REPORT

on Public Assessment of Activities of Government Order №0173100005411000247

"Services to implement activities of secondary and tertiary prevention of HIV infection among key population groups vulnerable to HIV infection in constituent entities of the Russian Federation within the framework of the Priority National Project “Health” in 2011"

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Executive Summary

In 2011, a group of NGOs, working in the sphere of HIV/AIDS prevention and rendering social services to patients, initiated public assessment of activities of Government Order №0173100005411000247 "Services to implement activities of secondary and tertiary prevention of HIV infection among key population groups vulnerable to HIV infection in constituent entities of the Russian Federation within the framework of the Priority National Project “Health” in 2011".

The Assessment was carried out on the basis of appropriate sample in 9 cities of 5 constituent entities of the Russian Federation by polling participants of the Government Order activities (contractors and customers), analyzing documents and statistic data, polling experts in the area of prevention and social work.

The main question of the Assessment: Is it possible, in 38 days, to provide quality services of informing and redirecting/forwarding 123062 representatives of vulnerable groups (drug-addicts, LGBs[1], STD[2] patients) to health care facilities for medical/social counselling and testing for HIV infection in 83 constituent entities of the Russian Federation?

Summary results of the Assessment:

- The main idea of the Government Order – attraction of ‘closed’ groups vulnerable to HIV infection to specialized health care facilities by efforts of NGOs – is quite tenable.
- Preparatory stage of the Activities (determining target groups’ access points, knowledge checks and instructing outreach workers, etc.) was not fulfilled in full compliance with the Government Order. It turned out impossible to complete scheduled preparatory work required to perform the Government Order Activities during the period of 5-10 days given to do that.
- A part of clients of the Activities does not refer to target groups defined by the Government Order, while achieved indicators are overstated. Achieving target figures of clients in all the constituent entities of Russia (total 123062 representatives of vulnerable groups) during 38.2 business days turned out impossible without violating requirements to work with certain target groups.
- Outreach workers were engaged without applying the technology of outreach work. Time-consuming work of building trust of target group representatives to the health care system and responsible behaviour to their health was practically omitted.
- Serious claims relate to organization of control over the Activities’ implementation that allows to trace the scope of performed work only approximately, without any quality criteria and compliance with tasks and aim of the Government Order. It is impossible to judge whether clients of the Activities refer to target groups and to verify quality of provided services and their compliance with clients’ needs based on used reporting forms.

General Conclusion:

Quality of work performed under Government Order №0173100005411000247 does not justify invested resources, lowers significance of interaction of health care authorities and non-commercial sector. The approach employed to organize work under this Government Order shapes negative experience of implementing joint initiatives, discredits public efforts in the field of HIV prevention. The results of the Public Assessment of completed Activities of the Government Order have confirmed reasonable character of apprehensions and comments articulated to the governmental customer by many specialized NGOs at the stage of open tenders.

Further use of similar patterns of organizing work to prevent HIV infection is seen as unreasonable and inefficient spending of state budget funds.

The Report also provides recommendations (page 23).

[1] Lesbians, gay-men and bisexuals.
[2] Sexually transmitted diseases.

Reasons and Goals of Public Assessment

"*Chronic disease caused by human immunodeficiency virus (HIV infection) causes heavy social / economic and democratic consequences for the Russian Federation, creates threat to personal, public, national security, and threats to existence of humanity, calls for protection of rights and legal interests of the population…"* – these are the words introducing the Federal Law dated 30 March 1995 №38-FZ "On Preventing Propagation of the Disease Caused by Human Immunodeficiency Virus (HIV Infection) in the Russian Federation". This Law explicitly states the need "*to apply modern efficient measures of comprehensive prevention of HIV infection"*. The Strategy of the National Security of the Russian Federation until 2020 (approved by the Decree of the President of the Russian Federation dated 12 May 2009 №537) considers mass propagation of HIV infection to be one of the main national security threats in the field of health of the nation and health care.

Taking into account such significance of epidemic consequences for Russia, general public expectations that health care authorities should pay considerable attention to the prevention of HIV infection are quite reasonable. However, in spite of legal framework and strategy declarations, prevention level leaves much to be desired. For the quarter of the century, during which HIV infection has been propagating in our country, no National HIV/AIDS Epidemics Fighting Strategy has been developed, prevention measures are short-term, fragmented, inconsistent, and therefore inefficient, while in 2011, average number of new acquisitions of the infection came up to 170 cases per day.

In compliance with the above law, the state guarantees that it shall regularly inform the population about available means of HIV prevention, including informing through mass media. Federal Law dated 30 March, 1999 №52-FZ "On Sanitary and Epidemiological Welfare of Population" acknowledges that expenditure liabilities of the state include measures aimed to ensure sanitary and epidemiological welfare of population by means of: prevention of diseases taken into account sanitary and epidemiological conditions and their dynamics forecast, implementing prevention measures, measures of hygienic education of the population and propaganda of healthy life style. It is worth noting that today's efficient strategies of and approaches to HIV/AIDS prevention are based on active involvement of non-profit and non-governmental organizations in planning, implementing and assessing the measures in question. With specific features of propagation of this disease, multi-lateral cooperation between all sectors of the society becomes of paramount importance.

In June 2011, T.A. Golikova, head of the Ministry of Health and Social Development of the Russian Federation, stated: "[In 2011], *NGOs and patient organizations will be allotted 500 million roubles*[3] *of target grants to implement HIV prevention and treatment programmes"*[4]. Actually, in 2011, 147.7 million roubles were allotted for prevention purposes under 13 lots[5], while contractors of public contracts were 5 organizations, among which only 1 was NGO. All measures were implemented in the last quarter of 2011, i.e. less than within 3 months, while prevention expenses per capita amounted to a little bit more than 1 rouble.

A group of NGOs involved in HIV prevention and social support of HIV infected people have decided to conduct public assessment of one of the Government Orders[6], posted by the Ministry of Health and Social Development in 2011 concerning HIV prevention. This Public Assessment aims to provide the society with unbiased data about the situation with HIV prevention in Russia through assessing measures related to certain Government Order[6].

We think it is necessary to clarify the state of affairs in the field of prevention programmes implemented by NGOs taking into account critical shortage of funding, to investigate whether considerable amounts allotted to prevention from the state budget are spent with high efficiency, and how all of this affects dynamics of HIV epidemics in Russia. The focus of this report is to facilitate to enhancing efficiency

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[3] Approx. 12.4 mln. Euro, at the official exchange rate on the date of this statement.
[4] http://positivenet.ru/files/golikova_statement_2011.pdf
[5] See http://zakupki.gov.ru lots №№0173100005411000247, 0173100005411000249, 0173100005411000264, 0173100005411000315, 0173100005411000348, 0173100005411000552.
[6] Lot №0173100005411000247.

and transparency of resource use based on positive, constructive and equitable dialogue between health care authorities and public sector.

According to the initiators of the Public Assessment, its need is caused by the following reasons:

1. HIV prevention is one of the top priority tasks of healthcare and counteraction in response to HIV/AIDS epidemics. Prevention measures require detailed planning, comprehensive approach, wide outreach, continuous work and consistency of measures. Specific features of the process of preparation to the Activities of the Government Order in question, its intention (content), and time spent to implement it have caused serious concern and doubts about its expected efficiency and the mere possibility to implement it with high quality. According to opinions articulated by experts representing specialized NGOs while planning the Government Order Activities, the latter may be performed with high quality in the period not less than 10 months.

2. To our opinion, the way this Government Order was developed and deployed gives rise to considerable risks of discrediting cooperation policy of the Ministry of Health and Social Development with the non-governmental sector. There is a danger that the outlined tendencies of cooperation in HIV prevention between the state and NGOs will be broken. There is also a reason to believe that the Government Order is to a greater extent oriented to "absorption" of the budget and developing formalized reporting on performed work targets instead of reaching socially significant and public-spirited goals of HIV prevention.

3. In spite of doubts of the Order being reasonable and feasible articulated by representatives of several specialized NGOs at the planning stage, representatives of the governmental customer did not include monitoring and assessment in the list of activities.

Results of the assessment will be used by NGOs working in the field of HIV/AIDS prevention that were not acting as contractors of the Order:

- To verify relevancy of criticism expressed by a number of NGOs at the stage of discussing the Activities' content (before releasing the tender) and after the governmental customer approved the Activities' content (after releasing the tender).
- To develop recommendations about content of future prevention measures and programmes and their management methods.
- To specify the role of NGOs in developing and implementing prevention programmes and to adjust forms and methods of interaction of NGOs and the Ministry of Health and Social Development of the Russian Federation aimed to prevent HIV.
- To gain experience of public monitoring/assessment of HIV prevention measures as one of the forms of participation of the civil society in implementing social programmes initiated by executive authorities of the Russian Federation.

Methodology of Assessment

Check List

To achieve the Assessment goals, a number of questions to be answered during the Assessment were laid down:

1. What results were achieved in the course of performing the Government Order? To what extent do they comply with expected results, required parameters of this Government Order (content, scope, quality)? If they don't comply, why?

2. What approaches, technologies, methods did the contractor use to perform the Order? What are their advantages / strength and restrictions / weaknesses?

3. How service performance under the contract was managed? What facilitated and hampered rendering the services?

4. Was the offered approach to rendering the services consistent? Was the offered approach to rendering the services efficient? Is it possible to replicate approaches, technologies and methods used by the contractor in terms of their benefit? If yes – how, if not – why?

5. What recommendations can be given about continuing the Government Order Activities?

Substantiation of the Assessment Approach. Data Acquisition Sources and Methods

It was planned to hold empiric study to answer the raised questions. In the course of the study it was necessary to collect and analyze qualitative and quantitative data revealing how the Government Order Activities had been implemented. To gather objective findings, we applied triangulation technique that includes survey of Activities' participants in order to collect quantitative data, analysis of available quantitative data of Activities' results and statistical data, survey of experts' opinions about Activities' implementation.

Participants directly involved in implementing the Activities and having the most complete information were used as the sources of qualitative data (see Appendix 3. List of Participants of Group and Face-to-Face Interviews). To enable the collection of qualitative data, it was planned to use the appropriate sample of certain territories, where the Activities were implemented. The main data collection tool was to become non-structured or half-structured interview. We held interviews with Activities' contractors, participants and partners in 9 cities of 5 regions (constituent entities). The following territory selection criteria were applied:

- available representatives of specialized NGOs ready to take part in primary data collection;
- Activities' participants being ready to provide these data based on the informed consent;
- a possibility to promptly collect the data during the final period of Activities' implementation (November-December 2011);
- a possibility to ensure confidentiality of information sources that will be ready to participate in the assessment only on the confidentiality basis.

Therefore, we planned to thoroughly examine a number of case studies, each of which refers to a certain region, and then to use additional data in order to decide, whether individual cases allow to understand how the Government Order had been performed in general.

