</td>
<td>3</td>
</tr>
<tr>
<td>Enough</td>
<td>17</td>
<td>38</td>
</tr>
<tr>
<td>Not much</td>
<td>51</td>
<td>30</td>
</tr>
<tr>
<td>Extremely poor</td>
<td>29</td>
<td>26</td>
</tr>
<tr>
<td>Difficult to answer</td>
<td>1.5</td>
<td>3</td>
</tr>
</tbody>
</table>

The table shows the percentage of respondents answering the specific suggested option for each region.
There is a lack of information among the NGOs and the private sector. The availability of information is less at regional than at federal level: a finding supported by several federal respondents' remarks:

"I have information more than average, relatively enough. But it is here in the ministry. If we'll go a bit down, to implementing bodies, and I am not speaking already about the institutions, it [meaning information] is decreasing in geometrical progression".

Table 12: Assessment of Available Information (in %).

<table>
<thead>
<tr>
<th>Suggested Options</th>
<th>Volgograd</th>
<th>Altai</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>S1</td>
<td>S2</td>
</tr>
<tr>
<td>Too much</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Enough</td>
<td>25</td>
<td>16</td>
</tr>
<tr>
<td>Not much</td>
<td>60</td>
<td>52</td>
</tr>
<tr>
<td>Extremely poor</td>
<td>10</td>
<td>28</td>
</tr>
<tr>
<td>Difficult to answer</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

The table shows the percentage of respondents answering the specific suggested option for each region and over the 4 survey stages.

*- where n in Sn refers to the recruitment of respondents

To find out what information was available in the regions, the respondents were asked about 12 pieces of information and to choose from the options: 'have'; 'do not have' or 'don't know'. Table 13 presents the proportion responding 'have' for each item; most others responded 'do not have'; as very few answered 'don't know'.

Table 13 shows that respondents have inadequate information about the epidemic and its evolution. There is a need for more behavioural data. Respondents identify a lack information on the economic consequences of the epidemic and cost effectiveness of interventions. Most of NGO representatives in both regions cite lack of statistical data and the need for more information about the problem. The private sector lacks any
information. In particular, at regional level, “precise information” are lacking. Federal respondents complained that they do not know “who is doing what in the country”.

### Table 13: Distribution of Answers Regarding Some Pieces of Information Available in the Regions (in %).

<table>
<thead>
<tr>
<th>Pieces of Information</th>
<th>Available information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Volgograd</td>
</tr>
<tr>
<td></td>
<td>S1*</td>
</tr>
<tr>
<td>Number of registered HIV/AIDS in region</td>
<td>95</td>
</tr>
<tr>
<td>Sex-age distribution of HIV/AIDS among infected</td>
<td>90</td>
</tr>
<tr>
<td>Socio-economic characteristics of HIV/AIDS infected population</td>
<td>70</td>
</tr>
<tr>
<td>Assessed estimate of real HIV/AIDS infected population number</td>
<td>45</td>
</tr>
<tr>
<td>Official number of drug users in region</td>
<td>60</td>
</tr>
<tr>
<td>Official number of CSW in region</td>
<td>40</td>
</tr>
<tr>
<td>Assessed estimate of real number of drug users and CSWs in region</td>
<td>20</td>
</tr>
<tr>
<td>Data about behaviour and risk factors among different risk groups</td>
<td>55</td>
</tr>
<tr>
<td>Models predicting epidemic future development in region</td>
<td>35</td>
</tr>
<tr>
<td>Data about economic consequences of HIV/AIDS in region</td>
<td>25</td>
</tr>
<tr>
<td>Data about efficiency of different preventive interventions</td>
<td>55</td>
</tr>
<tr>
<td>Comparative data on cost-effectiveness of preventive interventions</td>
<td>40</td>
</tr>
</tbody>
</table>

The table shows the percentage of respondents answering the specific suggested option for each region and over the 4 survey stages.

*- where n in Sn refers to the recruitment of respondents
6.16.1 Information Sources and Distribution Channels

The majority of respondents considered official governmental publications (law, order, letter, resolution) to be a reliable source of information. In particular, federal meetings, where information is disseminated in the form of a report and distributed in regions, were mentioned as a reliable source. Some respondents in Altai mentioned international projects as an accurate source. A few respondents in both regions also mentioned informal direct contacts with the vulnerable population as a reliable source of information.

For governmental organisations key information channels are the Statistics Centre, the AIDS Centre, and the MOH&SD. The Narcological centre, the Ministry of Interior Affairs and the Gossanepidnadzor, and the customs are also identified as information sources. For NGOs and the private sector representatives the primary source for information was the mass media; though most respondents considered it be an unreliable source. A few private sector respondents in Altai named certain NGOs as a source of information for their organisation, but still mentioned official governmental sources as being more reliable.

Most of governmental organisations, some NGOs and the majority of private sector respondents admitted that they did not provide information to anyone, they “just take it into consideration”. Some representatives from governmental organisations replied that they provided information (but only upon request) to organisations with which they directly worked and to those which were able to make a direct contribution to the issue. Most respondents from the Intersectoral Committee and governmental organisations mentioned that they “transfer information up” to higher authorities to whom they are subordinated.
A major source of information appeared to be the mass media, but most of respondents from the Intersectoral Committee and governmental organisations though this information "[was] not always accurate and originated from unreliable sources". Opinions of NGO and the private sector representatives were split; some trusted the media others did not. Many respondents still considered medical institutions to be a reliable source, but having no alternative, they get information from the mass media.

"Information used not the way it suppose to be...Federal mass media particularly TV, radio and newspapers provoking youth towards opposite lifestyle and we in regions can't do anything to oppose this."

Federal respondents blamed the mass media for the lack of unavailability of information because of high charges for media services. Federal respondents mentioned international organisations, business trips, the Internet and email as information sources.

**6.16.2 Information Forms**

The main preferred forms of information dissemination were written forms: scientific reports, journals and other publications, orders, letters and other official documentation, meetings protocols and resolutions, lectures and teaching manuals. Some respondents preferred tables and information summaries. Posters, brochures and other sorts of publications were very rarely mentioned. Some federal respondents mentioned the Internet as a form of information.

Intersectoral Committee members mentioned that the main way to use information was to create the above-mentioned documents and contribute to organised activities.

"Information is used almost monthly while determining the direction of prevention activities, creating official documents, during the development of projects, orders, programmes, laws or in the mass media. It is used in different variations or for lectures and individual discussions."

The Committee members used the available information to develop action against the epidemic and for training, including seminars and lectures. A particular theme that
emerged was the work with the youth related to the distribution of preventive information and healthy lifestyle promotion. Some respondents, mostly from HIV/AIDS Committee, stated that as part of their job they transferred information to all possible Committees and governmental organisations and to other groups only upon request. But, many respondents from governmental organisations, NGOs and particularly from the private sector were surprised that there was a need to transfer available information to anyone asking “why” information should be communicated. Few NGOs mentioned that they communicated information to the youth and vulnerable populations.

Some Federal respondents mentioned that they used Internet sites to place HIV-related information and these were accessible to anyone. A few respondents/government officials treated the available information as “secret” and did not make it available. Many NGOs and private sector representatives complained that they were unable to access information.

6.17 Advocacy

To find out about the respondents knowledge and understanding of advocacy, the respondents were asked to define advocacy, its targets and the conditions for successful HIV/AIDS advocacy. Overall there was poor understanding of any issue related to advocacy and its activities. Many respondents had heard the word for the first time. This section of the questionnaire got the poorest replies; answers were brief and haphazard.

6.17.1 Understanding of Advocacy

Almost all respondents in both regions failed to define ‘advocacy’. The vast majority thought advocacy was protection of the human rights of PLWHA, or protection of non-infected population.
"In our country, when person is getting sick he becomes extracted from society...so somehow his elementary rights should be protected. Not just elementary but all human rights”.

The rest of respondents tried to guess and suggested a variety of options.

"Good question. I'd like to see the person who will be able to answer this question...as I understood it...it's suggesting issues somehow connected with HIV/AIDS, yes? Its could be different aspects, like connected with treatment, prevention, problems connected with target groups...firstly on legislative level...Public opinion attraction, to resolve such issues. How good I've formulated, am I right? ".

Federal respondents’ familiarity with the terminology was slightly better. One respondent remarked that advocacy should be a specially designed project. A federal respondent remarked:

"There is no such word in Russian. I am doing it all my life, but it can't be translated. Advocacy is support."

6.17.2 Main Directions and Contributing Factors

Generally, there was a poor understanding of advocacy, with most respondents suggesting that advocacy should be directed towards human rights. Several respondents suggested advocacy should reflect laws and legislation, provide regular updated information to the population about comprehensive HIV related issues, and help generate financial resources. Some respondents thought advocacy should be targeted towards information and education of the population. In addition, some federal and Volgograd respondents mentioned advocacy should be directed at prevention and access to treatment.

"More prevention needed, and then fewer headaches will be".

V2-8, page 16
As to what could help organise successful advocacy, the majority identified trained staff and increased information flow, while many referred to financial support. Some suggested laws and governmental ownership could help develop advocacy activities. A few NGO representatives suggested involving PLWHA in advocacy. A couple of respondents in Volgograd mentioned that advocacy could be used to change population lifestyles through propaganda.

"Perhaps creation of stable political environment about this issue. Perhaps creation of tolerate attitude of society towards this issue and creation of climate and structures which will have ownership of issue and somehow will be able to influence it".

V3-2, page 14

One of the federal respondents, reflecting on the experience with harm reduction, mentioned that advocacy should be done by international donor organisations. Several respondents proposed that the mass media and NGOs should conduct advocacy.

This chapter described the respondents' views on: (i) the role of different players in the area of HIV/AIDS; (ii) co-operation and co-ordination of activities; (iii) perception of the HIV epidemic and its impact; (iv) policy documents and interventions; (v) level of funding for HIV-related activities; (vi) information and communication. The discussion of the results and analysis of the main findings are presented in next chapter.
The HIV epidemic has proved to be a multidimensional problem, influenced by social, cultural, economic, political and legal contexts (HIV/AIDS in Europe: Moving from Death Sentence to Chronic Disease Management, 2006). As the United Nations Research Institute for Social Development (UNRISD) suggests, better understanding requires an analysis of the response to the epidemic, which is a “combination of forces-political, corporate, religious, bureaucratic, and public advocacy that influence HIV/AIDS prevention, care and treatment” (Dickinson, 2006).

The role of the broad context was taken into account when assessing the response to epidemic in Russia. In addition, the analytic framework adopted for health policy analysis (figure 1 in chapter 2) in Russia considered contextual issues. The Russian response to HIV is weak and this research has explored the reasons for this lack of attention.

The results indicate several barriers to developing an appropriate response: (i) the country had other competing priorities, (ii) financial problems due to economic instability, (iii) political considerations, especially as regards opposition from key power groups, (iii) structural and organisational problems, (iv) inadequate information on HIV epidemic and its impact, (v) lack of commitment and leadership from senior politicians, and (vi) poor attitudes towards HIV due to widespread stigma.

The research shows that the main reason for poor response to the epidemic is the stigma and the perception that the epidemic is a problem of marginalised groups, not yet affecting the general population and the elite. Hence, the problem root is not poor implementation of policy but reluctance to implement policy. Thus the solution to the problem is to change the perception of the Russian authorities on the nature of the epidemic.
7.1 Country Priorities

As discussed in Chapter 2, attitudes towards HIV depend on the definition of the problem and whether HIV considered to be a priority by the policy makers. In turn, prioritisation of HIV depends on how the policy makers define ‘health’. Modern definitions of health do not consider health to be just an absence of diagnosable illness but broaden this to include coherent functioning of a strong community, economic well-being, crime control, acceptable municipal services, intact families, effective schools and other manifestation of favourable social conditions. Successful integration of these social and behavioural factors creates a favourable environment contributing to individuals’ physical health and social well-being (Greenwald et al., 2003).

The research shows that, although the health of the population is an important issue for the policy makers, it remains marginalised amongst the country’s other social and economic problems. This finding is supported by earlier research, which shows health and health care to be a relatively low priority in Russia (Bobrik & Twigg, 2007). Moreover, the results show that in the regions studied and amongst the federal respondents HIV/AIDS is not amongst the top health priorities. Thus the results partly explain the reasons behind the poor response HIV/AIDS; i.e. other important issues are competing with HIV/AIDS.

While the response to HIV is unjustifiably inadequate, it is important to note that Russia faces other health challenges (alcohol, circulatory disease, TB, cancer and injuries) (The World Bank, 2005a), which are higher up on the priority list. A recently signed bilateral agreement (between the MOH&SD and WHO) for 2006/2007, which indicated priorities for the country’s health, listed HIV/AIDS as the third priority area (WHO, 2006).

Although each region has its own general and health problems, this does not justify the lack of attention given to HIV, especially given the trajectory of the epidemic. Exploration of the reasons behind the choice of priorities revealed that stakeholders mostly relied on their subjective understanding of the problem and very rarely on statistics. While statistics were cited as being useful in decision-making at the federal level, the regional decision makers were influenced by their own intuition. Priorities
were chosen according to gut feeling, tacit knowledge and experience, rather than on information or statistical data.

Does this mean that there is no information about the epidemic and its consequences, or that the information is available but not used for decision-making? The low priority given to HIV can, in part, be explained by the narrow understanding of HIV, which is perceived as a personal health problem of the marginalised and high-risk groups (Davis & Dickinson, 2004). Although statistical data exist in Russia, these data are either inaccurate or not used to inform and sensitise policy makers. The regions do not use the information they have to pressurise the government to develop an adequate response. Even if there are concerns on HIV, regional governments (and the senior policy makers) have their own agenda, and the civil society or the specialists do not have enough power to influence and initiate change.

In Russia, policy-making has elements of rational and disjointed models of decision-making. Decisions and actions use an institutional and environmental framework, with the involvement of actors (which have the same agendas) from different positions. Judgements follow existing pathways aiming for outcomes that are politically feasible. Only politically feasible options are considered when making decisions. This explains how issues gain priority and why the government is more oriented to supporting economic and defence issues. Historically, in Russia, health has been financed through incremental budgeting rather than according to actual costs. So the sector adjusts activities within allocated budget, without considering the real cost of implementing these activities. As discussed in the policy chapter such rules and routines will be difficult to change.

Given the budget allocation process in Russia, prioritising of HIV/AIDS issues and resource allocation is not designed to address the causes of HIV infection. The priority is to control infection within the medical system and to prevent MTCT prevention. Involvement of the government in other prevention activities, like harm reduction, is considered politically risky, because of the social tension caused by attitudes towards drug use and treatment of PLWHA. In 2001, per capita financial allocation for treatment was about eight cents. In the same year the coverage of three-drug ART was 1% of registered HIV patients (Davis & Dickinson, 2004). To give priority to HIV would mean commitment, which would require allocation of resources and actions to mitigate
HIV impact, whereas neglecting the issue justifies inaction. The latter (neglect) is economically and politically more convenient for the government. Creating a public perception that the issue concerns only vulnerable groups means localising the issue within segregated sections of the population, and diminishing the significance and magnitude of the problem for the civil society and policy makers.

The analysis identifies two major challenges: (i) how to increase the input of knowledge to decision-making and priority setting by policy makers, and (ii) how to change the societal perception and understanding of the issue and make the process of policy making more participatory. Addressing the first challenge will help to make policies more evidence based, and addressing the second will facilitate advocacy and increase community involvement in generating the political will to control the problem. In both cases, the actions of health professionals is crucial, as they ought to make the problem widely known to the population and policy makers which lack information. Having adequate knowledge and understanding of the issue will increase population awareness and change their behaviour, thereby contributing to prevention and reducing further spread of the epidemic. Information will also help change the ideology of the population and decrease stigma, making society more tolerant and supportive towards the affected population. Information would also enable the policy makers to have a better understanding of the problem and its consequences and what could be done. This would encourage closer working relationship with health care providers and help increase political commitment of the leadership, needed to address the HIV epidemic.

