

MID-TERM EVALUATION
OF THE
USAID/ RUSSIA
MATERNAL AND CHILD HEALTH INITIATIVE
(MCHI) PROJECT
HRN-I-00-98-00032-00 Delivery Order No. 813

IMPLEMENTED BY
JOHN SNOW, INCORPORATED

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This Mid-Term Evaluation of the USAID/ Russia Maternal and Child Health Initiative (MCHI) Project HRN-I-00-98-00032-00 Delivery Order No. 813 Implemented by John Snow, Incorporated was made possible through support provided by USAID/ Russia under the terms of HRN-I-00-98-00032-00 Delivery Order No. 813. The opinions expressed herein are those of the authors and do not necessarily reflect the views of USAID.

Acronyms and Abbreviations

AIDS	acquired immune deficiency syndrome
ARO	Assistance to Russian Orphans
CA	Cooperating Agency
CDC	Centers for Disease Control and Prevention
COP	Chief of Party
CSW	commercial sex worker
CTO	Cognizant Technical Officer
EE/EA	Eastern Europe and Eurasia
EII	Early Intervention Institute
FCMC	family centered maternity care
FCT	Facility Coordinating Team
FORF	Future of Russia Foundation
GDA	Global Development Alliance
G-R	Gideon-Richter
HIV	human immunodeficiency virus
HR 2020	Healthy Russia 2020
IDU	injection drug user
IEC	information, education and communication
IR	Intermediate Result
IUD	intrauterine device
IV	intravenous
IWR	Interregional Working Group
JSI	John Snow, Incorporated
LAM	lactational amenorrhea method
MCH	maternal child health
MCHI	Maternal Child Health Initiative
MOH	Ministry of Health
MOHSD	Ministry of Health and Social Development
MOU	Memorandum of Understanding
MTCT	mother-to-child transmission
NGO	non-governmental organization
ob-gyn	obstetrician-gynecologist
PHC	Primary Health Care
PMTCT	prevention of mother to child transmission of HIV
QAP	Quality Assurance Project
RC	Regional Coordinator
RCT	Regional Coordinating Team
RFE	Russian Far East
RSOG	Russian Society of Obstetricians/ Gynecologists
SO	Strategic Objective
SOW	Scope of Work
STI	sexually transmitted infection
SWOT	strengths, weaknesses, opportunities, threats
TASC	Maternal and Child Health Technical Assistance and Support Contract

TO	Task Order
TOT	training of trainers
UNAIDS	Joint United Nations Programme on HIV/ AIDS
UNFPA	United Nations' Population Fund
UNICEF	United Nations' Children's Fund
US	United States
USAID	United States Agency for International Development
USG	United States Government
VCT	voluntary counseling and testing
VRF	Vishnevskaya-Rostropovich Foundation
WEI	World Education, Incorporated
WGY	Inter-regional Working Group on Youth Reproductive Health
WHO	World Health Organization
WIN	Women and Infant Health

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I. Executive Summary

In September 2003, the Russian mission of the United States Agency for International Development (USAID/Russia) awarded a task order (TO) to John Snow, Inc. (JSI) under the Maternal and Child Health Technical Assistance and Support Contract (TASC I) to implement their three-year Maternal and Child Health Initiative (MCHI) project whose stated objective was to ensure the adoption of internationally recognized maternal child health (MCH) standards and practices by the targeted health facilities in Russia.

As outlined in the original Contract, the following **Results** are to be achieved by the end of the Project:

- A Russian organization with a strong MCH mandate empowered, strengthened, and able to continue the promotion and provision of MCH innovations in Russia beyond the period of USAID's assistance.
- Internationally recognized standards and USAID promoted MCH practices adopted by targeted health facilities in at least ten regions of the Russian Federation, in addition to the two WIN Project's pilot regions.
- The abortion rate reduced in the targeted regions.
- Use of modern contraceptives as a mean to prevent unwanted pregnancies increased in the targeted regions.
- Youth-friendly services introduced and adopted by selected regions based on their unique needs and circumstances.
- Access to reproductive health services and information for men increased in the targeted regions.
- Introduction of newly developed protocols and internationally recognized standards into basic medical school educational materials initiated.

As outlined in a later modification, the following **additional Results** are also to be achieved:

- MCHI practices integrated in two more regions in the Russian Far East.
- Family planning services with a special focus on post-partum and post-abortion clients strengthened in all MCHI regions.
- A comprehensive reproductive health program for youth developed and implemented in at least two MCHI regions.
- Hepatitis B vaccination program for adolescents implemented in partnership with Vishnevskaya-Rostropovich Foundation (VRF) in the Far East.
- Early Intervention model developed by USAID-funded Assistance to Russian Orphans Program (ARO) integrated in MCHI model.
- A collaborative model on PMTCT-plus developed and implemented together with ARO in Irkutsk and other regions.
- New activities included and monitored in the overall monitoring and evaluation plan. Overall project results documented and disseminated in the pilot regions and nationwide.

In March 2005, MCHI reached its mid-point; this report attempts to assess MCHI's accomplishments to date and current status. A complete list of the team's conclusions and recommendations is found in Section XII.

The team found that the Maternal Child Health Initiative is a project that is definitely working. Change can happen. The **capacity building** that has occurred at the regional level is impressive, and the potential for continued achievement and further expansion within the target regions is great.

The design and implementation process of the MCHI Project is an **excellent model** (and already has been in Ukraine) for similar work in other countries and for the incorporation of additional evidence-based, internationally-recognized standards of care into the Russian health care system (e.g. additional reproductive health, family planning, and HIV/ AIDS interventions; tobacco; tuberculosis). Because of its client-centered, client-friendly approach, the MCHI model is also a good model for reaching traditionally hard-to-reach and/ or stigmatized populations (prisons, rehab centers, institutionalized youth) in need of these same services.

While not designed to impact national statistics, MCHI has the **potential to scale up further** than it has. The Project already reaches a substantial part of the 14 MCHI target regions which, taken all together, constitute more than one-sixth of Russia's total population. Both **replicability** and **sustainability** are key MCHI success stories. MCHI has benefited greatly from USAID/ Russia's consistent vision, commitment and support for the MCHI interventions

Conclusion: The selection process and criteria worked extremely well and are key contributors to the Project's robustness. The competitive element was innovative and positive. The co-financing requirement was also motivating. The requirement that the facilities chosen be an inter-related set of maternities, women's consultation clinics, children's polyclinics, family planning centers, and HIV/ AIDS center helped to horizontalize previously vertical institutions and to standardize the content and continuity of care.

Conclusion: It is highly likely that the evidence-based interventions introduced by MCHI will be sustained in target facilities beyond the life of the Project and that adoption of those interventions will be rolled out or spread throughout most, if not all, of the other health facilities in the target regions.

"I was very nervous when I went to Perm (for FCMC training) ...it is very hard to change rules and practices. The Perm trainers were excellent, and I got a lot of support from the City Health Department to implement the changes. I now go to every MCHI training and meeting that I can, and would like to see the Regional maternity and others included in MCHI...we need to increase the spread of this kind of service!" Chief ob-gyn, Vologda

Conclusion: It is unlikely that the MCHI interventions would spread to neighboring regions without organized intervention and support of some sort.

Conclusion: A frank and open discussion between MCHI and USAID/ Russia is needed regarding realistic options for continuing the scale-up of MCH innovations in Russia, given that it is unlikely the Russian Society of Obstetricians-Gynecologists (RSOG) will be able to fill this role. While the assessment team heard talk of adding up to three

additional regions to the current MCHI portfolio should additional funds become available, other options for scaling up might have more impact and allow broader implementation of key MCH innovations. A key concern is losing the momentum of MCHI when the current funding cycle ends in 2006.

Recommendation: Consideration should be given to initiating a broad, early dissemination phase under MCHI in which the resources created by WIN and MCHI are widely showcased and “packaged” and replication scaled up yet again in a less resource-intensive fashion. Materials, trainers, and achievements in various regions would be packaged for easy access by a larger number of regions using largely their own resources in a basically **Russia-to-Russia** exchange. MCHI could again solicit applications from this third tier of regions. A special effort should be made to target most of the Russian Far East (RFE) and to stress family planning and PMTCT. A series of “launch”-type conferences and cross-regional exchanges with “star” regions could be structured to help this third tier of regions get jump started.

The adoption and integration of **internationally-recognized, evidence-based standards** is occurring at a very impressive pace across an impressive range of political and health institutions actively involving an impressive number of people over an impressive geographic area. Inter-linking components and multi-level focus give it strength, breadth, adaptability and flexibility.

The MCHI approach and content is, for Russia, an idea whose time has come. The MCHI **process** (participatory, interactive, kind, respectful) is a major message that Russian counterparts were longing to hear and to which they’ve responded in kind. In effect, an effort is made to model with the regions the client-centered mother-friendly, baby-friendly, youth-friendly, family-friendly approach that the Project is striving to introduce into Russia’s reproductive health services. **Continuity of care** is reportedly becoming more consistent across facilities. The regional/ municipal/ facility-level contributions (financially and in-kind) are far in excess of what was initially expected. Project **leveraging** is substantial.



Conclusion: By identifying and supporting “catalyst” institutions and individuals, MCHI has helped multi-level leadership implement bold, rapid, substantive changes

Recommendation: It would be informative and useful to “capture” the degree to which MCHI has leveraged resources in the pilot regions. JSI should help MCHI develop a methodology and tool for doing this.

MCHI efforts to collaborate and coordinate are palpable. **Coordination** with donors and USAID-funded CAs is **close and synergistic** rather than proforma and perfunctory. Collaboration with Russian regional and municipal government partners has been strategic and successful. One of the **challenges** MCHI has faced is the **institutional development of RSOG** as its primary Russian partner organization. Realistically, there is no other known organization that would have been a stronger choice.

Conclusion: RSOG is a very appropriate and worthy partner for implementing the MCHI Project but would not be able to continue or expand the scale up unaided.

The MCHI Project has **strong management**. While paying close attention to contractual requirements, the Project has been **very responsive and adaptive** to changing external conditions, especially with regard to **incorporating HIV/ AIDS and PMTCT**-related activities and increasingly focusing Project attention on the **Russian Far East** as well as incorporating the Vishnevskaya-Rostropovich Foundation as a subcontractor.

Recommendation: JSI should help MCHI further introduce its “HIV/AIDS in the Workplace” policy.

HIV/AIDS and PMTCT work benefit from MCHI’s **strong technical and managerial capabilities**. The planned **PMTCT+FP Study** should provide valuable data for decision making to inform the development of strong future policy and service standards.

Conclusion: Although not included in the original MCHI Contract, in response to external realities and the needs of USAID/ Russia, MCHI has become a major leader in Russia for PMTCT policy development and service standards of care

Conclusion: The MCHI project design provides an excellent mechanism for humanizing, “horizontalizing” and integrating the care of HIV+ women and their infants into the health care system, a need that will grow exponentially as Russia’s HIV/ AIDS epidemic progresses.

In addition, the development of a collaborative **PMTCT-plus model** is progressing. This **synergistic** model for PMTCT-plus has the potential to revolutionize care for HIV affected families. MCHI has also worked with ARO to **integrate ARO’s Early Intervention model** into multiple MCHI training materials and is considered to be a substantive, positive addition that has especially strengthened the counseling component of these courses.

An important frontier in evidence-based programming is **youth reproductive health**. The **MCHI Youth Reproductive Health Task Force** has been formed and is active. Youth are not explicitly included, either directly or in an advisory capacity.

Recommendation: Global standards require that when the target group is youth, youth should have a voice in reviewing planned interventions.

Recommendation: MCHI should prioritize the completion of the program and evidence review by the Working Group on Youth but extend the expected completion date for compilation and use of the Youth Reproductive Health Replication Package until late 2005.

MCHI has done much to increase **male participation** in family planning and other reproductive health services. Due to factors beyond MCHI's control, the major Couples Campaign that is part of the coordination strategy with Healthy Russia 2020 has been delayed by six months but is expected to be launched shortly.

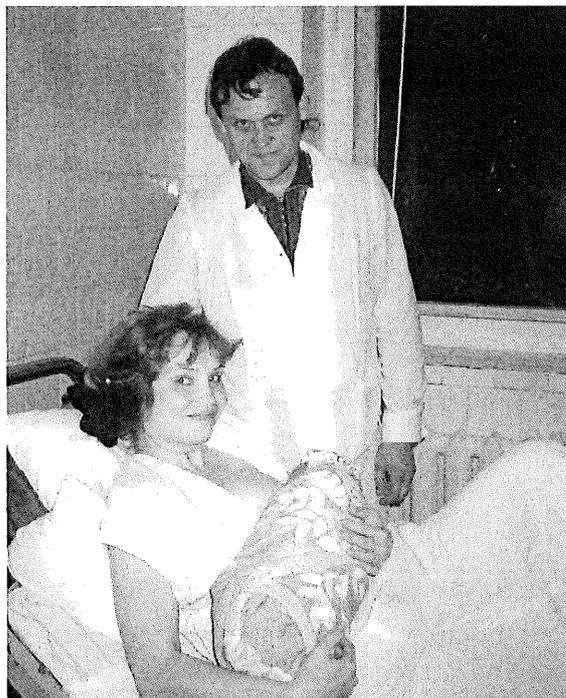
Conclusion: Considerable attention has been given to increasing active male participation and support at multiple junctures, and the results are visible. Male participation, including that of youth, has increased at MCHI sites in FCMC, breastfeeding support, family planning, post-abortion care, and counseling. **Gender integration** is more than adequate.

Recommendation: MCHI should continue to work closely with Healthy Russia 2020 on the Couples Campaign and related activities, using HR 2020 monitoring and mid-term evaluation results to advise MCHI RCTs on progress to date and any recommended mid-course adjustments.

Access to **quality family planning services** is being expanded. The regions do appear to have a core of family planning trainers and a basic family planning training capability

Conclusion: MCHI has placed needed emphasis on family planning, doing much to "horizontalize" and integrate family planning services broadly into MCH care. More attention needs to be given to developing providers' basic fund of knowledge regarding contraceptive methods. **Provider barriers**, such as the limited role of front-line providers and misinformation, further limit client access to an already limited choice of family planning methods.

Conclusion: Clearly much has been done recently to "horizontalize" and integrate family planning services; it would be worth the time and resources to further reinforce these gains and to focus



on missed opportunities at the facility level.

Recommendation: A review of the current MCHI Family Planning Replication Package materials focusing on contraceptive technology and cross-service counseling could help to strengthen and reinforce the program. The Project's family planning trainers should be involved in this process, reinforcing their skills and knowledge and integrating their experiences from the prior family planning TOT and courses. A second round TOT for the regional trainers could focus on identifying missed opportunities to reinforce pre- and post-partum and post-abortion counseling and would create an even more solid cadre of experienced family planning trainers in the 14 regions. In the context of the soon-to-begin "Couples Campaign", this would create an environment of increased opportunity for cross-counseling on family planning and STI/HIV primary prevention as well as PMTCT.

Influencing the Russian professional medical community has been a **great challenge**. Much work remains to be done for new MCH practices to be disseminated and accepted throughout Russia, and for federal standards to reflect evidence-based best practices. A **comprehensive Documentation and Dissemination Plan** is currently being finalized and MCHI is already implementing various actions outlined in the draft Plan. MCHI is actively seeking to better use the Internet for dissemination; the MCHI website now under development will extend dissemination of technical materials throughout Russia, the EE/EA region and potentially the world.

This year, USAID published a calendar entitled "12 Months of Telling Our Story" to help document the "uncounted thousands of lives" that USAID touches and that are "the true faces of America's foreign assistance programs". The team felt they met and saw hundreds of those faces in the course of this assessment. For February, the story is Russia Adopts New Methods of Prenatal and Infant Care and describes the interventions begun under WIN and scaled up by MCHI.

II. Introduction

In September 2003, the Russian mission of the United States Agency for International Development (USAID/Russia) awarded a task order (TO) to John Snow, Inc. (JSI) under the Maternal and Child Health Technical Assistance and Support Contract (TASC I) to implement their three-year Maternal and Child Health Initiative (MCHI) project whose stated objective was to ensure the adoption of internationally recognized maternal child health (MCH) standards and practices by the targeted health facilities in Russia.

The Maternal Child Health Initiative was designed to support and contribute to USAID/Russia's Strategic Objective, SO 3.2: *Use of Improved Health and Child Welfare Practices Increased*; Indicator 3.2.3: *Abortion rates*; Intermediate Result 3.2, IR1: *Access to More Effective Primary Health Care (PHC) Services Increased*; and its indicator: *Number of health facilities implementing evidence-based maternal and child health care practices* and to build upon USAID/Russia's very successful previous pilot, the 1999-2003 Women and Infants' Health (WIN) Project.

The Women and Infants' Health Project, also implemented by JSI, had promoted a range of interventions in model sites in Perm Oblast and Novgorod Oblast and had provided a new service model for the Russian health care system. WIN supported creation of a training and resource center, assembled and designed training curricula and information, education and communication (IEC), developed a group of Russian master trainers and established a core group of local best trainers. WIN also developed a number of data-based presentations for introducing evidence-based practices to new participants, derived from WIN monitoring and evaluation data as well as from its participants. The WIN Project also prepared a guide for replication of WIN interventions in other regions, and its advocacy for policy change led to the development of three protocols for health care practice based on internationally-recognized standards regarding breastfeeding, post-abortion care and infection control in maternity hospitals. The Post-abortion Care Guidelines were issued as a federal guideline ("precaz") by the then Ministry of Health (MOH), now Ministry of Health and Social Development (MOHSD).

In May 2004, modification #1 to the MCHI contract increased the funding ceiling, changed the designated Cognizant Technical Officer (CTO) and added a new reporting requirement. In July 2004, modification #2 increased the funding ceiling and amended the statement of work to emphasize strengthening and expanding reproductive health and family planning services. Also in July 2004, modification #3 added incremental funding. In September 2004, modification #4 again increased the funding ceiling and amended the statement of work to include the Future of Russia Foundation (FORF) as a subcontractor to help establish a model perinatal health care program at the Moscow Region Perinatal Center in Balashikha using Global Development Alliance (GDA) funding.