Unfortunately, representatives / employees of the State Order Contractor[7] refused to provide us data in a number of selected regions. To our opinion, the refusal has no reasonable and unbiased grounds. Reference to any "commercial secret" or "prohibition of superiors" seemed to be strange to us, especially taken into account that many facilitators of this Public Assessment were involved in public and open meetings held between NGOs' representatives and those of the government customer in summer and

[7] All-Russia Public Organization "Union of People Living with HIV".

autumn of 2011. Focus of these meetings covered different aspects of the Activities. Generally, any assessment is focused on getting new practice-oriented information and improving the approach being assessed, that is why lack of interest in such assessment and setting any obstacles for it may not be seen as justified.

To analyze quantitative data, we used information published by the government contractor employees on results of their work in e-newsletter itpcru@googlegroups.com or at www.hivnet.ru. As expert source of information, we used materials of discussions dealing with Activities' progress and results among representatives of NGOs dealing with HIV prevention, and statistic data about number of representatives of vulnerable population groups tested for HIV in the Russian Federation in 2011. Data obtained during assessment were compared to requirements of the tender documents of the Government Order №0173100005411000247 published on the official website of the Russian Federation, where order information is published[8].

In our opinion, data gathered from 5 regions (constituent entities), information obtained from publicly available sources and experts, and statistic data allow us to set forth informed suggestions, conclusions and recommendations presented in this report. We are also prepared for argumentative discussion of our conclusions and recommendations, if we are provided with information on the activities that was not available to us in the course of the assessment.

[8] http://zakupki.gov.ru/pgz/public/action/orders/info/common_info/show?notificationId=1364729

Assessment Results

1. Achieved Results; Complying with Expected Targets

1.1. Algorithm and Concept of Activities

To compare expected and actual results, it is first necessary to understand algorithm and concept of the planned Government Order work. The Government Order documents define the Activities' algorithm as follows:

During 5-10 days of the preparatory stage:

1. It is necessary to develop consolidated information of informing and redirecting / forwarding representatives of three population groups vulnerable to HIV infection (drug addicts, LGBs and STD patients) to health care facilities in each constituent entity of the Russian Federation. This information is agreed with the government customer and includes three types of data: place and working hours of specialized health care facilities, working schedule of specialists of these facilities, general information about HIV infection. The main part of the consolidated information is evident to be individual for every constituent entity of the Russian Federation.
2. It is necessary to make up a list of "access points" (at least 3 in every constituent entity, i.e., at least 249 access points total), and their characteristics in relation to 3 population groups vulnerable to HIV infection. Individual approach based on specific characteristics of the group is used when working with every group.
3. Preparatory measures for outreach workers are held, including: developing rules of outreach work, safety and first aid rules, forming outreach crews of at least 2 people, issuing access point maps and work schedules, holding trainings, providing stationery and reporting forms. Evidently, this is the stage, when contracts between the contractor and outreach workers must be concluded, whose estimated number, according to the documents, may come up to 1769 people.

   The 2nd stage (calculated average term is 38.2 business days according to the Government Order):

4. Employed outreach workers render services to representatives of vulnerable groups: informing about location and work schedule of health care facilities, work schedule of specialists; redirecting / forwarding them to such facilities for medical / social counselling and testing for HIV infection. Every region / constituent entity has its own target number of clients. The reporting accounted only clients that attended health care facilities for counselling and testing[9]. The reporting form is filled in to fix the fact of service delivery. Thus, it should be understood that even if information service was provided, but a client did not attend the health care facility, the service is formally considered not to have been rendered. Total number of clients all over the country should come up to at least 123062 people.

   It is worth mentioning that though Government Order documents provide that clients should attend health care facilities for medical / social counselling and testing for HIV infection, these services are not rendered by the government contractor. Counselling and testing of representatives of population groups vulnerable to HIV were to be performed by health care facilities' staff. Therefore, liability of the government contractor for work with clients and efficiency of this work, once the clients are inside health care facilities, is not formalized in any way. Another issue that is not formalized is whether bringing a client that has already been registered in health care facilities is considered to be a rendered service.

5. A final report is issued, including the report of measures pursuant to paragraphs 1-4, consolidated register of reporting forms, analytical conclusions, and suggestions for prevention measures system for these groups.

[9] See Explanations to the tender documents under order №0173100005411000247.

Conclusion: The main idea of the Government Order and prevention measures is justified to a certain extent. As a rule, health care facilities (including AIDS Centres) do not have their own access to closed target groups and need third-party assistance in attracting them. It is worth mentioning, however, that efficient prevention should not be reduced only to measures of the assessed Government Order. Thus, the intention of work described in the Government Order is to set prerequisites for attracting potential clients to health care facilities. Such work is focused on finding people that need medical and social counselling, and on discovering new cases of HIV infection by results of the testing. The emphasis is made on the groups that are most vulnerable to HIV infection, and for which such services are most demanded. Assessment and analysis of how this idea was implemented are given below. Health care facilities being ready for influx of clients, taking into account their current workload, available possibilities for testing for HIV infection[10], willingness to render pre- and post testing counselling, quality of social services rendered there, meeting needs of these vulnerable groups, – these are separate issues beyond the scope of this assessment in need of individual examination.

1.2. Expected and Actual Results of the 1st Stage of Work

The first stage should have left multiple documentary records of work. Among others, such records were to include both general documents that were the same for all Activities' participants, and documents that were unique for each region. Documented results of the 1st stage were requested from the Contractor and the government customer. For the time the report was issued no answer was given.

According to the data gathered in the course of assessment, at the first stage of work outreach workers having experience in secondary and tertiary prevention projects were invited. Engaged outreach workers included employees of other NGOs that were not official contractors under these Activities, regular staff of state AIDS Centres, and those, who are currently not employed by any organization dealing with HIV/AIDS.

Most often, invited outreach workers had already known local and regional prevention and treatment facilities, where representatives of target groups were to be directed. The most experienced outreach workers had also known access points.

Neither publicly available information of the held Activities, nor information gathered during surveys contained any evidence that at the first stage of work all Government Order requirements to the organization of work were performed completely and in compliance with the terms of reference, that is:

- consolidated information of rendering services was agreed with the Customers (i.e. the Ministry of Health and Social Development of the Russian Federation);
- target group access points and their characteristics were defined (at least three for each constituent entity of the Russian Federation, total 249);
- rules of outreach work, safety and first aid rules were developed and introduced to outreach workers;
- it was checked whether outreach workers' knowledge level was sufficient to provide information services, redirecting / forwarding services;
- the principle of forming outreach workers' crew was complied with (at least 2 people) and outreach work schedules were developed;
- "access points" were mapped and briefings before going to "access points" were held.

In the regions, where we have managed to obtain information about how the 1st stage of work had been implemented, there is evidence that the Government Order was performed not exactly as determined in the Government Order documents. In particular:

[10] Comment: In 2011, many regions faced the lack of test systems required to hold necessary medical tests. This was caused by the fact that for the first time test systems were not purchased on a centralized basis (by the federal government), it took a long time to allot subsidies (to regions), while no respective funds were provided for in the regional budgets.

- according to outreach workers, they were instructed by a regional work coordinator by telephone, with instructions dealing only with filling in referral forms, no other training held (including introduction to outreach work, safety and first aid rules);
- access points and prevention and treatment facilities were determined by outreach workers independently based on their own experience and were not agreed with anyone;
- some outreach workers engaged in the Activities turned out to be workers of health care facilities, who performed work during their principal employment time receiving remuneration under the Government Order, which challenges the very idea, whether it is necessary to involve NGOs in performing work that can be done by health care facilities workers.

It is worth mentioning that a number of regional prevention and treatment facilities, which are key in terms of prevention work (AIDS centres, alcohol and drug addiction treatment hospitals, sexual health clinics), had no information of the Activities being held (e.g., in Orenburg). In addition, there was no explicit evidence that 1769 outreach workers had been actually engaged to perform the work (such number was calculated in the Government Order documents). On average, 21 outreach workers per region were planned to be engaged. At the same time, according to our data, only three outreach workers acted in such densely populated and epidemic-struck area as Leningrad Region. However, according to the Government Order, number of outreach workers was to come up to 21 people (as calculated taken into account the number of population). Though this is not the Government Order target, it is noteworthy that possible considerable lack of actually engaged outreach workers confirms previously expressed doubts in a large number of such workers that can be promptly mobilized in our country, as well as incorrect calculation of the Government Order amount of funding linked to this number.

Conclusion: With a strong indication, one can assert that the 1st preparatory stage was not performed in full compliance with the Government Order. It turned out impossible to complete scheduled preparatory work required to implement Government Order Activities during the period of 5-10 days given to do that.

1.3. Expected and Actual Results of the 2nd Stage of Work

Expected/planned Activities (those defined in the Government Order) and those performed were compared according to the following parameters:

- Target groups of the Government Order;
- Number of target groups' representatives covered by the services;
- Character of the services and Activities' algorithm.

1.3.1. Target Groups

The Government Order description exactly defines key population groups vulnerable to HIV infection that were to be rendered secondary and tertiary prevention services to. These are drug addicts, LGBs and STD patients, irrespective of their HIV status. The Government Order description lacks clear definition of "access points"[11] that would allow approaching these groups. However, the requirement to use outreach workers to render the services expressly indicates that "access points" are places, where representatives of the above target groups of the Activities can be met. Therefore, the logic suggests that these must be people currently not covered by social and medical services and even facing limited access to these for any reasons. Taking into account that giving information of work schedule and bringing clients that already receive services in the health care facilities would be irrational use of funds, it is reasonable to believe that health care facilities must accept new clients or those, who have never been examined or were examined a long time ago (without passing periodic health examination) from among the three groups.

[11] "Access Point is the place, where representatives of key population groups vulnerable to HIV infection are provided with information services by the Contractor in the most efficient way in the scope of consolidated information…" (from the Government Order documents).

From the data we obtained it becomes clear that the government contractors rendered information, redirecting / forwarding services far beyond “access points” only. Judging by multiple data obtained in the course of the assessment, the government contractors contacted health care facilities for drug addicts and STD patients, and other medical institutions. Outreach workers came to non-state rehabilitation centres for drug addicts, informed and redirected university students, students of secondary and basic vocational education, long-distance drivers that could hardly be referred to target groups of the Government Order.

This is how it is represented in reports of the contractor’s representatives and interviews held with them and with clients: "*We have worked with teenager students of vocational colleges*", "*We were working with young people that came to study here*", "*In the course of regular medical check-up I was told to fill in and get a referral, though I pass tests once in half a year in any way*", "*Our work has covered long-distance drivers*", "*We handed out coupons during educational events*", "*We attended local night clubs, where young people gather*", "*We went to test students*", etc. This witnesses that the Activities’ target groups were extended beyond those defined in the Government Order documents with those, who already receive medical services in specialized state and non-state organizations, and youth not belonging to the Activities’ target groups.

Currently, in the course of assessment it is impossible to state the share of those referring and not belonging to the Activities’ target groups from among total number of people included in the final indicators of those “covered by the Activities”. Such impossibility is accounted by the specific character of the monitoring system applied under the Government Order. However outreach workers we surveyed acknowledged that proportion of those who attended prevention and treatment facilities as a result of outreach work actually performed in the course of the Activities, and all those that were dealt with and motivated to come to prevention and treatment facilities, on average could equal to not more than 1 to 10, or 1 to 8 at its best.

