

**ASSESSMENT
OF THE
USAID/RUSSIA
WOMEN AND INFANT HEALTH (WIN) PROJECT**

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December 2001

**Submitted by:
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**Submitted to:
The United States Agency for International Development/Russia
Under USAID Contract No. HRN-C-00-00-00007-00**

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Assessment of the USAID/Russia Women and Infant Health (WIN) Project was made possible through support provided by the United States Agency for International Development (USAID)/Russia under the terms of Contract Number HRN–C–00–00–00007–00, POPTECH Assignment Number 2001–032. The opinions expressed herein are those of the authors and do not necessarily reflect the views of USAID.

ACRONYMS AND ABBREVIATIONS

ACNM	American College of Nurse-Midwives
AIHA	American International Health Association
C-section	Cesarean birth
CDC	Centers for Disease Control and Prevention
CEDPA	Centre for Development and Population Activities
CNM	Certified nurse-midwife
ELD	Electoral district
FCMC	Family-centered maternity care
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
IEC	Information, education, and communication
IMR	Infant mortality rate
IUD	Intrauterine device
JHU/CCP	Johns Hopkins University/Center for Communication Programs
JSI	John Snow, Inc.
KAP	Knowledge, attitudes, and practice
LAM	Lactational amenorrhea method
MAQ	Maximizing access to quality health care
MCH	Maternal and child health
MMR	Maternal mortality rate
NCHS	National Center for Health Statistics
NGO	Nongovernmental organization
PIH	Pregnancy-induced hypertension
PSI	Population Services International
RCT	Randomized controlled trial
RDS	Respiratory distress syndrome
RFPA	Russian Family Planning Association
STD	Sexually transmitted disease
STI	Sexually transmitted infection
TASC/IQC	Technical Assistance Service Contract/Indefinite Quantity Contract
TFR	Total fertility rate
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
URC/CHS	University Research Corporation/Center for Human Services
USAID	United States Agency for International Development
VCIOM	All Russia Centre for Public Opinion and Market Research
WHO	World Health Organization
WIN	Women and Infant Health Project
WRHP	Women's Reproductive Health Project

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EXECUTIVE SUMMARY

INTRODUCTION

The Women and Infant Health (WIN) project, funded by the United States Agency for International Development (USAID)/Russia for implementation between June 1999 and June 2002, aims to improve the effectiveness of maternal and infant health services. Working in close collaboration with Russia's Ministry of Health, the project was designed to improve the quality of care provided by obstetricians/gynecologists, pediatricians, midwives, and nurses. The project has focused largely on training to improve the care provided to women during pregnancy, labor, delivery, and the postpartum period; support for breastfeeding; and family planning counseling provided to women after births and abortions. The project is being implemented in the cities of Perm and Berezniki in Perm oblast and Novgorod City in Veliky Novgorod oblast.

Under the USAID/Washington Technical Assistance Service Contract/Indefinite Quantity Contract (TASC/IQC) mechanism, John Snow, Inc. (JSI) was awarded a three-year contract in June 1999 to implement the WIN project. The project may now be extended for a fourth year, from June 2002 to June 2003. Partner organizations collaborating with JSI in implementing the WIN project are Johns Hopkins University's Center for Communication Programs (JHU/CCP), EngenderHealth (formerly AVSC International), and the University Research Corporation's Center for Human Services (URC/CHS).

The long-term goals of the WIN project are to reduce maternal and infant mortality and morbidity in the project's three sites. These goals are to be achieved by providing training and technical assistance to improve the effectiveness of selected maternal and infant health services, with special emphasis on reducing unwanted pregnancies and abortions. Inputs to improve family planning are provided within the broader context of maternal and infant health, with important project components focusing on maternity care; postabortion care; promotion of breastfeeding and preventive health care of infants; and prevention of sexually transmitted infections (STIs). Major themes of the project include

- training in evidence-based medicine,
- application of and training in quality assurance methods,
- client-centered approaches to reproductive health services,
- improving communications between health care providers and clients, and
- promoting preventive health practices.