As outlined in the original Contract, the following **Results** are to be achieved by the end of the Project:

- A Russian organization with a strong MCH mandate empowered, strengthened, and able to continue the promotion and provision of MCH innovations in Russia beyond the period of USAID's assistance.
- Internationally recognized standards and USAID promoted MCH practices adopted by targeted health facilities in at least ten regions of the Russian Federation, in addition to the two WIN Project's pilot regions.
- The abortion rate reduced in the targeted regions.
- Use of modern contraceptives as a mean to prevent unwanted pregnancies increased in the targeted regions.
- Youth-friendly services introduced and adopted by selected regions based on their unique needs and circumstances.
- Access to reproductive health services and information for men increased in the targeted regions.
- Introduction of newly developed protocols and internationally recognized standards into basic medical school educational materials initiated.

As outlined in modification # 2, the following additional **Results** are also to be achieved:

- MCHI practices integrated in two more regions in the Russian Far East.

- Family planning services with a special focus on post-partum and post-abortion clients strengthened in all MCHI regions.
- A comprehensive reproductive health program for youth developed and implemented in at least two MCHI regions.
- Hepatitis B vaccination program for adolescents implemented in partnership with Vishnevskaya-Rostropovich Foundation (VRF) in the Far East.
- Early Intervention model developed by USAID-funded Assistance to Russian Orphans Program (ARO) integrated in MCHI model.
- A collaborative model on PMTCT-plus developed and implemented together with ARO in Irkutsk and other regions.
- New activities included and monitored in the overall monitoring and evaluation plan. Overall project results documented and disseminated in the pilot regions and nationwide.

Also included in the MCHI mandate, as outlined in the MCHI contract, was the requirement that *“At the mid-term and end of the Task Order, the contractor shall prepare a report that highlights accomplishments against work-plans, gives the status of the expected results, addresses lessons learned during implementation, and suggests solutions for resolving constraints identified. The report should demonstrate how Russian partners will continue activities beyond the completion of the project to ensure project sustainability.”* In March 2005, MCHI reached its mid-point; this report attempts to assess MCHI’s accomplishments to date and current status.

III. Background

Russia has made significant progress during the past two decades toward improving the health status of women and children. Compared to Western Europe, the United States, and recommended international standards, however, a gap still remains. Although encouraging declines have been recorded, Russia’s maternal mortality rate, infant mortality rate and abortion rate continue to be of concern, as does a reportedly increasing infertility rate.

In addition to poor maternal and child health status, Russia faces another predicament, a low birth rate. Although some recent reports indicate that the birth rate in Russia may be increasing, the overall trend is still low. Understandably, the resulting decline in the population has become one of the of the Russian government’s major concerns.

The use of modern contraception does not have a long history or well-developed service delivery infrastructure in Russia. Abortion has historically been the primary means of birth control. Triggered by political and church worries about Russia’s falling population size and concerns surrounding the morality of induced abortion, coupled with misunderstandings about family planning and its role in maternal and infant health, in 1998 direct public sector support for family planning was discontinued by the State Duma. Funding was merged into the Safe Motherhood Program; this step resulted in limiting access to contraception for couples that may not be able to afford its cost.

USAID’s maternal and child health initiatives to date, in particular the Women’s Reproductive Health Project and the Women and Infants’ Health Project, along with other USAID and

international donors' interventions, have set up effective models to address some of these challenges and improve services provided to women and infants. Nevertheless, the need for continued health system development was recognized as most Russian health care facilities continued to perform out-dated and non-evidence-based practices. It was in this context that the Maternal Child Health Initiative was designed and awarded.

Increasingly, as WIN was ending and MCHI was beginning, Russia's attention and the attention of USAID/ Russia turned to Russia's worsening HIV/ AIDS situation. In 2003, USAID/ Russia developed a five-year operational plan for HIV/ AIDS prevention in which HIV/ AIDS was identified as a key foreign policy objective for the United States (US) mission to Russia and as the number one health priority for the US mission in the social sector. Already USAID was the lead bilateral donor in Russia on HIV/ AIDS; the expectation was that the entire health portfolio would be realigned to reflect the new priorities, including the addition of prevention of mother-to-child transmission (PMTCT) of the human immunodeficiency virus (HIV) activities to WIN/ MCHI.

IV. Methodology

The MCHI mid-term assessment utilized rapid appraisal methods. The two-person evaluation team based the findings presented in this report on a review of MCHI documents and Project reports, assessment visits to three of the 14 Project regions (Vologda Oblast, Tyumen Oblast and the Komi Republic), and a broad array of key informant interviews.

The Team

This was an internal JSI mid-term review, completed by two senior JSI employees with decades of experience in international public health programming; see Appendix A: Scope of Work (SOW) for a summary of their qualifications.

In addition, the team was joined by Harriet Destler, Chief of Health Programs for Eastern Europe and Eurasia, USAID/ Washington, for all three regional visits. Larissa Petrossyan, Project Manager, USAID/ Russia and MCHI CTO, joined the team for the visits to both Vologda Oblast and Tyumen Oblast as did the MCHI Chief of Party (COP), Natalia Vartapetova. The MCHI Training Coordinator, Elena Stemkovskaya, joined the group for the visit to the Komi Republic.

Orientation

The team met with USAID Regional Health Chief Destler; USAID/ Russia Health Office Director, Betsy Brown; USAID/ Russia Deputy Health Office Director Sylva Etian; Project Manager and MCHI CTO Petrossyan; and MCHI COP Vartapetova for orientation sessions before beginning key informant interviews and regional field visits. During these meetings, the SOW, team responsibilities and schedules for regional travel were reviewed, and USAID provided additional guidance to the team on areas of particular interest including health financing, contraceptive method mix, reproductive health for youth, eligibility criteria for contraceptive use, and the potential for replicability of the MCHI model in regions outside of the 14 MCHI project intervention regions.

Assessment Tools

Illustrative questions to guide the evaluation process were provided to the team as part of the SOW. These questions did guide the process and also formed the basis for a Regional Assessment Guide (Appendix B: Regional Assessment Tool) developed before and during the first regional visit to Vologda Oblast. This tool was used as a guide but could not be systematically used during the visits, primarily because so many facilities were visited in each region. In addition, the richness of the visits would have been interrupted by adherence to a strict protocol for information collection.

Review of MCHI Documents and Reports

A large selection of documents were reviewed, their content analyzed and further questions asked of MCHI staff, staff of collaborating organizations, and health officials at federal, regional, municipal and facility levels. Appendix C: Documents Reviewed provides a list of all documents reviewed. Throughout the course of the work in Russia and afterwards, additional documents were obtained and added to this list.

Regional Field Visits

The SOW included visits to three of the 14 MCHI regions: Vologda Oblast, Tyumen Oblast and the Komi Republic. Actual geographic zones visited include Vologda Municipality, Tyumen Municipality, and Syktyvkar Municipality (including Ezhva City) in the Komi Republic. The team did not visit any of the original WIN Project sites. Appendix D: Regional Site Visit Schedules includes the schedules for the visits. Each visit covered two full days; in addition regional health authorities, MCHI Regional Coordinators (RCs) and many MCHI Regional Coordinating Team (RCT) members and Facility Coordinating Team (FCT) members met with us during meal times and in the evenings.

MCHI clinical sites including maternity hospitals, women's consultation clinics, pediatric polyclinics, and specialized sites including family planning rooms, breastfeeding areas and HIV/AIDS Centers were all visited. In Vologda and Syktyvkar, the team also visited non-project clinical sites. The vast amount of information collected on the regional visits is reflected throughout this report in examples and quotations as well as in the findings, conclusions and recommendations.

Key Informant, RCT, and FCT Interviews and other Interactions

Key informant, RCT, FCT and other group interviews took place, as well as short conversations with clients and sometimes with their family members. The team completed more than 25 key informant interviews in Moscow and in the three regions during the site visits. The team also benefited from on-going discussions with USAID and MCHI staff who accompanied them on the regional field visits, which provided an opportunity for on-going "key informant interviews" as the team visited sites and collected additional questions.

Overall, the team, including USAID and MCH staff, interacted with more than one hundred and fifty regional, municipal and facility level staff. The names of most of these contacts are listed in Appendix E: Contact Lists. This Appendix is divided into four lists by geographic area. In addition, approximately forty clients agreed to be asked questions by one of more member of the visiting group; sometimes accompanying family members were also involved in these conversations, especially in maternities where husbands and mothers were often present.

Gap Analysis, Analysis, Conclusions and Recommendations

The information and data collected was reviewed by the two-person team and a gap analysis completed after the third regional field visit. Every attempt was made to complete the collection of relevant information, data and materials in a timely way. Analysis methods including strengths, weaknesses, opportunities, threats (SWOT), timeline and others were applied as appropriate. Extensive use of hundreds of pages of notes from the field visits was also important. The results are organized in the following way in most sections of the report:

Mandate: MCHI expected Results and Tasks
Progress to Date
Regional Visits
Findings
Conclusions
Recommendations

The final section includes a summary of key conclusions and recommendations that identify constraints or elements for further enhancing successes and that delineate issues related to replicability and sustainability of priority interventions after the end of the MCHI Project.

V. Current Status of Expected Results and Tasks

A. Russian Partner Organization

Mandate:

The Result “A Russian organization with a strong MCH mandate empowered, strengthened, and able to continue the promotion and provision of MCH innovations in Russia beyond the period of USAID’s assistance” is to be achieved via two main **Tasks**:

1) “The Contractor shall identify and partner with a key Russian health organization with a strong MCH mandate in order to promote and carry out the replication component of the activity. The selection criteria used to identify this partner organization should include, but not be limited to, the ability of the Russian partner to cost-share (for example contribution of overhead, staff time, office space/equipment, etc.). In addition, the organization should have a favorable reputation and be well-respected by the Russian government health authorities, academicians, and the international donor community in Russia” and

2) “One of the tasks of the Contractor shall be to develop and build the capacity of the selected Russian organization throughout the course of the contract, to enable it to follow-on and continue similar replication efforts after USAID programming ends in Russia. The

Contractor shall develop a detailed plan outlining both the involvement of the partner organization in the overall implementation process and interventions that will be undertaken to build the capacity of the Russian partner."

Progress to date:

After due consideration, JSI chose the Russian Society of Obstetricians/ Gynecologists (RSOG), a non-commercial professional membership organization and a registered non-governmental organization (NGO), as their prime Russian partner for implementing the Maternal Child Health Initiative. On 9 October 2003, at the very start of the MCHI Project, RSOG and JSI signed a Memorandum of Understanding (MOU). RSOG then appointed a MCHI/ RSOG Coordinator, a respected physician who had already been involved in WIN as an expert in family planning and thus was already cognizant of the Project's goals and objectives. As part of the RSOG/ MCHI collaboration strategy, it was agreed that regional RSOG members should be part of the Regional Coordinating Teams responsible for overseeing Project implementation at the regional level. RSOG would also be part of the MCHI Interregional Working Group (IWG) and thus would participate in initial and follow-up site visits. It was also planned that some RSOG members would become trainers, thus providing RSOG with training capability and providing MCHI with needed additions to their cadre of consulting trainers. MCHI was to submit articles for publication in the RSOG journal. Quite early in the Project, the idea developed to have JSI hold its planned Eastern Europe and Eurasia (EE/EA) Regional Conference in Moscow in October 2004 at the time of the RSOG annual "Mother and Child" Congress.

In June 2004, a senior staff member from JSI's partner organization, World Education, Incorporated (WEI), conducted an assessment to help determine the extent to which RSOG could be engaged in a capacity building process to enable them to continue the MCHI work beyond the period of USAID's assistance. This assessment involved studying RSOG's goals and objectives, its structure, its major activities, how RSOG's Board is constituted and functions, and the relationship between RSOG centrally and RSOG regionally.

In essence, RSOG's structure parallels the official state structure; one's role in RSOG is determined more by position than by personal characteristics. No one defines him/herself first and foremost as an RSOG official. A change in state position would bring a change in RSOG position. The head obstetrician-gynecologist (ob-gyn) at the Ministry of Health has traditionally been the president. A self-organized, self-selected and self-perpetuating 50 member Presidium governs RSOG and selects the nine-member executive committee. Reportedly there are committees that deal with issues such as quality assessment, education and certification, and medical ethics, etc. but they meet informally and sporadically.

There are 54 "official" branches in the 89 Russian regions. Smaller regions may have "unofficial" branches and/or may join up with neighboring regions. The RSOG regional branches are traditionally headed by their head ob-gyns. The relationships between regional RSOG groups and central RSO are reportedly personal rather than organizational.

RSOG is, in many ways, an informal organization; it does not have any permanent staff or infrastructure. Not all of Russia's 33,000 ob-gyns belong to RSOG, but RSOG is not able to say

exactly who does and who doesn't. Estimates are between one half at minimum to two-thirds as maximum. There is a membership fee (~500 rubles) but not all pay it and non-paying ob-gyns may still consider themselves members. A portion of dues collected is retained regionally; the rest goes to RSOG centrally.

RSOG does publish a journal that is distributed only to dues paying members. A major RSOG function – centrally and regionally – is the organizing of seminars and conferences, generally with substantive financial support from pharmaceutical companies. The pharmaceutical companies also underwrite most publications and may fund young professionals for short periods of specialist training abroad. Each fall, RSOG hosts an annual convention in Moscow that draws up to 1,500 attendees. MCHI together with key RSOG members are planning to publish a number of articles in national medical journals.

RSOG is well-recognized and well-respected. The President of RSOG signs all certificates issued by the MCHI training courses, lending prestige and credibility to the training provided. RSOG "approval" is also on Project materials which underscores the quality and importance of the contents. Regionally, for Project implementers to say they have the support of RSOG makes the MCHI activities more Russian, a very important attribute at the regional level. RSOG helps MCHI with information dissemination via the RSOG journal and via presentations at conferences and seminars. RSOG has agreed to include information on regional efforts in the RSOG journal.

RSOG is currently an organization in transition, in part due to major external changes: the ongoing restructuring of the MOHSD and the advent of federally-mandated obligatory free medical services. RSOG would like to be in more of a position to advocate for policy change at the federal level. It is interested in helping to determine standards of care. It would also like to take on some of the MOH's licensing and continuing education roles but recognizes it does not have the structure, funding or capacity currently to do this.

After the June 2004 WEI assessment visit, a proposal was made to RSOG outlining areas of good "fit" between RSOG needs and resources and MCHI needs and resources. The three areas highlighted were developing standards and guidelines, providing clearly defined training support and exploring an independent regional level pilot program with RSOG groups in Kaluga and Perm Oblasts.

In October 2004, with logistical and organizational support from MCHI and financial support from JSI headquarters, JSI held a four-day Eastern Europe and Eurasia Regional Conference in Moscow. The first day, representatives from JSI/ Boston, JSI/ Washington and JSI projects in Central Asia, Georgia, Romania and Ukraine joined representatives from the 14 MCHI regions, the MOHSD, RSOG, and USAID/ Russia to hear a keynote address by JSI's President on "Reproductive Healthcare Challenges in the 21st Century". This was followed by small group work to discuss and prioritize the major existing and emerging issues in the EE/EA region and a panel discussion on integrating HIV/AIDS work into reproductive health services. The second day coincided with the opening day of the RSOG Annual Meeting at which JSI presented a three-hour session on "Implementing Modern Maternal Child Health and Reproductive Health Practices in Eastern Europe and the Newly Independent States" which highlighted JSI work

underway in Russia, Central Asia, Romania and Ukraine. RSOG's Vice-President, Professor Vladimir Serov, opened the JSI session. RSOG anticipated a relatively modest interest in the JSI session and provided a room that seated approximately 200 people. The actual response was beyond everyone's expectations; there was standing room only in the room while a very large group of people stood in the hall outside the room and listened through headsets. Day three was devoted to country updates and feedback from the RSOG presentation and day four to a monitoring and evaluation workshop. Abstracts of the JSI presentations were included in the RSOG Annual Meeting program. Also, for two days of the RSOG Meeting, JSI had a booth in the exhibition hall where information and materials on the JSI EE/EA projects were available.

In the interim since the WEI assessment visit, RSOG has been involved to some extent in the development of PMTCT guidelines and initial meetings have been held with Kaluga and Perm representatives and plans of mutual activities developed. Most important, RSOG does recognize the existence of active, change-oriented regional leaders and wants to begin moving from a "paper structure" to a more active, functional structure. To this end, they have asked JSI to conduct a special training in May for regional leaders from each MCHI region plus central RSOG. The focus will be on developing RSOG's strategic thinking and planning over the next two years. RSOG hopes that with new ideas and new skills, they can be more effective at influencing policy makers and medical university/ medical college educational leaders. The informal agenda is also to strengthen the bond between central and regional RSOG.

MCHI is working informally with the Russian Pediatric Society and is exploring the possibility of their jointly publishing a PMTCT newsletter or other informational materials and/or involving them in the Project's youth work but this organization has a more commercial focus than RSOG and similar organizational constraints.

Regional Visits:

With probing, ob-gyns would acknowledge considering themselves to be RSOG members but no one really saw RSOG membership as a key part of their professional identity. Regional groups appear to act independently of RSOG centrally and they may have somewhat different concerns. An issue may be that RSOG centrally is composed predominantly of academicians while RSOG regionally is composed predominantly of clinicians. Regional groups do report an interest in more involvement at the federal level but they don't yet identify RSOG as the likely conduit for that involvement.

Finding: Due to RSOG's lack of formal structure, direct RSOG involvement in MCHI is heavily concentrated in a single individual who is the official MCHI/ RSOG liaison and is also the Project expert on reproductive health.

Finding: Realistically, there is no other known organization that would have been a stronger choice. In Russia, the specialist associations have yet to have a major role in decision making but their influence is reportedly growing.

Finding: Despite its limitations, RSOG is a very appropriate and worthy partner for implementing the MCHI Project

Finding: Working with RSOG has led to greater dissemination of MCHI innovations through professional channels than working through the MOHSD alone would have afforded.

Conclusion: While a very appropriate and worthy partner for implementing the MCHI Project, RSOG would not be able to continue or expand the scale up unaided. Providing the level and extent of the capacity building that RSOG would need to allow them to continue MCHI-type interventions is beyond the resources (time, human, financial) of MCHI, nor could RSOG absorb such intense capacity building efforts, even if available, at this time.

Conclusion: Relevant and feasible organizational development work with RSOG should be continued as appropriate.