Dealing with a more educated population would “smooth” the process of implementation of policies and decrease public resistance caused by values and norms. Moreover, education and information could encourage development of “public pressure” towards policy makers: making them more accountable for their activities and pressurising them to develop sound policies. This would be the logical sequence of events in a democratic society, but Russia unfortunately has its own version of democracy.

In Russia, the decision-making is state-centred. To date, society-centred influences have been weak, as the civil society is disorganised and poorly developed. By developing and educating the public, the civil society will be given a “weapon” which they can use
to pressurise the government. Whereas, keeping the public unaware and holding back information will enable the policy makers “to gain a weapon” to control the public: who have a blind trust of the government. Perhaps this is why, while acknowledging a lack of awareness among public and, admitting that public require information about the issue, information on HIV is not widely distributed. Thus, even if the authorities have information, there is no catalyst to promote the translation of information into knowledge and then reflect it in actions. This creates inertia in the public who do not hold the authorities accountable for their actions. If public knowledge reached a critical mass, it could create pressure, which would be difficult to deflect and control, and which would require the development of adequate measures to control the epidemic. As results indicated the priorities are defined by the President and regional administrations work in line with federal decisions. Discovering who sets priorities in the Presidential apparatus would help improve our understanding on why there is a lack of attention to HIV/AIDS.

7.2 Information Hardships

Information is a key weapon in the battle against HIV/AIDS (ASIS&T, 2006). Organisations marshal their information resources and capabilities and transform information into knowledge to assure its further use to sustain and enhance their performance (Choo, 2002). In such organisations the information management process is continuous, involving constant environmental scanning, and systematic knowledge creation to inform decisions and to develop strategies (Choo, 2002).

The transformation of data into information, information into knowledge, knowledge into activity and finally activity into behaviour is a gradual process requiring support. Knowledge is information successfully interpreted and combined with experience, context and reflection to create understanding entrenched within the beliefs and values of the individuals (Davenport et al., 1997). Information transfer is a knowledge management process, which involves the identification and utilisation of information (Davy, 2006). This process helps the recipient to create the new knowledge necessary to assist in meeting particular needs. Knowledge flow is affected by managerial practice, organisational resources and environmental constraints. In turn, knowledge management is influenced by culture, quantity and quality of knowledge, clarity and
frequency of available communication channels and the contextual characteristics (Davy, 2006). As presented in the results, this coherent process is absent in Russia where unprocessed data are available: data not transformed into information and thus poorly assessed and utilised.

Although earlier research suggests that knowledge about HIV/AIDS in Russia is generally poor (Bobrik & Twigg, 2007), the results of my research contradict this commonly held perception. Answering directly to the question about information availability, and assessing their own knowledge and sources of information about AIDS, respondents were moderately conversant with the subject. Further cross-check analysis indicated that while discussing other themes (e.g. the magnitude of the epidemic, its influence on the private sector, the formation of public opinion, sex education, information necessary for cooperation and coordination of activities, etc), the respondents complained about lack of information. Mapping of answers helped to identify the source of contradictions. Analyses concluded that information was mostly concentrated amongst the health specialists. Lack of communication, dissemination of findings of research and dissemination of knowledge about the subject caused misperception and misunderstanding of the issue, thus diminishing the magnitude of its impact. This influences the assessment of the situation objectively, resulting in a lack of priority given to the issue.

My analysis demonstrated a lack of information in the regions, especially the NGOs and the private sector. Even the federal officials, who are decision-makers, were not happy with the amount of information available to them. If information is available, it seems to be concentrated within certain groups, but there is no system for sharing this information or providing it to relevant groups. But, the assessment of one's own knowledge is very subjective and can be biased. In checking the responses of few respondents who were happy with their information, it was found that their nature of work was directly related to the collection of information. The utilisation of the existing information was poor.

Information is important at all levels, from national and local authority decision-makers to grassroots and individual levels. Information should be transferred in forms useful for decision-making and be targeted at different user groups (United Nations, 2006). Information is important not only for statistical and scientific use for understanding the
magnitude of the problem to plan activities and resources accordingly, but is also important to organise responses in terms of decisions, and to allow informed choices, develop policies and strategies to combat the epidemic. Information could be used for coordinating activities between agencies and services. Finally, information is crucial for population awareness and knowledge to participate in preventive activities addressing behaviour change.

Information creates knowledge changing behaviour and improves responses to epidemics. Communication is the crucial link in this transformation process. To achieve success and improve communication, there is a need to re-arrange health communications into a two-way exchange: entering a dialogue that takes into account social forces that shape knowledge and perceptions related to health issues (Lee & Garvin, 2006). The literature suggests a health communication framework, which assumes that behaviour change will result from the successful introduction of a change in the individuals’ knowledge, attitudes and beliefs. Though many authors criticise such an approach, considering it linear, most healthcare providers use this approach in health communication. In Russia, the authorities lack adequate information, and have narrow values influenced by traditional norms and emotions due to stigma. These adversely affect the decision-making process, and the development and implementation of sound HIV/AIDS related policies. Even for professionals, recommendations from respected professionals and colleagues are a powerful force for change compared with evidence-based guidelines. In health care, knowledge and information, represents only one aspect of health care decision-making. External factors like the setting, the administration, the financial and other resources available, the political climate and the country’s priorities and internal factors like individual priorities and objectives, personal values and potential personal gains and losses are important factors which influencing decisions more than evidence (Jadad & Enkin, 2000). The literature suggests that modern decision-makers prefer clear, short, unequivocal, personal, vivid, engaging, meaningful and relevant messages provided by professionals, whereas the target audience message should be through vivid stories and anecdotes, which are the most powerful tools available to influence public.

For information to be useful, it should be put into context, explicated, experimented with and confirmed. The belief that better informed individuals could behave adequately, whereas poor information results in unhealthy lifestyle, fails to take account
of structural barriers that may obstruct an individual’s ability to exercise choice. Nor
does it consider social and economic factors interfering with the ability to pursue an
individual’s decisions. An interdisciplinary approach and consideration of economic,
social and political factors could help in better understanding of the problem and help
develop feasible solutions to the problem. The main purpose is to find solutions to
problem rather then just answers to questions. Knowledge is grounded in collective and
individual experience (Ehrlich & Cash, 2006). Factors such as inequality, social
relations, and structural issues are influential factor determining health of population
and argue that a continued critical evaluation of health programmes is needed to reveal
the deeply embedded power differentials located in the medical and public health field.

The literature identifies another problem, i.e. the expert technical language that makes
health information inaccessible to the average person and policy makers. Thus, the
information provided by scientists and professionals has limited use, and there is a
question of usability and practicality of certain amounts of information (Lee & Garvin,
2006).

The literature identifies a number of obstacles to information dissemination: society
based norms and traditions, illiteracy, a limited awareness and understanding of the
information needs of people and scarce resources (ASIS&T, 2006). Our research
indicates that the main barrier is a lack of communication between the agencies that
organise and facilitate the dissemination processes.

The successful experience of a decrease in the prevalence of epidemic (from 18.5% in
1995 to 6% in 2003), in Uganda is partly attributed to an information dissemination
strategy (Albright & Kawooya, 2005). Lack of accurate information and awareness
about an epidemic creates incorrect notions about the infection and its transmission. On
the other hand, general knowledge about a disease is not always translated into essential
knowledge (Batambuze, 2003). Information will increase awareness, and be translated
into knowledge to inform choice of healthy behaviour.

Other important aspects are the reliability and the sources and channels of information
flow, as well as timely access to information that could be understood (Jadad & Enkin,
2000; Lee & Garvin, 2006). Choice of information dissemination method (published
materials: books, brochures, leaflets and posters; audio-video materials; oral
communication: seminars, presentations; drama, poetry, singing and dancing; awareness campaigns; etc.) will be driven by local cultural specifics, and society needs to access all possible audiences. Personal sources are more effective compared to the radio, information and communication technologies (ICTs) (Albright & Kawooya, 2005). Events which affect people close to a person are more likely to influence behaviour change in that individual. Phenomena witnessed by the subject or eyewitness, as well as face-to-face recommendations are more influential and have greater impact rather than second-hand data. However, the results of our survey indicate that stakeholders in Russia prefer to communicate through written official documents. Perhaps, the bureaucratic system in Russia and the hierarchical system of management, could explain this choice of communication.

Two of the main sources of information respondents mentioned were the Government and the mass media. The mass media is a powerful information source and has a big audience. It has enormous influence and can therefore be used dissemination of appropriate health information (Rosen et al., 2003). The results demonstrate poor performance of the mass media in increasing the awareness of the population. This is because there are no systems of communication between the health authorities and the media representatives. Conflicting messages in the media confuse the population and create misperceptions about the problem. Consequently, active involvement of the entertainment industry in combating HIV/AIDS could be considered a good advocacy channel to increase awareness on the epidemic, to promote healthy sexual behaviour, or to form public opinion. Although the importance of the mass media in the distribution of information and in increasing public awareness is known, the government, the main holder of information does not update and “feed” the media on regular basis.

Davis suggests that the “public knowledge of HIV/AIDS is rudimentary in most regions” of Russia (Davis & Dickinson, 2004). The Internet was identified by the respondents as a growing source of information, especially for the youth. The Internet assures rapid, effective and wide dissemination and exchange of information (Jadad & Enkin, 2000) but the quality and the content of available information on Internet vary. The literature search uncovered extensive confusion in Russian sources. It is obvious that there is no mechanism for information transfer and control. In this context control has nothing to do with democracy or freedom of opinion or speech, but the correction of inaccurate or misleading information, which could cause significant harm.
Information could be obtained and processed not only at the government level. Especially for HIV/AIDS and other sensitive issues, where the access of governmental organisations to certain groups of population is poorly developed, NGOs and communities could be valuable sources for grass-roots level contact and the establishment and primary information collection (United Nations, 1995). Whereas, in Russia there is one-way system: information is collected for limited use by groups of officials and is not circulated into the community and is poorly transferred to NGOs. Another misuse of information is related to the development of attitudes towards the issue by population. The literature suggests evidence that the youth and CSWs lack accurate information about HIV transmission and condom use, which encourages risky behaviour (Kalichman et al., 2000). The same source indicates that in Russia, knowledge, awareness and protective attitudes to HIV among the population is poor, especially amongst most vulnerable population.

Networks (including NGOs, CBOs, civil society and the private sector representatives) play an important role in increasing awareness through the exchange of experience, through coordinating efforts and sharing resources and promoting the development of policies (Irungu, 2004). Most of the respondents agreed that NGOs could provide information to the population. However, it seems that this group has not been provided with adequate information and that the main guardian of information, the government, is not disseminating the information to NGOs for dissemination and for work with the population. There is a better flow of information between governmental organisations than between governmental organisations and the NGOs and the private sector. The information exchange process needs to be improved between all stakeholders including intra-governmental exchange. Mobilising the capacity of the scientific and research institutions could help identify the missing information necessary for decision-making and encourage attempts to fill these information gaps.

7.3 Political Hindrances

To understand a government’s response to epidemic it helps to analyse the context, and particularly the political and institutional factors which shape the dynamics of epidemic
and the key drivers of change (Dickinson, 2006). A country’s HIV response is shaped by the country specific history and its political economy, the political context (local, national and international), the combination of political views and the timing of actions (realm of politics), as well as the current state of the country’s social, economic and cultural development. The political response is itself determined by the political incentives for leaders to confront the epidemic and the ability to develop actions based on existing medical and scientific information and knowledge (Dickinson, 2006; Manning, 2002).

Strongly centralised top down approach to policy prevents a diversity of approaches creates an environment that hinders the participation and operation of NGOs and CBOs. Whereas, a more diffuse and decentralised political power creates favourable conditions for institutional development. Such institutions could challenge local governments, and advocate for policy makers to adopt rapid, flexible policies at sub-national level. These institutions can also work with communities to increase their knowledge and to advocate healthy behaviour. Highly concentrated political power within a single political party, creates lack of incentive to challenge existing policies because who could be replaced or reassigned by the party leadership, as regional leaders are appointed by their national leadership rather than a local constituency (Dickinson, 2006; Manning, 2002). As Davis states in an analysis of governance related to the response to the epidemic, in spite of re-distribution of power from Moscow to regions, there are still mechanisms at the federal level to exert strong control over regional governments. The latter power depends on their economic importance and constitutional status, attitudes and the priorities of local elite, which reflects the difference in incentives felt by policy makers between regions, and between regional and the federal level of government (Davis & Dickinson, 2004).

Though in Russia theoretically there is decentralisation, the ‘degree of freedom’ of regions strongly varies and depends on a region’s economic contribution. However, even if there is decentralisation, the services organise their activities in line with federal guidelines. Such an environment prevents a creative and diverse response to epidemic and suppresses NGOs and CBOs activities. Moreover, professionals who hold information and have better understanding of the issue prefer “not to intervene” in government decision-making. In Russia, despite the periodic change of authorities, the ruling class/system with its strong ideology still remains in power and controls the
system. It introduces incremental changes without major impact, or effective outcomes. Once the elite has set-up standards and rules, the country’s organisations will follow the formulas laid down, which would result in the organisations become homogeneous and easy to control. The solution to this problem is to encourage diversification and modification creating multiple options, which will allow the choice of the option that best accommodates the local situation, allowing change to be successfully replicated. The issue is the way the elite develops new standards or models which is highly centralised without taking into account societal views.

In the case of Russia, the centralised approach, where strong institutional rules and strict controls do not allow professional habits to become routines and rules, hinder professional-initiated change. When there is a slight progress, initiated by healthcare personnel, the resistance from the government in institutionalising new routines into rules is strong. These changes are not institutionalised, often due to inadequate resource allocation to support change. This helps to explain why there is such a ‘dull’ response to the epidemic. To date, the perception of epidemic has not progressed beyond ‘the phase of delusion’, where it is perceived only as a problem of a target population and linked with stigmatised risky behaviour. In this case the officials could initiate change by establishing new rules to be followed by personnel.

Another benefit of decentralised governance comes from the democratic approach to policy and decision-making, where criticism of existing policies is a proven mechanism for improving them. Democratic societies encourage credible sources of information and public awareness, through a free press and free speech, thereby potentially creating demand for a government response to the epidemic and greater citizen empowerment and participation. At the same time, democratic governance encourages transparency and accountability, participation and responsiveness, as well as the rule of law. Last, but not least, democracy provides a legal system preventing human rights’ violation and discrimination, which impede the development of a response to HIV (Davis & Dickinson, 2004; Dickinson, 2006; Whiteside, 1999). In Russia, there is lack of supporting environment for the development of democratic society, and a society, which will keep the government accountable and responsible for its decisions. Moreover, violation of laws, by government itself, undermines human rights, leading to discrimination and stigma, and ignorance of the HIV problem in general.
The literature suggests that a country's law and legislation could either facilitate or obstruct effective policy implementation. There are three models for a legal response to epidemic: i) proscriptive (penalises certain forms of conduct); ii) protective (upholds the rights and interests of particular classes of people); iii) instrumental (uses laws to promote the desired changes in values and patterns of social interaction) (Hamblin, 2006). Though there is no clear-cut distinction between these models and legal clauses could have elements of the different models within them. Proscriptive laws being by nature coercive and using criminal sanctions against non-compliance (compulsive testing, punishment for drug use or commercial sex) to reduce the spread of epidemic, and at the same time hinder cooperation from those with risks in preventive activities (e.g. avoiding medical services and diagnosis because of fear of punishment). This would support the rise of epidemic. Protective laws (anti-discriminatory acts and human rights protection) are considered an effective model in assisting HIV/AIDS policy. The instrumental model operates on a broader level and longer-term, by mediating rights and obligations between individuals, aimed at changing underlying values and patterns of social interaction, which eventually creates a better environment for management of HIV infections (Hamblin, 2006). In Russia, HIV-related laws could be characterised as proscriptive (e.g. IDU related laws), which create obstacles for prevention and mitigation of the epidemic.