It is anticipated that the goals of the project will be achieved by successfully meeting the following objectives:

- provide family-centered maternity care that encourages exclusive breastfeeding and rooming-in,
- provide high-quality prenatal and postnatal care,
- increase training on neonatal resuscitation,
- improve family planning counseling and services during the postabortion and postpartum period,

- increase counseling for STIs, and
- train health care workers to recognize and counsel women who are victims of violence and provide adequate referrals.

SETTING FOR THE WIN PROJECT

Owing mainly to Russia's low fertility rate, the Russian population is declining at a rate of about 6 percent per year. It has been estimated that the current population (145.5 million as of July 2000) will decline to about 125 million by 2025 and 104 million by 2050 (United Nations, 2001:29). The total fertility rate (TFR) as of 2000 was 1.2 children per woman. Only 18.0 percent of the population was below the age of 15 compared with 21.7 percent in the United States (United Nations, 2001:49–50).

Russia's infant mortality rate as of 2000 was 16.7 deaths per 1,000 live births, a figure that is approximately double the level currently prevailing in the United States (United Nations, 2001:41–42). The four leading causes of infant mortality in Russia are complications originating in the perinatal period, congenital abnormalities, pneumonia and influenza, and infectious disease (National Center for Health Statistics [NCHS], 1999:16).

The national government is currently giving priority to preserving and increasing the size of Russia's population. In 1999, direct public sector support for family planning was discontinued by the State Duma (one of the two houses of parliament), and funding was merged into the safe motherhood initiative that now constitutes a major component of the presidential "Children of Russia" program. This action was apparently triggered by political and church worries about Russia's falling population size and concerns surrounding the morality of induced abortion. One of the results of this action is that access to contraception could be more limited for couples that may not be able to afford its cost.

The use of modern contraception does not have a long history or well-developed service delivery infrastructure in Russia. For decades, abortion has been the primary means of family planning in Russia. Currently, each woman averages 2–3 abortions during her lifetime, and some women may have as many as 15 or 20 abortions (Goldberg and Serbanescu, 2001). It should also be noted that the abortion rate has fallen from about 14 abortions per 100 women in 1988 to just under 8 in 1997. This decline has coincided with modest gains in the use of modern contraceptive methods, particularly pills and intrauterine devices (IUDs). The USAID reproductive health strategy currently includes helping Russia convert from reliance on abortion as a primary means to prevent unwanted births to the use of safe and effective methods of contraception.

METHODOLOGY FOR THE ASSESSMENT

The team considered the goals and objectives for USAID's overall WIN strategy and reviewed activities described in WIN project documents in organizing this assessment. In addition to evaluating the performance and accomplishments of the project to date, the following expected results for the project were used to guide the assessment of project impacts:

- a reduction in overall abortion rates with significant reduction in repeat abortions,
- an increase in contraceptive use among sexually active women,
- an increase in the number of women exclusively breastfeeding,
- an increase in the number of hospitals providing rooming-in to mothers,
- an increase in the number of hospitals offering family-centered maternity care as a birthing option,
- guidelines, protocols, and standards defining new approaches to women’s and infant health services and practices developed, and
- a decrease in perinatal mortality in project sites.

THE PROMOTION OF FAMILY-CENTERED MATERNITY CARE IN THE WIN PROJECT

One of the key elements of the WIN project is the introduction and strengthening of family-centered maternity care (FCMC) practices in Russia. FCMC is evidence-based medicine applied to the care of pregnant women and their newborns:

- **Mother-Friendly Care**
 - Is designed to meet the informational, social, emotional, comfort, and support needs of pregnant women and their families during pregnancy and childbirth;
 - Emphasizes education and preparation to enable the pregnant woman to take a knowledgeable, active role in promoting her own health and that of her fetus and baby;
 - Encourages involvement of the pregnant woman’s family members or other persons of her choice in preparation for childbirth and motherhood and invites their supportive presence during labor and birth;
 - Avoids unnecessary use of invasive, uncomfortable and/or restrictive procedures;
 - Encourages women to be active during labor—to sit up, walk, assume any comfortable position, change positions frequently, and avoid the supine and lithotomy positions; and
 - Manages birth as a process requiring cleanliness but not sterility.