Conclusion: A frank and open discussion between MCHI and USAID/ Russia is needed regarding realistic options for continuing the scale-up of MCH innovations in Russia begun under WIN and greatly expanded under MCHI, given that it is unlikely RSOG will be able to fill this role in the foreseeable future. While the assessment team heard talk of adding up to three additional regions to the current MCHI portfolio should additional funds become available, other options for scaling up might have more impact and allow broader implementation of key MCH innovations. A key concern is losing the momentum of MCHI when the current funding cycle ends in 2006.

Recommendation: Consideration should be given to initiating a broad, early dissemination phase under MCHI in which the resources created by WIN and MCHI are widely showcased and “packaged” and replication scaled up yet again in a less resource-intensive fashion. Materials, trainers, and achievements in various regions would be packaged for easy access by a larger number of regions using largely their own resources in a basically Russia-to-Russia exchange. As was done previously, MCHI could again solicit applications from this third tier of regions. A special effort should be made to target most of the Russian Far East (RFE) and to stress PMTCT. A series of “launch”-type conferences and cross-regional exchanges with “star” regions could be structured to help this third tier of regions get started.

B. Adoption of Internationally-Recognized, Evidence-Based Standards

Mandate:

The **Result** “*Internationally recognized standards and USAID promoted MCH practices adopted by targeted health facilities in at least ten regions of the Russian Federation, in addition to the two WIN Project’s pilot regions*” is to be achieved via three main **Tasks**:

1) “*The Contractor shall compile a comprehensive Replication Package, including guidelines, protocols, and practices defining new approaches to MCH services. This package should include the WIN Project’s “how-to-guide,” materials developed under the Women’s Reproductive Health Project, and other USAID funded MCH initiatives to date. This package should also include any other newly developed and appropriate MCH practices by other donor organizations.*”

2) “Ten new regions shall be selected on a competitive base for the implementation of the replication component of this activity. The Contractor shall propose a design for the selection process, including selection criteria to be used to identify the participating oblasts and the corresponding health facilities. Cost sharing, a supportive regional health administration, and in-kind staff time shall be included among the selection criteria. Priority should be given to US government and USAID priority regions, as well as those sites where other AID or USG projects are being implemented. Thirteen oblasts have already expressed their interest to replicate the WIN model. It is anticipated that more regions will request such assistance during the final WIN dissemination conference, planned for May 2003. The advocacy and dissemination efforts under Healthy Russia 2020 and Phase III of the Quality Assurance Project will also help boost regional interest.”

3) “A comprehensive replication strategy shall be developed by the Contractor specifying the process and timelines for newly selected health facilities. The Contractor, along with the Russian partner organization, shall carry out and facilitate this process. It is expected, however, that by the beginning of the third year, the role of the Contractor shall evolve to only facilitate and oversee this process, whereas the actual administration and delivery elements of the replication component will be conducted by the Russian partner in collaboration with the targeted health facilities. The range of interventions to support the replication process may include health provider training, restructuring of services, technical assistance, cross-regional visits, etc. Resources developed under the WIN Project, i.e., a pool of master trainers and the training center in Perm, as well as other resources developed under USAID programs (including models supporting the institutionalization process developed under Phase III of USAID’s Quality Assurance Project) should be utilized. In addition, the replication plan should be adapted to be appropriate for each targeted region or facility to address their unique needs and circumstances.”

Contract modification #2 added a second **Result**: “MCHI practices integrated in two more regions in the Russian Far East” to be achieved via an additional **Task**:

4) “The current replication strategy and planned interventions under the MCHI three year workplan should be expanded to Primorsky Krai and Khabarovsk Krai in the Far East.”

Progress to date:

In October 2003, at the end of the Project’s first month, the MCHI Project convened a working meeting of MCH experts and consultants from Moscow and Perm plus Project staff to develop the criteria and methodology for selecting the new MCHI regions and to outline the replication strategy for implementing the Project in the new regions.

Already, after the WIN Dissemination Conference in May 2003 and the advocacy and dissemination efforts of Healthy Russia 2020 and the Quality Assurance Project, close to 20 regions had indicated interest in replicating the WIN model. At the start of MCHI, the nature of the Project and the selection criteria were widely publicized via the RSOG Annual Meeting, MOH announcements, professional journals, e-mail, pharmaceutical company distributors, and word of mouth (see Appendix F: MCHI Selection Criteria). Ultimately, 39 of Russia’s 89 regions submitted applications.

A selection committee formed at this time then reviewed the 39 applications received and conducted oral interviews with both administrative heads and facility heads to be certain they understood MCHI's key concepts. The following 10 regions were selected: Altai Krai, Irkutsk Oblast, Kaluga Oblast, Komi Republic, Krasnoyarsk Krai, Murmansk Oblast, Omsk Oblast, Orenburg Oblast, Tyumen Oblast, and Vologda Oblast.

The 10 sites ultimately selected were officially announced 12 January 2004, and MCHI signed agreements with the Regional Health Care Administrations shortly thereafter. Mutually agreed upon Regional Coordinators were selected who then formed Regional Coordinating Teams.

In January 2004, as an integral part of the Project's replication strategy, MCHI convened a two-day Interregional Working Group meeting composed of representatives from RSOG, MOHSD and USAID; the Project experts in family-centered maternity care (FCMC), breastfeeding, antenatal care, neonatal care, newborn resuscitation, and infection control; and Project staff to address multiple components of Project implementation. Together, the working group reportedly reviewed the upcoming MCHI Launch Conference, the annual work plan, and the monitoring and evaluation plan including key indicators and also discussed how to strengthen the MCHI training courses. In addition the IWG reviewed a standardized set of presentations on the WIN experience and the planned MCHI interventions designed to assist in policy development and the creation of a supportive environment. The group also developed a schedule for initial site visits to the new regions.

In mid-February 2004, a three-day MCHI Launch Conference was conducted in Perm. The more than 100 participants included multiple representatives from the Regional Coordinating Teams from the 10 new regions as well as representatives from RSOG, the medical press, Healthy Russia 2020, USAID/ Russia and JSI/Boston. During this Conference, participants heard in detail about the WIN results and the core integrated MCHI internationally-recognized evidence-based practices: FCMC, exclusive breastfeeding, essential newborn care, family planning, infection control, and PMTCT. Overviews of the Project training courses were presented and two half-days were devoted to site visits to pilot facilities to see implementation results firsthand. Each regional delegation then drafted its own region-specific workplan. Appendix G: MCHI Input Matrix illustrates what has occurred and is planned for each region.

In early March 2004, several weeks after the Launch Conference, the RCT members responsible for conducting the baseline facility surveys in their respective regions attended a two-day Monitoring and Evaluation Workshop in Moscow. The Workshop further introduced the Project's monitoring and evaluation system and trained participants in facility-based survey techniques and data entry using SPSS software. Prior to the Workshop, the survey questionnaires had been finalized and field tested by Project experts and staff. Shortly thereafter, baseline data collection for the facility-based surveys started in all 10 new regions and was completed in May. The collection of official medical statistical data at the facility, municipal and oblast levels was also begun. A special monitoring form was also developed for follow-up supervision visits to be done twice yearly to monitor progress, provide technical assistance, address implementation issues, and adjust Project activities if necessary.

Also beginning in March, representatives of the Interregional Working Group together with Project staff visited all 10 new regions to help in policy development and needs assessment and to discuss and finalize the region-specific MCHI implementation plans. The IWG met again after the first four visits to review results to date and then completed the remaining six visits by mid-May.

By May 2004, Project training had started in earnest with multiple courses being given in multiple locations.

Although PMTCT was not included in the original Contract, from the very start of the MCHI Project, MCHI and USAID/Russia agreed that HIV/ AIDS and PMTCT should be integrated into MCHI activities. This focus also necessitated incorporating the regional HIV/ AIDS Centers into Project activities, an intervention also beyond the scope of the original Project. In June 2004, with support from World Education, Project experts and staff together with representatives from the

Comprehensive Replication Packages were initially planned for the following content areas:

- **Family Planning/Reproductive Health/ HIV/AIDS Prevention**
- **Family Centered Maternity Care/ PMTCT**
- **Breastfeeding/ Baby-Friendly Initiative/ HIV/AIDS Prevention**
- **Newborn Care and Breastfeeding/ PMTCT**
- **Neonatal Resuscitation**
- **Infection/ HIV Control in Maternities**
- **Antenatal/ PMTCT**
- **Youth Friendly Services/ HIV Prevention**

Novgorod branch of the Early Intervention Institute (EII) supported by Assistance to Russian Orphans, USAID/ Russia and the JSI/ Ukraine Maternal and Infant Health Project held a two-day workshop to update the antenatal component, incorporate EII and PMTCT approaches and materials, and reconsider its formatting. (The completed, reformatted course was recently pretested in Vologda in March; minor changes have since been made and it is ready for use.) During this same time period, materials used in the breastfeeding course were also updated to include more materials on family planning and PMTCT.

In July 2004, per Contract modification #2, two additional regions were added to the MCHI portfolio: Khabarovsk Krai and Primorsky Krai, both in the Russian Far East. By September, agreements with the new regions had been signed, initial site visits had been conducted, region-specific workplans had been developed and both new regions had been incorporated into the training plans. In October the two new regions received monitoring and evaluation training, including the methodology for conducting their facility-based surveys.

To meet MCHI's expanded training needs, MCHI also worked to expand their cadre of trainers, adding six family planning trainers, two breastfeeding trainers and 2 FCMC trainers. Appendix H: Current MCHI Replication Packages indicates the Replication Packages currently used for MCHI training; these are in constant revision in order to improve their content. Appendix I: Training By Region and Topic details the training received to date by the target regions.

At this point in the implementation process in the 10 new regions, Project staff report no particular major, special concerns about any of the 10 regions selected. Some facility leaders were described by staff as being "old-fashioned" and/ or faced with dealing with a very aggressive and resistant sanitary-epidemiology department initially but their facilities have now

made substantial progress. It is now believed one of the initially most resistant and old-fashioned regions overall may end up being one of the brightest stars.

The ability of RSOG to assume responsibility for the administration and delivery elements of the replication component in MCHI's final year and beyond has been addressed in the previous section.

Regional Visits:

During the three regional visits, the support and enthusiasm at multiple levels for the changes and innovations introduced by MCHI were broad, deep and infectious. The regions visited were forward thinking and vibrant and each had contributed substantially (financially and in-kind) to support the MCHI interventions. At all levels, the public authorities and the health providers expressed pride in what they'd accomplished; they felt they'd chosen their implementing sites well and they saw MCHI as showcasing new approaches and appropriate technologies. Family planning and breastfeeding were not new concepts, of course, but many aspects of FCMC and PMTCT were truly revolutionary. Many acknowledged that the pace of implementation has been very brisk but they seemed to thrive on it.

"I am truly amazed at what I've seen. We've gotten big changes at modest cost by investing in our human resources via your training." Head of health department in Vologda reporting on earlier visits to the Project facilities in his Oblast

The training process and the trainers themselves were highly praised. Multiple references were made about the original MCHI Launch Conference in Perm being energizing and exciting. The participatory, interactive training techniques were widely appreciated as was the interdisciplinary approach modeled by the composition of the trainers as well as by the mix of participants in the courses. The trainers themselves were described as being kind, respectful, interactive, energetic, highly professional and accessible, a welcome compliment given the effort that WIN previously and now MCHI have devoted to developing a strong cadre of all Russian trainers. Many also spoke highly of the competency and strength of the MCHI staff in Moscow, describing the Project as well managed and responsive to their needs.

"You taught trainers to listen to the opinions of others. We never felt forced to do anything. We had many discussions, some quite heated!" RCT member Vologda

The expectation that those selected by the RCTs to attend the MCHI courses be ready and willing to train others upon their return appears to have been extremely well fulfilled. In many other health projects, this "cascade" training approach has been problematic but it appears to be functioning well in the three regions visited. First of all, attendees are chosen in part based on their interest and willingness to share their experiences with others; this readiness and willingness to train others is an explicit criterion for selection. Secondly, most if not all MCHI courses include counseling and communication

"Your training showed us how to communicate more closely with our patients, in all areas, not just breastfeeding" Ob-gyn, Tyumen

components. To strengthen the “cascade” training related to family planning, two to three individuals from each region have participated in a special “training of trainers” (TOT) course.

The considerable physical changes, especially in the maternities, are very obvious. Many sites, for instance, have converted delivery halls into spacious, single delivery rooms. Most maternity houses visited have stopped routinely requiring perineal shaves, enemas, or intravenous (IV) lines; if not, they are at least optional. The team saw partographs in active use. Many staff reported decreases in medications used, decreases in episiotomies (but slight increases in perineal tears), as well as decreases in the use of IV anesthesia and more reliance on local anesthesia when needed. In most facilities, there was a wide range of printed materials on the walls, as well as frequent handouts.

“Before MCHI, our maternity houses were like prisons. Women feared being there.” Vologda maternity house ob-gyn

More than the physical changes in their facilities and more than their deepened knowledge of evidence-based practices, many in the regions stressed the changes in their ways of thinking, in their “mentality”, as the most powerful outcome of being involved with the MCHI Project. The process and content of MCHI seems to have been exceptionally timely for Russia. Many saw the Project as fostering a renewed support and respect for the Russian family, values that they felt had suffered in recent times but that were core to the Russian spirit. They spoke of a “transformation”. Many also spoke of the Project as having changed totally the way they related to their patients and clients, as well as the way health professionals related to each other. They spoke of being less “authoritative” and more “humane”. They spoke of a strong sense of partnership. The RCs and RCT members also spoke of a camaraderie that had started at the Perm Launch Conference and that only grew stronger with each opportunity to interact with other regions and learn of their experiences. They clearly relished opportunities to participate in meetings and courses together and to visit others’ sites. They also relished hosting courses in their region so they could reciprocate and show off their own work.

Almost everyone mentioned how quiet and calm the maternity wards had become, that the women were much more relaxed and the newborns rarely cried. Indeed, the team too was struck by the quietness and we all laughed when the wail of a newborn pierced the air immediately upon being born. The new mothers reported being very happy, especially those who’d had a previous delivery experience for comparison. Rooming-in was essentially universal. Midwives, especially, described feeling empowered and finding new purpose in their work. Many reported seeing a shift of responsibility from doctors to midwives and several commented on how especially relevant this new role could be in a rural context.

Post-partum women reported walking around, being allowed to eat and/or drink, using alternative birthing positions, having immediate skin-to-skin contact with their newborn, etc. Although not yet usual, it was not uncommon for a partner or family member to be present for the labor and delivery.

The federally-mandated obligatory free health services include basic childbirth services but not all the “extras”. Some FCMC interventions (private delivery room, partnership delivery, rooming-in) were already available to some degree in many of the regions but were only available to a few and at an extra cost; the impact of MCHI has been to make these services much more the standard and to make them more universally available to all families. In some facilities visited, patients do pay extra for, for example, a room with a Jacuzzi or a room where family members can stay overnight. One facility reported earning 2 million rubles from such extra services the year before, funds which was used to make further renovations and buy additional equipment.

The team was struck by the openness with which challenges and implementation issues were described and shared. During facility visits, staff often shared their initial feelings of resistance or skepticism. Lingering concerns about the possibility of increased rates of nosocomial infections were expressed, often in the context of observing that many FCMC interventions were in violation of federal preceaz mandates. Many voiced a strong need to bring federal regulations into line with the new practices. Many non-Project sites are eager to participate and would welcome being included in the MCHI portfolio. Some of these non-Project sites are eager to adopt Project approaches but are concerned about being in violation of federal mandates without the “protection” of being a designated-MCHI facility. In Vologda, the team visited the non-Project Oblast maternity where rooming-in is common but authorities are cautious about allowing partnership deliveries because they are in violation of the federal regulations.

Although MCHI by design has an urban focus, in the regions visited, there appeared to be an awareness of the Project throughout the entire region. In Tyumen, for example, the upcoming annual regional RSOG conference will draw some 250 ob-gyns from all districts in Tyumen Oblast and will include a major presentation on the MCHI interventions. The previous year, an MCHI staff person had been invited to present at the conference. Some regions are rolling out various MCHI components beyond their original target sites using their own resources or other resources they’ve identified. Especially at maternity houses that frequently receive women from outside of their catchment (generally by referral), staff stressed the need for the Project interventions to be rolled out throughout the region so that all women are prepared for and can take advantage of the new approaches.

“I was very nervous when I went to Perm (for FCMC training) ...it is very hard to change rules and practices. The Perm trainers were excellent, and I got a lot of support from the City Health Department to implement the changes. I now go to every MCHI training and meeting that I can, and would like to see the Regional maternity and others included in MCHI...we need to increase the spread of this kind of service!” Chief ob-gyn, Vologda

Beginning with the initial site visits to the 10 regions conducted by representatives of the IWG and Project staff, media interest in MCHI implementation has been strong and encouraging. MCHI and the regions have been extremely skillful and successful at mobilizing and focusing press and media attention on their activities and accomplishments. Efforts in this area are discussed in detail in Section VII: Documentation and Dissemination and Appendix K: Dissemination of MCHI Methods and Results

Finding: The adoption and integration of internationally-recognized, evidence-based standards is occurring at a very impressive pace across an impressive range of political and health institutions actively involving an impressive number of people over an impressive geographic area. Inter-linking components and multi-level focus give it strength, breadth, adaptability and flexibility.

Finding: Building on the successes of WIN and adapting additional materials from CDC, WHO, UNFPA, and UNICEF to regional and municipal needs has enabled MCHI to promote evidence-based interventions more efficiently.

Finding: The MCHI approach and content is, for Russia, an idea whose time has come. The MCHI process (participatory, interactive, kind, respectful) is a major message that Russian counterparts were longing to hear and to which they've responded in kind. Throughout MCHI, explicit efforts are made to carry out project implementation in a participatory, transparent, low hierarchical manner. In effect, an effort is made to model with the regions the client-centered mother-friendly, baby-friendly, youth-friendly, family-friendly approach that the Project is striving to introduce into Russia's reproductive health services. The training component especially models this approach.

Finding: Continuity of care is reportedly becoming more consistent across facilities. Providers in the maternities often reported that the women arriving for delivery had been well prepared by the women's consultation clinics' antenatal care and childbirth preparation classes.

Finding: The regions see a big need for a federal precat that supports MCHI interventions in order to facilitate and enable the further rolling out and adoption of MCHI practices throughout the regions.

Finding: The regional/ municipal/ facility-level contributions (financially and in-kind) are far in excess of what was initially expected.

Finding: The regions strongly feel the need for revised federal guidelines that support MCHI interventions, and would facilitate and enable the further rolling out and adoption of MCHI practices throughout the regions.