Policies should consider and address the organisational, professional and social context of the problem. Policies driven by a political objective alone are unable to change practice if not supported by professionals, and fail to consider the organisational aspects related to implementation, in terms of resources and infrastructure. Any policy directed to change practice requires specialist contribution. On the other hand, the patient as a consumer of the service needs to keep specialists and policy makers accountable for their health. In this way the policies and actions adopted would be directed towards improving their health condition (Watt, 2005). Without health professionals' and patient's involvement in the health care decision-making process, health legislation will be distorted by budgetary compromise and the interests of other sectors rather than be aimed at excellence in health care delivery (Faciszewski & Krueger, 2004). Most stakeholders interviewed considered HIV as a health problem and agreed that health specialists should manage HIV. But the health professionals' opinions are not considered in decision-making. The Duma and the President are identified as the main
decision-makers. Moreover, discussions on financial allocations to health activities do not involve professionals.

A major challenge in a multi-sectoral AIDS response is the coordination of activities within and among different sectors and partners (Kalla, 2006). Government ownership is one of the mechanisms for assuring that all required sectors are involved in and contribute to a process. Discussing leadership, (in relation to priority settings, responsibility for the country's epidemic, sex education in schools, involvement with PLWHA in legislation, etc.) the respondents from the regions put the main burden for leadership on the Federal government, the President and the Duma, despite the decision-making (in theory) being decentralised to regions. Is inertia or lack of initiative from the regions the reason, or is this the result of power being highly centralised with the Federal authorities; i.e. is this the result of a lack of democracy? Moreover, even the Federal respondents looked for the President to use words such as sex education, HIV/AIDS, in his address, which would signal the future directions of central policy. It appeared that the only person who can make decisions in all areas is the President.

Recently, president Putin declared year 2007 as a Year of Russian Language, assuming to support activities and events ought to promote the importance and development of the language (2006). Such declaration, without doubt, will be supported by funding and resources. What prevents the Russian authorities to declare year as "AIDS free" or "safe sex", or it is less important for nation survival and future? The words health, population or "country's future", or economic development, and population welfare could be interpreted as a signal to action on HIV/AIDS, yet they are not. Is it that these words are not specific enough for HIV/AIDS or sex education?

In spite of the claims of devolved authority, it is obvious that authority and power are centralised in Moscow. This is a reflection of 70 years of highly centralised planning and management of activities. It appears that the regions not have the capacity to be decentralised i.e. they an attempt to avoid decision-making because of the lack of qualified staff. Is it that there is no decentralisation in practice, or a lack of confidence to take responsibility? The answer is both: there are no democratic mechanisms to support expression of different opinions. At the same time, there is no opportunity to develop a community, which would keep specialists accountable and boost their professionalism. Absence of such mechanisms creates voluntarism by the government,
which protect its political power, deliberately preventing any development of the community and health professionals. Despite several normative documents and laws adopted by the regional authorities, enforcement of the law had stagnated. In the opinion of experts, successful measures against HIV spread, require the development of a new legal basis.

It is too early to presume that immediate action will follow, but it seems that the ice has began to melt. Recently, President Putin promised to put HIV on the agenda (Russia, the G8, and HIV, 2006). Whilst bearing in mind the high political environment of the G8 where the pledge was made, and remembering that pervious declarations haven’t been supported by actions, it is still hoped that, because of the worsening epidemic and shift from concentrated into generalised epidemic, this declaration could be used as a wake-up call for the federal, and particularly the regional policy makers.

Large-scale change requires strong leadership (Alvord, Brown, & Letts, 2006). It is naive to think that the country’s President could take this role. The President’s actions could prioritise the issue, but further developments and directions to change require another coordinating body. This is the supposed role of the newly established Coordination Committee. But it has no executive power, thus can’t fulfil this role. The task of leadership is to build bridges between the stakeholders and facilitate successful negotiations among the various interested groups (Alvord et al., 2006), which requires a certain degree of power to be able to organise and control relationships between stakeholders. This body should be able to facilitate the process of stakeholder analyses, designed to help organisations and government in their strategic thinking, while formulating the problem and developing solutions. This exercise is important, as it can be used to link political rationality with technical rationality, which could assure mobilisation of support.

Inadequate financing of services is a major partial problem (UNDP, 1999). Even if there was political commitment, it would be limited to a theoretical approach and would not be supported practically because of lack of financial means for implementation of activities. This would not is basically what is happening in reality. The Intersectoral Committee develops plans for activities but does not participate in discussions related to financial allocations. So allocated funds are insufficient to support implementation. As
a result, implementation stagnates and intentions are purely declarative; just statements in documents to make the country appear to be in-line with international strategies.

The role of international partners is crucial in linking civil society and government (Kalla, 2006). There a further contradiction, in that one of the disseminators of information was supposed to be the NGOs, who were not themselves getting enough information from the government to pass it to the public. So who is supposed to create a supportive public opinion if not the government or NGOs? If there is no public representation, the public needs and thoughts are not considered by the government. What then are decisions based on and for whom they are made? Does the government have other mechanisms to collect public opinion rather than from the public itself, and other mechanisms to address them? Obviously, the public is expected to stay ‘inert’ and just follow and approve government decisions. The literature suggests that NGOs play a vital role in fuelling the interests of civil society, which then could pressurise the government and its elite to develop a better response to the epidemic (Barnett et al., 1996; Barnett & Whiteside, 2000; Gómez, 2005). The key factor here is the presence of a democratic environment, in which the NGOs and civil society operates. They could then form critical mass of NGOs present in the country able to keep government accountable. In Russia both factors real democracy and developed civil society are absent. Perhaps this is the main reason for poor involvement and limited information exchange between NGOs and governmental organisations, as well as ignorance of the importance of NGOs to capacity building in Russia. It appears that, government activities are directed towards the elimination of forces that create accountability and act as an opposition. For example, recent laws tightened control over NGOs, and though there is no assessment of impact of this law on NGOs’ work, it could be expected that it will hinder many NGO activities, which oppose the government (needle and syringe exchange, human rights and democracy advocacy, etc.). Perhaps these strong historically ingrained values are the main hindrances to prioritising HIV as an issue generating poor financial allocations, and inadequate policy development and implementation. The same values hinder introduction in schools of federally funded sex education programmes, generate the strong stigmatisation and discrimination against vulnerable populations, human rights violations and undermine treatment and other health service provision.
The findings indicate that the federal respondents thought that the regions and public could be involved in activities related to HIV/AIDS. In most cases, the importance of public opinion and social norms and values were emphasised as determining behaviour. While formulating policies it is important to counter social resistance, because of the public’s values and beliefs. Gomez, analysing political influence on the Russian government response to HIV/AIDS, suggests that historical institutionalisation of Christian norms, with a combination of Victorian politics, and conservative communist values, led to the development of a judgmental viewpoint amongst the federal elite, and institutions towards “immoral” sex and substance use, which hindered the development of the government’s response to HIV/AIDS (Gómez, 2005). On the one hand, decision makers need public involvement to be able to garner public opinion and reflect it in their decisions and the formulation of legislation. On the other hand, they need public support to be able to implement their decisions. Another question is what they are doing to involve the public? Our study respondents suggested that prior to the introduction of any intervention (sex education in schools, involving PLWHA) it is crucial to gain a positive public attitude to overcome any stigma. Paradoxically, despite acknowledging this, there is very little involvement of the population or social groups in the legislative process or in decision-making; theory is far from practice. Moreover, given the importance of the population’s support, there is not much done to inform them about the issues and to sensitise them to “get them mature” that they be able to judge and understand the problems. Perhaps, this is one of the reasons that the laws and policies remained unimplemented.

All the factors identified earlier influence the formation of policy in Russia. Grindle analysed the policy process in developing and developed countries (Grindle & Thomas, 1991). In applying Grindle’s approach to policy analysis, it was obvious that Russia is different and neither of the two suggested models could be applied to understand its policy process. According to some features, e.g. five year planning system, excess capacity of highly educated and well-trained specialists, Russia could be considered a developed country. On the other hand, such features as highly centralised system (despite theoretically there being decentralisation), strong authoritarian regime, a dependent media, and underdeveloped civil society makes Russia a developing countries. At the same time it should be admitted that Russia covers a huge territory and could be divided into two parts, before the Urals (moderately developed) and beyond the Urals (highly under-developed).
To conclude, Russia has features of a developed country, but behaves like a developing country; the reason being its traditional mentality and unwillingness to change it. The reason of such contradiction is perhaps the strong influence of the political party up to date, strong propaganda and ideology, which affects the population’s mentality and directs in decisions. Russia’s population is aging and the views of old generation are prevailing, which hinders development of new approaches. The elite is strong and powerful and thus able to defend its interests, so any attempt to influence their perceptions, attitudes and actions will be a waste of resources; evolutionary developments will give incremental change and insignificant results. Change is really likely to occur when the HIV/AIDS crisis moves to an epidemic in the general population and become a threat on a national magnitude.

In Russia there is interplay of progressive and ideological models of policy change, as there is a strong interrelation of political and ideological values. Moreover, political values are developed based on ideological values. Thus, to initiate change of political values, firstly it is necessary to tackle ideological values. When respondents were asked their opinion about what could help to improve the situation, or get public support for HIV/AIDS activities, the word “propaganda” was used and the “need of ideology” was mentioned. It could be that propaganda and ideology mean the same as advocacy in the minds of the respondents. Could propaganda be used by the government to implement beneficial policies, and could the same propaganda be adopted by the NGOs to convey the message to the government? Possibly. As witnessed by the past 70 years, the successful implementation of this technique was used to lead the country. In Russia historically, “propaganda” has been used as an instrument to influence political structures, or even change them, and with that change policy. So propaganda could be considered as a kind of advocacy, or as part of an advocacy campaign. The country has for almost 70 years experienced propaganda, developed and implemented in response to party ideologies and objectives. Moreover, they managed to spread this ideology to neighbourhood countries. The revolution in 1917 could be considered as an example of well developed “advocacy campaign”, have been successfully implemented to change policy. Can propaganda be used to support successful implementation of public health measures in Russia? Almost all respondents from both regions fail to define ‘advocacy’, confusing it with the human rights of the HIV infected population. At the same time,
most respondents think that the public opinion and government law could contribute to advocacy. Almost half of the respondents defined some elements or certain targets of advocacy, but the rest either were not familiar at all with 'advocacy' and referred to human rights protection for the HIV infected population. Few respondents mentioned prevention and information dissemination. As a successful precondition for advocacy the federal respondents mentioned the need for specialists. Thus, the answer to the question about the use of propaganda why not if this is a historical response to country needs.

7.4 Financing Shortfalls

Financing HIV/AIDS activities has been of concern since early in the epidemic. Internationally it is proposed, that financing of HIV/AIDS activities should come from a partnership drawing on many sources: governmental and philanthropic agencies, multilateral organisations, local budgets, the business community and individuals (Lief & Izazola-Licea, 2006). The problem of financing increased with the introduction of ART, costing US$10,000 per patient per year, which significantly reduced HIV-related deaths and improved the health status of the infected population. In addition to treatment, the costs increased due to the medical expenses for doctors, laboratory tests, and drugs for the prevention or treatment of HIV-related opportunistic infections, making the average cost per patient US$18,000-US$20,000, with expenses depending on the level of complications from HIV-related illnesses (Financing HIV/AIDS Care: A Quilt With Many Holes, 2004). The burden of the disease is higher on poor, unemployed and vulnerable population. Even for those who have resources, the high cost quickly exhausts these making them dependant on the public sector for care. In addition advancing disease often disables individuals preventing them from work and making them dependant on public funding. Nevertheless, some studies indicated that “cost effectiveness ratios of combination therapy for HIV infection ranged from US$13,000 – US$23,000 per quality-adjusted year of life gained (vs. no therapy) compared to US$150,000 per quality-adjusted years of life gained for dialysis patient” (Financing HIV/AIDS Care: A Quilt With Many Holes, 2004). So despite the high cost HIV treatment and care is comparatively cost-effective.
The lack of priority given to HIV is reflected in limited resource allocation. The shortage of financing was blamed on an inability to combat the epidemic and the many other problems of country. It is obvious that there is a lack of financing. This financial shortfall was considered as the cornerstone for all other problems. It is debatable whether HIV is not a priority because of the shortage of finances across the country or whether there is inadequate financial resource allocation to the area of HIV because of its lack of priority?

The literature suggests that HIV funding usually reaches projects through four main funding streams: donations from national governments, multilateral organisations, private sector and domestic spending. Domestic and national spending usually increases along with a national/local budget increase, whether due to greater productivity and economic growth, improved trade, or debt relief (Funding the Fight Against AIDS, 2007). In addition, domestic funding means commitment and sustainability in dealing with the issue. In recent years, there has been growth in the Russian economy because of increasing oil and gas trade, also increase of oil prices (GDP per capita rose from US$2139 in 2001 to US$11,100 in 2005), whereas it not has been followed by an increase in financial allocations to HIV/AIDS issues. In 2003, in Altay krai, HIV/AIDS activities represented 0.95% of health expenditure. HIV/AIDS activities are financed from federal, regional and municipal budgets, Federal and Territorial Health Insurance Funds, user fees, voluntary and/or private health insurance schemes and donor organisations. The Federal HIV/AIDS programme, for period 2002-2006, was allocated approximately US$0.12 per infected person per year (Atun et al., 2005).

One of the important aspects to assure an adequate response to the epidemic is increasing national and local budget contributions to prevention, care and treatment, as well as impact mitigation, also to mobilise private sector resources (UNDP, 2006). In 2002, the federal allocation was about 5% of its total planned expenditure on the HIV/AIDS sub-programme, which reflects the state's attitude and approach to administration surrounding the problem (Davis & Dickinson, 2004). At the same time, it should be admitted that adequately financing of HIV/AIDS is a global problem; despite international efforts and increasing contributions by international agencies and funds, there are substantial disparities between HIV/AIDS financial needs and availability, and between needs and programming capacity (UNAIDS, 2003b). It is
suggested that the contribution of local governments should be increased, and at the same time, within country donations should be mobilised.

It can be debated whether the problem is a lack of appropriate financing or whether there is "leakage" of resources because of the inefficient use of those allocated. Our study found that talking about regional health problems, many of respondents found the organisation of the health system to be a problem. The respondents concern was the poor quality of services provided, financial problems, and poor organisation of systems, mismanagement and the poor condition of health facilities. Specifically, it was emphasised many times that the population had poor access to health care services, because of the unaffordable fees (official and unofficial). All these indicate inefficient use of targeted resource due to mismanagement. They criticised the health care reforms and the way the system was run and managed. The latter is also found by authors who have analysed health care reforms in Russia (Garner, 1996; McKee et al., 2005; McKee & Nolte, 2004). However, in a case when there are limited resources, prioritisation of issue becomes vital. The solution to this problem could be an improvement and increase of transparency and accountability of monitoring system of national and international financing. The fact is that stakeholders were puzzled how the allocations are made and how the expenditures are monitored. This finding is supported by other research findings, according to which there is no formal mechanisms for assessment of the degree to which spending correspond to programmatic priorities (Bobrik & Twigg, 2007). Perhaps organisational and structural changes could help address the problem.

7.5 Misalignment of Structural and Organisational Arrangements with Multisectoral Response

During interviews the issue of system organisation and management was mentioned as being poor, inefficient and ineffective. This was mentioned as a big shortfall and the reason for many problems in controlling the epidemic. Despite there being four ministries in Russia (Justice, Internal Affairs, Defence and Health) involved in responding to the epidemic, the leading role is given to Ministry of Health and Social Development (MH&SD). Coordination of activities between ministries at the federal level is weak because of different approaches, and also laws related to issues like harm
reduction and CSW. Even within the health system the main responsibility is given to the Department of State Sanitary-Epidemiologic Surveillance (DSSES) whose main emphasis is screening of citizens. This determines the perception of fight against HIV; making it mostly about prevention and ignoring the role of curative services and research (Davis & Dickinson, 2004).