Conclusion: Achieving target figures of clients in the constituent entities (total 123062 representatives of vulnerable groups) during 38.2 business days turned out impossible without violating requirements to work with certain target groups. There is a probability that larger part of the Activities’ clients in certain constituent entities do not belong to target groups defined by the Government Order, while achieved figures are overstated.

1.3.2. Number of Representatives of Target Groups

Comparison of quantitative data of achieving client targets as broken down by constituent entities of the Russian Federation is shown in the Appendix. The table is made up based on the data of the Activities’ contractor reports published in e-newsletter itpcru@googlegroups.com and on www.hivnet.ru.

For the date of report publication, final data for only 21 constituent entities out of 83 regions of the Russian Federation were presented in publicly available sources. Out of them, only 12 regions (57%) have final figures that are equal to or exceed expected values. No data have been published for 62 regions. Total target performance in regions that have published data equals to 92%, with the minimum value of services clients being 49.3% (1460 instead of expected 2961 in the Republic of Tatarstan), while average (not weighted) performance is 95%.

In their public self-reports, contractors use an uncertain wording of "*number of vulnerable group representatives involved in the project*" instead of more compliant wording "number of vulnerable group representatives directed to health care facilities for counselling and testing". Judging by what groups contractors actually worked with (see section 1.3.1), total figures turned out to include all persons, with whom outreach workers managed to meet, irrespective of whether they belonged to target groups or not. Thus, even published quantitative results are most probably overstated, since the contractor has partially substituted both target groups and services rendered to them, i.e., instead of target groups and services provided for, other services were also rendered to other groups.

In the regions, where we managed to hold interviews with Activities’ participants, we were communicated the following facts that are important for understanding the content related to quantitative data. In one region we were informed that referral forms had been provided to them only one week before the official

date of the end of work. A number of doctors working in prevention and treatment facilities that were key for the Activities stated that no target groups' representatives attended them according to referrals provided by outreach workers. Outreach workers informed that no Activities methodology training had been held, they had just been explained by telephone how to fill in referrals. One could suggest that by no means all outreach workers and workers of prevention and treatment facilities knew of the most important conditions of the Government Order, such as clients belonging to the target groups and ultimate objective of work with them (bringing to health care facilities for counselling and testing).

Taking into account target number of clients vulnerable to HIV infection and the aim of bringing them to health care facilities (testing), statistics of testing for HIV infection and new cases of HIV in 2011 can be expected to considerably grow as compared to the previous year due to Government Order work. Difference between figures of 2010 and 2011 is supposed to be at least (any significant) part of 123062 new clients. Workers of specialized prevention and treatment facilities, outreach workers, with whom we managed to discuss the Activities' progress, noted that no "influx" of attendance of the facilities was observed in October and November.

Many outreach workers, with whom interviews were held, and a number of doctors of prevention and treatment facilities mentioned that such large-scale engagement of NGOs' representatives in secondary and tertiary prevention for target groups' representatives was a proper and useful thing to do. At the same time they stated with confidence that it was impossible to prepare and perform the work of such scale and set parameters in two months.

It is worth mentioning that published Resolution of Rospotrebnadzor dated February 13, 2012 №16 "Of Emergency Measures of Counteracting HIV Infection in the Russian Federation"[12] stated reduced number of medical examinations among representatives of groups vulnerable to HIV. In particular, the Resolution asserts the following: *"Serious drawbacks are observed in diagnostic testing for HIV infection. In spite of high level of medical examination of population in 2011 exceeding 24.7 million (104.4% of the planned annual number),* ***number of tested representatives from risk groups has reduced considerably****, which undoubtedly adversely affects epidemiologic situation in the country, prevents unbiased analysis of the situation in general and impedes its development forecast for the future. Thus,* ***2011 saw 7.9% reduction of number of drug addicts and 7.4% reduction of STD patients passing tests for HIV as compared with 2010;*** *with 12.0% reduction among prison population. In some constituent entities of the Russian Federation low figures related to medical examination of population for HIV infection were recorded, including: the Kabardino-Balkar Republic (66.5%), the Republic of Karelia (85.7%), the Primorsk Territory (87.2), the Karachay-Cherkess Republic (90%), the Republic of Adygeya (91.8%), the Novosibirsk Region (91.6%) as compared to the plan".*[13]

Conclusion: Available data of performing targets and statistics of medical examination of population for HIV infection make it clear that in a number of regions quantitative indicators were not reached. Such regions with failed targets also confirm that achieving targets of rendering services to vulnerable groups' representatives in 38.2 business days turned out to be impossible.

1.3.3. Nature of Rendered Services and Activities' Algorithm

From our point of view, the Government Order documents contain some inconsistencies and inaccuracies that could affect the deviations in the Contractor's performance that were discovered in the course of the assessment and described in the sections above.

From "Purpose of Services" of the tender documents section: "*In 2011, the purpose of services implement activities of secondary and tertiary prevention of HIV infection among key groups of population vulnerable*

[12] www.rospotrebnadzor.ru

[13] For the reference: Activities funded from the state budget and aimed to prevent propagation of HIV infection in 2010 (under the Resolution of the Government of the Russian Federation dated December 23, 2009 №1079) were not deployed in all constituent entities of the Russian Federation, were focused mainly on rendering services to people with confirmed HIV status, provided for rendering services to only several thousands of clients, and therefore, could not considerably modify the medical examination statistics for 2010.

to HIV infection is to develop and implement the system of measures designed to reduce intensity of HIV propagation in key groups of population vulnerable to HIV infection through the following measures:

- *HIV testing of representatives of key groups of population vulnerable to HIV infection;*
- *making HIV positive representatives of key groups of population vulnerable to HIV infection pass verification tests in HIV/AIDS centres with further registration of new HIV cases;*
- *building responsible behaviour in relation to their own health and health of other people among representatives of key groups of population vulnerable to HIV infection;*
- *engaging required number of outreach workers having access to key groups of population vulnerable to HIV infection to rendering the services*".

In "Stage 2" section it is specified that the contractor shall provide the following services:

- "*Informing about place and working hours of health care institutions and work schedule of specialists employed as consultants of health care institutions to deliver medical and social assistance and support to representatives of key groups of population vulnerable to HIV infection;*
- *Directing / forwarding them to health care facilities for medical / social counselling and HIV testing*".

Pursuant to these wordings, the following conclusions can be made:

- The purpose of the Services prescribes that HIV positive clients should pass verification tests in AIDS Centres and should be registered. This is reasonable and correct follow-up of medical and social support services for HIV positive people, which is also regulated by health and disease control rules[14]. However, according to the Government Order, work of contractor is completed at the moment when a client enters the health care facilities for testing. At the same time, reporting form is executed, and the target indicator is increased for 1 client. Support of the client after he/she has attended a health care facility or has got positive test results is not specifically provided for in the Government Order Activities and remains at the discretion of the contractor.
- It is not clear how the contractor was to build clients' "responsible behaviour in relation to their own health and health of other people". This is a complicated and long-lasting process. At the same time, the terms of reference specified that contractors were only to inform their clients of "the place and working hours…", and to direct and forward them to health care facilities. In addition, one cannot agree with the fact that "general information of HIV infection, including the need to pass tests and prevention measures" may turn out to be sufficient to alter people's behaviour; the term of 38 days is not enough, either.

  Brief description of the expected result provided in the official Explanation of the Tender Documents seems to completely abandon the requirement to build responsible behaviour: "*The final result of the information services, redirection / forwarding of representatives of the key population group is their attendance of health care facilities for medical and social counselling and HIV testing*".
- Engaging outreach workers is defined as an integral component of reaching the Government Order purpose. However, reducing social services for groups vulnerable to HIV only to outreach work cannot be deemed sufficient. Even though Government Order services are restricted to solely outreach work, the more important it is to ensure quality of this work. Meanwhile, according to opinions of experienced outreach workers, timeline of the Activities was absolutely infeasible to ensure high quality of the implementation of the Government Order. It was also impossible to prepare qualified outreach workers. Engaging poor qualified outreach workers to work with the three "key population groups" is of low efficiency and unreasonable in terms of spending considerable funds.

Taking into account the Activities' purpose, number of rendered services must be in line with number of the so-called "pre-test consultations" that are provided already by specialists of health care facilities and

[14] Para 5.11.1.2 of Health and Disease Control Rules SP 3.1.5.2826-10 "Prevention of HIV Infection" (approved by the Resolution of the Chief Medical Officer of the Russian Federation as of January 11, 2011 №1).

are mandatory according to the standards[15]. As shown above in section 1.3.2, somewhat considerable increase that could at least to some extent correspond to 123062 people as planned by the Government Order is not observed.

According to surveys and information distributed by the contractor, the following is evident. There are practically no regions, where each contractor's employer strictly complied with the Activities algorithm and adhered to all set parameters of rendering the services. Where certain outreach workers actually focused their efforts on performing a more complicated task – searching for representatives of target groups in access points – number of informed clients forwarded for counselling would be considerably less than that from outreach workers, who were involved in primary prevention or worked with groups other than those vulnerable to HIV and specified in the terms of reference. This is mentioned by both outreach workers and specialists of health care facilities. It is most probable that in regions showing figures that approach planned indicators rendered services comply with the terms of reference only partially.

Conclusions:

Inconsistencies / inaccuracies contained in the Government Order documents, including lack of contractor's obligation to more closely interact with AIDS Centres, together with insufficient coordination of outreach workers by the contractor, are a possible reason of violations of the Government Order requirements to work with key groups vulnerable to HIV. Inconsistent description of the Government Order services, incomplete compliance between the Activities and the aims "let off the leash" for loose interpretation of the Government Order purpose and concept at one's own discretion, which could facilitate to arbitrary extension of the list of "target" groups, incomplete and deficient support process, focus on mechanically gaining required figures, based on which one could formally comply with results in question.

Role of the NGO-contractor of the Activities turned out to be restricted by searching for, informing and directing representatives of target groups to the specialized prevention and treatment facilities. The Activities' algorithm, its deadline were outlined absolutely without taking into account needs of target groups and actual possibilities of NGOs in altering behaviour, overcoming barriers that hampered provision of social and medical services to the three target groups. Even with such restricted role of NGOs, it turned out impossible to perform the role in the scope specified in the Activities in the time provided.

Taking into account that NGOs (without meaning only the government contractor) accumulate most experience and competences in social support, the Activities' approach employed to organize work and distribute responsibilities between health care facilities and NGOs cannot be deemed sensible.

Another important parameter of the Activities is its deadline that caused main complaints of NGOs and became one of the main reasons, for which most of them refused to participate in the tender. According to the Government Order data, the work was to be completed by 5 December 2011, while reporting was to be submitted not later than 10 December. Meanwhile, the official website, where order information is published, displayed "Work in Progress" status for most contracts under this Government Order until 10 January 2012, while "Completed" status was to have been displayed for performed contracts. For certain lots, "Completed" status was published on 31 December 2011 in 1 case, 10 January 2012 in 6 cases out of 8, and 22 February 2012 in 1 case[16]. The reasons of such delay are unknown.