Finding: The Project is working! Change can happen! The capacity building that has occurred at the regional level is impressive, and the potential for continued achievement and further expansion within the target regions is great.

Conclusion: The selection process (incorporating an element of self-selection which promoted commitment and built in readiness) and criteria worked extremely well and are key contributors to the Project's robustness. The competitive element was innovative and positive. The co-financing requirement was also motivating. Requiring letters of support from municipal and regional authorities and from the regional RSOG branch helped instill a broad sense of ownership from the beginning. The requirement that the facilities chosen be an inter-related set of maternities, women's consultation clinics, children's polyclinics, family planning centers, and HIV/ AIDS center helped to horizontalize previously vertical institutions and to standardize the content and continuity of care.

Conclusion: Investing in human capital and access to (international) evidence-based interventions in Russia can lead to rapid and major changes in clinical practices over short periods of time.

Conclusion: By identifying and supporting “catalyst” institutions and individuals, MCHI has helped multi-level leadership implement bold, rapid, substantive changes.

**“We pay attention to quality and to public opinion. The patient focus is the most important part of this project”
Tyumen head of maternity house.**

Recommendation: It would be informative and useful to “capture” the degree to which MCHI has leveraged resources in the pilot regions. JSI should help MCHI develop a methodology and tool for doing this. ARO reportedly has done something similar and could be a helpful partner.

C. Youth: An Important Frontier in Evidence-Based Programming

Mandate:

The **Result** “*Youth-friendly services introduced and adopted by selected regions based on their unique needs and circumstances*” is to be achieved via the following **Task**:

1) “*Compile a comprehensive package on youth-friendly health services that will include materials developed by UNFPA, UNICEF, WIN, and the Association of Youth Friendly Clinics. Concurrently, an implementation work-plan and schedule shall be developed by JSI to introduce youth-friendly health services in the selected facilities based on their needs, interests, and circumstances.*”

Contract modification #2 modified the original Result and Task. The new **Result** “*A comprehensive reproductive health program for youth developed and implemented in at least two MCHI regions*” is to be achieved via the following **Task**:

1) “*To develop a comprehensive reproductive program for youth, an MCHI interregional working group on youth reproductive health shall be established. This group will consist of representatives from the regions, MCHI consultants and staff. The working group shall review existing programs, regional, national and international experience on reproductive health programs on youth and develop a comprehensive reproductive health program for youth including policy document, training curriculum for health providers, information for youth, follow-up and monitoring and evaluation plans. The Program shall be implemented in at least 2 of the MCHI regions.*”

Progress to Date:

MCHI touches thousands of youth, especially those between the ages of 15 and 24, because of its MCH and RH mandate. However, this group usually has specific characteristics not addressed by programs designed primarily for adults. In Russia, like in most industrialized countries, youth are at increased risk of unwanted pregnancy, abortion, sexually transmitted infections (STIs) and

HIV infection (including an increased biological vulnerability to STIs/HIV/AIDS) and other negative health outcomes.

Limited but current statistics show that injection drug users (IDUs) in Russia are primarily aged 18-25, and women and men who exchange sex for money are primarily under age 26 (USAID/ Russia, 2003). The overlap between youth who exchange sex for money and those who use injection drugs appears to be high, and HIV+ rates in this group have risen to 30-50%. While all youth are not currently classified as a “high-risk” group for HIV, youth represent a significant portion of new HIV infections and of primary high-risk groups like IDUs and people who exchange sex for money.

“MCHI has already made a difference in improving services to youth by linking services and specialists. A family planning provider trained by MCHI now serves 25-30 15-18 year olds every day in the Pediatric Polyclinic. This is all counseling and is different and more intense than the Federal pediatric program but works well within it. Girls get more STI and pregnancy prevention information; boys get better prepared for military service including learning more about STIs and HIV.” MCHI RCT member, Tyumen

Youth aged 15-24 receive reproductive health services and related counseling through maternity houses, pediatric polyclinics, women’s consultation centers for family planning and abortion services, specialized family planning and HIV/AIDS Centers, youth health services and related counseling in all sites. All types of sites are frequented by youth, in varying degrees in different regions. In about half of the MCHI regions, youth aged 15-24 make up the majority of both antenatal and family planning clients but less than the majority of abortion clients according to the MCHI 2004 Facility Survey: Report of Main Findings. The MCHI Baseline Assessment Report noted that all regions were interested in improving or expanding youth services.

Over the past two years, a number of studies and programs in Russia have made their data and experiences available. For example, qualitative research published by “Healthy Russia 2020” in 2005 points to unique information about respondents age 18-24:

- Females aged 18-24 are more likely than males and their older female cohort to say they listen to the opinions of female relatives close to their age and girlfriends, particularly when the information is related to negative experiences with certain contraceptives and abortion.
- There is a widely held opinion that doctors are not competent because professional training is substandard in medical institutions. However, females aged 18-24 said they trust doctors when they are personable, friendly, attentive and sensitive.
- Younger women, 18-24, felt that only specialized medical sites can provide reliable information about family planning and reproductive health and that mass media is less trusted. The exception seems to be social marketing campaigns (not brand or product-specific marketing).
- Young males said that only condom advertisements can be trusted. All males also tend to trust the family planning and reproductive health information they find on the Internet while only older females trust the Internet.
- There is no consensus on the ideal sources of family planning/ reproductive health information among young people. Males tended to cite no ideal source of information, and

they sometimes said personal experience was the ideal. Young females preferred information from within the family but also thought classes at the local maternity house would be ideal.

- Most young respondents saw protecting their reproductive health as a component of a healthy lifestyle, not as a series of specific medical measures to take.
- Females appeared to be heavily influenced by male initiative in protecting their reproductive health, but males seldom initiate any joint actions. Females take limited male participation as the norm.
- All the female respondents had negative attitudes towards abortion, but those who had had one did not necessarily use contraceptives or reconsider attitudes towards contraceptives.
- Condoms are seen as primarily a contraceptive of the young. Some males and some females complained that buying condoms is a barrier because of the behavior of drugstore personnel.

In combination with other studies and program results about youth (Open Society, MOH and Regional Health Departments, UNICEF, UNFPA, other donors), there is now an expanded body of data and information available about youth when compared to what was available in 2003.

Linkages within MCHI and between MCHI and other programs have also improved programs; see Section V.G. on the hepatitis B vaccination program for adolescents implemented in partnership with the Vishnevskaya-Rostropovich Foundation in the Russian Far East.

The original contractual **Result** noted that materials developed by UNFPA, UNICEF, WIN, and the Association of Youth Friendly Clinics be utilized to develop the Youth Reproductive Health Replication Package for MCHI. The provider training curriculum on Youth Friendly Services developed by WIN and the Association of Youth Friendly Clinics reflects international standards for youth friendly clinics. It was successfully applied in the WIN sites and is part of the MCHI Replication Package. However, MCHI staff and consultants found less appropriate and innovative programming at UNICEF and UNFPA sites than expected during the data collection process for the MCHI Baseline Assessment and found other sites and international experience of interest as well. This led to the new Result and Task in contract modification #2 that directs MCHI to create a Working Group on Youth to be responsible for creating a “*comprehensive reproductive health program for youth including policy*”

Youth Reproductive Health Programs in MCHI Regions

Three MCHI regions, (Altai Krai, Novgorod Oblast, and Orenburg Oblast) have produced their own local youth strategies and in some cases use a replication package including WIN training materials. These programs tend to have started before MCHI; in Velikiy Novgorod, the WIN advocacy network was utilized to include educational as well as health structures. Each one is unique. While effectiveness data is generally not available, Barnaul in Altai Krai notes that their UNICEF-sponsored program has led to “improved effectiveness including lower abortion rates among youth.” In another three MCHI regions (Tyumen Oblast, Primorsky Krai and Khabarovsk Krai) including the two newest RFE regions, there are new or existing programs for youth that reflect one or more pieces of a comprehensive youth package. For example, in Khabarovsk Krai, the health authorities have created a youth-friendly reproductive health curriculum for medical students. Also in Khabarovsk Krai, USAID’s ‘US-RFE Partnership Activity Health Also in Khabarovsk Krai, USAID’s “US-RFE Partnership Activity Health Partnerships” supports the creation of a Health Fair Center to sustainably increase regional capacity to conduct health fairs promoting healthy lifestyles; youth are a targeted group. In Tyumen, actions include a new “parallel” site at the University to reach young adults. Other MCHI regions have programs that target youth in high-risk groups.

document, training curriculum for health providers, information for youth, follow-up and monitoring and evaluation plans.”

The process for creating a comprehensive youth reproductive health program based on available regional, national and international evidence is already under way. MCHI has created an Inter-regional Working Group on Youth Reproductive Health (WGY), including representatives from Altai Krai, Novgorod Oblast, Tyumen Oblast and Orenburg Oblast as well as MCHI staff and consultants. Primorsky Krai may be joining the WGY as well. The WGY was organized early in 2005 and first met as a group in March 2005; see Appendix G: MCHI Input Matrix. The next meeting is planned for May 2005, when members of the WGY will visit at least two functioning youth service delivery sites; these are likely to be Barnaul in Orenburg Oblast and Velikiy Novgorod in Novgorod Oblast.

Vologda HIV/ AIDS Center: Youth Peer Outreach Programs

Volunteer youth peer educators (age 15- 24) are trained to work at the railway station during the summer months, when there is heavy tourist travel to Vologda. A total of 600 have been trained to date and about 30 remain active all year long. The Center’s peer educators do outreach to schools and other public gathering sites including the library and sports facilities during the school year, targeting 13-15 year olds. They provide information (not counseling) on preventing the spread of HIV/AIDS and referral information for counseling and other services.

The Department of Prevention also works with prisoners and school children, and does outreach to drug users in the community. They interface with the local Association of People Living with HIV/AIDS; there are currently at least 74 teens living with HIV in Vologda.

In the spring of 2005, MCHI was planning to complete the first revised draft of the Youth Reproductive Health Replication Package through work with the WGY by June 2005 with the intent to begin using the new Replication Package in sites by July 2005.

Finding: The context for achieving the youth contractual Result is complex and MCHI can play a major role in collecting available information and data and in producing a Replication Package that reflects current state of the art evidence. There are more data and information available on youth in Russia than during WIN and early on in MCHI, in addition to international and European standards that are relevant to consider. 2005 is an ideal time for a technical and programmatic review before finalizing a comprehensive Youth Reproductive Health Replication Package.

Finding: At the current pace of activities, and given the great interest in better serving youth in many sites in MCHI regions, MCHI will have no difficulty meeting the goal of “a *comprehensive reproductive health program for youth developed and implemented in at least two MCHI regions*”. The challenge is the competition for competent technical resources to deal with youth health, both within the broader MCHI group and on a national level in Russia.

Finding: The MCHI Youth Reproductive Health Task Force has been formed and is active. It includes representatives from five regions plus MCHI staff and consultants. Youth are not explicitly included, either directly or in an advisory capacity.

Recommendation: Global standards require that when the target group is youth, youth should have a voice in reviewing planned interventions. There are at least two options: one or more youth should be added to the WGY directly or MCHI and partners could create a Youth Advisory Committee to work with MCHI and the WGY. Youth that are medical or nursing students, peer educators or otherwise active in reproductive health-related NGOs in any MCHI region would be excellent candidates.

Recommendation: MCHI should prioritize the completion of the program and evidence review by the Working Group on Youth but extend the expected completion date for compilation and use of the Youth Reproductive Health Replication Package until late 2005. MCHI should continue its search for a consultant who can assist the WGY with the analysis of current evidence-based medicine and social science relative to youth: the Centers for Disease Control and Prevention (CDC), Advocates for Youth, the European Union, and the World Health Organization (WHO) all have published on this issue. MCHI can hold another forum with the WGY to share information from various sources before the finalization of the Replication Package in order to ensure that it reflects current Russian and European knowledge on youth reproductive health best practices.

D. Male Involvement

Mandate:

The **Result** “Access to reproductive health services and information for men increased in the targeted regions” is to be achieved via the **Task**:

1) *The Contractor, together with its Russian partner, shall develop appropriate strategies and interventions to increase male participation in family planning counseling and other reproductive health services. The Contractor shall propose a coordination strategy outlining linkages with Healthy Russia 2020 in regards to planned communication interventions on reproductive health issues.*

Additionally, under “**Gender Involvement**”, the Contract notes: “*Although the primary focus of this activity is improving health care services for women and infants, gender integration is an important component of the proposed activity. The new activity must include information and communication interventions targeted at both women and men beneficiaries. Men play a crucial role in the decision-making process around family planning issues. Men and families in general should be encouraged to benefit from the comprehensive family-centered maternal care approach as active family member participants. The activity should reach male audiences through communication interventions as well as services offered by the targeted health facilities. This activity should also focus on creative models of increasing male participation in reproductive health issues.*”

Progress to date:

In the Russian context, the social and psychological barriers to men seeking care are well-documented and pervasive, making increased access to reproductive health information and services an important priority for MCHI. MCHI supports information and communication

interventions targeted at both women and men beneficiaries and supports service delivery interventions that create a positive environment for increased male access to participation in reproductive health care for men and their families.

MCHI has developed appropriate strategies and interventions to increase male participation in family planning counseling and other reproductive health services. These include interventions in training, communications, monitoring, and follow-up visits that support male involvement. MCHI has emphasized male involvement in several training programs for providers, especially in family planning counseling, and is using each additional training component as a way to reinforce methods for increasing male involvement in reproductive health care. The site-based monitoring tool for follow-up visits also reflects this concern for male involvement.

A critical partnership for MCHI in the area of male involvement and communications is their alliance with Healthy Russia 2020 (HR 2020). A Coordination Strategy for joint actions was developed and approved by USAID/ Russia in February 2004. A “Couples Campaign” is a part of this plan. Research results and experts were used to design the campaign and the overall goal of the Couples’ Campaign is: “To promote creating habits of responsible behavior for improvement of reproductive health of men and women in regions of Russia.” There are specific objectives related to increasing awareness, changing attitudes, and changing behaviors of both men and women aged 18-35.

The forthcoming multi-media Couples Campaign should provide measurable support to increasing reproductive health awareness, changing male attitudes, and changing male behaviors related to family planning, mutual care for partners including risk for STIs and HIV, the importance of communication about reproductive health issues between couples, and abortion. Components will include radio and TV spots and talk shows; print materials for men and women; booklets for service providers; magazine and newspaper articles; and advocacy events. The Campaign will operate in all 14 MCHI regions, and the monitoring and evaluation component has been well-defined. HR 2020 will report on the results, with dates for this defined by when the campaign is launched. The campaign increases MCHI’s already substantive efforts to integrate gender issues into MCHI.



In addition to the Couples Campaign, Healthy Russia 2020 has developed the curriculum to provide training to representatives from all MCHI regions in “Effective Communications in the Area of Reproductive Health.” This workshop, scheduled for April 2005 after several months’

delay, will be held in preparation for the launch of the Couples Campaign. This training will assist MCHI regions in best utilizing and supporting the Couples Campaign events and materials and in planning to effectively use their own considerable resources to support the Campaign's aims. (A date for the launch and availability of the materials has not yet been announced by HR 2020.)

Regional Visits:

Adult male and youth have visibly benefited from improved physical and emotional access to reproductive health care. FCMC, with its emphasis on partnership deliveries and the active involvement of partners during labor, has completely changed the atmosphere. Men are not only allowed into spaces formerly reserved for women and health care providers alone, but they are invited in and supported in their new roles by nurses, midwives, doctors and others. During visits to seven MCHI-supported maternity facilities, male partners were visible in each one. They were holding their newborns, massaging their wives while they labored, holding hands and talking to the women they cared about. Both men and women interviewed about their experience of male participation spoke happily about the positive personal and family impact of having men participating actively in maternity services.

Antenatal care centers in maternity hospitals and women's consultation clinics, breastfeeding support rooms in pediatric polyclinics, post-partum and post-abortion care service areas, and youth consultation rooms are all reporting increased numbers of men accompanying their female partners for both services and counseling. Providers report low to no attendance in prenatal classes. Men still feel uncomfortable attending Mother's School (the traditionally named rooms for prenatal classes) in many places. No wonder!

Providers at site visits in all three regions discussed male participation with enthusiasm. Providers and health managers were often surprised by how much they liked the changes that male participation brought to service delivery for MCH. Since the early implementation phase of MCHI, RCTs and FCTs in many facilities and at the regional levels have been working together to help create better services for families, including more consistent reaching out to boys and men, and the results are visible.

Finding: MCHI has developed and is implementing appropriate strategies and interventions to increase male participation in family planning and other reproductive health services. The coordination strategy with Healthy Russia 2020, approved by USAID in early 2004, includes a major Couples Campaign on reproductive health issues.

Finding: Delays of at least six months in the multi-media campaign addressing male involvement are beyond the reasonable control of MCHI as the technical design of the actions is the primary responsibility of a partner organization. This may or may not have an impact on MCHI's final results regarding men's increased access to both reproductive health services and information as the delay has decreased the time of impact between the campaign and the final MCHI surveys that will measure male participation in three types of services.

Conclusion: Considerable attention has been given to increasing active male participation and support at multiple junctures, and the results are visible. Male participation, including that of

youth, has increased at MCHI sites in FCMC, breastfeeding support, family planning, post-abortion care, and counseling. Gender integration is more than adequate.

Conclusion: The technical and financial resources put into increasing male participation have had an impact even before the launch of the multi-media, multi-channel Couples Campaign; results are very visible in sites with functioning FCMC. It is not possible to estimate results in areas more difficult to impact, including behaviors related to STIs, family planning and abortion.

Recommendation: MCHI should continue to work closely with Healthy Russia 2020 on the Couples Campaign and related activities, using HR 2020 monitoring and mid-term evaluation results to advise MCHI RCTs on progress to date and any recommended mid-course adjustments.