The results indicate that opinions about the contribution of each sector were quite well structured, with some minor confusion about the role of leading the prevention activities. In May 2004 the MOH&SD created an Advisory Committee for the coordination of activities, inspite of which most respondents complained about lack of coordination of activities and organisation of joint actions to combat the epidemic. The main problems generating this lack of cooperation between different governmental organisations and between governmental institutions and NGOs were: lack of information provided about activities, lack of financial support, and the unclear division of responsibilities. This poses the question of whether the relevant department is not effective in planning activities and distributing tasks. It would seem a waste of resources to create a body without adequate prove and authority, but according to respondents, the newly created body does not have an executive power, and is nothing more than just a bureaucratic institution created to please UNAIDS and to “match” international standards. With the absence of civil society and NGO pressure, the international community is the only pressure challenging the Russian government to improve its response.

Before attributing responsibility, it is important to query whether there is the appropriate capacity for implementation of made decisions by medical staff. Though Russia has enough human resources and infrastructure for implementing interventions, but existing services are poorly organized and managed, with poor knowledge management and continuous quality improvement processes. The Russian health care system is organised into disease-specific separation, with strict vertical programmes targeting specific diseases and patients. This prevents knowledge reaching professionals working in general care, leading to stigmatisation of the HIV-positive population. In addition, the lack of incorporation of HIV into primary care services generates haphazard detection and prevention efforts, which bypass the populations most at risk. In addition, patients with co-infections which would be dealt with by different parts of the health system fall through this net (Russia, the G8, and HIV, 2006).
The idea that NGOs and private sector could conduct preventive activities in the workplace was very welcomed. However, it was simultaneously acknowledged that these bodies were lacking information and the capacity to conduct such activities. In addition, the authorities admitted that they are not working to fill these gaps and are not providing any training or professional advice, nor supplying prevention materials, all of which suggests that no effort is being made to change the situation. The role of the private sector was mostly considered as contributing sponsorship but there were no initiatives on behalf of authorities to encourage this, for example, by decreasing taxes on sponsorship contributions. The private sector was blamed for not taking the problem seriously, for not assessing the epidemic thoroughly, and not understanding the magnitude of harm to the private sector. Again, we face the problem of lack of awareness. If the authorities acknowledge that the private sector lacks information, how can that same sector be expected to judge the epidemics consequences? Who, if not government should provide the private sector with information, even if via NGOs? Federal respondents blamed the private sector for not participating in HIV activities, and NGOs for poor prevention activities, but never mentioned their input in organisation and coordination of such activities. Though they think that the government is “the host” and the “decision-maker”, they don’t act in this role failing in both coordination and leadership. Being proactive as a groups is important, but still there should be a body to motivate, provide leadership and coordinate activities, and it is obvious that the respondents see the federal authorities in that role.

It is likely that the role of the private sector working with government will increase as the legal environment for private enterprise activities improves and its influence on the country economic development increases. The currently private sector oligarchs act as an ‘invisible power’ in decision-making party because they financially support the ruling parties elections. They not only influence, but also direct the government in its policies. Thus the private sector could become a major collaborator in prevention activities, once it realizes the magnitude of the problem and possible consequences for business. The TPAA suggests that the business community is willing to participate and contribute (TPAA, 2006), our findings at the regional level suggested that the private sector is still “inactive” and also is “out of step” as not involved by governmental organisations in any activities related to HIV/AIDS. Again we observe a theoretical approach that welcomes collaboration, but one that is proactive is not practically
supported by any activity. It seems that there is a lack of trust generated by different professional experiences and differences in approach that has created a poor environment for cooperation. This though is not helped by the lack of communication. As the results show, there is no process in place for sharing existing information. Building the capacity of NGOs and increasing their professionalism could help with this but in addition to the NGOs being more proactive and assertive, the government itself could also try to develop this potential and provide information and training to facilitate the NGOs, perhaps through international community involvement. Then, NGOs could be quite useful at addressing the issues, especially when, for political reasons; government can not act and have poor access to risk groups. NGOs should not be viewed as an opposition, but as partners.

The important role of the international donors in improving NGO capacity and influence is accepted, but there are dangers to such involvement. Such involvement can create government inaction and decrease the governments’ participation reducing responsibility and ownership. The government can misconceive the function of donor agencies and rely on international agencies to carry the entire burden, thus lessening their funding of activities. In Altai in 2003, the lions share of prevention activities were funded from donor contributions (Atun et al., 2005). To solve this problem, there could be a strict co financing requirement, and most importantly there could be very tight accountability mechanisms to monitor, not only performance, but also utilisation of resources. Funding should be dependent upon recipient providing realistic proposals for the future sustainability of programmes where in this case sustainability would mean activities continuing once the donor support is withdrawn. Such a requirement would be a difficult but necessary barrier ensuring genuine commitment.

PLWHA have the potential to be invaluable when enrolled in HIV/AIDS activities. They can act as speakers (advocate behavioural change), implementers (participate in organised activities like peer education, outreach activities), experts (act professionally as a source of information, knowledge and skills) and decision-makes (contribute to policy making) (Kalla, 2006). In contradiction to literature, our findings indicated that though respondents almost unanimously agreed that there is a need for involvement of PLWHA in decision-making, there is no organisation involved in this process. Moreover, in both regions almost all respondents fail to nominate any organisation of
PLWHA. This once gain indicates that policy declarations are not acted on; perhaps fears of discrimination makes any organisation for PLWHA “invisible”.

Improved communication and more involvement of NGOs and private sector representatives, will not only allow to mobilize of latent potential, but also lead to mainstreaming of activities and the efficient use of limited resources. Dissemination of information, through improved communication and better cooperation between different sectors, could shift responsibility for the epidemic on to all sectors and communities, away from medical/health institutions, still leaving them the leading role, of organizing and coordinating activities to combat the epidemic.

7.6 Stigma

Goffman and other scholars explored stigma, and suggest four attributes of a disease which create stigma: i) infected person seen responsible for having the disease; ii) disease is progressive and incurable; iii) poor understanding of the disease by public; iv) the symptoms cannot be concealed (Stigma and HIV/AIDS: A Review of the Literature, 2006). So HIV/AIDS fits perfectly this profile for stigmatisation. Stigma affects peoples’ self-esteem, mental health, access to care, providers’ willingness to treat, violence, and HIV incidence. So interventions should be directed towards stigma and against stigma. In addressing stigma a statutory and regulatory approaches, developing appropriate laws and policies as well as programmes and services, particularly mass education, voluntary testing and counselling are key elements of public strategy. Activities to decrease the impact of stigma could be targeted towards improving care and access of patients to health care services, improving quality of life of patients, emotional support of PLWHA and also their peers and family members (Stigma and HIV/AIDS: A Review of the Literature, 2006). The literature suggests the following factors, which contribute to HIV/AIDS related stigma (HIV and AIDS Stigma and Discrimination, 2006):

- it is a life threatening disease;
- the fear of getting infected;
- the disease is associated with previously marginalized groups practicing risky behaviour;
• HIV/AIDS infected people are deemed to bear responsibility for infection;
• religious and moral beliefs can conceive of the disease as a punishment for moral failings.

In addition, I would suggest that there is a reaction including “fear to unknown” as many lack the information and knowledge to judge and analyse the problem. In many cases even without facing risk of infection, there is prejudiced attitude toward CSW and IDU. The stigma associated with HIV is driven by disrespect and denial of these population and their needs, unconnected with any fear of infection. It is related to disapproval of lifestyle, rather than disease. HIV/AIDS has just aggravated the situation with fear of infection as an excuse to act explicitly. This disrespect is found at all societal levels and is reflected in decisions on treatment provision, and consequent financing/resource allocation and prioritisation of AIDS.

Theoretically there was no resistance to any initiatives. Whether it was the introduction of sex education, involvement of those HIV infected in the legislative process, universal coverage of treatment for PLWHA, cooperation between sectors, all were welcomed by the majority of research participants. However, practically none of above mentioned activities are in place, and theory is not supported by practice. The situation is made worse by the fact that, in most cases, the respondents see the gaps and also know the solutions, but still there is no action to change things to make them better.

Societies response to epidemic has been characterised by fear, stigma and discrimination which were fuelled by anxiety about and prejudices against affected groups (UNAIDS, 2000). Stigma is a powerful tool for social control. It is also a convenient tool for blaming certain groups, and by excluding them from society, which can release society from its responsibility to care for such a population. This is reflected in denied access to services and treatment (HIV and AIDS Stigma and Discrimination, 2006). The findings supported this last statement, as this is exactly the case in Russia. Being unable to tackle the issue, it is very useful instead of trying to resolve the problem, to connect the disease burden with a certain category of people, excluding them from society and releasing government from responsibility for their future. In Russia, HIV is associated with marginalized groups and their behaviour, so it becomes responsibility of those individuals, rather than one for society or policy leaders.
There is simple no respect of risk groups, they considered as a shame of society without trying to understand the causes and problems creating such behaviour. The acceptance of social and economic factors could help create a demand to solve these problems, putting policy makers under pressure. Denial of the problem is the most convenient solution and claiming that the problem created by behaviour puts burden on individuals. So stigma could be tackled on society level through education and knowledge increase regarding HIV prevention and control. As Herek showed in analysing several studies related to stigma, young and more educated people are less prone to stigmatise HIV than older and are less educated people (Stigma and HIV/AIDS: A Review of the Literature, 2006).

As the literature suggests, laws, rules and policies (compulsory screening and testing, limiting travel and access to country) can increase stigmatisation (HIV and AIDS Stigma and Discrimination, 2006; Stigma and HIV/AIDS: A Review of the Literature, 2006; UNAIDS, 2000). To address stigma programmatic, legal and policy arenas should be tackled (Stigma and HIV/AIDS: A Review of the Literature, 2006). The worst effect is that stigmatisation influences the services provision and decreases the pool of volunteers and medical personnel, who either refuse to treat patients, or trying to hide the fact that they work with HIV patients from the fear of being stigmatised themselves. Religious believes and lack of education as well as lack of HIV related knowledge fuel HIV/AIDS related stigma. Findings of the research supported by the literature, which suggests that stigma inhibits voluntary testing and counselling, creates homophobia and prejudice against drug users and sex workers and limits HIV treatment (Bobrik & Twigg, 2007).

Stigma is the major barrier to patients in applying to medical facilities and for diagnoses and for treatment (HIV and AIDS Stigma and Discrimination, 2006; UNAIDS, 2000). Applying could disclose their status just because they are observed accusing those services, but also there is no trust in the confidentiality of services and information could be “passed by accident” to employers and neighbours, creating discrimination and exclusion from society, resulting in job loss and affecting not only themselves, but peers and family members as well. One indicator of this is that death certificates are falsified. Especially in Russia, where laws can easily be bypassed and ignored, anti-discriminatory legislation and policies cannot change much peoples’ perception. The best solution is generating a change of community attitude, through information and by
example. Society could be “activated” by knowledge and involvement of affected people into activities, giving them responsibilities, by involvement and trust requires adequate laws and resources but willingness remains the major motor.

Changes in opinion could be initiated by the simultaneous promotion of similar messages by political leaders, medical specialists and NGOs through mass media. This is possible because of the inter-connection of the local political, economic and media elite who monopolised public influence. This could rupture strongly believed prejudice controlling people understanding values and attitudes more then 70 years (Davis & Dickinson, 2004). Currently, a few international organisation in Russia (Harm Reduction Network, Transatlantic Partners Against AIDS) are attempting to address stigma through dissemination of information among the population, risk groups and business communities (TPAA, 2006). Though the scale of these efforts is small, it is a good start and a valuable experience for further replication through the country.

7.7 Main Activities to Combat the Epidemic

The Ottawa Declaration on health promotion stated that health promotion should be directed towards: i) building a healthy public policy; ii) creating a supportive environment; iii) strengthening community action; iv) developing personal skills; v) re-orienting health services (WHO, 1986). All of the above, described in the literature, should be the aims of activities development to combat any public health issue. Instead, our results indicate that a majority of stakeholders are involved in prevention activities. Furthermore, if resources increased they state that they would prefer further expansion of prevention activities.

Interventions for prevention of HIV epidemic could be directed towards different aspects of risk behaviour and at-risk populations. Activities could involve, but not be limited to education promoting safer behaviour, treatment of opportunistic and cofactor infections and condom distribution. Attempts also could be made to change the structural factors (poverty, sexual inequity, unemployment, etc.) that generate risky behaviour. In most cases these factors are neglected, while attempting to achieve behavioural change (Pisani et al., 2003). The choice of activity could be determined by
the local socio-economic, cultural and legal environment, as well as available social and health service infrastructure. Another aspect that is important to consider while choosing interventions is the possible outcome of each intervention rather just simply the attempting to undertake specific activities (Grassly et al., 2001).

Investing the time and resources in exploring the fundamental factors leading to risk behaviour could be beneficial. These factors include the psychological issues leading to risk and the individual socio-cultural, political and economic context in which the risk takes place. Social norms are powerful force, influencing individuals' perception and beliefs. Understanding the important role of social norms could prevent the authorities from overemphasizing the individual responsibility for their behaviour. Despite the stakeholders acknowledgement of the social and economic context they did not recognise the need to consider them when developing a response to epidemic. I believe that understanding and combat stigma is the main barrier to developing a rational response. Causes are well characterised but in planning activities to address these causes relegated and individual responsibility highlighted. This provides a convenient sight away from the responsibilities of the authorities and service providers and develops general negligence.

Targeting prevention at risk groups has to be delicately balanced. Whilst infection is found in those who have high risks, such individuals are members of society. Predicting who will be exposed to risk and why there is not clear cut, and by marginalizing and stigmatising at risk groups, society is failing in its duty of care and developing problems for the future.

At the same time we totally ignore the existence of socially 'welfare' (celebrities, officials and authorities) group practicing risky behaviour expressed by drug abuse and unsafe sex, who mainly are 'invisible' because of the denied access to this population. If their problem is not socially driven so misperception of pleasure and entertainment of drug use is to blame? The evidence suggests that the policy makers understanding of the problem is very superficial and specialist input is crucial in closing this knowledge gap. Whilst acknowledging that policy making is far from rational and acknowledging that a clear understanding is not a panacea, it is still vital that the issues are raised and that stigma is addressed.
7.7.1 Prevention

UNAIDS suggests that the only way of stopping the epidemic is prevention of new infections (UNAIDS, 2005c). Intervention for prevention should be directed towards both the infected and susceptible population at the same time (Vernazza et al., 1999). The prevention strategy should involve treatment of drug dependency (pharmacological and psychological), harm reduction (sterile needle and syringe access, outreach and education), voluntary testing and counselling, antiretroviral therapy, prevention and treatment of STIs (Preventing HIV Infection Among Injecting Drug Users in High Risk Countries, 2006). “A successful HIV prevention program is defined as one which averts or reduces risk behaviour, which could lead to infection with the virus, and is cost-beneficial” (Chronic Conditions Information Network, 2006). According to the US Centres for Disease Control (CDC) (National Commission on AIDS, 2006), the characteristics of a successful prevention program should:

- Address community and individuals’ needs of HIV prevention.
- Deliver messages tailored to the target audience needs and must be (a) sensitive to the particular culture, age, educational level, sex, geography, race-ethnicity, sexual orientation, values, beliefs, and norms, and other factors; (b) be appropriate to the developmental level and linguistically specifies.
- Have a general principle of program planning and evaluation, including goals, objectives, and strategies.
- Provide interventions considering behavioural and social science theory and research.
- Be monitored to determine if the stated programme outcome objectives are achieved.
- Contribute sufficient resources (financial, human, material, and temporal) as required.

UNAIDS stated that the AIDS epidemic can only be reversed by effective HIV prevention measures intensified in scale and scope. It is suggested that the implementation of a comprehensive HIV prevention could avert 63% of new infections predicted to occur 2002-2010. International experience of HIV prevention indicates decrease in the incidence in Uganda, Thailand, Spain and Brazil (UNAIDS, 2005b). These countries’ success is mainly attributed to either condom use promotion (Thailand), good governance of treatment (Brazil), strong political will and leadership (Uganda).
These examples of best practice could be replicated in other settings, but it is important to consider the context, content and confluence between context and content of programmes (Grassly et al., 2001).