- **Baby-Friendly Hospital Practices**
 - Designed to promote breastfeeding, maternal-infant bonding, lactational amenorrhea, and to reduce newborn infections;
 - Provided to the mother and baby after the baby is born;
 - Promoted worldwide by WHO;
 - Key elements include
 - ▶ skin-to-skin contact between mother and baby,
 - ▶ rooming-in,
 - ▶ exclusive breastfeeding for first 6 months of life,
 - ▶ breastfeeding on demand,
 - ▶ no bottles,
 - ▶ no pacifiers, and
 - ▶ expert assistance to prevent and solve breastfeeding problems.

PRINCIPAL FINDINGS AND CONCLUSIONS

JSI is performing well in its role as the WIN project coordinator. Each partnering organization brings comparative expertise to the project that complements the overall project effort. Having these four organizations working together as a consortium appears to be working effectively. This success can be attributed to the highly capable leadership of the JSI resident project director; good working relations between project staff, consultants, and host country counterparts; the effective management of the project by the Health Division of USAID/Russia; and the relatively small size of the consortium.

The WIN project is financed at approximately US \$4.0 million over three years. Considering the project design, the scope, and the results expected, the project has a very limited budget. Given the standards of donor-funded projects in other countries, the expectations for the project should be more narrowly defined and commensurate with the available funding and implementation time period for the project.

Russian health providers and mothers that were interviewed during this assessment greatly appreciate and are genuinely enthusiastic about the WIN project. Not only is this small project meeting many of its objectives, but it is also generating enormous good will for USAID and the American people. Russian doctors and midwives are overwhelmingly positive about what they have learned and the resulting changes in how they take care of women. Women and their family members are happy about their birth experiences and grateful for the care they receive, which is very different from what is usually available. Doctors in charge of the services report that the WIN innovations have transformed how doctors and midwives relate to their patients, and that the changes “have been like a breath of fresh air, both for providers and for women.”

In addition, service providers in all three cities reported financial benefits due to less use of medicines and supplies for procedures that are now used less frequently, such as sterile

suture materials, analgesic and anesthetic drugs, baby formula, antibiotics, and intravenous solutions. This money is now available for other uses.

Service providers are also learning the benefits of avoiding the unnecessary use of invasive procedures. They are also impressed and increasingly interested in the importance of basing care on evidence of efficacy. This project may be providing effective lessons in health care reform at the implementation rather than the policy level, without labeling it as such.

The one expectation currently advanced for the project that may be difficult to attain is a major reduction in first time and repeat abortions. Expecting to achieve a rapid rise in family planning use sufficient to significantly reduce abortions over the three-year implementation period of the WIN project may have been unrealistic.

MEASURES OF WIN PROJECT PERFORMANCE

For the purposes of this assessment, reliance was placed on the project's monitoring and evaluation system that compiles quarterly clinic-based information from administrative offices and health facilities affiliated with the WIN project. Service statistics compiled by the WIN project clearly indicate that many of the project's essential FCMC components are being effectively implemented. This is particularly true in the case of exclusive breastfeeding. Other FCMC elements being promoted by the WIN project also appear to be taking hold in health facilities. Nearly all mothers are now rooming-in with their babies, rather than relying on nurseries for life support. This is a remarkable departure from the practices of the recent past. The percentage of mothers with family support during labor and delivery, while still below 50 percent in all participating maternity hospitals, is steadily rising in most instances.

Reliance on pain medications appears to be declining in many WIN project sites. The incidence of episiotomies for vaginal deliveries has also declined. However, cesarean-section levels (which are lower than in the United States) do not appear to have declined substantially in any WIN project site.