E. Medical School Involvement

Mandate:

The **Result** “*Introduction of newly developed protocols and internationally recognized standards into basic medical school educational materials initiated*” is to be achieved via two

Tasks:

1) “*A respected national Russian entity shall be identified by the Contractor to facilitate the introduction of the protocols developed based on internationally recognized standards into basic medical school educational materials. This organization can either be the same Russian partner selected to assist with the replication component, or another. The Contractor shall identify one or more potential candidates suitable for this partnership and a list of proposed selection criteria and*

2) “*Medical school curricula shall be revised to include the latest internationally recognized MCH standards and procedures for inclusion in the local and national medical school educational materials. A team representing the Contractor, the Russian counterpart, and faculty members from selected medical institutions shall be created to oversee the achievement of this task. This activity will be the start of a long-term effort toward introducing change into the medical education curricula in Russia, working closely with the selected counterpart. It is expected that the Russian counterpart will continue this dynamic process after USAID programming ends in Russia. The Contractor shall outline a plan describing how it proposes to achieve this task. This task shall be closely linked and coordinated with the activities of the Healthy Russia 2020’s “Evidence-based Medicine Committee”.*

Progress to date:

From the beginning, MCHI thought it desirable that the “*Russian organization with a strong maternal child mandate*” with which they would choose to partner overall should also be the “*respected national Russian entity to facilitate the introduction of the protocols developed based on internationally recognized standards into basic medical school educational materials.*” And, indeed, had MCHI been looking only for a partner to work on medical education, RSOG would likely have been their first choice.

One of the MCHI selection criteria for inclusion in the Project was the existence of a medical school in the region. All selected regions have a medical academy, university, school, or college. Nine of the regions have medical schools training physicians. The regional working groups almost universally include representatives from the pediatric and ob-gyn departments of these institutions and these representatives have also been included in multiple MCHI training courses. Regional medical institution representatives were also purposefully included in the Interregional Working Group. After the October 2004 JSI presentation at the RSOG Annual Meeting, the dean of the Moscow Medical Academy, generally regarded as one of Russia's most prestigious medical universities, also joined the IWG.

In March 2005, MCHI conducted a six-day orientation workshop in Perm designed explicitly for medical university and academy representatives. All but three (Kaluga Oblast, Khabarovsk Krai, Novgorod Oblast) of the 14 MCHI regions were represented. The workshop combined both didactic presentations on modern perinatal and family-centered maternity care and clinical visits to the Perm pilot sites. As part of the workshop, each representative developed a strategy and plan for further integrating the Project's approaches and materials into pre-service and post-graduate curricula. Many indicated a need for help acquiring books and replicating materials. HR 2020 does not currently have a functioning "Evidence-based Medicine Committee".

Regional Visits:

In each region visited, representatives of both medical and/ or nursing training institutions spoke of their plans and efforts to incorporate MCHI materials into their pre-service and post-graduate curricula but it was not possible to assess the status of those efforts. Those who had attended the recent Perm workshop spoke highly of their experiences there.

Finding: The introduction of internationally-recognized, evidence-based standards for selected maternal child health interventions into the pre-service and post-graduate curricula of training institutions for physicians, nurses and midwives has been initiated in at least 11 of the 14 MCHI regions plus a major state medical academy in Moscow. .

F. Family Planning Services

Mandate:

Beginning in WIN and continuing into MCHI, family planning has been a key core intervention. Contract modification #2 strengthened the emphasis on family planning by adding a new **Result** "*Family planning services with a special focus on post-partum and post-abortion clients strengthened in all MCHI regions*" to be achieved via four **Tasks**:

1) "*To strengthen family planning activities the Contractor shall provide more training in sites, with a special focus on post-partum and post-abortion clients as counseling of these women is one of the main issues in provision of family planning services. To improve continuity of care, linkages between women's consultations, maternity hospitals and children polyclinics should be increased. Pediatricians and pediatric nurses should be trained to provide family*

planning education and counseling to post-partum women during both home and polyclinic visits.”

2) “To reinforce training and assist in implementation, regular follow-up visits will be established. Experienced family planning consultants should help to consolidate and ensure skills in newly introduced practices; identify problems preventing application of new skills in clinic routine; assist medical providers in seeking adequate solution to problems; and support collaboration and knowledge transfer between providers and clients.”;

3) “To increase a core group of family planning experts, training of trainers on counseling skills and in-depth technical family planning issues for regional representatives, Russian Society of Obstetricians-Gynecologists (RSOG) and medical schools should be provided. MCHI master trainers (trained under WIN) will begin to train a core group of family planning/ reproductive health trainers from participating regions (usually members of RSOG). This core group of trainers will consist of staff from regional and city Family Planning Centers, Ob/Gyn Department of Refresher Training Institute, Medical College for Nurses and Midwives and Medical Institute/ University/ Academy. These local trainers will learn to use MCHI Family Planning/ Reproductive Health and HIV/AIDS Prevention Training Package. The Package will include the male involvement module to help establish a male-friendly environment at Women’s Consultation Centers, Maternity Hospitals and Family Planning Centers. Family planning local trainers will conduct FP/RH training activities for all obstetrician-gynecologists, nurses, and midwives from participating facilities in the region. Mid-level personnel in gynecology, women’s consultation centers and Family Planning Centers will be trained to provide group family planning education sessions in in-patient settings.”; and

4) “The project should collaborate with pharmaceutical companies and pharmacies to ensure that family planning methods are available at pilot sites.”.

Progress to date:

The very first training courses offered by MCHI to the new regions focused on family planning. In May 2004, a six-day Family Planning Training of Trainers course was held in Moscow in which two to three people from each of twelve regions participated (ten new regions plus two prior WIN regions). Some of those trained had the almost immediate opportunity to participate as co-trainers in four-day family planning courses offered in Kaluga for Kaluga, Murmansk and Perm Oblasts; in Vologda for Vologda Oblast and the Komi Republic; and in Irkutsk for Irkutsk Oblast and Krasnoyarsk Krai (see Appendix I: Training by Region and Topic) Later training courses were given in Tyumen for Tyumen Oblast, in Omsk for Omsk Oblast, in Primorsky Krai for Primorsky and Khabarovsk Krai, and in Barnaul for Altai Krai and Orenburg Oblast. Only one original WIN region, Novgorod Oblast, has not received additional family planning training to date under MCHI. In addition to the courses mentioned, the expectation was that the new regional family planning trainers would develop regional training plans and train a broad range of health professionals at their regional MCHI sites. Progress against these plans is to be checked during follow-up visits.

Russian families face a number of constraints with regard to receiving quality family planning services. The external environment has changed markedly since the federal family planning program was discontinued in 1999. Less sex education, including family planning information is reportedly available in schools due to lack of legislative support and religious opposition. The federally-mandated free package of obligatory services includes maternity care and abortions but

not family planning services. Fortunately, some regions do cover family planning services out of their own funds, including the provision of free contraceptives to high-risk groups. Free contraceptives, however, appear to be very limited, and only include oral contraceptives, intrauterine devices (IUDs) and sometimes condoms. Definitions of high-risk groups vary and generally include a combination of low-income women, students and adolescents, and “vulnerable” populations.

The range of available modern methods is unnecessarily narrow; oral contraceptives, IUDs, condoms and emergency contraception seem widely available although access for rural populations is more restricted. Depo Provera is reportedly no longer registered in Russia and is not currently being manufactured in Russia and so is not generally available. Norplant is also not registered.

Age and parity restrictions limit access to female sterilization nation-wide. Provider barriers are extreme. The quality of counseling reflects many of these problems. Only ob-gyns can provide contraceptive methods; other physicians and other health care providers can only counsel. Russia is attempting to introduce the concept of family medicine. A family medicine doctor could provide counseling, yes, but could not, for example, insert an IUD.

The pharmacies have all been privatized; pharmacists can give information about contraceptives but can’t “counsel”. The role of private pharmacies and their staff in both access to and information about contraceptives should not be understated. However, direct work with private pharmacies is outside the scope of MCHI for the time being.

When MCHI launched its activities, it approached three pharmaceutical companies looking for partnerships with regard to family planning. Six months later, Gideon-Richter (G-R) responded enthusiastically; no other company responded. G-R sells some of the least expensive contraceptives in Russia and, in some regions, their contraceptives are included in the essential drug lists and are disseminated free of charge. G-R is present in all 14 MCHI regions, has participated in regional training, and is helping to disseminate informational materials in maternity hospitals. It is expected that G-R will provide MCHI with provider survey and family planning data, including market analyses of the increase in contraceptive usage, late in 2005. Gideon-Richter has supported the reprinting of MCHI family planning materials and has helped to create new educational materials for regional health workers. G-R is also disseminating MCHI materials in non-Project regions, thus furthering the reach of the Project. MCHI estimates that the partnership has enabled the project to save over \$20,000 in materials and supplies, savings which the Project has put toward further regional training. See Appendix J: Partnering with Gideon-Richter for more information on this partnership.

Regional visits:

In each region visited, the team saw multiple examples of expanded “horizontalized” family planning services incorporated into women’s consultation clinics, into post-partum and post-abortion services and into polyclinics serving adolescents. Several sites reported adding staff specifically to improve the provision of family planning information.

Historically Russia has had a narrow method mix with a strong reliance on IUDs and a reported bias against oral pills. Anecdotally, considerable interest in the pill was indicated by multiple providers, especially coming from young, urban women. Concern was voiced that women start using orals without proper counseling which results in high failure rates and unwanted pregnancies that then end in abortion. It has been estimated that perhaps half of repeat abortions are due to method failure. Preservation of fertility and prevention and treatment of infertility are major concerns. (In Tyumen, there is a special fund to support the treatment of infertility.) Reportedly slightly more than half of infertility is primary infertility, slightly less than half secondary. Estimates by regional health personnel are that 60-80% of secondary infertility is attributed to abortion sequelae.

It was noted that some post-partum women reported no contraceptive counseling to date. Although staff indicated that such counseling was done just prior to discharge, if family planning were adequately introduced as part of antenatal care, one might expect post-partum women to report having already considered their options. Also it was noted that family planning counseling was not always provided as part of the breastfeeding support activities, apart from information regarding the lactational amenorrhea method (LAM).

One ob-gyn who had attended the May 2004 Moscow family planning TOT expressed a need for more contraceptive information; she felt the TOT had stressed process and had (incorrectly, at least in her case) just assumed everyone knew the content. Additionally, from multiple providers, considerable misinformation was heard regarding what contraceptives a nullip could or could not use, the length of time an IUD was effective, what method should be recommended to women over 35 (withdrawal!). Provider bias may also be an ongoing issue.

Finding: The regions do appear to have a core of family planning trainers and a basic family planning training capability.

Finding: Coordination and collaboration with pharmaceutical companies is primarily done by regional health authorities. The limited contraceptive mix used by most couples throughout Russia seems to be available through private pharmacies in public clinics.

Finding: MCHI estimates that the partnership with Gideon-Richter has enabled the project to save over \$20000 in materials and supplies. MCHI will continue to document this success story.

Finding: Some regions receive free contraceptives for special populations. This strategy may be risky because supply is uneven at the clinic level; the impact of uneven supply for low-income high-risk clients in Russia is unknown.

Conclusion: MCHI has placed needed emphasis on family planning, doing much to “horizontalize” and integrate family planning services broadly into MCH care. More attention needs to be given to developing providers’ basic fund of knowledge regarding contraceptive methods. Provider barriers, such as the limited role of front-line providers and misinformation, further limit client access to an already limited choice of family planning methods.

Conclusion: Clearly much has been done recently to “horizontalize” and integrate family planning services; it would be worth the time and resources to further reinforce these gains and to focus on missed opportunities at the facility level.

Recommendation: MCHI regions have many challenges to overcome in improving access to and use of modern family planning methods, as reinforced again in findings from recent focus group research by HR 2020. A review of the current MCHI Family Planning Replication Package materials focusing on contraceptive technology and cross-service counseling could help to strengthen and reinforce the program. The Project’s family planning trainers should be involved in this process, reinforcing their skills and knowledge and integrating their experiences from the prior family planning TOT and courses. A second round TOT for the regional trainers could focus on identifying missed opportunities to reinforce pre- and post-partum and post-abortion counseling and would create an even more solid cadre of experienced family planning trainers in the 14 regions. In the context of the soon-to-begin “Couples Campaign”, this would create an environment of increased opportunity for cross-counseling on family planning and STI/HIV primary prevention as well as PMTCT.

G. Hepatitis B Vaccinations in Russian Far East

Mandate:

In 2004, MCHI was asked to assist USAID/Russia by moving funds and support through the MCHI contract mechanism to the Vishnevskaya-Rostropovich Foundation for vaccination program for adolescents in the Russian Far East. Contract modification #2 added the **Result:** “*Hepatitis B vaccination program for adolescents implemented in partnership with Vishnevskaya-Rostropovich Foundation in the Far East*” to be achieved via **Task:**

1) *The Contractor shall implement a Hepatitis B vaccination program for adolescents in at least one region in the Far East through a partnership with the Vishnevskaya-Rostropovich Foundation. The funds for this activity should be tracked and reported on separately.*

Progress to Date:

The MCHI mid-term evaluation team did not visit the Russian Far East but did attend a presentation of the Vishnevskaya-Rostropovich Foundation on their Hepatitis B vaccination activities at USAID. The subcontract between JSI and VRF was signed in November 2004, extending VRF’s existing Hepatitis B vaccination program to Primorsky Krai where the MCHI Project already worked. The program that VRF implements appears to use the same strategy in all regions of Russia, regardless of funding source. VRF works with other funding sources in approximately 18 other regions. Therefore, the addition of Primorsky Krai to the VRF portfolio provides support to an already existing but not yet nationwide program. The VRF program is complementary to MCHI’s objective to improve reproductive health in selected RFE regions in the East.

In all regions, aiming to reduce the incidence of Hepatitis B among adolescents, VRF builds cold chain maintenance capacity and human resources by working exclusively through the existing health infrastructure. Equipment, vaccines and supplies are provided as needed and their use

carefully monitored. Health workers are trained. Parents and school children receive leaflets and schools receive posters about the Hepatitis B campaign and its benefits.

By December 2004, administrative procedures including those for vaccine and cold chain procurement were reportedly completed. Program activities began in March 2005, with the first vaccination campaign scheduled for April 2005. Mr. Jess Bratton, RFE Coordinator at USAID/Russia, speaking to a meeting of Cooperating Agencies (CAs) working in the RFE, noted the success the VRF had had in efficient procurement and customs clearance.

The Vishnevskaya-Rostropovich Foundation expects at least a 95% coverage rate. They also expect their efforts to be sustained through the allocation of local and Russian federal funds by late 2007. The MOHSD has requested that RVF add additional regions. At this time, there is no reason to doubt that VRF will reach their coverage rate targets in Primorsky Krai, creating an excellent synergy with MCHI actions that also aim to improve the health of adolescents and young adults.

Finding: The Hepatitis B vaccination program implemented in partnership with Vishnevskaya-Rostropovich Foundation in the Russian Far East reportedly is progressing smoothly.

Finding: The funds for the VRF Hepatitis B vaccination program are being tracked and reported on separately by MCHI.

Finding: Using already existing and successful partners, like the VRF, to implement specialized activities with concrete objectives in existing Project regions may enhance synergy to improve health indicators and provide good value in the efficient use of US development assistance funds.

H. Integration of ARO Early Intervention Model

Modification #2 added a new **Result:** “*Early Intervention model developed by USAID-funded Assistance to Russian Orphans Program (ARO) integrated in MCHI models*” to be achieved via the following **Task:**

1) “*The Contractor shall work with the Early Intervention Institute, its branch in Novgorod and other relevant programs to introduce early intervention activities as feasible in MCHI pilot regions and facilities.*”

Progress to date:

The Assistance to Russian Orphans’ Early Intervention model is designed to foster a positive emotional/ psychological environment during pregnancy and childbirth and to further promote maternal/ child bonding. Although designed specifically to counter abandonment, it is applicable to all pregnancies and births and is very congruent with the MCHI model. Staff feels its holistic, humanistic approach highlights respect for the newborn and emphasizes the need to be “newborn-friendly” as well as “women-friendly”. Its approach is viewed as being very supportive to families with babies having disabilities.

In May 2004, MCHI and the Early Intervention Institute began exploring ways to collaborate. As a result, the head of EII’s Velikiy Novgorod branch participated in the June antenatal curriculum

workshop where the ARO-supported Early Intervention model and EII materials were incorporated into a reformatted antenatal curriculum. Contract modification #2 in effect “legitimized” this ongoing collaboration. Beginning with the September FCMC training in Irkutsk, the Early Intervention model was also incorporated into the FCMC training schedule, including lectures by expert trainers and the distribution of ARO/ EII materials to all participants as support for additional policy and service delivery practice changes at MCHI sites. In March 2005, the revised antenatal care curriculum was field-tested in Vologda. Recently, ARO shared some new materials on bonding which have been prepared as handouts for an upcoming round of ANC training courses.

Finding: ARO’s Early Intervention model is being integrated into multiple MCHI training materials and is considered to be a substantive, positive addition that has especially strengthened the counseling component of these courses.

I. Development of Collaborative PMTCT-plus Model

Mandate:

Contract Modification #2 added a new **Result:** “*A collaborative model on PMTCT-plus developed and implemented together with ARO in Irkutsk and other regions*” that is to be achieved via the following **Task:**

- 1) “*The Contractor shall work with ARO to develop a collaborative model on PMTCT-plus in Irkutsk and other regions.*”

Progress to Date:

MCHI staff have made multiple and continued efforts to develop a collaborative model on PMTCT-plus with ARO and implement it in Irkutsk and other regions. Each project has a specific approach and key groups of leaders and potential implementers in their targeted sector. For MCHI, it is the medical community and health sector while ARO’s domain is child welfare and social services. In addition, ARO has a strong mandate to work with NGOs and peristatal institutions as well as with government institutions, while MCHI works primarily through regional and municipal government health departments with the assistance of one large NGO (RSOG) and its membership.

In creating a collaborative model for PMTCT-plus, MCHI staff work closely with ARO staff to share information and discuss linkages. For example, both MCHI and ARO work with Professor E. E. Voronin and his staff at the Federal Center for HIV+ Pregnant Women and Children in St. Petersburg, but MCHI works with this group on the development of PMTCT medical guidelines and ARO works with them on the development of social service guidelines for HIV+ women and children.

The comparative advantage of the ARO-MCHI model for PMTCT-plus is that it integrates PMTCT into the mainstream health system as opposed to treating PMTCT as a specialized, separate subject. This will help the public health system to better cope with the new stage of the HIV epidemic, when more and more HIV+ pregnant women will no longer belong to high-risk

groups like IDUs and commercial sex workers (CSWs). Adding the “plus” means that the health sector may begin to actively look for and develop links to critical social services.