The results indicate that most respondents mentioned prevention as an activity that currently Russia implement to combat the epidemic. At the same time, prevention was mentioned as the activity that respondents would like to expand with additional financing. In Altai Krai the HIV/AIDS allocation in 2003 was distributed with 47% to curative, 26% to diagnostic and 18% to supply in outpatient services and only 7.8% to prevention and public health activities (Atun et al., 2005). Preventive activities involve information dissemination to increase the populations’ awareness, implementation of special programmes with the target populations to decrease the spread of the epidemic, implementation of sex education, and harm reduction programmes. A concern about an increase in MTCT was especially prominent and accordingly expansion of MTCT prevention activities was a priority. There is an increase in MTCT, and there is widespread discrimination, including from health professionals, towards mothers and children with HIV and only 10% of those needing HAART in 2005 received treatment (IFC Against AIDS: Russia, 2007).

Most prevention efforts are targeted towards the high risk groups (CSW, IDS) putting the “blame” mainly on “service providers”, i.e. CSW and ignoring the responsibility that equally shared by “service consumers”, i.e. clients. Demand boosts supply and safe sex practice is much more important to advocate among service users. CSWs’ clients are suppose to protect themselves from getting infected, as in most cases workers themselves have insufficient power to negotiate safe sex, or are for extra pay ready to practice risk. A priority area for prevention could be targeted at changing the poor attitude of condom use among the general population, and the stating point should be youth at schools, colleges and universities. Targeting prevention and dividing the population into categories itself creates stigma towards those groups and creates a false perception of safety, so any message of prevention should be designed and developed for specific activities with the population involved (i.e. if those sexually active with many different partners) for general population rather then for specific groups. What about those who are active and changing their partners but not ask to be paid? Are they supposed to be safe, of course not. General preventive knowledge of risky behaviour could act for individuals as ‘double protection’, as firstly they will be able to control
their own behaviour and secondly being able to identify possible threats from others' behaviour, being able to either suggest that they change their actions, or refuse to participate in actions that share risks.

At the same time, a vital issue is the quality of preventive activities and whether they address and cover the needs of populations, policy makers and risky behaviours. According to the National Commission on AIDS report behavioural and social sciences, to lower the risk of HIV Infection, there is a need of following eight factors (Hotgrave, 1995):

- readiness for behavioural risk-reduction;
- elimination of environment barriers blocking the behaviour change;
- skills to implement behavioural change;
- perception of new behaviour by public;
- peers encouragement and support of the behaviour change;
- consistency image with the new behaviour;
- perception of the new behaviour and its reinforcement;
- belief to new behavioural change;

Risk perception and behaviour are determined by different possible interactions of individuals, social interaction of individuals, social interaction within networks and social groups, networks, sub-cultural risky behaviour norms and wider cultural risk behaviour norms (Course Materials for MSc on Drug and Alcohol Policy and Intervention, 2003). The HIV epidemic brought about public health interest in the long standing combination of substance use and sex as risk behaviours attributed to infection spread (Rhodes & Hartnoll, 1996; Stimson et al., 1998). To develop adequate activities and be able to address issues, there is a need of understanding the reasons and mechanisms of risky behaviour. In increasing awareness it crucial that community leaders and leaders of faith organisations participate, so they can be trained and then act as the main sources for knowledge distribution (The Role of Buddhist Monks and Community Leaders in HIV/AIDS Prevention and Care, 2006).

There are several theories (attribution, relapse prevention, self-efficacy) attempting to explain behavioural interventions. The common of understanding of these theories is based on an assumption “that behaviour is determined by the cognition people have about their behaviour” developed by Weiner, who suggested that behaviour could be
interpreted and also predicted by analysing past experience in achieving goal (success vs. failure), as well as interpretation of reasons for failure (four possible combinations of dependent variables of internal vs. external and stable vs. unstable). In addition, theory also consists of an affective component, which is the relation between the locus and controllability, on the one hand, and emotions and behaviour, on the other (Boer et al., 1991; Weiner, 1985). So attribution depends on success, emotions and behaviour. Without getting into details of each theory, which are basically modification of certain factors like (motivating people to change, teaching of coping mechanisms, information distribution to increase self-efficacy, training for extreme scenarios, etc.), these theories have been widely used in health education aimed at behaviour change, attempting to tackle different public health issues (smoking, weight loss, coping with critical life events and accidents, chronic illnesses, etc.). Peoples behaviour is possible to change by changing the attribution they make, which determines their behaviour and leads to different consequences (attribute for failure should be perceived as internal, unstable and controllable) (Boer et al., 1991). As stakeholders’ responses indicated, there is more judgmental and stigmatic attitude and approach rather than sympathetic and willingness to understand and help these people in changing their lifestyle.

There is a paradox between theory and practice. Though there is a clear understanding that the policy process is far from rational, while trying to analyse policy we are guided by the rational deductive method of logic (epidemiologic statistics indicates disease advancement, thus the response should be increase financing to be able to organise adequate activities of prevention, control, care and treatment). There is evidence that the epidemic is “shaped” by context and structural factors, yet in response the main activities are directed towards behavioural change, ignoring the social, economic and political factors determining epidemic. Despite it being admitted that epidemic could only be addressed by a multisectoral approach the main response and burden is still on the health sector. Although it is acknowledged that to combat the epidemic requires comprehensive participation of all stakeholders (governmental agencies, specialist services, NGOs and CBOs, private sector, civil and donor communities), the government and health care specialists are still expected to be responsible for managing the epidemic. It is also acknowledged that effective and efficient use of resources could maximise the outcomes of implemented efforts, still there is fragmented coordination in addressing the issue, which indicates a waste of scarce resources. Results indicate that there is sufficient analysis available to understand the problem, and solutions to
problems were suggested by interviewed stakeholders, including mechanisms to overcome bottlenecks. The challenge is to bring theory into practice. So the key question is what is hindering the process?

Activities should be built on the country’s actual ‘how things work’ approach, rather then on the theoretical ‘how things should be’ prescriptive approach, written into policy documents. I would suggest that solutions to the problems should be guided by what is possible to implement, rather than by examining activities implemented by other countries and shaping “theoretical solutions” through adjusting them to country’s specifics. This is the reason that the research decided to analyse not only the existing written policy documents but also current practice, with an in-depth understanding of approaches and perceptions to the problem by all existing and potential stakeholders.

Taking into consideration stakeholders’ perceptions and suggestions it is proposed that the advocacy strategy should be directed towards expanding urgent preventive activities with emphasis on knowledge, aiming at increasing of information and awareness among different groups: policy makers, population, professionals, risky behaviour practicing groups. The rationale behind this suggestion is that “the stigma controls the response” and the problem is the negative attitude towards the epidemic and related issues. Expanded preventive activity directed towards measuring information (with consideration of information transfer into knowledge) could change the attitude of stakeholders and wider population towards the epidemic. On the one hand, this could improve the environment in which the epidemic develops, in terms of adequate laws, policies, funding and resources and the populations social participation, on the other hand, knowledge could change the populations behaviour, which will prevent new infections and also create more supportive environment for those already infected. Better awareness will directly contribute to a decrease in stigma. Schematically it is illustrated in Figure 20 below.

This thesis suggests a prevention strategy according to which IEC (information, education and communication) could be directed towards decrease of stigma and discrimination. Based on the literature, countries report successful combat with HIV/AIDS using main strategy of prevention as IEC strategies (Albright & Kawooya, 2005; ASIS&T, 2006). Widespread dissemination of HIV/AIDS information allows to gain knowledge required for change of behavioural response to epidemic on one hand,
and on the other inform policies supporting to develop political and structural response to epidemic. Though acknowledging that increase of awareness is not the only remedy against stigma, the choice was based on the results of analysis of respondents’ answers. Based on the opinions of the majority of policy makers, who suggested expanding preventive activities, and also based on the fact that there is a lack of information and the transfer of existing information to knowledge has failed, it is suggested to start with “information attack”. This would contribute to a better understanding of the problem by policy makers and population. It better be differentiated by themes; baseline knowledge, recipient audiences, desired outcomes/purpose. The required information should be different for different groups, and be directed towards different purposes, so consequently be of different depth and levels. These groups are:

- Policy makers to assure better understanding the problem and be able to analyse comprehensively to come up with feasible solutions to the problem.
- Risky behaviours to reduce harm and avoid further spread of infection.
- General population to prevent new infections and “protect” them from risky behaviour, also develop tolerance and supportive environment for activities implementation.
- Specialists to improve their existing knowledge and activate their actions to coordinate activities, provide services and required materials for adequate response.

The Russian population has historically been exposed to propaganda, which has been used effectively to control and direct the populations’ behaviour, as well impose ideas and to develop their attitudes. Without inferring that an advocacy campaign is the same as propaganda, but bearing in mind that both have many common implementation mechanisms and channels of influencing population behaviour, it is presumed that the proposed strategy of the advocacy campaign will succeed, if not, at least it would alert the populations to attempt to perceive the issue more seriously.

Basic information about safer sex, epidemic transmission modes, updates on the country epidemic situation, etc. could not only decrease the epidemic spread, but also decrease stigma within general population, making them more tolerant and supportive towards HIV affected population. Regular information supply to mass media will prevent myths and fears developing amongst population. At the same time, stigma decrease will create population support allowing to improve existing care and social protection of PLWHA
and their families. On the other hand, information about available services will assure timely screening and diagnosis, as well as inform affected population about support services.

Better supply of information through all available services (medical, educational, media, community and faith organisations) will increase knowledge and understanding of issues by policy makers. The latter group is responsible for sensible policy development and implementation through assuring adequate resource allocation and coordination of activities. It will help policy makers to prioritise the issue while allocating resources. The role of media is central in increasing knowledge, as it could be a buffer between all related parties: on the one hand, information through the media could increase the populations understanding of the issue, and on the other, working with policy makers, the media could sensitise the public about policy makers’ efforts and their achievements assuring their accountability to the public. At the same time, transparency and accountability about HIV/AIDS stakeholders’ activities will improve coordination of efforts, and will increase efficiency and effectiveness of resource utilisation, also increasing CBO, NGO capacity and participation and the public contribution to implementation of activities. Last but not least, through media the population could learn about their role and how they could contribute to the implementation of policies and also participate in policy formation through public discussions and debates.

The figure 20 below presents the suggested advocacy scheme, where the arrow symbolizes the intervention strategy, in the square there is the suggested activity of implementation and the outgoing “leaves” shows the outcomes of interventions.
Figure 20: Advocacy Model of Preventive Activities to Change HIV/AIDS Policy

**Preventive Strategy**

**Population**
- Increased knowledge and understanding of the problem
- Changed perception of the issue
- Development of safer behaviour
- Practicing health lifestyle
- Changed attitude towards affected population
- More tolerant and supportive environment
- More concerned attitude and pressure on policy makers
- Participation and involvement in policy making
- More supportive in implementation of policies
- Increased accountability of policy makers

**Risky Behaviours**
- Increased knowledge about transmission and prevention
- Practice safer behaviour
- Understanding their entitlements to health and at workplace
- Voluntary testing, treatment and counselling
- Better quality of life
- More demand for human rights consideration and service provision
- Empowerment and contribution to policy making
- More pressure on policy makers
- Support in policies implementation
- Cooperation with professionals and policy makers

**Policy Makers**
- Better understanding of the epidemic
- Attitude change towards the issues
- Prioritization of the problems
- Adequate response in terms of:
  - resource allocation and efficient use of resources
  - adequate laws and legislation
  - supportive socio-economic environment
- Monitoring and evaluation of implementation of agreements and policies
- Safety nets for affected population and their families
- Better cooperation and coordination of activities
- Promote participatory policy making process
- Wider involvement of civil society, media and service users in decision-making process
- Increased transparency and accountability

**Information campaign aimed at increasing knowledge and change of perception, behaviour, attitude, leading to decreased stigma towards HIV/AIDS and resulting in improved communication and adequate response to epidemic**

**Professional Stakeholders**
- Updated knowledge and expansion of research
- Changed perception and more tolerable attitude towards affected
- Active participation in policy and decision making
- Leadership in information campaigns for policy makers, general population and groups practicing risky behaviour
- Close collaboration with other sectors representatives and international agencies
- Improved communication with media and civil society
- Widen services provided to affected population
- More preventive activities directed towards risky behaviours
- Closer cooperation with policy makers and participation in evidence based policy making
At this stage it is difficult to predict the possibility of implementation and assessment stages of the suggested model and also to what extent the interventions will succeed. There are minor improvements (presidential attention, information developed for policymakers, professionals' training) that have followed the completion of this research. Mainly due to the efforts of a few local professionals and some international agencies the problem has started to be taken more seriously, though this is still far from adequate. The country is still facing high turnover of the staff leading to uncertainty in the sector. Being unable to predict the changes that country will undergo after upcoming elections, it is difficult to forecast the pathway of epidemic development. Based on experience of other countries, and the possible developing pathways presented in this model, it is possible, if not to change, but to improve the situation today before it is too late. It should also be considered that the advocacy process, as well as the epidemic itself, is a dynamic process requiring constant analysis and adjustment of existing policy response to epidemic development. Thus is required constant assessment of interventions and improvements to the implemented models.

7.7.2 Intravenous Drug Use

HIV/AIDS is an adverse consequence of drug use and unfortunately the problem does not affect only drug users but through them could spread to entire community. So prevention of HIV transmission could be organised in consideration of both individual and society (Jarlais et al., 1993). The literature suggests different reasons for drug use; whether it is driven because of lack of motivation to do other things, curiosity, psychological pre-disposition seeking unusual experience, influence of social context, the outcome is the same (Burroughs, 1969; Hunt & Chambers, 1975). The health and social consequences of IDU are: HIV infection; hepatitis A, B and C infection; STIs, including syphilis; gonorrhoea and herpes; overdose; tuberculosis and pneumonia; other bacterial, fungal, parasitic and viral infections, such as endocarditis and malaria; skin complaints and damage; vein damage; the effect of crime, violence and homicide; accidents; deterioration in mental health and social functioning (Donohoe & Wodak, 1998; Stimson et al., 1998). Perception and response to drug problem is highly dependent on the involvement of wider society and religious organisations in the issues, as well as countries' morals, politics, policies and human rights issues (Course
Materials for MSc on Drug and Alcohol Policy and Intervention, 2003). To reduce and prevent drug use, the risk factors influencing HIV risk among IDU could be addressed on individual (severity of dependence, type of used drug, co-occurring psychiatric disorders) and structural levels (drug trafficking routes, appropriate drug laws and its enforcement, economic and political instability, injecting environment and culture, stigma and discrimination) (Preventing HIV Infection Among Injecting Drug Users in High Risk Countries, 2006).

The UN recommended activities for HIV prevention among drug abusers should include: AIDS education, life skills training, condom distribution, voluntary and confidential counselling and HIV testing, access to clean needles and syringes, bleach materials, and referral to a variety of treatment option. A review of effectiveness of these programmes found no indication of an increase of drug use because of provision of such activities (Preventing The Transmission of HIV Among Drug Abusers: A Position Paper of the United Nations System, 2006).

As Hamblin argues, the socio-economic dependence is the most significant risk factor for HIV infection, rather then sexual or drug-use activities. A critical part of effective strategy to reduce the spread of epidemic is considered to be efforts to address socio-economic risk factors (Hamblin, 2006). So prevention could be directed to protect vulnerable groups against the risks of HIV, caused by economic and social conditions (CSW driven by poverty, affordability of condoms, accessibility of STI treatment).