Given the increased use of exclusive breastfeeding and the introduction of other FCMC practices in affiliated WIN project health facilities, is there evidence of improved infant health and survival? The WIN project's monitoring and evaluation system tracks numerous indicators of infant morbidity as well as levels of perinatal, neonatal, and infant mortality. Many of these measures clearly show that the WIN project is making a substantial contribution in a very short time. For example, the percentage of infants admitted to intensive care in maternity hospitals has fallen in most project sites. Upper respiratory tract infections and pneumonia have declined in many children's polyclinics. The percentage of infants with jaundice has fallen substantially in some project sites. Another encouraging trend is that the incidence of ear infections (otitis) is about 50 percent lower in health facilities previously reporting high infection rates.

Unfortunately, the number of new family planning acceptors and users does not appear to have risen over the short 15-month reporting period of the project. In fact, in one family planning center, levels of acceptance and use actually declined. The main methods being accepted in family planning centers are pills and condoms, with IUDs, injectable contraceptives, and emergency contraception (morning after pills) being less frequently

employed. Continued use of contraception in the project's study areas is a critically important indicator of project performance. These findings clearly point to the need to strengthen the provision of family planning counseling and services during the last year of the WIN project.

Reports from the gynecological units of maternity hospitals affiliated with the WIN project indicate that there have been some modest reductions in the number of abortions performed in some facilities, but little in the way of decline elsewhere. However, the WIN project does appear to be achieving some success in increasing the percentage of women who accept a family planning method after having an abortion. For example, in the gynecological unit of the Perm-21 maternity hospital, the percentage of abortion clients accepting family planning rose from just 8 percent in the period from July to September 2000 to 57 percent between July and September 2001. This impressive rise, which has not been matched in other areas, may partly be due to the provision of free contraception as part of an operations research study investigating the crucial role family planning can have in reducing abortion levels.

RECOMMENDATIONS

The WIN project should be funded for an additional year to take advantage of and consolidate the success of the project as implemented in the three current sites. A five-year follow-on project should be designed to further enrich the WIN model and to expand the reach of its innovations into every region of the country. In addition, an intensified effort to combat human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) should be a centerpiece of USAID's future health programming in Russia. To this end, the introduction of an affordable high-quality branded condom through an expanded social marketing effort should be a priority over the coming years. A U.S.–Russia commission on reproductive health should be established to better understand and support efforts in this area.

The strategy for extending the reach of WIN project interventions, both in a fourth-year extension and in a follow-on project, should rely heavily on full utilization of extant Russian systems to disseminate new knowledge, practices, and standards throughout the medical/health care system.

The goal should be to provide the additional inputs needed to make the important, successful innovations that have already been introduced strong enough to continue, thrive, and be replicated and institutionalized through processes that are part of the indigenous Russian system. If USAID does not continue to work in this area, then these innovations would continue on the strength of their inherent effectiveness and attractiveness to Russian maternal and child health professionals.

A new five-year project should start in June 2003 and end in May 2008 to permit nondisruptive transition to a new project and to allow sufficient time for implementation. The WIN model should be expanded to one oblast in each of the seven federal regions. This would require replication in five new oblasts, in addition to continuation of the project in Perm and Veliky Novgorod oblasts.

Finally, it is imperative to note that the team is very concerned about the current rise of HIV/AIDS infection in Russia as the epidemic begins to move beyond intravenous drug

users. Russia's health system is not giving adequate attention to HIV prevention. The WIN project provides training to obstetricians/gynecologists and midwives, two categories of health workers that have critical roles in managing sexually transmitted diseases (STDs). Significantly greater resources will need to be directed toward the prevention and treatment of STDs (most critically HIV/AIDS) in the future.

Therefore, in addition to the expansion of a WIN follow-on project, USAID should devote a significant amount of its health assistance efforts in Russia to providing subsidized contraceptives, especially condoms, in order to reduce the spread of HIV infection (which is expanding rapidly beyond injectable drug users) and to reduce the need for abortions. USAID should finance condoms on a massive scale, as well as the development and implementation of a social marketing of condoms program to promote a quality-branded condom at an affordable price, supported by a nationwide campaign targeting the 15–24 year age group.