2. Applied Technologies, their Advantages and Limitations

The Government Order description suggests using such social work technologies (approaches) as information awareness, outreach work, redirection and forwarding. These approaches are just listed, with their final objective (bringing clients to health care facilities) stated without any direct instructions to use specific methods or a certain minimum of methodology components. Methodology of outreach work,

[15] Para 6 of article 7 of Federal Law dated 30 March, 1995 No 38-FZ; Para 5.6 of Health and Disease Control Rules SP 3.1.5.2826-10 "Prevention of HIV Infection" (approved by the Resolution of the Chief Medical Officer of the Russian Federation as of January 11, 2011 №1).

[16] http://zakupki.gov.ru/pgz/public/action/orders/info/contract_info/show?notificationId=1430237

redirection and forwarding is not strictly regulated, therefore employed approaches may vary. However one can't but agree that such technologies, irrespective of specific way they are implemented, are supposed to solve tasks of improving quality of life, in terms of prevention meaning altering people's behaviour towards more reliable, provision of efficient medical and social help, and developing adherence to prevention and treatment. These elements are integral to social work expressed in redirecting/forwarding and outreach work. This is also emphasized by a number of guidelines[17] including those referred to by the Government Order documents[18]. Therefore, in principle, the Government Order referring to these technologies automatically implies that social work should proceed without interruption. In other words, client support may not complete with termination of responsibility for the client after he / she is brought to health care facilities in exchange for a reporting document. Client support should not be stopped at the time he or she attends a doctor, as his / her social needs are usually not restricted to that extent.

In case of the Government Order, the role of social work and prevention was diminished thus resulting in a failure to perform proper work aimed to shape reliable behaviour of clients. One can hardly find people who do not understand that services of heath care facilities cannot possibly embrace all social needs of vulnerable groups in the context of prevention and protection of their heath. This is also recognized in Health and Disease Control SP 3.1.5.2826-10 "Prevention of HIV Infection" (approved by the Resolution of the Chief Medical Officer of the Russian Federation as of 11 January 2011 №1)[19].

Content of the contractor's offers to the government customer related to the Activities' performance is not known to us. Contractor's own methodologies (published) are either not available or not known. Information support of the prevention Activities in the context of other Government Orders is not of methodological nature. Even more so, another somewhat suspecting circumstance is that, when trying to hold interviews with Activities' contractors in some regions in order to find out what technologies of information awareness, outreach work and redirection were used, they refused to be interviewed. The refusal reasons were similar, for example: "*our supervisors has forbidden us*" or "*this is secret information because it is… of secret nature*", or because "this *information is subject to commercial secret*"[20].

In regions, where we were provided with reliable information of how exactly representatives of target groups had been informed and forwarded to health care facilities, outreach workers themselves confirmed that their work had been underproductive because of the Activities' time restrictions. Please note that this was articulated by outreach workers having many years' experience of such work. These outreach workers were searching for target group representatives in "access points" they had previously known based on their gained experience. But their Government Order work cannot be deemed outreach work technology in its proper sense, since actually non-recurrent contact of an outreach worker and a target group representative is underproductive. To be efficient, prevention-oriented outreach work should imply a series of meetings and activities that can finally result in not only client integration in the system of state social and medical services, but his / her continued support until his / her problems are solved.

Thus, outreach workers' actions in the context of this Government Order are separate special methods used, together with other methods, for secondary and tertiary prevention of HIV infection, but they cannot be considered consistent prevention technologies. These methods are insufficient for secondary and tertiary prevention as, being applied separately, they cannot ensure desired effect in a short period of time.

Adequate outreach work consists in diverse kinds of work with target groups: from searching for clients in the field up to solving burning social problems of these people. The most important task of such service providers is literally gaining trust of target group representatives and building their motivation to be integrated in the healthcare system. Methods of outreach work, information awareness, redirection and

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[17] See www.spdfund.org/news1/manual_2011/, www.unodc.org/russia/ru/publications/hiv-aids.html; next reference.

[18] See www.ohi.ru/files/gr_sec.zip - reference to this document is provided in the Government Order documents solely to justify the calculated number of outreach workers, without connection to general methodology (comm.).

[19] Para 9.4-9.5.

[20] Having compared terms of performing these Activities and provisions of the Federal Law of the Russian Federation as of July 29, 2004 №98-FZ "About Commercial Confidentiality", and taking into account the article 32 of the Federal Law as of January 12, 1996 №7-FZ "About Non-Commercial Organizations", we don't think that any information of performing the Government Order can be referred to commercial secret.

forwarding are a part of and are inside of these technologies. Experience of specialized organizations shows that it takes much more time than two months given to perform the Government Order only to gain trust of target group representatives to intermediaries. Representatives of many NGOs had warned about it in their expert opinions on the Activities' concept submitted to the government customer.

The following deviations from the Government Order concept can also be found in the contractor's work:

- Medical and social institutions served as access points. In their public reports, the Activities' task force noted that, according to their opinion, they had successfully "performed work" in non-state drug rehabilitation centres. Here, according to the task force, they used certain training and information measures; however, the nature of those measures was not disclosed. Similar work was performed by task force in medical and residential social facilities: hospitals and hostels, AIDS Centres, sexual health clinics, centres for homeless, etc. This "information awareness and training" work was of group character.

  It is not clear, why in this case task force referred state and municipal health care and social facilities to "access points". In those facilities one can find people, who are already registered for follow-up care and who have already attended specialists of health care or social protection system. This way, the contractor has considerably simplified its work by searching for clients to be tested among those people who are already accessible for the health care system. Another point to be clarified is to what extent the work with such clients was focused to motivate participants to come to specialized health care facilities, and whether such work was performed at all? The answer to this question is meaningful in terms of feasibility of spending funds on solving the Government Order tasks that could be solved by health care facilities without a contractor organization involved.

- In some cases task force representatives noted that they had held the so-called peer support groups for injection drug users, work with teenagers aged 16-18, work with MSMs, that information had been distributed through pharmacies' chains (i.e., among people not necessarily referring to target groups of the Government Order), which, strictly speaking, was not specified by the Government Order. Listed activities are undoubtedly useful tools of prevention work. However, it is important to understand that though such useful work may be performed by any organizations at their discretion, stricter compliance with the Government Order requirements is desirable when it goes about federal budget funds allotted for certain Activities.

There is no point in considering here technologies or work with population groups not belonging to target group representatives, as such activities expressly contradict to the terms and conditions of the Government Order.

Conclusions:

The Government Order contractor has partially substituted a more complicated work of searching for and bringing less non-needy clients from access points determined by the Government Order and less accessible for health care facilities, with another, simpler work not specified by the Government Order performed in the health care facilities, where clients were more prepared to be brought to AIDS Centres. One can assume that such extension of a range of access points violating the purpose of the Government Order was forced and resulted from impossibility to achieve targets by the deadline.

Supposedly, being severely restricted in time, the government contractor had to represent other results of its prevention-related organizational activities instead of results of the Government Order work, irrespective of whether it was directly related to tasks and requirements of the Government Order. Such state of affairs is manifestation of unfair competition in the field of social services rendered by NGOs.

It was impossible to fully deploy outreach work technology because main terms and conditions of the Government Order were developed without taking into account specific features of behaviour and needs of target group representatives as related to the system of state and municipal social and health care services. Outreach workers were engaged without applying the technology of outreach work.

3. Management of Activities

Implementation of the Government Order services in 83 constituent entities of the Russian Federation suggested a management structure in place that would allow to plan the Activities, organize the process, coordinate task force, outreach workers, flows of information and documents, to control and cause required motivation (incentives). Let's consider the process of providing the Government Order services in the context of the above management functions.

Activities' schedule actually corresponds to the 1st stage of work described in section 1.2. As stated above, it is impossible to perform preparatory stage of the Activities of such scale during 5-10 days, and in our case planning and preparation were not performed fully in compliance with the Government Order.

To organize the work, the contractor selected and appointed a coordinator for each region. As a rule, each coordinator was a member of the contractor organization. In part of the cases coordinators were employees of other NGOs, while in some other cases they worked for health care facilities. The contractor concluded individual contracts with coordinators. The contractor organization's management body provided coordinators with forms designed to account clients. Coordinators invited outreach workers they knew or managed to execute the Activities, and individual contracts were concluded with them as well.

Thus, three-stage management system was built to run the Activities: management of the contractor organization – regional coordinators – outreach workers.

The role of contractor organization management consisted in informing coordinators about main parameters of the Government Order, organizing and controlling Activities' measures specified by the Government Order, distributing and collecting accounting forms, instructing coordinators on how to perform work and record work performance, concluding work contracts with outreach workers and submitting reporting to the government customer. Coordinators searched for and invited outreach workers to perform the work, delivered them instructions and documents, participated in implementing the Activities, interacted with health care facilities. Not being properly instructed and prepared about the way to render services, outreach workers independently determined methods and forms of performing the Activities and working with target groups based on their previous experience.

The number of outreach workers actually involved in the Activities is unknown but may be estimated as several hundreds. In this system, contractor organization's management could not physically directly control and direct activities of outreach workers in the course of Activities. Regional coordinators, in their turn, did not have any administrative levers, and therefore could not control activities of outreach workers to the extent sufficient. As already stated above, no methodology training (both in terms of outreach work and in terms of the Activities' algorithm) was held. According to the held surveys, outreach workers were instructed only by telephone on how to fill in primary reporting forms. Actually, outreach workers acted based on their own idea of how the planned scope of work could be performed and using their own social project experience. To some extent, the contractor relied not so much on its own potential, but on capabilities of engaged outreach workers, whom finally the performance depended upon.

It is also worth noting that in a number of cases regular staff of health care facilities, i.e., psychologists, doctors and social workers were engaged to perform the Activities as outreach workers in the regions. In other cases, workers of local NGOs of respective specialization were engaged as outreach workers. At the same time, they were not supposed to show it off: "*or their managers would call them to account*". In this case, the role of the contractor organization was actually reduced to the function of an NGO-operator, that is, a structure that neither rendered nor organized services directly, but was an intermediary in redistribution of financial assets for performing work in question. In a sense, this is outsourcing and transfer of burden of work performance to "actual doers" (regional NGOs and outreach workers) with retaining the liability and "right of ownership" to the achieved result. In this connection a question arises of whether it is expedient to centralize state budget resources in one "monopoly" contractor, who is unable to perform the Government Order by its own efforts, while dozens of NGOs need support and are ready to offer their services and potential[21].