Though projections of the epidemic in urban Russia, are uncertain because of uncertainty about sexual behaviour, its clear that rapidly increasing sexual transmission of HIV gain importance as the epidemic among IDU increases. Moreover, sexual transmission rapidly increases even among IDU. Accordingly, safe sex and condom use should become central messages in harm reduction programmes for IDU, and also for general population and CSW. Without diminishing the role of syringe exchange and substitute therapy in risks reduction, the effectiveness of epidemic prevention increases along with safe sex promotion (Grassly et al., 2002; Timoshkin et al., 2006). Results of economic analysis and modelling aimed to assess the cost-effectiveness of interventions to prevent and control HIV/AIDS, indicated that needle exchange and condom distribution to IDU, who are not commercial sex workers is the most cost-effective intervention in Russia, though the number of averted infections was low. So
intervention in IDU and CSW could generate a larger prevention effect, still being more cost-effective. This fact is explained by the predominant HIV transmission route being through IDU (Timoshkin et al., 2006).

The main concern of stakeholders was that implementation of harm reduction and syringe exchange programmes could relax pressures on the IDU population to stop having an adverse effect. Also the stakeholders wanted proof of the efficiency of programme implemented worldwide and locally. There is a worldwide evidence of harm reduction intervention effectiveness in stemming the transmission of HIV and other blood-born viruses among drug users, particularly due to increased access to sterile syringes (Rogers & Ruefli, 2004; Stimson et al., 1998). The other important achievement of harm reduction programmes is incremental and life sustaining change for drug users, mainly how they deal with drug-use problem, type of drug use (stable vs. chaotic) (Rogers & Ruefli, 2004). International experience assessing of needle exchange programmes indicated that HIV infection among IDU decreased (Jarlais et al., 1993). To date research found no evidence of increase in numbers of new drug injectors because of syringe exchange or any other harm reduction activities (USCF, 2006). Also programmes do not facilitate any increase of drug use among IDU or the general public. The cost-effectiveness of such an intervention has also been shown as it can cost US$9,400 per averted infection in comparison of US$195,188 cost of per patient treatment of HIV infected (USCF, 2006). At the same time, though there is an evidence of reduction of AIDS related to risk behaviour (multiperson use of equipment, bleach consumption, condom use, decrease of blood-born infections, etc.), there is no direct evidence of to what precise extent harm reduction programmes including syringe exchange activities reduced HIV transmission among IDUs. It is difficult to determine, because of combination of different interventions at a time. At the same time, termination or curtailment of programme indicated increase in transmission of HIV (Course Materials for MSc on Drug and Alcohol Policy and Intervention, 2003; Jarlais et al., 1993).

The notion of harm reduction was developed in late 1970s for alcohol abuse problem (Course Materials for MSc on Drug and Alcohol Policy and Intervention, 2003; Jarlais et al., 1993). It was then developed for drug use problem from 1980, along with increase of awareness about possible implications from HIV/AIDS for drug users, aiming to decrease impact for these target group (Course Materials for MSc on Drug
and Alcohol Policy and Intervention, 2003). The notion was driven from the evidence of lack of success of drug control policies in eliminating drug use. The rationale was to limit damage on individual, community and society levels through the suggested activities (Rhodes & Hartnoll, 1996). Harm reduction programmes perceive the problem not so much as drug use itself, but its harmful consequences, and aims to reduce adverse consequences of drug use by changing habits and approaches to the problem (Course Materials for MSc on Drug and Alcohol Policy and Intervention, 2003; Jarlais et al., 1993; Rhodes & Hartnoll, 1996). Despite different approaches to eliminate illicit drug use they have failed in achieving their goal, at least the harm control and reduction could be though short-term solution rather then a goal but still could change situation, especially in HIV transmission by clean syringe distribution, disinfectants provision, prevention of overdose and better administration of drug, educating the harms of multiperson use of equipment, counselling and condom distribution to practice safe sex, HIV testing and counselling, substitution therapy implementation. Different activities provided at the same time allowing drug users to choose the type of harm reduction that it is best for them to follow. Apart from targeting drug users, these programmes ought to tackle the stigmatisation associated with drug use and HIV/AIDS, as well as discouraging people from initiating drug use by sensitising them to possible harms and consequences (Jarlais et al., 1993). So harm reduction programmes should raise awareness, make contact with target population, and provide means for behaviour change and endorse harm reduction measures (ACME; Course Materials for MSc on Drug and Alcohol Policy and Intervention, 2003).

As the major transmission mode is IDU in Russia (2006), treatment of drug addition and implementation of harm reduction programmes, could be one of the solutions to expand prevention activities. As witnessed by experience the methods used to date have failed in controlling drug problem despite the efforts in treatment, law enforcement and prevention. Treatment of drug addition is claimed to be an effective and cost-effective method of reduction of drug use (Reuter & Pollack, 2005). However, Reuter reviewing the literature about the effectiveness of treatment, prevention and law enforcements impact on decrease of drug use, found that there is a lack of evidence that even a relatively well-funded treatment system can reduce the drug user pool or an individuals’ drug consumption, though they could reduce harm to individuals and community. Prevention activities have useful and modest effect at the individual level, but has limited support of a cumulative impact. As to law enforcement, the review found that
even intensified policies and sanctions fail to decrease drug prevalence or drug-related harm (Reuter & Pollack, 2005).

In Russia, the literature reports several barriers (financial constraints, fear of being registered as drug user, low efficacy of treatment services) to access to treatment from drug dependency. Strong stigma and a lack of confidentiality within the country could lead to employment loss of their drug addiction habit is disclosed. As a result, the MOH recommended activities (detoxification, rehabilitation and follow up outpatient observation) are below international standards and patient coverage is poor; only 25% of patients utilise rehabilitation, and even fewer, follow-up services. Treatment is highly medicalised and ignores holistic approaches of treatment diversity among IDUs (Narcology and Addictology, 2004; Bobroba & et al., 2006). Despite the amount of confiscated heroin from drug dealers increasing, the number of drug users does not decline. Though the literature suggests that treatment (pharmacological and psychological) of drug dependency is vital for prevention of HIV transmission (Preventing HIV Infection Among Injecting Drug Users in High Risk Countries 2006b), treatment is only 30% effective (2004a; New Methods of Treatment and Rehabilitation in Narcology, 2004). Drug services (hereafter narcology) work in only 10% and current narcology services in Russia are under crisis. There is no respect towards the patient, and also specialists fail to implement an individual approach to patients, by analysing mechanisms caused drug addiction of patients. There are attempts to re-establish compulsory treatment, also is widespread using anti-human ‘oversive’ (non-traditional) methods of drug treatment such as punishment, whipping, coding (based on fear), stereo-toxic surgery, electroshock and stress therapy. There is strong resistance and unwillingness from specialists to introduce change and implement modern internationally proven effective methods of treatment (2004a; 2004b).

Though harm reduction activities in Russia started from late 1997, and as of 2002, almost 52 syringe exchange programmes are operating all over Russia, the coverage of the IDU population remains poor (only 19.9% instead of 60%, the target recommended by UNAIDS) (Harm Reduction: Theory and Practice, 2000; Preventing HIV Infection Among Injecting Drug Users in High Risk Countries, 2006; Sarang et al., 2006). Programmes include information dissemination through outreach services, provision of medical and psychological consultations, referral to medical institutions, condom and
syringe distribution (Sarang, 2000). Effectiveness of harm reduction programme in Russia was assessed on the example of Sverdlovsk city (is on the first place in Russia by cumulative numbers of HIV infected, where from 1992 to 2002 the drug use increased by 54 times). Results indicated that in the intervention group, after implementation of harm reduction programme twice increased the clean instrument use, decreased sequence of common syringe use (from 66% to 32.9%), developed safer habits of drug use, though there was no change in sexual behaviour (only regular participants of the programme reported 1.5-2 times greater use of condoms). The study also found no increase of social and criminal tension in society during the programme, especially as most high officials supported the programme (Kanarski, 2004). Other limited assessments of substitute therapy in Russia, indicated improvement of patients’ social activity and quality of life. These programmes also increase patients’ trust in narcology dispensers and indicated patient satisfaction. Despite this evidence 44.8% of Russian narcologists are against of methadone therapy (2004a).

7.7.3 Sex Education

So far, the predominant mode of HIV transmission remains sexual contacts (Vemazza et al., 1999). The literature suggests several reasons for failure to practice safe sex, e.g. emotional denial of potential risks, fatalism with respect to HIV transmission, association of infidelity because of condom use, barriers to negotiate safe sex, perceived loss of erotic pleasure associated with condom use, etc (Jarlais et al., 1993). Lack of awareness and information on sexual matters could be reflected in the development of harmful behaviour, which could further lead to sexually transmitted diseases, unwanted pregnancy, contraception misuse, unhealthy sexuality and poor sexual and interpersonal relationships (Donati et al., 2000; Gevorgyan et al., 2005a; Mellanby et al., 1995).

Social and behavioural research indicated that in Russia there has been an increase in rates of sexually active amongst young people, a decline in age at first sex, and an increase in proportion of young people sexually active with multiple partners (Kalichman et al., 2000). The published literature suggests that in-school reproductive health education is the most cost-effective intervention aimed at reaching teenagers (Gevorgyan et al., 2005a; Rosen, 2004; UNICEF, 2002). Especially with the wide threat of HIV/AIDS infection, there is a growing importance of promoting good sexual
health, particularly among the younger generation (Chervyakov, 1997; Zharkov, 2005). Although school education is considered as the most efficient and cost-effective method of HIV prevention (International Institute for Educational Planning/UNESCO, 2003; The World Bank, 2002; WHO and UNESCO, 1994), in Russia sex education is not included in the schools’ curricula (Gómez, 2005; Grisin & Wallander, 2002). In the 1990s a number of initiatives promoting sexual education in Russian schools were established with the support of United Nations (UN) agencies, bilateral donors and some Russian NGOs. A framework for sexual education was developed; a text book was designed and a 3-year United Nations Population Fund-United Nations Educational, Scientific and Cultural Organisation (UNFPA-UNESCO) pilot project started in 16 schools throughout the country (Chervyakov, 1997; Zharkov, 2005). However, these initiatives soon came under attack from the communists’ government authorities, Pro-Life activists and the Russian Orthodox Church. In 1997 it was formally declared that “Russia does not need any sex education”; the UNFPA-UNESCO project was frozen; and the Ministry of Education cancelled its previously approved curriculum (Kon, 1995).

There was almost unanimous consensus that introducing sex education in schools is very important and possible, once some issues, with curricula content, age and teachers training are resolved. But after thorough analysis, answers about the reason for opposition to sex education make explicit that the population is believed not to be ready for such an introduction mainly because of the stigma related to sex and HIV. During the interviews there was a concern of the policy makers and parents that the introduction of sex education in schools could encourage early sexual activity. It could be argue that international evidence does not support this opinion. The WHO and the Global Programme on AIDS conducted a review of 35 studies on sex education in US, Europe, Australia, Mexico and Thailand and found no evidence that exposure to sex education led to earlier or increased sexual activity in young people. Moreover, it has also been found that sex education has even motivated youth to delay first sexual intercourse (Jacobs & Wolf, 1995; SIDA, 1995; UNICEF, 2002; Wellings et al., 1995; WHO and UNESCO, 1994). One of the key issues in sex education is condom use, which can prevent early pregnancy, STI and AIDS and it has been shown that there is a positive association between receiving information from school and use of contraception at first intercourse (Wellings et al, 1995).
Wider involvement of mass media could be another option to promote health sexual habits. The mass media is an effective means of disseminating information and increase awareness and is considered a powerful information source, having enormous influence on teenagers and therefore can be used for dissemination of appropriate health information (Matt et al., 2005a; Rosen, 2004). Apart from the fundamental role of the mass media in increase awareness, it also considered influential tool for propaganda used by the controlling power (Chomsky & Herman, 1988). The media can use the different techniques of “shock-horror”, advertisement, factual information, and fear arousal to influence the public (Course Materials for MSc on Drug and Alcohol Policy and Intervention, 2003). This was acknowledged by respondents, at the same time, understanding the devastating influence of the current poor quality information distributed through mass communication means in Russia. Despite international efforts to tackle this problem, through journalist training, efforts are fragmented and small scale, while mass campaigns are one-shot activities and occur mostly on World AIDS Days (Matt et al., 2005).

7.7.4 HIV Treatment

The WHO stated that one of the main reasons for the worsening HIV epidemic is limited access to treatment (Matic, 2004; WHO, 2004). Since 1996 combinations of anti-HIV treatments have been used, which reduced AIDS related mortality and transformed this fatal disease into a manageable chronic illness. ART reduced deaths from HIV/AIDS by almost 70% (WHO, 2004). Thereafter, treatment became an important part of public health response to combat the epidemic (Stimson et al., 1998). Despite this fact, in Eastern Europe and CIS there is an obstacle to wider access to treatment, because of differential pricing of antiviral drugs and limited availability of generic drugs (Matic, 2004). Particularly in Russia in 2004 the coverage of ART was less than 3% (despite the policy assures free, universal access) (WHO, 2004).

Such discriminatory approach to HIV treatment access is a direct violation of several international commitments; Universal Declaration of Human Rights (Articles 22, 25), resolution (49) of Commission on Human rights (1999), paragraph 18 of Comment of the Committee on Economic, Social and Cultural Rights (May 2000) (Preventing The Transmission of HIV Among Drug Abusers: A Position Paper of the United Nations System, 2006). For the success of HIV/AIDS prevention it is also important to protect
peoples’ human rights, especially those of vulnerable groups and respect their economic, health, social and cultural rights.

Currently there are two pharmaceutical companies in Russia producing two drugs (AZT and nicovir), though global standards suggests three anti-viral treatments (Gómez, 2005). As a response government has not put any attempts to increase funding to expand domestic production to increase treatment availability on the one hand and to decrease treatment cost on the other. Despite implementation of “3 by 5”, the coverage of treatment is still only 12%. This poor coverage is a substantial financial risk for PLWHA as out-of-pocket expenditures are significant proportion of total health expenditures allocated to HIV/AIDS (Atun et al., 2005). Increased coverage of HAART treatment will not only reduce mortality and morbidity, but also will be a prevention opportunity through counselling, testing and referral. Preventive interventions will be successful if they proactively address cultural values (UNAIDS, 2005a).

Though the majority of respondents were happy to provide universal coverage of HAART to PLWHA, there was still the perception that the approach should be differential between those infected as a result of their behaviour, and those who infected in medical facilities. One of the arguments was the challenge for the government in finding the financial resources to support the implementation of legislation. Furthermore, analysis trying to explore attitudes towards treatment provision found it explicit that there is still a stigma towards those HIV infected, to IDUs and the CSW population. The mode of transmission of infection is a determining factor in decision-making about who deserves treatment. In addition, in both regions only a couple of respondents knew of any NGO representing PLWHA. Either they don’t exist, or nobody is aware of them. This is a result of stigma. Could stigma be one of the main reasons for less attention to the problem? Moreover, analysing the answers, respondents’ mentioned that it is “their problem” and those whose behaviour was “normal” could avoid HIV. Perhaps this factor could also influence defining the priorities. Advocacy campaigns, human rights campaigns wider implementation and creation of a favourable social environment for de-stigmatising HIV/AIDS, could allow more involvement of PLWHA in decision-making, as well as in other activities to combat the epidemic.
Over centuries public health issues changed along with the development of the society. The 19th century could be considered an infectious disease era, when problems were mostly connected with measles, mumps, smallpox, polio, etc. As a response, due to active research and joint efforts of scientist and medics, vaccination was discovered and successfully used to eliminate the threat and the problem was taken under the control. The following 20th century challenged public health with new issues, connected with blood-vascular system diseases, oncological problem, respiratory system problems, etc. Again the response was to invest resources for investigation of the issue and come up with condition control and prevention mechanisms. Currently public health is challenged by behavioural problems like alcohol abuse, drug use, obesity, HIV, etc. Whereas the system acts as through it is in the stage of refusing to accept that these are serious problems, and needs efforts to investigate causes and moreover input from scientist, psychologists and health specialists to find solution to help people also find prevention methods. In contrast, these public health problem been considered as “theirs” and the response was to marginalize these people and isolate them in institutions and from society. I think its time to accept that currently public health is changing its “face” and an adequate public health response needs to be developed.