In implementing the collaboration in Irkutsk, MCHI worked with ARO to identify areas for collaboration and support. Since the Irkutsk health sector leadership had been actively involved with MCHI and had been active participants in the August 2004 PMTCT workshop there, they were prepared to attend and work with the ARO Regional Project Development Conference in February 2005. Previously in 2004, MCHI had also assisted ARO’s local partner, the Russian Red Cross, to access the medical community in preparation for their ARO-funded work in identifying and assisting HIV+ pregnant women. While the ARO grant to the Russian Red Cross in Irkutsk ended early in 2005, the Red Cross has continued to be an active and visible partner in the social sector in regards to HIV-affected women and children. ARO’s next planned action in Irkutsk is in May 2005; MCHI hopes that ARO will find conditions acceptable to continue work there with non-governmental partners.

In summary, the active collaboration on a joint MCHI/ARO PMTCT-plus model is well underway in Irkutsk. See Section V-H: Integration of ARO Early Intervention Model above for additional information on MCHI/ ARO collaboration and Section VI-A: PMTCT and Other Additional Project Activities below for a full description of MCHI’s other PMTCT activities.

Finding: Irkutsk collaboration in progress.

Finding: MCHI’s respected status among many Institutes and individuals in the medical community has helped ARO gain access to the medical sphere, thereby enabling critical links between the medical and social services to begin in some areas. This synergistic model for PMTCT-plus has the potential to revolutionize care for HIV affected families.

Recommendation: MCHI should meet with ARO to discuss ARO’s option to refund the Russian Red Cross in Irkutsk (if ARO requirements are met). MCHI can provide support in bridging the divide between the medical/health and social services sectors, with regional medical leadership and facility-level staff.

J. Abortion Rates and Contraceptive Prevalence Rates

Mandate:

At the conclusion of MCHI, the following two **Results** are to be achieved:

- 1) “The abortion rate reduced in the targeted regions.”
- 2) “Use of modern contraceptives as a mean to prevent unwanted pregnancies increased in the targeted regions.”

Progress to date:

Anecdotally, in all three regions visited, multiple people indicated that abortion rates were decreasing and contraceptive use becoming more effective and consistent.

Finding: Given the relatively short time that MCHI has been in existence, it is not yet possible to access concrete data regarding the abortion rates or the contraceptive prevalence rates in the MCHI targeted regions.

VI. PMTCT and Other Additional Project Activities

MCHI has undertaken a number of activities beyond the scope of the Contract that have enriched and enhanced the Project's implementation. Section VII: Documentation and Dissemination describes one of these "value-added" activities: the creation of a MCHI website. In addition, the Project's work regarding PMTCT and the extent to which WIN and MCHI have informed other USAID-supported projects in the EE/EA region are described below.

A. PMTCT

Increasingly, as WIN was ending and MCHI was beginning, Russia's attention and the attention of USAID/ Russia turned to Russia's worsening HIV/ AIDS situation. Although PMTCT was not included in the original Contract (except for being mentioned in an appendix describing UNICEF's work in Russia), from the very start of the MCHI Project, MCHI and USAID/Russia agreed that HIV/ AIDS and PMTCT would receive major attention within the MCHI project. .

Training Materials/ Evidence-Based Practices

The first step was to begin integrating HIV/ AIDS and PMTCT information into the MCHI training materials. MCHI immediately began collecting relevant materials dealing with current Russian statistics, risk assessment approaches, counseling and treatment issues, infection control standards, PMTCT guidelines, etc., for review, adaptation and incorporation. Handouts for MCHI consultants and trainers were developed.

Consequently, the December 2003 MCHI Three-Year Workplan gives considerable attention to HIV/ AIDS prevention generally and PMTCT specifically and at the February 2004 MCHI Launch Conference, PMTCT was included as one of the core integrated MCHI internationally-recognized evidence-based practices. At the same time, PMTCT was added to the existing breastfeeding curriculum. In March 2004, MCHI staff participated in USAID/ Russia's two-day workshop on the mission's new HIV/ AIDS strategy. As agreed to with "Healthy Russia 2020", new PMTCT materials – cue cards, brochures for clients, leaflets for providers – were collaboratively developed with Healthy Russia 2020.

MCHI also sought from the beginning to involve itself with the major Russian individuals and institutions dealing with PMTCT such as the Federal Scientific Center for the Prevention of MTCT/ HIV; the Federal Service for Surveillance in Consumer Rights Protection and Human Welfare's Department for HIV/ AIDS Control; the Federal Center for HIV+ Pregnant Women and Children, the Federal Pediatric AIDS Clinic; and the Future without AIDS Foundation

Russia currently does not have a confidential voluntary counseling and testing (VCT) system. Widespread involuntary testing occurs including of pregnant women. Reportedly, a federal precaz mandates HIV testing of all pregnant women at various stages of pregnancy. Children

born to HIV+ mothers are registered and tested at regular intervals until the age of 18 months, at which time they are removed from the registry if all tests are negative. Unfortunately, these children are generally institutionalized during most if not all of this time. Another donor is reportedly supporting efforts to reduce the length of time these children are surveyed before being removed from the registry if they continue to test negative.

In the visited regions, it appeared that MCHI is helping to create the needed linkages between the HIV/ AIDS Centers and the maternity houses/ women's consultation clinics/ pediatric polyclinics that will enable them to work together more efficiently to provide care to HIV+ pregnant women and their infants. When MCHI asked regional health leaders about major problems regarding PMTCT implementation during the September 2004 training in Irkutsk, one of the issues raised was that typically the HIV/AIDS Centers were "too far" in terms of service accessibility to many women's consultation clinics and maternity houses.

It was beyond the scope of this assessment to comment on the specific content of the care provided. However, it was certainly the case that nearly everyone recognized PMTCT as a matter of growing concern to Russia generally and to their region specifically and nearly everyone indicated a need for further work in this area.

PMTCT Guidelines

In September 2004, a two-day "PMTCT in MCHI Regions" workshop was held in Irkutsk for all MCHI Regional Coordinators and representatives from their HIV/ AIDS Centers. Other participants included the head of the Federal Service for Surveillance in Consumer Rights Protection and Human Welfare's Department for HIV/ AIDS Control and representatives from USAID/ Russia, AIHA's Ukraine PMTCT Project and the Elizabeth Glazier Foundation. Reportedly, the MCHI regional teams at that meeting indicated a very strong need for clinical/ organizational guidelines to improve the quality of PMTCT services. There was also consensus that the Quality Assurance Project (QAP) website could be used to share experiences and materials.

An MCHI working group on PMTCT guidelines was formed that in November 2004 began collaboration with the MOHSD's Institute for Management and Communication for Health. By February 2005, draft guidelines were ready for wider review.

This first draft of the PMTCT Guidelines was distributed to the MCHI regions by early March and, in mid-March, MCHI hosted a PMTCT Guidelines Workshop in St. Petersburg. Participants again included all MCHI Regional Coordinators and the heads of their HIV/ AIDS Centers; the Federal Service for Surveillance in Consumer Rights Protection and Human Welfare; USAID/ Russia; and, in addition to MOHSD's Institute for Management and Communication for Health, the head of MOHSD's Center for Assisting Pregnant Women and Children with HIV and the deputy head of MOHSD's Mother and Child Health Department. Revisions are being made and the finalized PMTCT Guidelines will soon be delivered to MOHSD. As part of this process, AIHA is translating and adapting the WHO PMTCT curriculum which MCHI will then consider incorporating into the PMTCT guidelines. The intent is to post the guidelines and curriculum on the MCHI website (see Section VII: Documentation and Dissemination).

PMTCT Coordination

As HIV/AIDS generally and PMTCT specifically have developed as areas of major concern and increasing activity, the need to collaborate and coordinate has also grown. To meet this need, the MOHSD had created a Coordinating Council on PMTCT whose membership includes representatives from institutions like the Joint United Nations Programme on HIV/ AIDS (UNAIDS), UNFPA, WHO, and USAID as well as representatives from some of the USAID-funded health projects, including MCHI.

In late 2004, MCHI did a small survey of the maternity care received by HIV+ women in Perm City Hospital #21. When the results were analyzed and presented to the MOHSD Coordinating Council, the consensus was that there was a great need for more information regarding PMTCT practices and the family planning services and options available to HIV+ women.

At the same time, USAID/ Russia also recognized the need for greater coordination among the USAID-funded health projects who often worked with the same counterparts in the same sites. In addition to a closer coordination of activities so as to avoid duplication and achieve synergy, there was also the need to ensure the consistency of key messages in materials and training courses. Equally important was the desire that all the USAID-funded groups be able to contribute to policy discussions in a timely way and that activities and achievements be presented to the MOHSD in a coordinated manner. In early 2004, USAID/ Russia asked MCHI to take the lead in coordinating the various USAID-funded projects with regard to PMTCT. Thus, as of February 2005, to ensure that the efforts of the various USAID-funded health projects complement and not duplicate each other, MCHI has assumed responsibility for co-coordinating the PMTCT component among the USAID- funded health projects as formally set out and agreed to by both. As part of this co-ordination function, MCHI serves as the key communication channel on PMTCT with the MOHSD.

PMTCT+FP Study

MCHI staff increasingly recognized the need to know more about 1) family planning method use among HIV+ women, and 2) existing PMTCT practices in order to better understand the challenges related to family planning and PMTCT among HIV+ women so as to develop better strategies for improving the quality of family planning and PMTCT services for HIV+ women.

The study design has been developed by MCHI staff together with other Russian experts. The objectives are to collect quantitative information on 1) the awareness of family planning options among HIV+ women who have recently delivered or had an abortion; 2) the use of modern contraceptive methods by HIV+ women; 3) the involvement of HIV+ women's partners in decision making about family planning issues; 4) healthcare workers' counseling of HIV+ women on family planning; 5) HIV testing practices; 6) PMTCT practices ante partum, peri partum and post-partum; and 7) the risk of MTCT. The study will also look at social and demographic factors and the prevalence of STIs and other risk factors. Additionally, the prevalence of stigma and discrimination by healthcare workers of HIV+ women will be

determined as well as the HIV+ women's level of satisfaction with the healthcare provided to them.

Strong safeguards to assure informed consent, privacy and confidentiality have been built into the study design. Nine regions with relatively high HIV prevalence rates and previous experience with quality data collection have been selected as study sites: Altai Krai, Irkutsk Oblast, Khabarovsk Krai, Krasnoyarsk Krai, Murmansk Oblast, Orenburg Oblast, Perm Oblast, Primorsky Krai and Tyumen Oblast.

As a follow-on to the mid-March PMTCT Guidelines Workshop in St. Petersburg, the resulting protocol was reviewed and discussed by a wide range of individuals and institutions: MOHSD and MOHSD's Center for Assisting Pregnant Women and Children with HIV; the Federal Service for Surveillance in Consumer Rights Protection and Human Welfare; USAID/ Russia and the MCHI regions' Mother and Child Health Departments and HIV/ AIDS Centers. It has also been reviewed by two of JSI's core competency centers – the JSI/WEI Center for HIV/AIDS and the JSI/ Center for Health Information, Monitoring and Evaluation (CHIME).

During this assessment, the final draft protocol was submitted to USAID/ Russia for approval, after which teams from the regions involved in the study will receive refresher training in data collection.

Finding: MCHI's strong technical and managerial capabilities provided the flexibility needed to allow MCHI to smoothly incorporate a major new component, PMTCT, into their program and thus be responsive to evolving external needs.

Finding: The planned PMTCT+FP Study should be expected to provide valuable data for decision making to inform the development of strong future policy and service standards.

Conclusion: Although not included in the original MCHI Contract, in response to external realities and the needs of USAID/ Russia, MCHI has become a major leader in Russia for PMTCT policy development and service standards of care

Conclusion: The MCHI project design provides an excellent mechanism for humanizing, "horizontalizing" and integrating the care of HIV+ women and their infants into the health care system, a need that will grow exponentially as Russia's HIV/ AIDS epidemic progresses.

Recommendation: Given MCHI's considerable investment of time and resources in PMTCT activities, the need for a contract amendment to include this important area of involvement should be discussed with USAID. PMTCT activities are in workplans that are approved by USAID and are referenced in the "Background" section of Contract Amendment #3 but, just as the regions would feel more comfortable with a federal preaz on FCMC, so would JSI be more comfortable with a contract amendment.

B. Influencing Eastern Europe: MCHI and USAID-funded Projects outside of Russia

The project design, implementation lessons learned and successes of first WIN and now MCHI has greatly influenced the design and implementation of several USAID-funded projects outside of Russia, especially in the EE/AA region. The Ukraine Maternal and Infant Health Project was designed in large part based on the WIN model and nearly all the expert trainers used by the Ukraine project were trained by the WIN/ MCHI expert trainers. The Healthy Women/ Georgia Project also incorporates many WIN/ MCHI approaches in its design and key technical staff have visited MCHI for more in-depth technical assistance regarding curricula and training approaches.

Finding: The design and implementation process of the MCHI Project is an excellent model (and already has been in Ukraine) for similar work in other countries, especially in former Communist-block countries. Additionally, it is an excellent model for the incorporation of additional evidence-based, internationally-recognized standards of care into the Russian health care system (e.g. additional reproductive health, family planning, and HIV/ AIDS interventions; tobacco; tuberculosis). Because of its client-centered, client-friendly approach, the MCHI model is also a good model for reaching traditionally hard-to-reach populations (prisons, drug rehab centers) in need of these same services.

VII. Documentation and Dissemination

Mandate:

The MCHI Contract includes no specific contractual Result or Task for documentation and dissemination but does include specific reporting requirements. These reporting requirements have determined the formal structure of MCHI documentation to date. The requirements include details on the content of regular reporting via a Quarterly Performance Report: *“The Contractor is expected to prepare and submit a quarterly report to the Mission within a month into each quarter. The information shall include progress according to workplan submitted at the beginning of the project, outcomes achieved, problems encountered, and solutions suggested. The report shall also indicate resolution of any problems reported in previous reports and a list of upcoming event anticipated for the next quarter.”* In addition, the Contract specifies that there will be quarterly Evaluation and Monitoring Reports and Financial Reports as well as both mid-term and final MCHI Project Reports.

Contract modification #2 added the **Result:** *“Overall project results documented and disseminated in the pilot regions and nationwide”* to be achieved via the following **Task:**

1) *Overall project results should be properly documented and disseminated to obstetricians, pediatricians, midwives, and nurses throughout Russia by writing and publishing papers in influential professional journals and giving presentations at appropriate professional meetings and conferences in the pilot regions and nationwide.*

Progress to Date:

MCHI’s success to date has been aided substantially by concerted efforts to document and disseminate Project results. The replication focus of the MCHI project design implies a large amount of dissemination of ideas and materials throughout the MCHI regions and beyond; in

addition, the Contract talks about the dissemination of MCHI models among USAID/Russia's other health partners and visa versa.

Initially, MCHI used a number of channels to disseminate information about the Project and the competitive selection process for participating as a region. The larger than expected application pool (39 of 89 regions applied) indicates both interest in the Project outcomes and success of efforts to inform regions about the competition. Those regions that did apply were evaluated on selection criteria (see Appendix F: MCHI Selection Criteria) which included: "Working with Mass Media". This attention to the importance of dissemination in the selection process indicates again that MCHI has consistently looked for ways to promote dissemination at low or no cost to MCHI.

MCHI staff and health authorities in the 14 regions have used media, the Internet, conferences, and other available outlets to share Project information and preliminary results. The results of much of this work in the media are summarized in Appendix K: Dissemination of MCHI Methods and Results. While information about dissemination through local media is not comprehensive since MCHI reporting does not currently capture all mediums from every region, it is clear that Internet news is very important. While assumed to be a low estimate, the number of known Internet articles used to disseminate information about MCHI is already over 300.

The importance of the Internet is clear, and MCHI has become aware of additional opportunities that could be seized by better using the Internet for dissemination. MCHI has decided to add the creation of a MCHI website to its objectives and has hired a local firm to complete the design. The website will enable anyone to download training materials, communications materials, plans and success stories. MCHI also plans to use the site to share photos of completed training sessions and other relevant files with their geographically very dispersed regions. This website project builds on the model of Perm's Resource Center website, created under the WIN Project. Perm has already committed to updating the contents of the Resource Center website to include new and updated elements from the MCHI Replication Packages (see Appendix H: Current Replication Packages).

MCHI has consistently produced Quarterly Reports that document Project activities in an organized and complete fashion. These reports, with their extensive annexes, provide an excellent archive of details about training courses, conferences and other activities. Since MCHI is at its half-way point, it is the correct time now to add more information to the Quarterly Reports about preliminary results including process indicators, lessons from the scale-up to date, collaborative efforts, additions to the Replication Packages, and challenges and problems encountered.

The new Result and Task make explicit the goal of sharing MCHI results within medical and public health circles in MCHI regions and throughout Russia. MCHI has had some success in infiltrating traditional medical and public health groups, working with and through their partner RSOG. In addition, MCHI has met with other medical professional groups in an effort to identify other opportunities for dissemination of MCHI models. It has not been easy, however, to influence professional groups with innovative ideas, even if the ideas are evidence-based.

Much work remains to be done for new MCH practices to be disseminated and accepted throughout Russia.

One important national dissemination event for medical professionals was the very well-received JSI session “Implementing Modern Maternal Child Health and Reproductive Health Practices in Eastern Europe and the Newly Independent States” which was part of the opening day of RSOG’s 2004 Annual Meeting in October 2004. RSOG participants were extremely interested in the exhibited materials from MCHI. Representatives from several Russian regions that do not participate in the Project requested to be included in the Project after attending the RSOG Annual Meeting and learning about MCHI.

MCHI uses regional conferences within Russia to spread information about approaches and results. Beginning with an ob-gyn regional conference in Tyumen in March 2004, MCHI has presented at eight conferences including four on aspects of HIV/AIDS.

WIN and MCHI have widely shared their experiences with USAID and their partners in Russia, Eastern Europe, Eurasia and elsewhere. In June 2003, after the worldwide biannual JSI International Division Meeting, the first JSI Eastern Europe/ Eurasia Regional Meeting was held in Washington. In October 2004, JSI held its second Eastern Europe and Eurasia Regional Conference in Moscow. Among the goals of the Conference were to share program interventions and lessons learned and to explore strategies for implementing evidence-based practices. Representatives from JSI projects in Central Asia, Georgia, Romania and Ukraine participated together with representatives from the 14 MCHI regions, MOHSD, RSOG and USAID/Russia.