I. INTRODUCTION

DESCRIPTION OF THE WIN PROJECT

The Women and Infant Health (WIN) project, funded by the United States Agency for International Development (USAID)/Russia for three years (June 1999–June 2002), aims to improve the effectiveness of selected maternal and infant health services. Working in close collaboration with Russia's Ministry of Health and oblast-level health officials, the project is working to strengthen the quality of care provided by obstetricians/gynecologists, pediatricians, midwives, and nurses. The project is being implemented in specific women's consultation centers, maternity hospitals, children's polyclinics, and family planning centers situated in the cities of Perm and Berezniki in Perm oblast and Veliky Novgorod City in Veliky Novgorod oblast. The WIN project is financed at about US \$4.0 million over three years.

WIN is a follow-on project to USAID's Women's Reproductive Health Project (WRHP), which was implemented over the four-year period from June 1995 to June 1999. This project focused primarily on family planning rather than maternal and infant health care.

Under the USAID/Washington Technical Assistance Service Contract/Indefinite Quantity Contract (TASC/IQC) mechanism, John Snow, Inc. (JSI) was awarded a three-year contract in June 1999 to implement the WIN project. The project may now be extended for a fourth year, from June 2002 to June 2003. Partner organizations collaborating with JSI in implementing the WIN project are Johns Hopkins University's Center for Communication Programs (JHU/CCP), EngenderHealth (formerly AVSC International), and the University Research Corporation's Center for Human Services (URC/CHS).

The long-term goals of the WIN project are to reduce maternal and infant mortality and morbidity in the project's three sites. These goals are to be achieved by providing training and technical assistance to improve the effectiveness of selected maternal and infant health services, with special emphasis on reducing unwanted pregnancies and abortions. Inputs to improve family planning are provided within the broader context of maternal and infant health, with important project components focusing on maternity care; postabortion care; promotion of breastfeeding and preventive health care of infants; and prevention of sexually transmitted infections (STIs). Major themes of the project include

- training in evidence-based medicine,
- application of and training in quality assurance methods,
- client-centered approaches to reproductive health services,
- improving communications between health care providers and clients, and
- promoting preventive health practices.

It is anticipated that the goals of the project will be achieved by successfully meeting the following objectives:

- provide family-centered maternity care that encourages exclusive breastfeeding and rooming-in,
- provide high-quality prenatal and postpartum care,

- increase training on neonatal resuscitation,
- improve family planning counseling and services during the postabortion and postpartum periods,
- increase counseling for STIs, and
- train health care workers to recognize and counsel women who are victims of violence and provide adequate referrals.

SETTING FOR THE WIN PROJECT

Owing mainly to Russia's low fertility rate, the Russian population is declining at a rate of about 6 percent per year. It has been estimated that the current population (145.5 million as of July 2000) will decline to about 125 million by 2025 and to 104 million by 2050 (United Nations, 2001:29). The total fertility rate (TFR) for 2000 was 1.2 children per woman. Only 18.0 percent of the population was below the age of 15 compared with 21.7 percent in the United States (United Nations, 2001:49–50).

Another factor contributing to the decline in Russia's population has been rising mortality during much of the past decade. This rise was particularly pronounced between 1990–94. Life expectancy among men and women in Russia was comparable to levels in the United States during the mid–1960s. Since then, the health status of the Russian people has fallen well below standards attained in Western Europe and the United States.

Much of this difference has resulted from rising adult male mortality. This increase has been driven by deaths due to external causes, such as alcoholism and accidents as well as circulatory and respiratory diseases (stemming in part from widespread use of tobacco and high levels of urban air pollution). Russian males born in the year 2000 could only expect to live 58.9 years, while life expectancy among Russian women born in 2000 was not much below European norms, namely, 72.0 years (Gorbacheva, 2001). As DaVanzo and Grammich (2001:40) note, “this difference in life expectancy by sex is among the largest in the world...in only seven other nations do differences in life expectancy by sex exceed ten years; six of these were formerly in the Soviet Union.”