[21] Comment: refusal of other non-profit organizations to participate in the tender was determined by the fact that wording of the Government Order requirements included elements of violation of principles of free competition, and by professional

Performance was to be controlled by the government customer as well, but since the Ministry of Health and Social Development of the Russian Federation could not do it directly, the letter requesting to support the Government Order work was sent to regional Departments of Health. Therefore, health care facilities were to become main institutions controlling achievement of expected results. According to the Activities' plan, the main control tool were primary reporting forms that were to be certified by a health care facility stamp after clients were brought and after an outreach worker had provided information, redirection / forwarding services. A half of the form was retained by a health care facility, while the other one was kept by the contractor. It is important to note that the referral form did not have to state client's name. Judging by this approach to control, the only way to check achieving the targets is collation of the outreach workers reporting with data of the collected forms from health care facilities. Though such client anonymity-based method does not exclude one and the same client being recorded in reporting several times, and having been directed to receive services repeatedly.

The tender documents contain considerable conceptual contradiction between the purposes of the Government Order and the description of performance control methods. "Reporting Documents" section of the Government Order states that the Activities' report should include, among other, the following: "*Consolidated register of primary reporting forms with attached forms stamped with seals of health care facilities that confirm number of representatives of key population groups vulnerable to infection with HIV that attended health care facilities in constituent entities of the Russian Federation…*". Since people 'vulnerable to HIV' are those who are not infected, it means that it is the number of HIV-negative and non-tested clients that must be reported by results of secondary and tertiary prevention measures. In addition to that, reporting forms should contain no personal data of clients, including their names as well. The Explanation of the Tender Documents present somewhat different wording: *"The scope and quality of the service of information awareness, redirection / forwarding rendered by an outreach worker is assessed by number of representatives of key population groups that came to health care facilities to be consulted and tested by health care professionals"*. This wording does not refer to HIV status, but it is still unclear how one can judge of the Activities' clients belonging to target groups based on only one anonymous reporting form.

In cases we managed to receive information in the course of the assessment, reporting forms were filled in as follows. Primary reporting forms were not handed out to target audience representatives. Most prevention and treatment facilities did not stamp forms that were not filled in. In some cases known to us, when such order may be considered doubtful, filled-in forms were stamped in the following cases:

1. Forms were filled in by outreach workers after informing target group representatives "in the field", then were brought to prevention and treatment facilities, where they were stamped irrespective of whether target group representatives had attended the prevention and treatment facilities before or not. According to interviewed outreach workers, in this case proportion of those informed and those who came to the prevention and treatment facilities amounts to approximately 10 to 1, i.e. about 10% of those informed by outreach workers attended health care facilities, while reporting included the other 90% of "clients" as well. If outreach worker contact is not recurrent, this is the maximum possible result. Interviewed heath care professionals told us that in this control system in place it was impossible to single out those, with whom an outreach worker had interacted, out of the entire flow of patients.
2. Employees of prevention and treatment facilities filled in the forms when accepting patients, who came to these facilities for the first time, or accepting repeatedly those, who had already been registered in these facilities, i.e. those, who were not forwarded there by outreach workers. As one of the patients interviewed by us put it, "*I even didn't understand that I took part in the Activities, it is just that in a regular check-up I was given referral to be tested for HIV and hepatitis. I replied that I had been recently tested in the medical facilities at the place of residence, but they objected that it was necessary to be tested in the course of some Activities, and all patients had to be tested irrespective of how long ago they had passed the tests. I wondered why it was necessary, but they*

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understanding of objective limitations impeding high-quality work performance under specified conditions. See materials of complaint to the Federal Antimonopoly Service:
http://zakupki.gov.ru/pgz/public/action/orders/info/contract_info/show?notificationId=1430237

answered that I was to pass the tests once in six months in any way, and told me not to ask any other questions". Most often, this way of filling in the forms was used in cases when outreach workers were from among regular staff of the specialized prevention and treatment facilities.

3. Forms were also filled in for group meetings of outreach workers with patients of drug rehabilitation centres, and students of basic, secondary and higher vocational educational institutions. In these cases forms were filled in by all participants of such meetings. From interviews with outreach workers: "*Students filled in stubs of primary reporting forms after they listened to the lecture. I don't know whether they went to take blood tests*". In a number of cases, such group meetings were held jointly by outreach workers and staff of prevention and treatment facilities.
4. Forms for target group representatives were filled in without attendance of clients. Number of interviewed outreach workers contacted target group representatives in such places as night clubs and informal meeting venues, or through closed Internet forums. In these cases, reporting forms were filled in and transferred to prevention and treatment facilities in the manner similar to that of the first option.

According to our opinion, in all four cases the procedure of gathering reporting data did not comply with the procedure established by the Government Order documents. Outreach workers interacted with Activities' target group representatives only in the first case and partially in the third case (rehabilitation centres' patients). In the second case, it made no sense to engage outreach workers, and the role of contractor organization wasn't of any use, either. In all other cases we deem it incorrect to speak about indicators of secondary and tertiary prevention of HIV.

We believe that final figures presented by the contractor contain a significant share of cases that do not correspond to the terms and conditions of this Government Order. It is worth noting that generally two types of recording of performed work are used to monitor HIV/AIDS prevention initiatives. The first one is based on a number of clients that receive different services. The second one is based on recording a number of services rendered to clients. Both approaches have advantages and disadvantages. But it is important to choose the type that best fits for monitoring of achieved results of a certain initiative. Prevention Activities may have different purposes and algorithms. In this case, monitoring system based on recording the number of clients was selected, but it was latently replaced with the system based on recording the number of rendered services. That is why interpretation of figures without analyzing the Activities' progress cannot be defined uniquely.

Based on the analysis of the Government Order performance management procedure, we single out the following key factors either facilitating or hampering the Activities' performance. In this context, success rate is understood to a larger extent as a formal achievement of targets than efficiency and quality of the final result.

Facilitating	Impeding
Knowledge and skills of experienced outreach workers acquired earlier, in previous initiatives and projects, and special training beyond the Government Order. Support of employees of specialized prevention and treatment facilities reinforced by the instruction of health care authorities.	Activities' algorithm that doesn't take into account specific features of social position of target groups, on which these Activities focused. Unfeasible time constraints of work. The Government Order control system that failed to communicate the main conception of the Activities and ensure control over their performance. Non-instructive system of recording of performed work that provides meaningless figures that can't be interpreted in a unique manner. Lack of clear differentiation of primary, secondary and tertiary prevention in the Government Order terms of reference.

Conclusions:

Gaps in the Government Order documents that were highlighted to the government customer already at the tender stage (including written applications, hearings in the Federal Antimonopoly Service) became one of the reasons of gaps in the Government Order performance management. This was also aggravated by the contractor freely interpreting inconsistent and contradictory requirements of the Government Order. Serious claims relate to the organization of control over Activities' implementation that allows to trace the scope of performed work only approximately, without any quality criteria and compliance with tasks and aim of the Government Order.

The Activities' performance control system could not compensate for faults of the initial Activities' algorithm and evidently inadequate time constraints of implementation.

The underlying approach of the system of recording Activities' results that was described unclearly turned out to be violated in view of achieving targets on 'whatever it takes' basis.

Pre-conditions of deviating from the Government Order concept and prevention purpose emerged already at the tender documentation stage and were echoed in the Government Order performance reporting. The main deviation is related to non-compliance with requirements to target group selection, which is also expressed in the substitution of terms by the contractor that submitted data of persons "engaged in the initiative" instead of data of representatives of three target groups determined by initial terms and conditions of the Government Order.

Even if the Government Order has returned any successful results, these became possible not due to the contractor's efforts, but due to skills and experience of individual engaged outreach workers, whose potential had been acquired earlier, not in the context of the Government Order. One can't also refer to any contribution of the Government Order in developing outreach work methods and support of this sector of social services in principle, as neither preparatory stage, nor time constraints of performance, not the Activities' performance management system could facilitate these.

4. Sustainability and Capacity for Replication of the Proposed Service Delivery Approach

We define sustainability as a possibility to apply and replicate social work technology used to perform the Government Order after the project termination. We will not consider cases of work with students of educational institutions. We will consider only cases of actual outreach work with the target group representatives that avoid attending prevention and treatment facilities for a number of reasons. This seems to us to be the main idea of the Activities.

Currently, the only considerable source of funding large-scale outreach work aimed to support secondary and tertiary prevention of HIV infection and other socially significant diseases in our country covering all regions of the Russian Federation may be only the state budget complemented with budgets of regions. In Russia, one can also find similar projects financed from international or foreign sources or sources that can be referred to Russian private philanthropy. But these examples are precious few and they are too small-scale to talk about consistent country-wide work.

Therefore, employed approach cannot be sustainable with no federal-level source of finance.

As already shown above when answering other questions, efficiency of outreach work organization in principle cannot be high in parameters established by this Government Order. The main reasons are time restrictions for work performance. The method of Government Order performance used in the course of the Activities is inefficient, either. A small group of managers is unable to simultaneously control work performance in all country regions. For these reasons the service approach cannot be deemed sustainable, and its further replication is inexpedient.

Most probably, such work can be efficiently handled by a variety of independent regional and local NGOs, in case they are provided unified methods of work, their employees are properly instructed, and due control is ensured in relation to performance of at least minimum standards of outreach work and other

social services recognized in this professional field. The provided set of methods must be proven, with available examples of use in our country[22].

Social service technologies can be replicated in our country in relatively short terms, since Russia has enough specialists of proper qualification and required practical experience. For example, this possibility was demonstrated by prevention measures performed by a partnership of NGOs in 2010. However the key differences were that timeline of the preparation process complied with the scope of the Activities, its overall duration exceeded six months, the management, monitoring and evaluation system was developed, there were several contractor organizations with clearly delineated responsibilities, while the form of relations with the government customer was that of subsidy, not a commercial Government Order. Though in this case by results of work it was also concluded that it would be necessary to considerably extend duration of prevention measures.

Conclusions:

Sufficient sustainability and efficiency of such work cannot be ensured without measures of the secondary and tertiary prevention of HIV infection being regularly funded from the federal budget.

Technologies of HIV prevention and social services that allow to overcome barriers to render medical and social services to population groups vulnerable to HIV infection can not be deployed in Russia by efforts of one organization.

[22] See reference 17 on page 15.

Conclusions & Recommendations

Conclusions

1. The main idea of the Government Order consisting in attracting closed groups vulnerable to HIV infection to the specialized health care facilities by efforts of NGOs is quite tenable.

2. The 1st preparatory stage was not performed completely. Time given for the 1st period turned out to be insufficient to perform all work established by the Government Order in full scope.

3. There are reasons to believe that part of Activities' clients do not belong to target groups determined by the Government Order.

4. According to data publicly presented by the contractor (21 regions), in a number of regions actual figures were 30-50% lower than planned values of target indicators (Tatarstan, the Smolensk Region, Yakutia, the Tyumen Region).

5. Deviations from Government Order initial conditions related to set and quantity of target groups were most probably caused by substantial contradictions of the Government Order conditions, inconsistency between declared Activities' purposes and established methods of their implementation.

6. Activities' algorithm and deadlines did not take into account real needs of target groups in relation to the system of state and municipal social and health care services. Other points not taken into account include actual possibilities of NGOs in altering behaviour, overcoming barriers hampering provision of social and medical services to three target groups.