Towards the end of this assessment, in mid-April, two back-to-back meetings in Bucharest gave MCHI the opportunity to further disseminate their strategies and results. USAID/ Washington sponsored an Eastern Europe regional meeting on family planning, which was followed by a JSI Eastern Europe Chiefs of Party meeting. The USAID regional family planning meeting grouped Ministry of Health and USAID officials as well as USAID CA representatives with their counterparts from throughout Eastern Europe. The JSI meeting provided more opportunities to promote the coordination, collaboration and synergy between the various JSI projects in EE/EA through sharing of materials, lessons learned and expertise. By all accounts, MCHI used these opportunities to share information and results and to gather information about next steps. A third JSI EE/EA Regional Meeting will follow the June 2005 JSI International Division Meeting in Washington later this year. MCHI will be a major presenter at both the International Division Meeting whose theme is “Public Health Impact: Experiences in Scaling Up” and the EE/EA Regional Meeting that follows.

Another important channel of dissemination for MCHI models and results is the use of formal and informal advocacy networks. Advocacy networks exist in all 14 MCHI regions, a few created by the USAID-supported Policy Project, some created independently and spontaneously, and others growing out of the MCHI-supported activities. Advocacy networks that function out of more formal organizations have occurred through the MCHI Regional Coordinating Teams and the Facility Coordinating Teams. The advocacy networks in MCHI regions try to disseminate MCHI methods and findings throughout the staff of Health Departments and

sometimes Social Affairs Departments, as well as through various committees or councils related to women and children's health. Several regional MCHI advocacy networks work especially well with the press, including influencing journalists and public relations staff at the regional level.

Among the MCHI Regional Coordinators, networking has become a common occurrence and often a method for disseminating project activities and results. These Coordinators know much about what is going on in other MCHI regions and work to share information with each other. Learning more about what these networks communicate to each other could shed light on how to use them better.

Regional Visits:

Based on the assessment team's experience in three regions, dissemination of MCHI activities and use of press resources seems common. Regional Health Departments have public relations officers who assist with these tasks. During each of the three field visits, regional health authorities had requested press coverage of the team's visit; in each region, the press attention was considerable with televised segments of the facility tours and on-camera interviews with MCHI and USAID staff. Segments varied in length from two to five minutes and were reportedly broadcast multiple times. Representatives of the written press were also present; it is not known if articles were later published.

Finding: MCHI is actively seeking to better use the Internet for dissemination; the MCHI website now under development will extend dissemination of technical materials throughout Russia, the EE/EA region and potentially the world.

Finding: A comprehensive Documentation and Dissemination Plan is currently being finalized and MCHI is actively involved in implementing various actions outlined in the draft Plan. MCHI is currently doing much of what needs to be done to document and disseminate overall project results in the pilot regions and nationwide.

Finding: Influencing the Russian professional medical community has been a great challenge, even in the context of a strategy of evidence-based international standards. Much work remains to be done for new MCH practices to be disseminated and accepted throughout Russia, and for federal standards to reflect evidence-based best practices.

Recommendation: Given how challenging it is to influence overall medical opinion in Russia, MCHI staff should provisionally plan both subject matter and submission schedules for publishing in influential professional journals. Additional influence can be garnered if the articles can be reprinted and disseminated a second time.

Recommendation: Quarterly Reports should be utilized to document in a more specific manner preliminary results including process indicators, lessons from the scale-up to date, collaborative efforts, additions to the Replication Packages, and creative methods for expanding impact.

VIII. Coordination

Mandate:

USAID/ Russia has consistently made real efforts to enhance coordination and collaboration among its projects in order to avoid duplication and achieve as much synergy as possible. Consequently, MCHI was charged with *“In addition to Healthy Russia 2020, a major cross-cutting USAID/Russia health initiative, the Contractor shall closely coordinate its activities with the following USAID health activities:*

1. *American International Health Alliance’s (AIHA) Health Partnerships,*
2. *Assistance to Russian Orphans (ARO) program,*
3. *Quality Assurance Project (QAP),*
4. *Policy Project, and, as appropriate,*
5. *USAID’s ongoing HIV/AIDS and STIs prevention activities.*

USAID/Russia’s health activities seek to promote improved, evidence-based standards in health practices and protocols nationwide. To streamline the achievement of this objective, a carefully planned and consistently applied coordination plan is essential. The Contractor shall indicate how it is planning to establish and ensure coordination with the above-mentioned and other relevant USAID initiatives.

- The new MCH activity shall collaborate closely with USAID’s **Healthy Russia 2020**, which serves as an information and general dissemination tool through its web portal, media campaigns and advocacy component. Healthy Russia 2020 will take the lead in mobilizing advocacy groups and policy makers in order to facilitate the promotion of newly developed guidelines and protocols. In addition to advocacy, in order to ensure continuity and consistency in the messages delivered, the Contractor shall coordinate the new MCH activities directly with those of Healthy Russia 2020, especially as they relate to health education, information, and communication interventions.
- The Contractor shall share materials and models developed under the new MCH activity with health partnerships managed under **AIHA**, and use, to the fullest extent possible, relevant materials developed by these partnerships. Many of these partnerships have focused on serving women and children.
- The project shall coordinate with USAID’s **ARO** program training and educational activities on quality maternity care and baby-friendly hospital practices, including skin-to-skin contact between mother and newborn, early initiation of breastfeeding, minimal separation of mother and infant, which reduce early abandonment. For example, the Contractor could include the Early Intervention model developed under the ARO project in the overall replication package.
- The Contractor shall coordinate with USAID’s **QAP**. This project has developed a cost-effective model of disseminating evidence-based protocols and practices that can be adapted for various medical and health care interventions and practices. This model should be assessed by the Contractor to facilitate the replication component of the proposed MCH activity. For example, the Contractor can include MCH related

protocols, such as Respiratory Distress Syndrome and Pregnancy Induced Hypertension, developed under QAP in the overall replication package.

- The Contractor shall share information and materials as needed with the **POLICY** project. This project works with NGOs to develop support for women's reproductive health issues among policy makers. The Contractor should utilize Policy's national and regional advocacy networks on reproductive health to promote and advocate for MCH practices developed under this activity.

In addition to USAID's internal programmatic coordination, the Contractor will collaborate with federal and regional governmental entities as well as other donors and programs in order to ensure effective project outcomes.

Progress to date:

The area, population, diversity and complexity of Russia make close collaboration and cooperation at multiple levels and with a wide variety of individuals and institutions a key component of all MCHI activities.

Healthy Russia: The majority of the MCHI materials were originally developed under WIN. As agreed, Healthy Russia 2020 reproduced the relevant WIN materials and distributed them to the MCHI regions in a timely fashion. In addition, new PMTCT materials – cue cards, brochures for clients, and leaflets for providers – were collaboratively developed. The HR 2020 Couples Campaign, originally scheduled for launch in September 2004, has been postponed several times and at this point is scheduled for launch in May 2005, although the non-print materials are reportedly still being developed and pretested. The MCHI regions will be trained by HR 2020 in the use of the Couples Campaign materials in late April to support MCHI's male involvement component.

AIHA: MCHI and AIHA have frequently collaborated, especially with regard to HIV/ AIDS and PCTMT. MCHI's COP visited the AIHA PMTCT Project in Odessa, Ukraine in May 2004 and the head of that project came to Russia to participate in the MCHI-hosted PMTCT workshop in Irkutsk that September. MCHI's COP recently participated in AIHA's planning meeting on HIV/ AIDS treatment care and support.

ARO: The contract suggestion that MCHI might include the ARO-supported Early Intervention model in its replication package became an explicit Result under Contract modification #2 and this collaboration is described in detail in Section V-H: ***Integration of ARO Early Intervention Model***. Modification #2 also included as an explicit Result that MCHI and ARO develop a collaborative PMTCT-plus model to be implemented in Irkutsk and other regions. This collaboration is described in detail in Section V-I: ***Development of Collaborative PMTCT-plus Model***.

QAP: MCHI has worked directly with the QAP-created Center for Quality (housed at the National Research Institute for Medical Information and Health) and the head of the Center participated in the Irkutsk PMTCT workshop. The QAP-developed protocols for respiratory

distress syndrome and pregnancy-induced hypertension are referenced in the MCHI replication packages but it is beyond the scope of the Project to explicitly train on these subjects.

The Project, in its PMTCT work especially, has also collaborated with the Elizabeth Glaser Foundation and the “Globus” project.

Policy Project: In a few MCHI regions, the advocacy networks created by the Policy Project have developed good linkages to the Project. In others, other networks have developed that have been more functional. MCHI does seek to link with the Policy networks whenever possible.

Government of the Russian Federation: As is the case in many countries, the Ministry of Health’s personnel (and sometimes policies) change frequently. Recently two ministries were merged to create the Ministry of Health and Social Development. MCHI’s current counterparts have been in place since June 2004 and staff report good relationships with them. It is not always clear that the MOHSD sees MCHI as integral to its work and as part of its portfolio; MCHI may tend to be viewed as international aid rather than an integrally Russian program. MOHSD however may be changing its viewpoint. The Ministry wants very much to make the MCHI PMTCT guidelines national policy and sees UNICEF, WHO and MCHI as their partners in this.

Regional and Municipal Governments: MCHI’s close, collegial and successful work with the regional and municipal governments in the 14 MCHI regions has been described in detail throughout this report.

Finding: Coordination with donors and USAID-funded CAs is close and synergistic rather than proforma and perfunctory.

Finding: Collaboration with Russian regional and municipal government partners has been strategic and successful.

Recommendation: MCHI should seek opportunities to deepen the understanding of actual MCHI results in the regions within MOHSD.

IX. Monitoring and Evaluation

Mandate:

According to the MCHI **Contract**, *“The Contractor shall develop an overall monitoring and evaluation plan to measure the impact and outcomes of the activity as indicated under the “Expected Results” and “Tasks to be Achieved” sections of this document. This plan shall be used to monitor progress and provide definitive evidence of project impact in accordance with the indicated results. The plan shall include how each of the results will be measured and how the data will be collected. The plan shall further discuss quality control efforts to ensure good data collection, periodic analysis of data collected, and periodic quantitative and qualitative reports of data analysis—including baseline, interim, and final reports.”*

Additionally, Modification #2 added a **Result** “*New activities included and monitored in the overall monitoring and evaluation plan*” to be achieved via the **Task**

1) “*New activities shall be included and monitored in the overall monitoring and evaluation plan*”.

Progress to date: Soon after the start of Project implementation, the MCHI monitoring and evaluation plan was prepared and submitted to USAID/ Russia on schedule, including indicators. At the same time, the strategy for implementing the baseline facility surveys was outlined. During the WIN project, both household surveys and facility surveys that interviewed both providers and clients had been conducted. The conclusion during WIN was that the most useful data came from the client portion of the facility survey; therefore, MCHI planned from the beginning to only interview clients.

In early March 2004, several weeks after the Launch Conference, the RCT members responsible for conducting the baseline facility surveys in their respective regions attended a two-day Monitoring and Evaluation Workshop in Moscow. The Workshop further introduced the Project’s monitoring and evaluation system and trained participants in facility-based survey techniques and data entry using SSPS software. Prior to the Workshop, the survey questionnaires had been finalized and field tested by Project experts and staff. Shortly thereafter, baseline data collection for the facility-based surveys started in all 10 new regions and was completed in May. The collection of official medical statistical data at the facility, municipal and oblast levels was also begun.

Within a few months of adding Khabarovsk Krai and Primorsky Krai to the MCHI portfolio, the two new regions received monitoring and evaluation training, including the methodology for conducting their facility-based surveys. The MCHI database now includes questionnaire results from 4545 antenatal women, 4585 post-partum women, 3491 abortion clients, and 4888 clients at women’s consultation clinics.

A special monitoring form was also developed for follow-up supervision visits to be done twice yearly to monitor progress, provide technical assistance, address implementation issues, and adjust Project activities if necessary. Experience to date is that the Project may be collecting more quantitative data on these visits than is necessary or useful or can be effectively analyzed and used in a timely manner. The follow-up team can see qualitatively what is working, what is not working and what needs additional work. Often they can provide immediate feedback via small workshops or by modeling supportive supervision.

All 14 regions (12 MCHI + 2 WIN) will get endline surveys. At this point in the Project, MCHI’s expectation is that each region will definitely show positive changes but feel that it is not realistic to expect changes of the magnitude seen under WIN; the MCHI regions are much more independent and the Project oversight and supervision much less intense than under WIN.

Regional visits: Anecdotally, facilities reported changes noted already: close to 100% rooming-in, up from 70-80% at one Tyumen maternity; also 30% of deliveries with family support in first month after FCMC training, up from 6% month before training.

Finding: The strong monitoring and evaluation system developed by WIN is also, with minor modifications, serving MCHI well.

Finding: The new regions and activities added by Modification #2 have been fully incorporated in the MCHI monitoring and evaluation plan.

Recommendation: MCHI should review the amount of data collection involved in the supervision visits with an eye to defining what is really useful and what might be set aside.

X. Project Management

Mandate:

The MCHI **Contract** requires that “*Within one month of signing the contract, the contractor shall provide a **preliminary three-year work-plan** addressing: 1) the creation of an in-country presence including office and staff, 2) determination of site selection criteria and process, 3) formalization of the Russian counterpart(s) and their partnership mechanisms (i.e., contract, MOU, etc.)—both for the entity that would be responsible for the replication component and for the one responsible for initiating the integration of new guidelines and protocols into the higher medical education curricula.*

*Within two months of signing the contract, the contractor shall establish an **office** in Moscow and recruit all the program staff for the duration of the project.*

Within four months of signing the contract:

- *a **three-year work-plan** shall be submitted,*
- *the **sites** shall be selected,*
- *the **replication strategy** shall be developed,*
- ***baseline data** shall be collected, either from existing sources or through other instruments,*
- *a **monitoring and evaluation plan** shall be submitted.*

The work-plan shall cover all activities for the three-year period, including a timeline and benchmarks for each activity.”

Progress to date:

MCHI has fulfilled all of its contractual requirements in a timely and efficient manner. The Contract Deliverables Schedule is totally on schedule. The MCHI COP and the MCHI staff were praised repeatedly in the regions and by other key informants for their crisp and efficient management of the Project. The MCHI office in Moscow appears to be very well supported and backstopped by JSI/ Boston. MCHI has been very skillful at accessing and leveraging the resources of JSI and WEI in a strategic and timely fashion.

JSI decision to host the second EE/EA Regional Meeting in Russia lent additional credibility and a broadened perspective to MCHI's work with RSOG and the target regions. (Conversely, JSI's EE/EA meeting was also greatly enriched by the contributions of RSOG and the regional representatives.) At this meeting, JSI's corporate policy on "HIV/AIDS in the Workplace" was presented and reportedly engendered much interest on the part of the MCHI, MOHSA and other Russian groups.

As intended, JSI/Boston has taken full responsibility for managing the Future of Russia Foundation pass through.

Finding: While paying close attention to contractual requirements, the Project has been very responsive and adaptive to changing external conditions, especially with regard to incorporating HIV/ AIDS and PMTCT-related activities, increasingly focusing Project attention on the Russian Far East as well as incorporating the Vishnevskaya-Rostropovich Foundation as a subcontractor.

Conclusion: JSI management in-country and in the home office has been strong and mutually responsive.

Recommendation: JSI should help MCHI further introduce its "HIV/AIDS in the Workplace" policy.

XI. Estimates of Project Sustainability, Coverage and Reach

A universal concern during project implementation is what will happen once the project ends and what will be the likely long term impact. Although MCHI is only at its mid-point, the assessment team felt it important to address these issues now.

The team then considered the likelihood that these interventions would be "rolled out" or spread beyond the target facilities to include other facilities in the region. Anecdotally the regions visited reported various plans and efforts already underway to introduce the new MCHI approaches beyond the target facilities. To assess how likely this was to happen, the team tried to estimate what percentage of the region was already included in Project activities in order to understand the magnitude of each region's "roll-out" task. Doing this brought to light the wide disparity of the MCHI regions in terms of population and geographical area. The target facilities in some regions are municipal facilities only; in others, both oblast and municipal facilities are involved. Looking at catchment areas was not helpful due to overlap and the fact that oblast-level facilities defined the whole region as their catchment area. Finally it was decided to look at the number and percentage of births occurring in Project facilities compared to the total number of births in the region. For the most part, babies born at a particular maternity have received their antenatal care and will receive their infant care at the affiliated women's consultation clinics and pediatric polyclinics so it was felt that looking at the number and % of deliveries was a good proxy for coverage. The results, shown in Table A are extremely encouraging. Already, a very large percentage of births occur in target facilities.

Table A: Regional Characteristics and Coverage Estimates

	Total Population	Oblast or Municipal or Both?	Rank by Pop (out of 89)	Rank by Area (out of 89)	Total # of Deliveries in Region	# of Deliveries at Project Sites	% of Total Deliveries
MCHI Regions Original 10							
Altai Krai (Barnaul)	2,607,426	Municipal	20	25	26,873	4,712	18 %
Irkutsk Oblast (Irkutsk, Bratsk)	2,581,705	Both	21	6	29,000	10,536	36 %
Kaluga Oblast (Kaluga)	1,041,641	Both	52	68	8,237	4,636	56 %
Komi Republic (Syktyvkar, Vorkuta)	1,018,674	Both	54	15	11,320	7,187	63 %
Krasnoyarsk Krai (Krasnoyarsk)	2,966,042	Municipal	13	2	29,623	4,255	14 %
Murmansk Oblast (Murmansk)	892,534	Municipal	61	29	8,843	4,521	51 %
Omsk Oblast (Omsk, Tara)	2,079,220	Both	25	31	21,664	5,305	24 %
Orenburg Oblast (Orenburg)	2,179,551	Municipal	24	32	23,793	4,009	17%
Tyumen Oblast (Tyumen, Tobolsk)	1,333,800	Municipal	40	3	15,059	5,969	40 %
Vologda Oblast (Vologda, Cherepovetch)	1,269,568	Municipal	42	28	13,134	3,728	28 %
MCHI Regions Additional 2							
Khabarovsk Krai (Khabarovsk, Komsomolsk-na-Amure)	1,436,570	Municipal	35	5	16,047	3,568	22 %
Primorsky Krai (Vladivostok, Nakhodka)	2,071,210	Both	26	26	21,741	5,192	24 %
WIN Regions Original 2							
Perm Oblast (Perm, Berezniki)	2,819,421	Municipal	15	27	29,915	8,279	28 %
Novgorod Oblast (V. Novgorod)	694,355	Municipal	69	51	6,462	3,624	56 %
TOTALS	24,991,717						

As can be seen in Table B, the MCHI facilities in four regions already cover more than 50% of their regions' births and another seven cover between 20% and 40%. Only three cover less than 20% and they cover 14%, 17% and 18% respectively. It is not known what percentage could be considered a "critical mass" after which roll-out would be assured but the consensus is that the likelihood is high for most if not all of the MCHI regions.