The analysis of policy in Russia related to HIV/AIDS revealed that it actually addresses most aspects of HIV/AIDS. However, from the interviews it is clear that the policy can be seen as ‘appeasement’, whilst the intentions of the policy makers is clear in the poor actual response to the epidemic. Respondents demonstrated an understanding of the complex theories surrounding HIV and its control and in most cases also suggested solutions to the problems. The main barrier to policy implementation in this area is the lack of willingness to act rather than the shortage of resources cited by many study participants. Historical experience in Russia demonstrates that the country is capable of overcoming difficulties and has on several occasions the population has shown great endurance. The prerequisite for historical success was determination to act. This is the missing key to combating the HIV/AIDS epidemic. This lack of determination is a direct reflection of the perception of the epidemic and of attitudes towards the affected population. The social construction of the target populations shapes the policy agenda and the design the policy in relation to HIV/AIDS. Thus, to address HIV/AIDS, a change in perception of the epidemic and of attitudes towards the affected populations is crucial amongst general population, policy makers and the professionals involved in shaping the response to the epidemic.
The thesis suggests that this issue could be addressed through advocacy and proposes conducting an ‘information campaign’ to increase general awareness about HIV/AIDS. At the same time, though emphasizing the importance of the knowledge, the thesis also acknowledges that knowledge alone is not enough to assure behaviour change. The dissemination of knowledge could be used to initiate change, but wider understanding of mechanisms underpinning behaviour and the complex correlated influences of different political, economic, socio-cultural factors is required to assure the sustainability of any change; transforming existing roles and making them routine. For example, there is not a simple unity between problems and their causes; many problems have several causes and solutions need to be multidimensional. The interlinked causes of problems requires careful consideration in any advocacy process, so as to avoid unintended consequences and harm. Only an approach, which acknowledges and works through the complexity of the causal chain can bring about the desired outcomes.

7.8 Contribution of the Thesis

There are several substantial contributions of this research which adds to earlier studies which explored the Russian policy making in general and in relation to HIV/AIDS issues particular. The data collated and analysed provided rich empirical evidence to support some existing knowledge but also provided new knowledge to illuminate the policy process in the Russian context.

First the thesis developed a new approach to analysing implementation of HIV policies, amongst the elite, concluding that the problem is not related to resources, but related to willingness to implement the policies. Policy making itself is supposed to consider the possibilities, resources, resistances and tensions of societies and develop feasible policies assuring their implementation. Whereas, because of international pressure and for political reasons policies are made already knowing that the policy makers will not implement them. In part this is because there is no public demand for accountability. Also there are no developed coalitions to advocate and enforce policies implementation. This allowed policy makers to “hid behind the excuse” of resource shortage. The real policy is stigma and ignorance of the problem as it is connected to risky populations.
The research suggested that Russian policy consists of two elements ‘appeasement’ and ‘intended’ elements; and because of strong stigma, even ‘intended’ elements are not implemented. So the poor response is not because of the low priority given to HIV/AIDS, the lack of resources or information, but is determined by a stigmatising attitude towards those infected and a lack of leadership by authorities to tackle this stigma. The thesis suggests building on prevention activities directed towards breaking stigma, through information campaigns aimed at increasing knowledge and understanding of the issue by general population, policy makers and professionals. This strategy could have wider implications, because better understanding of the problem itself by specialists, policy makers, the public and target populations could also provide prevention through the population practicing safer sex and harm reduction, preventing new infections.

The second substantial contribution is that the advocacy should be considered as a two-way process. Not only do the opposition needs to practice advocacy to make its voice heard by policy makers, but also policy makers need to practice advocacy to be able to enforce their policies and get them accepted by the public. This is especially true for the issues related to public health. If there is a resistance towards implementation of laws (directed to behavioural change such as safe sex, alcohol abuse, smoking cessation, etc) the government could improve this implementation of its policies by advocating healthy lifestyles.

There is a misperception that advocacy could be developed in all directions, whereas this thesis suggests that it is better to focus and direct all efforts towards one activity. Though the choice of the activity could be decided by advocating organisations, there are number of problems. In Russia civil society is poorly developed and lacking capacity to explore, via research, the best option. In addition, because of the lack of democracy, there is a threat of consequences in pressurising the government. Hence, the thesis suggests choosing a strategic approach, addressing the issues one at a time. It seems appropriate to choose the option for which the health professionals voted i.e. prevention. This was the reason that the thesis conducted analysis of HIV/AIDS policy, to learn what would be the best option for advocacy (see initiation phase on figure 7). The results of the analysis suggested that most of the respondents claimed that the best option for Russia would be expansion of prevention activities; the thesis developed an advocacy model for a prevention strategy. The developed model is suggests directing
efforts towards expanding preventive activities, with emphasis on knowledge, aiming at increasing information and awareness among different groups: policy makers, population, professionals, groups practicing risky behaviour (this will respond the planning phase in figure 7). Unfortunately, for obvious reasons (limited time, finances, resources) the thesis cannot go beyond this stage implementing entire suggested model (implementation, assessment and adjustment phases). The expected outcomes of the suggested intervention are described in discussions (see also page 150-152) schematically presented in figure 20.

Another interesting finding relates to the locus of power. It was considered that power was decentralised: Russia has highly centralised management system and the regions are dependent on central government in making their own decisions. At the same time, there were no effective mechanisms within the central government to control the situation in the regions, and if the direction desired by central government contradicted 'regional values', central government would be unable to control the regional situation. This 'relative independence' is a consequence of the economic 'power' of the regions and the lack of a concern for national security.

7.9 Summary of Limitations

The major limitation of research relates to the validity and representativeness of the interviews. The purposeful non-probability sampling followed by non-probability snowball sampling were aimed at reaching the elite, responsible for HIV/AIDS policy, so cannot represent the full range about the views in Russia.

Validity is extremely difficult to assess in qualitative research. However, attempts at exploring consistency, cross-referencing and analysis of pilot results helped to understand potential problems and allowed to adjust the questionnaire and address this issue before moving to the main study. It is clear that two major issues have influenced the results. First, the respondents have an official stance, because of which their answers might reflect organisation opinion rather than their genuine opinions. However, the research was seeking the official stance rather then personal perspectives. Second, the interviewers tend to deviate from the instructions and some of the interviews were
limited by time pressure, restricting from being more complex and involve nuances. This issue was address by the volume of the collected materials in combination with literature review. A major barrier to present perfectly apposite citations was the translation of the sometimes incomplete and poorly constructed sentences of the interviews. Last, but not least, not all statistical data is up-to-date, and research used the available data rather than desirable. Unfortunately, the research failed to address this issue, as the data availability problem is common for any research related to Russia.

In addition, to the questions surrounding the contemporary views of the subjects there are questions about the current situation in this rapidly changing environment. Russia is changing economically and politically, which raises the issue of generalisability of findings to other regions.

7.10 Further Research

The thesis developed a model of advocacy describing its possible benefits. The model was developed in accordance with the scheme presented in Figure 7, using only the initiation and planning phases. So the model presents the possible outcomes of the intervention only. Further research on the issues raised in this thesis should be focused on exploring the implementation, assessment and adjustment phases described in Figure 7. Such research could enable the implementation of the model. In particular, work should be focused on the collaboration with local authorities to develop the advocacy message and detailed strategy for activities with implementation targeted for policy makers, population and professionals. Once the advocacy strategy has been implemented, assessment criteria should be developed and detailed evaluation of activities should be conducted to learn the results of the intervention. Further adjustments could be introduced building on achievements and emerged issues should be analysed to reflect in the policy. Thus, this could be constant process of implementation, evaluation and adjustment, until the epidemic has been dealt with.

An aspect that was not explored in this thesis, but could contribute to better understanding of the problem, and thus be addressed in developing the response, is an exploration of the general populations' believes, knowledge and attitudes towards HIV/AIDS, through a survey using stratified random probability sampling to get
generalisable data. These attitudes and beliefs were considered in brief here, but the information was in terms of the perception of stakeholders about the populations attitudes, whereas, it would be useful to learn from the population directly. To have a complete picture, it would be useful to collect information from affected population (exposed and their peers/family member), which would allow us to understand the expressions of stigma and discriminations in Russia. The latter would facilitate the issue being addressed more comprehensively.

7.11 Reflections

This research described the policy formation process in the Russian Federation as applied to HIV/AIDS, identified patterns of stakeholder participation and their attitude towards HIV/AIDS, in particularly how they perceived HIV/AIDS as a problem. It also elucidated the barriers and enablers in policy development. In addition, the research reviewed the existing advocacy experience and suggested an advocacy model applicable in the Russian context, which might stimulate policy change to tackle HIV/AIDS more effectively.

The main lesson from this research was that the response to HIV/AIDS crossed boundaries between medical, political, social, political and scientific understanding of HIV/AIDS policy in Russia. The issues have been analysed from these different perspectives and it has been learnt that the response to HIV/AIDS is not a linear process but a complex one, reflecting cultural, economic, political aspects of the country and societal values and norms.

The findings of this research are a reflection of complex analysis and are non-biased, despite grounded theories and previous knowledge of the issue being applied during the design of the research.

If the opportunity arose to revisit the research, I would address some of limitations faced during the data collection process. I would recruit more potential stakeholders on federal level, particularly NGOs and the private sector representatives, to learn their perceptions related to HIV/AIDS. It would also be useful to discuss the advocacy implementation process with organisations that operate in Russia. However, there are
few organisations involved in advocacy activities in Russia and the advocacy process is 'underdeveloped'. Whilst understanding of advocacy and its possibilities are limited, any information related to the issue could provide important incites about the process in Russia.

7.12 Conclusions

This thesis aimed to explore the policy process with regard to HIV/AIDS in the Russian Federation and how advocacy can be used to change HIV policies at regional and federal levels. The research used qualitative methods of inquiry to analyse stakeholders’ attitudes and perceptions of HIV and to inform an advocacy strategy to enhance HIV control efforts.

In previous chapters thesis discussed the main ideas and notions related to the policy making process, policies and policy implementations; how the change could occur and be institutionalised, the possible relationships that policy stakeholders could be engaged in during policy making process. The thesis also discussed the contribution of advocacy to the process of policy change and an advocacy model has been suggested for initiating policy change. Further, the epidemiology of HIV/AIDS in Russia has been described and analysed along with the environment and context in which it exists. Methods of data collection, management and analysis have been described and limitations of the research presented. The main findings of the research supported by citations and tables have been presented followed by discussions of findings. The findings have been analysed using the Sprechmann and Pelton Model in combination with thematic and domain analysis. Deeper understanding of political, cultural, social and economic issues that the country faces, as well as the power relationship between stakeholders and their incentive to affect or impede change has been used for analysis. Based on the findings and analysis an information campaign is recommended, aimed at increasing knowledge and changing perceptions, behaviours, and attitudes, to decrease stigma towards HIV/AIDS and result in improved communication and an adequate response to the epidemic. In the advocacy model developed possible outcomes of such an intervention for population, policy makers and stakeholders involved in the response has been described.
The findings from collected interviews could be summarized as follows: the poor response to HIV epidemic was due to other competing priorities within the country, financial problems, lack of political commitment and leadership, structural and organisational problems, inadequate information, poor attitudes towards the issue, and stigma. The interrelated causes of these problems necessitate careful consideration of the linkages in any advocacy process to avoid unintended consequences and harm. Only an approach which acknowledges and works through the complexity of causal change can bring about the desired outcomes of improved HIV prevention, treatment and care.

To assure the success of preventive activities, it is essential that unprecedented social and political mobilization be used to transform the norms, values and believes that fuel stigma and discrimination, which prevents health, community and social service provision on equity bases. Prevention interventions through communication campaign in the media, education and training should be directed to change prejudices, beliefs and attitudes that fuel stigmatisation and discrimination to foster social tolerance and solidarity with PLWHA and their families, as well as those who engage and practice risky behaviours.

Stigma and discrimination hinders the prevention and treatment of IDUs and PLWHA. Such a change would may be possible through wide advocacy to policy makers so that they understand and accept the process and create adequate mechanisms, laws and resource allocation. The advocacy must also reach the public to gain wider support and participation in implementation. The advocacy should be directed towards the development of policies, which consider human rights and are favourable to the vulnerable population (PLWHA, drug users, CSW, prisoners) and supporting treatment and health service provision. Advocacy could generate high political support as well as support by community leaders and religious organisations’ leaders involvement.

Prevention should involve elimination of the conditions that predispose people to have risky behaviours; whether they have are of social or economic origin (unemployment, organisation of youth leisure time, re-creation of sport and youth clubs, etc), which obviously requires resources which will become available only if HIV/AIDS is prioritised by policy and decision makers.
Media campaigns (press, radio, television, cinema) posters and leaflets, public meetings and talks, awareness days, public events and other activities, aimed increasing the public awareness, could be lead by health agencies and specialists to avoid inaccurate messages and the dissemination of misleading information. At the same time, such efforts will not assure the success without a supportive environment created by the coordinated activities of professionals, legislators and policy makers. The development of new technologies opens up possibilities and opportunities for their use in wider communication and information dissemination. At the same time “freedom of speech” can provokes the creating of “myth” and misinformation through the inaccurate information. Including specialists in the intervention and creation an appropriate legal environment is crucial, but at the same time, especially when dealing with Russia, with its history of predisposition to maintaining state political control over information, it will be important to consider how not to get into extreme of dictatorship and propaganda.

Despite perfect acceptance of the fact that prerequisites for health are very complex (combination of political, economic, social, cultural, environmental, behavioural and biological factors), often when seeking a solution to a problem this notion is totally neglected and the response developed based purely on the health specialist and patient interaction. It should be acknowledged that policy implementation possible if there is provider commitment, patient participation, government support and adequate infrastructure. Considering the comprehensive multi-sectoral factors underpinning the growth of HIV/AIDS, any preventive activity should involve the full authority and power of different sectors and levels of the government, with active involvement of all stakeholders (private sector, civic society/NGOs and community and religious leaders) and representatives from different affected groups.