7. Government Order task force had to substitute searching for target group representatives in access points with a work with non-target population groups.

8. Outreach workers were engaged without applying of technology of outreach work.

9. Gaps in the Government Order documents that were highlighted to the government customer already at the tender stage (including written applications, hearings in the Federal Antimonopoly Service) became one of the reasons of gaps in the Government Order performance management. Serious claims relate to the organization of control over Activities' implementation that allows to trace the scope of performed work only approximately, without any quality criteria and compliance with tasks and aim of the Government Order.

10. The Activities' performance control system could not compensate for faults of the initial Activities' algorithm and evidently inadequate time constraints of implementation.

11. Even if the Government Order has returned any successful results, these became possible not due to the contractor's efforts, but due to skills and experience of individual engaged outreach workers, whose potential had been acquired earlier, not in the context of the Government Order.

12. Sufficient sustainability and efficiency of such work cannot be ensured without measures of the secondary and tertiary prevention of HIV infection being regularly funded from the federal budget.

13. Technologies of HIV prevention and social services that allow to overcome barriers to render medical and social services to population groups vulnerable to HIV infection can not be deployed in Russia by efforts of one organization.

General Conclusion:

Quality of work performed under Government Order №0173100005411000247 does not justify invested resources, lowers significance of interaction of health care authorities and non-commercial sector. The approach employed to organize work under this Government Order shapes negative experience of implementing joint initiatives, discredits public efforts in the field of HIV prevention. The results of the Public Assessment of completed Activities of the Government Order have confirmed reasonable character of apprehensions and comments articulated to the governmental customer by many specialized NGOs at the stage of open tenders.

Further use of similar patterns of organizing work to prevent HIV infection is seen as unreasonable and inefficient spending of state budget funds.

Recommendations

1. HIV infection prevention measures must be planned, and technologies and target groups must be selected taking into account and based on experience of various NGOs working in this sphere. At the same time, the engine of communication and agreement between the federal health care authorities and NGO sector may be an extended workgroup built by NGOs as suggested by the Ministry of Health and Social Development in 2011. Terms of reference for prevention work must be based on results of such communication and agreement.

2. Terms of reference for prevention measures must be clearly stated taking into account practical experience and actual needs of target groups, which is a corner stone of compliance between the concept and eventual results of work.

3. Funds of the federal budget must be provided to prevention measures on a non-profit tender basis as target grants or subsidies. Taking into account specific character of prevention work, contractors and/or operators must be selected not on the minimum-price basis pursuant to the Federal Law №94-FZ, but judging by practical work experience, availability of proven methods and potential of interaction of a NGO with health care and social service authorities and institutions. Functions of co-contractors must be performed by different NGOs taking into account their specialization, while mutually complementing work and liability in the context of such initiatives must be distributed between them pursuant to their competencies. It is necessary to abandon discriminating practice of contractor selection based on the principles violating competition laws.

4. Activities' timeline must cover longer periods within a year, but not less than 10 months, and must provide for sufficient time to prepare required measures, including personnel training, guidelines development / adaptation, agreement of measures with health care and social service authorities and institutions, building the internal management and control system.

5. It is necessary to ensure continuity (reduction of interruption), to the extent possible, and consistency of HIV prevention measures after the end of a financial year and at the beginning of a new financial year.

6. HIV prevention measures must provide for implementing a monitoring and evaluation system at the planning stage. Target indicators recording system must be developed so as to meet the personal data protection requirements and at the same time to ensure proper control over achieving planned value of targets.

7. Lines of HIV prevention activities as the foundation for respective measures must ensue from the National HIV Fighting Strategy that must be developed and adopted in the short-term perspective, with a wide range of stakeholders involved.

Conclusion of Public Assessment, Additional Issues Emerged in the Course of Assessment

The submitted report is based on the data that were obtained in the course of the public assessment initiated by a number of NGOs that genuinely care about perspectives of prevention measures aimed to fight HIV infection. Usually, monitoring and evaluation initiators are customers and contractors wishing to understand the efficiency of employed approaches and provided funds. Results of such evaluation may remain unavailable to the general public. Unlike such common monitoring, the public assessment implies study performed by a third-party observer interested in the Activities results and acting on behalf of general public independently from both the customer and the contractor. This is how conflict of interests is resolved, with assessment results published. Public assessment is ever more demanded, when purposes of measures in question are of high social significance or considerable funds of the budget and taxpayers are spent. This is the case with HIV prevention.

The Budget Message of the President to the Federal Assembly of the Russian Federation as of June 23, 2008 stated: *"Further development of result-oriented budgeting practice. Every initiative should state certain initiative goals and indicators of assessment of their achievement throughout the initiative. If the initiative fails to achieve the set goals, it is necessary to refuse implementing it further timely amending regulations respectively"*.

Unfortunately, Government Orders for HIV prevention in 2011 did not include adequate monitoring and assessment. This additionally enhances importance of the public assessment that in our case was held with limited resources and to a greater extent on a voluntary basis. In our case we have actual limitations of the number of regions where we could hold surveys, and we also faced with the information being closed and with unwillingness of the government contractor to share this information. The data we gathered were complemented with analysis reports published by the government contractor, interview with NGOs' employees and HIV prevention experts, as well as statistic data of HIV testing that was bound to be influenced by the Government Order in question. Of course, this report doesn't claim exhaustive analysis or reveal all circumstances of the Government Order performance that could be assessed, especially because information was mostly closed to surveyors.

The assessment did not aim to provide representative data of results of performed work, but to focus on the Government Order parameters that were feasible to analyze, could demonstrate the most important aspects of prevention and answered the main question of the assessment: Is it possible, in 38 days, to provide quality services of informing and redirecting / forwarding 123062 representatives of vulnerable groups (drug-addicts, LGBs, STD patients) to health care facilities for medical / social counselling and testing for HIV infection in 83 constituent entities of the Russian Federation?

The problem is not that NGOs (except two) refused to participate in the Government Order already at the stage of open tender, as they knew the answer to this question in advance, but that no one listened to them. The main effect of this assessment is not in giving clear answer to the raised question, but in the fact that it is the first experience of public assessment that may facilitate efficient and up-to-date prevention approaches.

Many questions without any hope of intelligible answers are left beyond this assessment, but they are not less important for understanding correct organization of prevention measures and further actions to fight the epidemic, that is why we provide them below:

1. Why was the Government Order organized in 2011 in the way that allowed to start prevention work only in October? (For the reference: Federal Law as of December 13, 2010 №357-FZ "About the Federal Budget for 2011 and the Planning Period of 2012 and 2013", which provided funds for prevention, was adopted December 13, 2010).

2. Why did expenses on HIV prevention in 2011 equal to only 30% of the amount declared and stated in the federal budget, in spite of the statement of the head of the Ministry of Health and Social Development[23]?

3. Why did the government customer refuse to take into account the opinion of most NGOs articulated in a series of meetings and stating inexpediency of the Government Order measures in the current form?

4. Why didn't the Government Order even consider the possible role of NGOs as providers of social services and non-medical counselling, and did reduce their role to intermediary bringing clients to health care facilities? (For the reference: under the Government Order, the contractor paid only outreach workers' fees, and was selected only in one case out of 6 Government Orders for HIV prevention).

5. Why was Government Order Tender №0173100005411000247 developed in a way to be won by the only contractor with indications of violations of competition laws as deemed by the General Prosecutor Office of the Russian Federation?

6. Why did spending 82 million roubles on the Government Order №0173100005411000247 fail to attract more representatives of groups vulnerable to HIV to health care facilities that in the previous year, when funds for such goals had not been provided?

7. Was the government customer satisfied with performed work results, and if yes, in spite of violations of the conditions of the Government Order and data of this assessment, then why?

8. Why wasn't the National HIV Fighting Strategy adopted in Russia for 25 years of the development of HIV epidemics in the country, which would be the foundation to determine prevention measures priorities and lines of actions?

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[23] http://positivenet.ru/files/golikova_statement_2011.pdf

Appendix 1. Terms of Reference for Public Assessment

of Government Order №0173100005411000247 "Services to implement activities of secondary and tertiary prevention of HIV infection among key population groups vulnerable to HIV infection in constituent entities of the Russian Federation within the framework of the Priority National Project "Health" in 2011"

Substantiation of Public Assessment of the Activities' Performance and Results

The assessment was initiated by a number of socially-oriented NGOs dealing with HIV prevention: "New Life" (Orenburg), Irkutsk Regional Branch of the Russian Red Cross (Irkutsk), "Vera" Kazan' NGO of Drug-Addicts' Relatives (Kazan'), "Community of People Living with HIV" Interregional NGO (Moscow), "AntiAIDS" Non-Governmental Fund of Support Health Care and Education of Penza, "Positive Wave" Social Support and Health Care Fund (Saint Petersburg), involving other NGO-partners in different regions of the Russian Federation.

According to the initiators of the public assessment, its need is caused by the following reasons:

1. HIV prevention is one of the top priority tasks of healthcare and counteraction in response HIV/AIDS epidemics. Prevention measures require detailed planning, comprehensive approach, wide outreach, continuous work and consistency of measures. Specific features of the process of preparation to the Activities of the Government Order in question, its intention (content), and time spent to implement it have caused serious concern and doubts about its expected efficiency and the mere possibility to implement it with high quality. According to opinions articulated by experts representing specialized NGOs while planning the Government Order Activities, the latter may be performed with high quality in the period not less than 10 months.

2. There are concerns about high risk of discrediting the Ministry of Health and Social Development policy of cooperation with NGOs, emerging gap in outlined tendencies of cooperation between the government and NGOs. There is also a reason to believe that the Government Order is to a greater extent oriented to "absorption" of the budget and developing formalized reporting on performed work targets instead of reaching socially significant and public-spirited goals of HIV prevention.

3. In spite of doubts of the Order being reasonable and feasible articulated by representatives of several specialized NGOs at the planning stage, representatives of the governmental customer did not include monitoring and assessment in the list of activities.

Who Will Use Results of the Public Assessment, and How?

Results of the assessment will be used by NGOs working in the field of HIV/AIDS prevention that were not acting as contractors of the Order:

- To verify relevancy of criticism expressed by a number of NGOs at the stage of discussing the Activities' content (before releasing the tender) and after the governmental customer approved the Activities' content (after releasing the tender).
- To develop recommendations about content of future prevention measures and programmes and their management methods.
- To specify the role of NGOs in developing and implementing prevention programmes and to adjust forms and methods of interaction of NGOs and the Ministry of Health and Social Development of the Russian Federation aimed to prevent HIV.
- To gain experience, to develop practice and implement technologies of public monitoring of HIV prevention measures as one of the forms of participation of the civil society in public management, providing general public control and developing democratic institutions.

Public Assessment Check List

In the course of assessment it is necessary to answer the following questions:

1. What results were achieved in the course of performing the Government Order? To what extent do they comply with expected results, required parameters of this Government Order (content, scope, quality)? If they don't comply, why?