Table B: Regions Grouped by % of Total Deliveries Occurring in MCHI Facilities

<u>> 50 %</u>	<u>20-50%</u>	<u><20%</u>
Kaluga Oblast	Irkutsk Oblast	Altai Krai
Komi Republic	Omsk Oblast	Krasnoyarsk Krai
Murmansk Oblast	Tyumen Oblast	Orenburg Oblast
Novgorod Oblast	Vologda Oblast	
	Khabarovsk Krai	
	Primorsky Krai	
	Perm Oblast	

In short, a large majority of the regions are already well on their way to covering their whole population with the MCHI interventions. The team then considered if there was potential for spread beyond regional boundaries to neighboring regions. Generally it was concluded that, given regional realities, this was unlikely to happen without organized intervention and support of some sort.

Next, attention was given to the Project's likely impact vis-à-vis Russia as a whole. The Project works in 14 of Russia's 89 regions which all together have a population of close to 25 million. Given Russia's 2002 census population of almost 144 million, the MCHI Project is reaching more than 17% of Russia's total population, a not insignificant reach in a richly diverse multi-ethnic country that covers 11 time zones.

Finding: MCHI already reaches a substantial part of each target region.

Finding: Taken all together, the MCHI target regions constitute more than one-sixth of Russia's total population.

Conclusion: It is highly likely that the evidence-based interventions introduced by MCHI will be sustained in those facilities beyond the life of the Project.

Conclusion: It is highly likely that adoption of those interventions will be rolled out or spread throughout most, if not all, of the target regions.

Conclusion: It is unlikely that the MCHI interventions would spread to neighboring regions without organized intervention and support of some sort.

XII. Conclusions and Recommendations

The Maternal Child Health Initiative is a project that is working. Change can happen. The **capacity building** that has occurred at the regional level is impressive, and the potential for continued achievement and further expansion within the target regions is great.

The design and implementation process of the MCHI Project is an **excellent model** (and already has been in Ukraine) for similar work in other countries, especially in former Communist-block countries. Additionally, it is an excellent model for the incorporation of additional evidence-based, internationally-recognized standards of care into the Russian health care system (e.g. additional reproductive health, family planning, and HIV/ AIDS interventions; tobacco; tuberculosis). Because of its client-centered, client-friendly approach, the MCHI model is also a good model for reaching traditionally hard-to-reach and/ or stigmatized populations (prisons, drug rehab centers, institutionalized youth) in need of these same services.

While not designed to impact national statistics, MCHI has the potential to scale up further than it has. The Project already reaches a substantial part of each target region and, taken all together, the MCHI target regions constitute more than one-sixth of Russia's total population. Both **replicability** and **sustainability** are key MCHI success stories. Given the relatively short time that MCHI has been in existence, it is not yet possible to access concrete data regarding the abortion rates or the contraceptive prevalence rates in the MCHI targeted regions.

Conclusion: The selection process (incorporating an element of self-selection which promoted commitment and built in readiness) and criteria worked extremely well and are key contributors to the Project's robustness. The competitive element was innovative and positive. The co-financing requirement was also motivating. Requiring letters of support from municipal and regional authorities and from the regional RSOG branch helped instill a broad sense of ownership from the beginning. The requirement that the facilities chosen be an inter-related set of maternities, women's consultation clinics, children's polyclinics, family planning centers, and HIV/ AIDS center helped to horizontalize previously vertical institutions and to standardize the content and continuity of care.

Conclusion: It is highly likely that the evidence-based interventions introduced by MCHI will be sustained in those facilities beyond the life of the Project.

Conclusion: It is highly likely that adoption of those interventions will be rolled out or spread throughout most, if not all, of the target regions.

Conclusion: It is unlikely that the MCHI interventions would spread to neighboring regions without organized intervention and support of some sort.

Conclusion: A frank and open discussion between MCHI and USAID/ Russia is needed regarding realistic options for continuing the scale-up of MCH innovations in Russia begun under WIN and greatly expanded under MCHI, given that it is unlikely RSOG will be able to fill this role in the foreseeable future. While the assessment team heard talk of adding up to three additional regions to the current MCHI portfolio should additional funds become available, other options for scaling up might have more impact and allow

broader implementation of key MCH innovations. A key concern is losing the momentum of MCHI when the current funding cycle ends in 2006.

Recommendation: Consideration should be given to initiating a broad, early dissemination phase under MCHI in which the resources created by WIN and MCHI are widely showcased and “packaged” and replication scaled up yet again in a less resource-intensive fashion. Materials, trainers, and achievements in various regions would be packaged for easy access by a larger number of regions using largely their own resources in a basically Russia-to-Russia exchange. As was done previously, MCHI could again solicit applications from this third tier of regions. A special effort should be made to target most of the Russian Far East (RFE) and to stress PMTCT. A series of “launch”-type conferences and cross-regional exchanges with “star” regions could be structured to help this third tier of regions get started.

The adoption and integration of **internationally-recognized, evidence-based standards** is occurring at a very impressive pace across an impressive range of political and health institutions actively involving an impressive number of people over an impressive geographic area. Inter-linking components and multi-level focus give it strength, breadth, adaptability and flexibility. Building on the successes of WIN and adapting additional materials from CDC, WHO, UNFPA, and UNICEF has enabled MCHI to promote evidence-based interventions more efficiently.

The MCHI approach and content is, for Russia, an idea whose time has come. The MCHI **process** (participatory, interactive, kind, respectful) is a major message that Russian counterparts were longing to hear and to which they’ve responded in kind. Throughout MCHI, explicit efforts are made to carry out project implementation in a participatory, transparent, low hierarchical manner. In effect, an effort is made to model with the regions the client-centered mother-friendly, baby-friendly, youth-friendly, family-friendly approach that the Project is striving to introduce into Russia’s reproductive health services. The training component especially models this approach. **Continuity of care** is reportedly becoming more consistent across facilities. Providers in the maternities often reported that the women arriving for delivery had been well prepared by the women’s consultation clinics’ antenatal care and childbirth preparation classes. The regions see a big need for a **federal precaz** that supports MCHI interventions in order to facilitate and enable the further rolling out and adoption of MCHI practices throughout the regions.

The regional/ municipal/ facility-level contributions (financially and in-kind) are far in excess of what was initially expected. Project **leveraging** is substantial.

Conclusion: Investing in human capital and access to (international) evidence-based interventions in Russia can lead to rapid and major changes in clinical practices over short periods of time.

Conclusion: The introduction of internationally-recognized, evidence-based standards for selected maternal child health interventions into the **pre-service and post-graduate curricula** of training institutions for physicians, nurses and midwives has been initiated in at least 11 of the 14 MCHI regions plus a major state medical academy in Moscow.

Conclusion: By identifying and supporting “catalyst” institutions and individuals, MCHI has helped multi-level leadership implement bold, rapid, substantive changes

Recommendation: It would be informative and useful to “capture” the degree to which MCHI has leveraged resources in the pilot regions. JSI should help MCHI develop a methodology and tool for doing this. ARO reportedly has done something similar and could be a helpful partner.

MCHI efforts to collaborate and coordinate are palpable. **Coordination** with donors and USAID-funded CAs is **close and synergistic** rather than proforma and perfunctory. Collaboration with Russian regional and municipal government partners has been strategic and successful.

Recommendation: MCHI should seek opportunities to deepen the understanding of actual MCHI results in the regions within MOHSD.

One of the **challenges** MCHI has faced is the **institutional development of RSOG** as its primary Russian partner organization. Due to RSOG’s lack of formal structure, direct RSOG involvement in MCHI is heavily concentrated in a single individual who is the official MCHI/RSOG liaison and is also the Project expert on reproductive health. Realistically, there is no other known organization that would have been a stronger choice. In Russia, the specialist associations have yet to have a major role in decision making but their influence is reportedly growing. Working with RSOG has led to greater dissemination of MCHI innovations through professional channels than working through the MOHSD alone would have afforded.

Conclusion: Despite its limitations, the RSOG is a very appropriate and worthy partner for implementing the MCHI Project but it would not be able to continue or expand the scale up unaided. Providing the level and extent of the capacity building that RSOG would need to allow them to continue MCHI-type interventions is beyond the resources (time, human, financial) of MCHI, nor could RSOG absorb such intense capacity building efforts, even if available, at this time.

Conclusion: Relevant and feasible organizational development work with RSOG should be continued as appropriate.

The MCHI Project has **strong management**. While paying close attention to contractual requirements, the Project has been **very responsive and adaptive** to changing external conditions, especially with regard to incorporating **HIV/ AIDS and PMTCT**-related activities, increasingly focusing Project attention on the **Russian Far East** as well as incorporating the **Vishnevskaya-Rostropovich Foundation** as a subcontractor. The Hepatitis B vaccination program implemented in partnership with Vishnevskaya-Rostropovich Foundation in the Russian Far East reportedly is progressing smoothly. Using already existing and successful partners, like the VRF, to implement specialized activities with concrete objectives in existing Project regions may enhance synergy to improve health indicators and provide **good value** in the efficient use of US development assistance funds.

Conclusion: JSI management in-country and in the home office has been strong and mutually responsive.

Recommendation: JSI should help MCHI further introduce its “HIV/AIDS in the Workplace” policy.

HIV/AIDS and PMTCT work benefit from MCHI’s **strong technical and managerial capabilities**; these attributes provided the flexibility needed to allow MCHI to smoothly incorporate a major new component, PMTCT, into their program and thus be responsive to evolving external needs. The planned **PMTCT+FP Study** should be expected to provide valuable data for decision making to inform the development of strong future policy and service standards.

Conclusion: Although not included in the original MCHI Contract, in response to external realities and the needs of USAID/ Russia, MCHI has become a major leader in Russia for PMTCT policy development and service standards of care

Conclusion: The MCHI project design provides an excellent mechanism for humanizing, “horizontalizing” and integrating the care of HIV+ women and their infants into the health care system, a need that will grow exponentially as Russia’s HIV/ AIDS epidemic progresses.

Recommendation: Given MCHI’s considerable investment of time and resources in PMTCT activities, the need for a contract amendment to include this important area of involvement should be discussed with USAID. PMTCT activities are in workplans that are approved by USAID and are referenced in the “Background” section of Contract Amendment #3 but, just as the regions would feel more comfortable with a federal preceaz on FCMC, so would JSI be more comfortable with a contract amendment.

In addition, the development of a collaborative **PMTCT-plus model** is progressing. MCHI’s respected status among many Institutes and individuals in the medical community has helped ARO gain access to the medical sphere, thereby enabling critical links between the medical and social services to begin in some areas. This **synergistic** model for PMTCT-plus has the potential to revolutionize care for HIV affected families.

Recommendation: MCHI should meet with ARO to discuss ARO's option to refund the Russian Red Cross in Irkutsk (if ARO requirements are met). MCHI can provide support in bridging the divide between the medical/health and social services sectors, with regional medical leadership and facility-level staff.

MCHI has also worked with ARO to **integrate ARO's Early Intervention model** into multiple MCHI training materials and is considered to be a substantive, positive addition that has especially strengthened the counseling component of these courses.

An important frontier in evidence-based programming is **youth reproductive health**. The context for achieving the youth contractual Result is complex and MCHI can play a major role in collecting available information and data and in producing a **Youth Reproductive Health Replication Package** that reflects current state of the art evidence. There are more data and information available on youth in Russia than during WIN and early on in MCHI, in addition to international and European standards that are relevant to consider. At the current pace of activities, and given the great interest in better serving youth in many sites in MCHI regions, MCHI will have no difficulty meeting the goal of "*a comprehensive reproductive health program for youth developed and implemented in at least two MCHI regions*". The challenge is the competition for competent technical resources to deal with youth health, both within the broader MCHI group and on a national level in Russia. 2005 is an ideal time for a **technical and programmatic review** before finalizing a comprehensive Replication Package. The **MCHI Youth Reproductive Health Task Force** has been formed and is active. It includes representatives from five regions plus MCHI staff and consultants. Youth are not explicitly included, either directly or in an advisory capacity.

Recommendation: Global standards require that when the target group is youth, youth should have a voice in reviewing planned interventions. There are at least two options: one or more youth should be added to the WGY directly or MCHI and partners could create a Youth Advisory Committee to work with MCHI and the WGY. Youth that are medical or nursing students, peer educators or otherwise active in reproductive health-related NGOs in any MCHI region would be excellent candidates.

Recommendation: MCHI should prioritize the completion of the program and evidence review by the Working Group on Youth but extend the expected completion date for compilation and use of the Youth Reproductive Health Replication Package until late 2005. MCHI should continue its search for a consultant who can assist the WGY with the analysis of current evidence-based medicine and social science relative to youth. MCHI can hold another forum with the WGY to share information from various sources before the finalization of the Replication Package in order to ensure that it reflects current Russian and European knowledge on youth reproductive health best practices.

MCHI has developed and is implementing appropriate strategies and interventions to increase **male participation** in family planning and other reproductive health services. The coordination strategy with Healthy Russia 2020, approved by USAID in early 2004, includes a major Couples Campaign on reproductive health issues. Delays of at least six months in the multi-media campaign addressing male involvement are beyond the reasonable control of MCHI as the

technical design of the actions is the primary responsibility of a partner organization. This may or may not have an impact on MCHI's final results regarding men's increased access to both reproductive health services and information as the delay has decreased the time of impact between the campaign and the final MCHI surveys that will measure male participation in three types of services.

Conclusion: Considerable attention has been given to increasing active male participation and support at multiple junctures, and the results are visible. Male participation, including that of youth, has increased at MCHI sites in FCMC, breastfeeding support, family planning, post-abortion care, and counseling. **Gender integration** is more than adequate.

Conclusion: The technical and financial resources put into increasing male participation have had an impact even before the launch of the multi-media, multi-channel Couples Campaign; results are very visible in sites with functioning FCMC. It is not possible to estimate results in areas more difficult to impact, including behaviors related to STIs, family planning and abortion.

Recommendation: MCHI should continue to work closely with Healthy Russia 2020 on the Couples Campaign and related activities, using HR 2020 monitoring and mid-term evaluation results to advise MCHI RCTs on progress to date and any recommended mid-course adjustments.

Access to **quality family planning services** is being expanded. The regions do appear to have a core of family planning trainers and a basic family planning training capability. Coordination and collaboration with pharmaceutical companies is primarily done by regional health authorities. The **limited contraceptive mix** used by most couples throughout Russia seems to be available through private pharmacies in public clinics. MCHI estimates that the partnership with Gideon-Richter has enabled the project to **save over \$20,000** in materials and supplies. MCHI will continue to document this success story. Some regions receive free contraceptives for special populations. This strategy may be risky because supply is uneven at the clinic level; the impact of uneven supply for low-income high-risk clients in Russia is unknown.

Conclusion: MCHI has placed needed emphasis on family planning, doing much to "horizontalize" and integrate family planning services broadly into MCH care. More attention needs to be given to developing providers' basic fund of knowledge regarding contraceptive methods. **Provider barriers**, such as the limited role of front-line providers and misinformation, further limit client access to an already limited choice of family planning methods.

Conclusion: Clearly much has been done recently to "horizontalize" and integrate family planning services; it would be worth the time and resources to further reinforce these gains and to focus on missed opportunities at the facility level.

Recommendation: MCHI regions have many challenges to overcome in improving access to and use of modern family planning methods, as reinforced again in findings

from recent focus group research by HR 2020. A review of the current MCHI Family Planning Replication Package materials focusing on contraceptive technology and cross-service counseling could help to strengthen and reinforce the program. The Project's family planning trainers should be involved in this process, reinforcing their skills and knowledge and integrating their experiences from the prior family planning TOT and courses. A second round TOT for the regional trainers could focus on identifying missed opportunities to reinforce pre- and post-partum and post-abortion counseling and would create an even more solid cadre of experienced family planning trainers in the 14 regions. In the context of the soon-to-begin "Couples Campaign", this would create an environment of increased opportunity for cross-counseling on family planning and STI/HIV primary prevention as well as PMTCT.

The **strong monitoring and evaluation** system developed by WIN is, with minor modifications, serving MCHI well. The new regions and activities added by Contract Modification #2 have been fully incorporated in the MCHI monitoring and evaluation plan.

Recommendation: MCHI should review the amount of data collection involved in the supervision visits with an eye to defining what is really useful and what might be set aside.

Influencing the Russian professional medical community has been a **great challenge**, even in the context of a strategy of evidence-based international standards. Much work remains to be done for new MCH practices to be disseminated and accepted throughout Russia, and for federal standards to reflect evidence-based best practices. Overall "**Documentation and Dissemination**" will assist in increasing MCHI's influence. MCHI is actively seeking to better use the Internet for dissemination; the MCHI website now under development will extend dissemination of technical materials throughout Russia, the EE/EA region and potentially the world. A comprehensive Documentation and Dissemination Plan is currently being finalized and MCHI is actively involved in implementing various actions outlined in the draft Plan. MCHI is currently doing much of what needs to be done to document and disseminate overall project results in the pilot regions and nationwide.

Recommendation: Given how challenging it is to influence overall medical opinion in Russia, MCHI staff should provisionally plan both subject matter and submission schedules for publishing in influential professional journals. Additional influence can be garnered if the articles can be reprinted and disseminated a second time.

Recommendation: Quarterly Reports should be utilized to document in a more specific manner preliminary results including process indicators, lessons from the scale-up to date, collaborative efforts, additions to the Replication Packages, and creative methods for expanding impact.

This year, USAID published a calendar entitled "12 Months of Telling Our Story" to help document the "uncounted thousands of lives" that USAID touches and that are "the true faces of America's foreign assistance programs. The team felt they met and saw hundreds of those faces in the course of this assessment. For February, the story is Russia Adopts New Methods of

Prenatal and Infant Care and describes the interventions begun under WIN and scaled up by MCHI.