As a closing remark of this thesis I want to quote Armenian ‘toast’, which states: “Let us drink that our abilities match our aspirations”, so I hope, that the Russian authorities’ will develop an ambition to address the epidemic and that their abilities will match their ambitions.
References


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<table>
<thead>
<tr>
<th>Terminology</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Agenda</td>
<td>An outline listing the main topics to discuss during a meeting with policy makers, a planning team, or coalition.</td>
</tr>
<tr>
<td>Audience</td>
<td>A person or people to whom information is conveyed or messages are directed.</td>
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<tr>
<td>Civil Society</td>
<td>The range of institutions and organisations that connect people to government and the private sector. For CARE a strong civil society means ensuring a dynamic and beneficial relationship between government, business and the non-profit sectors that can contribute to the wellbeing of individual citizens.</td>
</tr>
<tr>
<td>Coalition</td>
<td>A group of organisations working together in a coordinated fashion toward a common goal and demonstrate support for (or against) a proposed policy.</td>
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<tr>
<td>Coding</td>
<td>An application of the codes to the transcript during which the data is broken down, conceptualized and put back together in a new way, helping to build theories from data.</td>
</tr>
<tr>
<td>Constituency</td>
<td>Core group of people/activists and organisations who support a particular policy viewpoint and speak for and represent much larger group of concerned people.</td>
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<tr>
<td>Credibility</td>
<td>Having the trust of others so that they will believe and value what you have to say.</td>
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<tr>
<td>Crisis</td>
<td>Is a situation in which decision makers confront surprise, a short time response, and threats to major values.</td>
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<tr>
<td>Criteria</td>
<td>Questions or standards used to measure progress toward a goal or compare different objectives.</td>
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<tr>
<td>Expert Informant</td>
<td>An advocacy role in which you provide technical advice and information to policy makers.</td>
</tr>
<tr>
<td>External Networking</td>
<td>The process of asking people you know outside your organisation for information about your target audience.</td>
</tr>
<tr>
<td>Habits</td>
<td>More or less self-actualizing dispositions or tendencies to engage in previously adopted or acquired forms of action.</td>
</tr>
<tr>
<td>Human Rights</td>
<td>The basic freedoms that are regarded as belonging fundamentally to all humans. Advocacy is a strategy that can be used to promote human rights.</td>
</tr>
<tr>
<td>Incubation Period</td>
<td>Period when symptoms of the disease are not expressed.</td>
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<tr>
<td>Institution</td>
<td>Shared assumptions which identify categories of human actors and their appropriate activities and relationships.</td>
</tr>
<tr>
<td>Internal Networking</td>
<td>The process of using resources in your own organisation (including people) to gain information you need.</td>
</tr>
<tr>
<td>Legitimacy</td>
<td>Generalised perception or assumption that the actors of the entity are desirable, proper or acceptable within socially constructed system.</td>
</tr>
<tr>
<td>Lobbyist</td>
<td>An advocacy role in which you enter the policy process as a full participant to directly influence policy.</td>
</tr>
</tbody>
</table>

* The preliminary sources are AIDSCAP and Teasdale.
Logframe  A summary plan that details goals, outputs, activities, and inputs in a logical table.
Isomorphism It's a constraining process that forces one unit in a population to resemble other units that face the same set of environmental conditions.
Issue Statement focused on the cases of the problem and suggesting direction to look for the solution.
Media Organized systems to deliver information to people such as radio, television, newspapers, magazines, or newsletters. (Sometimes also called "press.")
Message A statement that is designed to persuade others of a position or point of view. A message explains what you are proposing, why it is worth doing, and the positive impacts of your proposal.
Model A way of thinking about something helping to understand the issue.
Negotiation A communication process between two or more parties to reach an agreement or to resolve a conflict.
Network Consists from set of individuals or organisations linked by some relationship willing to assist one another or collaborate on a common goal.
Opponent An individual or group that is against the policy change that you and your allies advocate.
Organisation Is a collection of choices looking for problems, issues and feelings looking for decision situations in which they might be aired, solutions looking for issues to which they might b answer, and decision-making looking for work.
Outputs In advocacy, changes in knowledge, awareness, or opinions of target audiences that you monitor during an advocacy initiative.
Paradox It is simultaneous presence of contradictory, even mutually exclusive elements.
Policy A plan, course of action, or set of regulations adopted by government, businesses, or other institutions designed to influence and determine decisions or procedures.
Policy Analysis Usually the first step in planning an advocacy initiative. Policy analysis using social science multiple methods of enquiry and argument examines plans and regulations set by governments, business or other institutions, transform into policy relevant information to be used in political setting to resolve policy problem and how policies (or lack of policies or implementation) affect specific groups of the population.
Policy Discourse A specific ensemble of ideas, concepts, and categorizations that are produced, reproduced and transformed in particular set of practices and through which meaning is given to physical and social realities.
Policy Elite Formally charged people with making authoritative decisions in Government.
Policy Maker A person who has the authority and ability to create or change community, organisational, or governmental policies, programs, or laws above the household level.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Policy Map</td>
<td>A tool that can be used to identify and organize policy information.</td>
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<tr>
<td>Policy Recommendation</td>
<td>A formal statement of referring actions to be taken to address the problem.</td>
</tr>
<tr>
<td>Policy Research</td>
<td>The process of learning about a policy issue. Policy research can be formal, like writing a report, or informal, like asking people you know to explain the origins of an issue.</td>
</tr>
<tr>
<td>Policy Theme</td>
<td>The broad programmatic area or sector you will focus on in your advocacy, such as forestry, reproductive health, HIV/AIDS, urban poverty, disaster response, or ethnic conflict.</td>
</tr>
<tr>
<td>Pragmatic Validity</td>
<td>Establishment of standards against which data are compared.</td>
</tr>
<tr>
<td>Problem</td>
<td>A statement of an unsatisfactory situation.</td>
</tr>
<tr>
<td>Problem Tree Analysis</td>
<td>A technique for synthesizing and visualizing the results of a problem analyses. When policies are identified as causes of problems you want to solve, advocacy is a strategy to consider.</td>
</tr>
<tr>
<td>Primary Audience</td>
<td>The decision maker(s) with the authority to directly bring about the change necessary to reach your policy goal.</td>
</tr>
<tr>
<td>Probing</td>
<td>A stimulus used to obtain more extensive or explicit responses from respondents.</td>
</tr>
<tr>
<td>Protocol</td>
<td>A code, system, or tradition — written or understood — that prescribes correct etiquette. In advocacy, it refers to the proper way to approach policy makers or others engaged in advocacy.</td>
</tr>
<tr>
<td>Reflexivity</td>
<td>A sensitivity to the ways in which the researcher and the research process have shaped the data collected, including the role of prior assumptions and experience, which can influence even the most avowedly inductive enquiries.</td>
</tr>
<tr>
<td>Research</td>
<td>Any systematic effort; critical investigation and evaluation, theory building, data collection, analysis and codification related to issue aimed to increase the stock of knowledge.</td>
</tr>
<tr>
<td>Respondent Validation</td>
<td>Asking the people studied to confirm the findings.</td>
</tr>
<tr>
<td>Routine</td>
<td>Patterns of thought and action which are habitually adopted by groups of individuals.</td>
</tr>
<tr>
<td>Rules</td>
<td>Formally recognized way in which things should be done.</td>
</tr>
<tr>
<td>Secondary Audience</td>
<td>Individuals and groups that can influence decisions of your primary audience.</td>
</tr>
<tr>
<td>SMART</td>
<td>Specific, measurable, achievable, realistic, and time-bound. Project objectives should be SMART for all projects, including advocacy.</td>
</tr>
<tr>
<td>Stakeholders</td>
<td>Group or individuals instrumental to the firm and its well-being, who benefit from or are harmed by, and whose rights are violated or respected by corporate actions.</td>
</tr>
<tr>
<td>Stakeholder Saliency</td>
<td>Extent to which stakeholder is powerful, legitimate and the claim is urgent.</td>
</tr>
<tr>
<td>Tactics</td>
<td>Tactics are types of activities that support your strategy. Advocacy tactics are often chosen based on their level of risk, their cost, and their chances of success in the existing...</td>
</tr>
<tr>
<td><strong>Target Audience</strong></td>
<td>The person (or group of people) who can help bring about the policy change that you hope to achieve.</td>
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<tr>
<td>---------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
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<tr>
<td><strong>Triangulation</strong></td>
<td>Use of multiple data collection methods and procedures on the same content to study the same issue.</td>
</tr>
<tr>
<td><strong>Window Period</strong></td>
<td>Period between the onset of infection and the appearance of detectable antibodies to the virus.</td>
</tr>
</tbody>
</table>
Dear Ms Gevorgyan,

RREC 3632 - Knowledge For Action on HIV and STIs In The Russian Federation.
Analysis Of Policy And Support of Advocacy In HIV/AIDS.

Thank you for your application. The Chairman of the Riverside Research Ethics Committee, Dr Charles Mackworth-Young, has asked me to write to inform you that the above study has now been approved.

Please note the following conditions which form part of this approval:

[1] Your study has been assigned a unique reference number. This number must be quoted in any correspondence with the Committee concerning this study.

[2] This approval is for a limited period only. A letter from the principal investigator will be required in order to extend this period of approval.

[3] Any changes to the protocol or investigator team must be notified to the Committee. Such changes may not be implemented without the Committee’s approval.

[4] Any revised study documents submitted must be given a new version number/date.

[5] For projects with an expected duration of more than one year, an annual report from the principal investigator will be required. This will enable the Committee to maintain a full record of research.

[6] The Committee must be advised when a project is concluded and should be sent one copy of any publication arising from your study, or a summary if there is to be no publication.

[7] The Committee should be notified immediately of any serious adverse events that are believed to be study drug related or if the entire study is terminated prematurely.

[8] Please note that research conducted on NHS Trust premises must receive the approval of the relevant Research and Development department. Approval by the Committee for your project does not remove your responsibility to obtain this approval.

[9] You are responsible for consulting with colleagues and/or other groups who may be involved or affected by the research, e.g., extra work for laboratories. Approval by the Committee for your project does not remove your responsibility to negotiate such factors with your colleagues.
[10] You must ensure that nursing and other staff are made aware that research in progress on patients with whom they are concerned has been approved by the Committee.

[11] Pharmacy must be told about any drugs and all drug trials, and must be given the responsibility of receiving and dispensing any trial drug.

[12] All documents relating to the study, including Consent Forms for each patient (if applicable), must be stored securely and in such a way that they are readily identifiable and accessible. The Committee will be conducting random checks on the conduct of studies, and these will include inspection of documents.

May I take this opportunity to wish you well in your research. If any doubts or problems of an unexpected nature arise, please feel free to contact me at any time.

Yours sincerely

Miss Katherine Bolton
Administrator
Riverside Research Ethics Committee
(On behalf of the Chairman, Dr C G Mackworth-Young MA MD FRCP)

The Riverside Research Ethics Committee has approved the following:

RREC 3632 - Knowledge For Action on HIV and STIs In The Russian Federation.
Analysis Of Policy And Support of Advocacy In HIV/AIDS.

Ms R Gevorgyan, Ms K Sullivan (International Project Manager)

This study was considered by Chairman's action.

This study was first approved on the: 11/11/2003.


<table>
<thead>
<tr>
<th>Study History:</th>
<th>Comments</th>
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<tr>
<td>Application Form (06/11/03)</td>
<td>Approved 11/11/03</td>
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<tr>
<td>Participant Information Sheet and Consent Form (06/11/03)</td>
<td></td>
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<tr>
<td>Proposed Questions for Interview (undated)</td>
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</tbody>
</table>
Information Sheet for Research Participants:

Study title
Knowledge for Action on HIV and STIs in the Russian Federation
Analysis of policy and support of advocacy in HIV/AIDS

What is the purpose of the study?
We wish to determine stakeholders’ perceptions, attitudes and perspectives on HIV/AIDS in Altai Krai, Volgograd Oblast and Federal Level. The study forms a part of the Policy and advocacy output (output 4) of the “Knowledge for action for HIV/AIDS in the Russian Federation” programme, funded by the UK Department for International Development (DFID) through a grant to Imperial College London.

Do I have to take part?
It is up to you whether or not to take part. If you do decide to take part you are free to withdraw at any time.

What will happen to me if I take part?
You will be asked to take part in an interview, which lasts around 50 minutes. This interview will be recorded on a tape recorder.

Will my taking part in this study be kept confidential?
The interviews are confidential and anonymous. Names are not recorded. What you say in the interview will not be attributed to you personally. The interviews are tape recorded because we are interested in capturing the perspectives of service providers themselves. The tapes are stored in a safe place and are destroyed after they have been analysed.

What will happen to the results of the study?
The results of the study will be written up into a report which will be used to built on the existing policy related to HIV/AIDS prevention. No persons will be identified in any report or publication.

Contact for further information
You may contact—Ruzanna Gevorgyan at 0044 (0)20 7594 0772.

Your help will be of great value to us. Thank you for taking part in the study.

You will be given a copy of this Information Sheet and a signed consent form to keep.

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Title of Project:
Knowledge for Action on HIV and STIs in the Russian Federation
Analysis of policy and support of advocacy in HIV/AIDS

(The patient/volunteer should complete the whole of this sheet him/herself)

Have you read the Information Sheet?        Yes No
Have you had the opportunity to ask questions and discuss the study? Yes No
Have you received satisfactory answers to all of your questions? Yes No
Have you received enough information about the study? Yes No

Whom have you spoken to? (write name)

Do you understand that you are free to withdraw from the study, at any time, without having to give a reason, and without affecting the quality of your present or future medical care? Yes No

Do you agree to take part in this study? Yes No

I understand that the Local Ethics Committee may review this form as part of a monitoring process.

NAME IN BLOCK LETTERS:

Signature: Date:

SIGNATURE OF PERSON OBTAINING CONSENT

Signature: Ruzanna Gevorgyan Date: 06 November, 2003

Imperial College of Science, Technology and Medicine

Scientific Director: Dr Adrian Renton MD FFPHM a.renton@imperial.ac.uk
Programme Manager: Kathleen Sullivan k.sullivan@imperial.ac.uk
Russian Federation Coordinator: Dr E Filatova elena.filatova@unicef.ru
Appendix D

Coding System

1 (1) /regional problems
2 (1 1) /regional problems/political
3 (1 2) /regional problems/economic
4 (1 3) /regional problems/social
5 (1 4) /regional problems/medical
6 (2) /medical problems
7 (2 1) /medical problems/organisational
8 (2 2) /medical problems/diseases
9 (3) /priorities
10 (3 1) /priorities/HIV~AIDS
11 (3 2) /priorities/general
12 (3 3) /priorities/organisational
13 (4) /HIV~AIDS knowledge
14 (4 1) /HIV~AIDS knowledge/main principals
15 (4 2) /HIV~AIDS knowledge/complications
16 (4 3) /HIV~AIDS knowledge/fight
17 (4 4) /HIV~AIDS knowledge/actions
18 (5) /HIV~AIDS attitude
19 (5 1) /HIV~AIDS attitude/gov~ organisations
20 (5 2) /HIV~AIDS attitude/general population
21 (5 3) /HIV~AIDS attitude/vulnerability
22 (6) /intersectoral Committee
23 (6 1) /intersectoral Committee/objectives
24 (6 2) /intersectoral Committee/Committee work
25 (6 3) /intersectoral Committee/efficiency
26 (7) /HIV~AIDS Programme
27 (7 1) /HIV~AIDS Programme/knowledge
28 (7 2) /HIV~AIDS Programme/procedures
29 (7 3) /HIV~AIDS Programme/amendments
30 (8) /Social Partnership
31 (8 1) /Social Partnership/gov organisations
32 (8 2) /Social Partnership/NGOs
33 (8 3) /Social Partnership/private sector
34 (8 4) /Social Partnership/international organisations
35 (8 5) /Social Partnership/leadership
36 (9) /Cooperation problems
37 (10) /HIV~AIDS activities
38 (11) /prevention
39 (11 1) /prevention/employees
40 (11 2) /prevention/population
41 (11 3) /prevention/performance
42 (12) /Harm reduction
43 (12 1) /Harm reduction/support
44 (12 2) /Harm reduction/opinion
45 (12 3) /Harm reduction/sustaining organisations
46 (13) /sex education
47 (13 1) /sex education/support1
48 (13 2) /sex education/opinion1
49 (13 3) /sex education/sustaining organisations1
50 (14) /HIV+
51 (14 1) /HIV+/treatment
52 (14 2) /HIV+/other initiations
53 (14 3) /HIV+/existence of the organisation
54 (15) /financing
55 (15 1) /financing/assessment
56 (15 2) /financing/understanding
57 (15 3) /financing/directions
58 (15 3 1) /financing/directions/HIV~AIDS
59 (15 3 2) /financing/directions/other
60 (16) /information
61 (16 1) /information/existence
62 (16 2) /information/formes
63 (16 3) /information/sources
64 (17) /advocacy
65 (17 1) /advocacy/terminology
66 (17 2) /advocacy/directions
67 (17 3) /advocacy/success preconditions
Domain Analysis

This study had 4 cover terms of domain:

- HIV/AIDS Intersectoral Committee
  
  * Included terms: Health Committee, Education Committee, etc. (all Committees and organisations represented in the HIV/AIDS Intersectoral Committee)
  
  * Semantic relationship: members of Committee
  
  * Boundary: not participate in Committee work

- Government officials
  
  * Included terms: different governmental sectors’ decision-makers.
  
  * Semantic relationship: potential HIV/AIDS stakeholders.
  
  * Boundary: can’t be involved in HIV/AIDS work

- NGOs
  
  * Included terms: Names of the organisations
  
  * Semantic relationship: kind of organisation
  
  * Boundary: are not non governmental organisations

- Private sector representatives
  
  * Included terms: names of the firms, industry or services
  
  * Semantic relationship: type of business
  
  * Boundary: are not functional