2. What approaches, technologies, methods did the contractor use to perform the Order? What are their advantages / strength and restrictions / weaknesses?

3. How service performance under the contract was managed? What facilitated and hampered rendering the services?

4. Was the offered approach to rendering the services consistent? Was the offered approach to rendering the services efficient? Is it possible to replicate approaches, technologies and methods used by the contractor in terms of their benefit? If yes – how, if not – why?

5. What recommendations can be given about continuing these Activities?

General Public Assessment Methodology

To conduct the assessment it is planned to involve professional consultants specialized in monitoring and evaluation and having proper experience of evaluation of social programmes, who will coordinate relevant activities, provide recommendations to the customers and executors of the assessment about its methodology in order to obtain unbiased and reliable data.

To answer the questions as listed in the terms of reference, it is offered to conduct an empiric study collecting and analyzing qualitative and quantitative data revealing how the Government Order Activities have been performed. Participants directly involved in performing the Activities and having the most complete information will be used as data sources. To conduct the study, the appropriate sample of certain territories will be used. Territory selection criteria will be:

- available representatives of specialized NGOs ready to take part in primary data collection;
- Activities' participants being ready to provide these data based on the informed consent;
- a possibility to promptly collect the data during the final period of Activities' implementation (November-December 2011);
- a possibility to ensure confidentiality of information sources that will be ready to participate in the assessment only on the confidentiality basis.

In view of certain resource limitations, it is impossible to use representative sample, instead of which appropriate sample will be used. Non-structured or half-structured interview will be the main data collection tool. In the course of the assessment, it will be attempted to obtain quantitative data revealing the Activities' progress and results.

Thus, to answer the questions of the assessment, quality-based methodology will be used allowing to thoroughly analyze the Government Order Activities' progress and results in pre-defined number of cases.

The following participants of Activities will be information sources from each of the selected territories:

- Local Activities' coordinator (1 person)
- Outreach workers (2-3 persons)
- Head of a local heath care facility, where representatives of key groups vulnerable to HIV will be forwarded to (1 person)
- Employee of a heath care facility that delivers medical and social services to them to representatives of key groups (1-2 persons)
- Representatives of key groups that were provided or sought the services (3-4 persons, a group or face-to-face interview).

Thus, at least 8 respondents will be interviewed at each territory.

In the course of the assessment it is also expected to collect data about number of engaged outreach workers, number of performed redirections / forwardings of key group representatives and the number of consultations and medical examinations provided to them.

Public assessment report will be in strict compliance with the terms of reference. When analyzing data and issuing the report, "engagement assessment" elements will be used. The Work group of the Report will analyze all the obtained data together with those who participated in data collection. The report draft will be also submitted to all executors of the assessment.

Description of Data Collection Tool

Scenario of the Interview with a Head of Health Care Facilities

1. What do you know about the Activities of secondary and tertiary prevention of HIV infection among key population groups vulnerable to HIV infection in constituent entities of the Russian Federation held in your region? When and how did you learn about them?

2. Which organization, who exactly interacts with you concerning these Activities? How is this interaction arranged? How is staff of your institution involved in these Activities? Are you personally involved?

3. From your point of view, what results of Activities have been achieved by now?

4. How many people attended your institution through referrals of the Activities' task force, how are these people registered in your institution? How and where can these data be obtained? Which HIV vulnerable group do these people belong to? What happens to them after they come to you through the referral?

5. What do you think about the idea of the Activities? How do you evaluate the Activities' concept (including content and timeline of the Activities)? How do you assess the implementation? How do you see the role of NGOs in secondary and tertiary HIV prevention? From your point of view, what needs to be done to prevent HIV? Which approaches do you consider to be the most efficient? How can one ensure sustainability of implementing these approaches?

Scenario of the Interview with Employees of Health Care Facilities

1. What do you know about the Activities of secondary and tertiary prevention of HIV infection among key population groups vulnerable to HIV infection in constituent entities of the Russian Federation held in your region? When and how did you learn about them?

2. Which organization, who exactly interacts with you concerning these Activities? How is this interaction arranged? How is staff of your institution involved in these Activities? Are you personally involved?

3. How many people attended your institution through referrals of the Activities' task force, how are these people registered in your institution? How and where can these data be obtained? Which HIV vulnerable group do these people belong to? What happens to them after they come to you through the referral? How and what work is done with the people that were forwarded to you in the course of these Activities?

4. From your point of view, what results of Activities have been achieved by now?

5. What do you think about the idea of the Activities? How do you evaluate the Activities' concept (including contents and timeline)? How do you assess the implementation? How do you see the role of NGOs in secondary and tertiary HIV prevention? From your point of view, what needs to be done to prevent HIV? Which approaches do you consider to be the most efficient? How can one ensure sustainability of implementing these approaches?

Scenario of the Interview with a Local Coordinator of the Activities

1. Where are you employed and what position do you hold? What experience of participating in prevention programmes do you have? How have you become a local coordinator of the Activities? What are your responsibilities? With whom do you interact from the contractor organization? How was this interaction organized?

2. What does the Activities' concept consist of? What results were planned to achieve?

3. Please tell how the Activities were held in your region. What did you do in the preparatory stage (in relation to materials, outreach workers, health care facilities, access points, instruction briefing)? What was done at the main stage (team, technologies and methods of work, partner interaction)?

4. How were quantitative results calculated? How many people were forwarded to health care facilities?

5. What did you manage or fail to do? How do you evaluate the Activities' concept and the system of its implementation (including content and timeline)? Is it worth continuing? If yes, then how? Is it needed to change anything?

Scenario of the Interview with Outreach Workers

1. Where are you employed and what position do you hold? What experience of participating in prevention programmes do you have? How did you learn about the Activities? How have you become a participant of the Activities? What about your colleagues?

2. How do you see the Activities' concept? What were your responsibilities in these Activities, what were you to do?

3. How did you participate in these Activities at the preparatory stage? How was the preparation carried out? Who conducted the instruction briefing and how? What access points were selected? Who chose them and why? What materials were prepared and by whom? What health care institutions were chosen, and why? How would you assess quality and impact of these preparatory measures for you personally, for your colleagues?

4. What did you do while implementing the measures? What work was performed in access points and how? How did you interact with health care facilities? How many people did you manage to forward to heath care facilities? How did you determine that they referred to target groups defined by the Government Order? How was the registration of your work performance organized? How did you report and to whom? What happened to clients after you forwarded them to health care facilities?

5. What difficulties did you face when implementing the Activities? And on the contrary, what was the easiest part? What is the reason for difficulties, what helped you to overcome them?

6. How do you evaluate the Activities' concept (including content and timeline) and achieved results? Is this work worth continuing? Will this work be continued? If not, then why? If yes, under what conditions? What do you personally plan in the future in this respect?

Scenario of the Interview with Vulnerable Group Representatives Participating in the Activities

Interview should be started from the explanation, why this interview was organized. Confidentiality must be ensured.

1. Have you participated in similar Activities before?

2. How have you become a participant of the Activities? Who approached you and where? Please tell in details how it happened.

3. What was next, after the first meeting? To what health care institution were you forwarded? Did you go there? What happened there?

4. What are you going to do next? What do you need for this? What support or help will you need in the future?

Recommendations to conduct Interviews

Organization of the Interview

An interviewer will have to negotiate by him/herself about the interview and methods of recording data to be included in a written report (disclosing obtained data). It is necessary to openly state that the public assessment of the Activities is being carried out. The Activities is assessed by several NGOs at their own initiative. It is also possible to state reasons and purpose of the assessment described above. It is essential that the respondent gives informed consent for the interview. Since the assessment is carried out in multiple regions, it is possible to ensure confidentiality of data received from a certain respondent. The assessment report will provide a list of information sources, but quotations will be absolutely anonymous. Primary data of the interview are not included in the assessment report and are not published in view of protecting interests and confidentiality of respondents.

Interviewer's Attitude, Rules of Behaviour

The main rule of interviewing is not to participate in discussion and, ever more, in discussions with interviewees. Interview purpose is gaining information. It is inadmissible to assess information during the interview. The best interview technology is active non-directive listening[24]. It is important to ask all questions included in the scenario, irrespective of the questions' order. To answer the questions of the terms of reference, it is important to obtain complete detailed information known to a respondent.

Introducing and Starting the Interview

An interviewer should state his/her name, place of work, initiators of the assessment, purpose of use of information obtained from a respondent; the duration of the interview should also be specified (about one hour). Answer interviewee's questions, if any. Tell about confidentiality rules. The information letter about the assessment can also be provided.

Informed Consent and Confidentiality Rules

To observe interests and rights of respondents surveyed, it is important that they give informed consent to become the source of information for this assessment. Informed consent means that a person agrees that information obtained from him/her will be used to reach the goals of the assessment. Assessment must not be carried out to the detriment of its participants. To avoid this, confidentiality rules will be observed: generalized list of information sources (respondents) will be specified in the appendix to the assessment report. Thus, the assessment report will contain no personal data of the information sources quoted.

In this case confidentiality rules mean that if a respondent is ready to provide any data known to him/her and his/her personal considerations, but refuses to have his/her name included in the list of information sources, he/she is not considered to be the information source for this assessment.

Initiators of the assessment and contractors undertake to observe this confidentiality rule in any circumstances. This rule is based on professional standards of assessment adopted by the international community of project and programme assessment specialists and is in complete compliance with them.

Recording Information during the Interview

An interviewer writes down answers. It is not recommended to use voice recorder as it sets tense atmosphere during the interview. The best way is to write down additional impressions of the interview right after the interview without delay.

[24] Special listening technology implying focus on emphatic understanding of a speaker, supporting and encouraging him / her to speak freely on a subject, and efforts aimed to understand sense of what has been said by a speaker. In nondirective listening attempts to assess what has been said by a speaker are inadmissible. Personal reactions of a listener must be minimized and remain neutral to a speaker.

Processing Obtained Information

After the interview, written notes are deciphered and entered in a text file stating the information source.

Delivering Interview Results

Files with deciphered interviews are e-mailed to the assessment coordinator.

Appendix 2. Data on Performing Government Order Targets

The table is made up based on the data of the reports by the Activities' contractor published in e-newsletter itpcru@googlegroups.com and on www.hivnet.ru.

	Target Value	Performance Data	Difference	% of Performance
Volga Federal District, including:	**25 486**	**10 464**		
Republic of Bashkortostan	3 186	3 000	-186	94,2%
Republic of Mariy-El	547	550	3	100,5%
Republic of Mordovia	670			N/A
Republic of Tatarstan	2 961	1 460	-1 501	49,3%
Udmurt Republic	1 253			N/A
Chuvash Republic	978			N/A
Kirov Region	1 060			N/A
Nizhny Novgorod Region	2 626			N/A
Orenburg Region	1 989	1 989	0	100,0%
Penza Region	1 057			N/A
Perm Region	2 435			N/A
Samara Region	3 265			N/A
Saratov Region	2 138	2 138	0	100,0%
Ulyanovsk Region	1 321	1 327	6	100,5%
North Caucasus Federal District, including:	**6 816**	**0**		
Republic of Dagestan	1 995			N/A
Republic of Ingushetia	395			N/A
Kabardino-Balkar Republic	653			N/A
Karachay-Cherkess Republic	320			N/A
Republic of North Ossetia-Alania	526			N/A
Chechen Republic	965			N/A
Stavropol Territory	1 962			N/A
Northwestern Federal District, including:	**12 838**	**2 100**		
Republic of Karelia	538			N/A
Komi Republic	743			N/A
Arkhangelsk Region	907			N/A
Nenets Autonomous District	38			N/A
Vologda Region	928	1 000	72	107,8%
Kaliningrad Region	871	1 100	229	126,3%
Leningrad Region	1 377			N/A
Murmansk Region	759			N/A
Novgorod Region	531			N/A
Pskov Region	529			N/A
Saint-Petersburg	5 617			N/A
Central Federal District, including:	**32 298**	**4 433**		
Belgorod Region	1 137			N/A
Bryansk Region	998			N/A
Vladimir Region	1 151			N/A
Voronezh Region	1 647			N/A
Ivanovo Region	937			N/A
Kaluga Region	775			N/A
Kostroma Region	548	538	-10	98,2%
Kursk Region	838	938	100	111,9%
Lipetsk Region	857	1 257	400	146,7%
Moscow Region	6 197			N/A
Oryol Region	634			N/A
Ryazan Region	917			N/A
Smolensk Region	736	500	-236	67,9%
Tambov Region	827			N/A
Tver Region	1 208	1 200	-8	99,3%
Tula Region	1 275			N/A
Yaroslav Region	1 012			N/A
Moscow	10 604			N/A
Far Eastern Federal District, including:	**5 029**	**1 890**		
Sakha Republic (Yakutia)	702	400	-302	57,0%
Primorsk Territory	1 675			N/A
Khabarovsk Territory	1 087	1 110	23	102,1%

	Target Value	Performance Data	Difference	% of Performance
Amur Region	623			N/A
Kamchatka Region	252			N/A
Magadan Region	121			N/A
Sakhalin Region	379	380	1	100,3%
Jewish Autonomous Region	140			N/A
Chukotka Autonomous District	50			N/A
Ural Federal District, including:	**12 121**	**6 360**		
Kurgan Region	824	824	0	100,0%
Sverdlovsk Region	4 605			N/A
Tyumen Region	1 369	743	-626	54,3%
Khanty-Mansi Autonomous Area	1 593	1 500	-93	94,2%
Yamalo-Nenets Autonomous Region	437			N/A
Chelyabinsk Region	3 293	3 293	0	100,0%
Southern Federal District, including:	**10 581**	**0**		
Republic of Adygea	335			N/A
Republic of Kalmykia	212			N/A
Krasnodar Territory	3 973			N/A
Astrakhan Region	734			N/A
Volgograd Region	2 144			N/A
Rostov Region	3 183			N/A
Siberian Federal District, including:	**17 893**	**2 000**		
Altai Territory	2 227	2 000	-227	89,8%
Zabaikalye Territory	915			N/A
Irkutsk Region	3 143			N/A
Kemerovo Region	2 828			N/A
Krasnoyarsk Territory	2 480			N/A
Tomsk Region	789			N/A
Novosibirsk Region	2 271			N/A
Omsk Region	1 617			N/A
Republic of Altai	170			N/A
Republic of Buryatia	812			N/A
Republic of Tyva	236			N/A
Republic of Khakassia	405			N/A
TOTAL:	**123 062**	**27 247**		**22,1%**
Entered data about constituent entities:	83	21 no data – 62		

Sum of target values for constituent entities with entered data:	29 602	Total performance in constituent entities with entered data (27247/29602):	92,0%
Number of regions with fully performed targets:	12 (57,1%)	Minimum indicator value:	49,3%
Number of regions (out of constituent entities with entered data) with failed targets:	9 (42,9%)	Average indicator value for constituent entities with entered data:	95,2%

Appendix 3. List of Participants of Group and Face-to-Face Interviews

To ensure confidentiality, the report contains no names and contact data of respondents. In case of reasonable necessity these data may be provided to authorized bodies upon request.

Cities, in which surveys were held:

1. Vyborg, Leningrad Region
2. Irkutsk
3. Kazan, Republic of Tatarstan
4. Lomonosov, a part of Saint-Petersburg
5. Naberezhnye Chelny, Republic of Tatarstan
6. Novotroitsk, Orenburg Region
7. Orenburg
8. Orsk, Orenburg Region
9. Saint-Petersburg

Positions held by surveyed employees of health care facilities:

- Medical directors of health care facilities, including Centres of prevention and fight with AIDS and infectious diseases (AIDS Centres) – 5
- Deputy medical directors for organization-related and methodology work in health care facilities – 2
- Chiefs of medical prevention departments, chiefs of outpatient departments and infectious diseases departments in health care facilities – 3
- Psychologists, specialists of psychosocial counselling rooms of AIDS centres – 2
- Nurses – 2
- Chief narcologists – 1

Other respondents:

- Members of steering bodies of the contractor organization of the Activities – 1
- Activities' coordinators – 3
- Outreach workers, social workers and peer counsellors – 5
- Patients of health care facilities, including representatives of population groups vulnerable to HIV – 17

Total respondents: 41

(In view of certain resource limitations, it is impossible to use representative sample, instead of which appropriate sample was used.)

Appendix 4. List of Documents Used in the Course of Assessment

1. www.hivnet.ru – data on implementing the Government Order Activities' targets
2. http://zakupki.gov.ru – Government Order documents (notices, explanations, tender documents, minutes, contract data)
3. itpcru@googlegroups.com – public e-newsletter, data on implementing the Government Order Activities' targets
4. www.minzdravsoc.ru – website of the Ministry of Health and Social Development of the Russian Federation, news section
5. www.rost.ru – programmes of priority national projects, such as "Education", "Health", "Affordable and Comfortable Housing to Russian Citizens" for 2009-2012
6. Budget Message of the President to the Federal Assembly of the Russian Federation as of June 23, 2008
7. Documents of the complaint to the Federal Antimonopoly Service of the Russian Federation – http://zakupki.gov.ru/pgz/public/action/complaint/info?complaintId=422624
8. Decree of the Government of the Russian Federation as of December 23, 2009 №1079 "Of Approving Rules of Providing Subsidy from the Federal Budget to the Russian Red Cross All-Russian NGO for conducting HIV Prevention Measures"
9. Practical guide on the organization of social support of HIV infected patients (using experience of "schools of patients") – www.spdfund.org
10. Draft of the Resolution of Rospotrebnadzor "Of Emergency Measures of Counteracting HIV Infection in the Russian Federation"
11. Health and Disease Control Rules SP 3.1.5.2826-10 "Prevention of HIV Infection" (approved by the Resolution of the Chief Medical Officer of the Russian Federation as of January 11, 2011 №1).
12. Social support concerning HIV infection: standards of service delivery – www.unodc.org
13. Strategy of the National Security of the Russian Federation until 2020 (approved by the Decree of the President of the Russian Federation dated May 12, 2009 №537)
14. Patterns of forwarding drug users to prevention and treatment facilities. Guidelines – www.unodc.org
15. Unified guide for arranging comprehensive prevention of HIV infection, viral hepatitis B and C among vulnerable population groups in the civilian sector – www.ohi.ru
16. Federal Law dated 30 March, 1995 №38-FZ "On Preventing Propagation of the Disease Caused by Human Immunodeficiency Virus (HIV Infection) in the Russian Federation"
17. Federal Law as of January 12, 1996 №7-FZ "On Non-Profit Organizations"
18. Federal Law dated March 30, 1999 №52-FZ "On Sanitary and Epidemiological Welfare of Population"
19. Federal Law as of July 21, 2005 №94-FZ "About Placement of Orders for Goods, Works and Services for State and Municipal Needs"
20. Federal Law as of December 13, 2010 №357-FZ "About the Federal Budget for 2011 and the Planning Period of 2012 and 2013"

Appendix 5. Assessment Organizations

Non-profit organizations – customers, initiators and organizers of the public assessment:

"New Life": "New Life" Independent Non-Profit Organization (Orenburg) was established in 2002 by volunteers of group of mutual support of people living with HIV. The organization was officially registered December 1, 2003. Its mission is enhancing quality of life of people living with HIV. ANO "New Life" implements initiatives aimed to develop comprehensive services of comprehensive support of HIV affected people, both in Orenburg Region and at the national level, including access to periodic health examination, treatment and rehabilitation, HIV prevention in high risk groups, general public education aimed to improve tolerant attitude of population to people living with HIV. www.новаяжизнь56.рф

Irkutsk Regional Branch of "Russian Red Cross" All-Russia NGO was officially established in 1924 to fight socially significant diseases, assisting health authorities in the propaganda of medical knowledge, sanitary / preventive medicine and rehabilitation aimed to reduce disease incidence and injury rate. In the beginning of 90s, with changes of economic environment in the country, Red Cross adjusted and chose lines of activities of the most importance and demand. Today, Irkutsk Regional Branch of Red Cross implements a number of initiatives aimed: to advocate healthy life style, prevent HIV/AIDS and drug use, to teach first aid methods and domiciliary nursing to population, to take care about patients in home facilities by efforts of sisters of charity and Red Cross nurses, etc. www.redcross-irkutsk.org

"Vera": "Vera" Kazan NGO of Drug-Addicts' Relatives was established in 2001. Its mission is helping and supporting people in difficult life situations, and their relatives, and enhancing quality of life of people living with HIV. Vera implements projects aimed to render social rehabilitation services to people in difficult life situations, and their relatives, as well as non-medical services to people living with HIV. r-vetroff@nm.ru

"Community of People Living with HIV": "Community of People Living with HIV" Interregional NGO (Moscow) was established in 1998. Its mission is enhancing quality of life of people living with HIV. "Community of People Living with HIV" implements nation-wide projects and initiatives aimed to develop social services and access to treatment and support of people living with HIV, to build adherence to periodic health examination and treatment, to prevent HIV infection, enhance information awareness and knowledge about HIV infection and treatment. www.positivenet.ru, www.arvt.ru

"AntiAIDS" Non-Governmental Foundation of Support of Penza Health Care and Education is a non-government organization established in 1995 by health care specialists, journalists, psychologists and active people in order to develop and implement initiatives aimed to prevent HIV infection among population of the region, with top priority given to prevention in groups with high risk of HIV infection. www.penza.aids.ru

"Positive Wave" Social Support and Health Care Fund (Saint Petersburg) was established in 2008 to provide HIV prevention services to vulnerable groups and to support people living with HIV in the Leningrad Region. Main lines of activities are developing non-medical services for people living with HIV in North-western Federal District, presenting interests of people living with HIV in terms of equal access to high-quality medical and social services in the Leningrad Region, preventing HIV infection, viral hepatitis and tuberculosis among vulnerable groups. www.pozvolna.ru

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