The United Nations reports that Russia's infant mortality rate as of 2000 was 16.7 deaths per 1,000 live births, a figure that is about double the level in the United States (United Nations, 2001:41–42). During the period from 1990 to 1994, Russia's infant mortality rate actually rose slightly (from 17.4 in 1990 to 19.9 deaths per 1,000 live births in 1993), but since 1993, it gradually fell to levels prevailing at the start of the decade (National Center for Health Statistics [NCHS], 1999:16). However, according to a recent speech by the Russian federal minister of health, the Russian infant mortality rate (IMR) had actually fallen to 15.3 deaths per 1,000 live births in 2000 and had declined further to 15.0 during the first 8 months of 2001. This speech also noted that the number of births in Russia now appears to be rising slightly. There were approximately 52,000 more births in 2000 than in 1999.

It is not clear whether infant mortality statistics in Russia are derived using internationally accepted definitions. It has been reported that infants that weigh less than

1,000 grams, are less than 28 weeks gestation, or are less than 35 centimeters in length at birth, must survive 7 days before being considered a live birth (NCHS, 1999:16). If true, this would artificially lower infant mortality levels in comparison with estimates from other countries. It is also not apparent whether fetal deaths are always included in estimates of perinatal mortality, which is usually defined as fetal deaths after 28 weeks of gestation plus deaths in the first 7 days of life. This methodological issue requires further study by actuarial and demographic experts.

The four leading causes of infant mortality in Russia are complications originating in the perinatal period, congenital abnormalities, pneumonia and influenza, and infectious disease (NCHS, 1999:16). In 1996, the IMR from congenital malformations and other conditions of the perinatal period was slightly more than twice as high in Russia as in Germany. On the other hand, the Russian IMR was 7 times higher than the German rate for injuries and poisoning, almost 19 times higher for infections, 27 times higher for all respiratory diseases, and nearly 50 times higher for deaths caused by pneumonia (NCHS, 1999). These findings suggest that efforts to reduce infant mortality in Russia will be most productive if aimed at breastfeeding; conditions that affect the quality of care provided to children in their homes, including the quality of information and assistance available to mothers; and prevention, diagnosis, and treatment of respiratory infections (including reduction of smoking).

The national government is currently giving priority to preserving and increasing the size of Russia's population. In 1999, direct public sector support for family planning was discontinued by the State Duma (one of the two houses of parliament) and funding was merged into the safe motherhood initiative that now constitutes a major component of the presidential "Children of Russia" program. This action was apparently triggered by political and church worries about Russia's falling population size and concerns surrounding the morality of induced abortion. One of the results of this action is that access to contraception could be more limited for couples that may not be able to afford its cost.

For decades, abortion has been the primary means of family planning in Russia. Russia was the first country to legalize abortion (1920), although abortion was later made illegal between 1936 and 1955 in order to encourage higher birth rates. Currently, each woman averages 2–3 abortions during her lifetime, and some women may have as many as 15–20 abortions (Goldberg and Serbanescu, 2001). The use of modern contraception does not have a long history or well-developed service delivery infrastructure in Russia.

As of 1995–96, the Russian abortion rate was 6.7 abortions per 100 women of childbearing age (DaVanzo and Grammich, 2001:27). Only Cuba, Romania, and Vietnam had higher abortion rates in those years. However, the abortion rate declined from about 14 abortions per 100 women in 1988 to fewer than 8 by 1997. This decline coincided with modest gains in the use of modern contraceptive methods, particularly pills and intrauterine devices (IUDs).

There is widespread concern that abortion plays a significant role in elevating maternal morbidity, mortality, and infertility. Recent Russian research, summarized in Davanzo and Grammich (2001:27–28), suggests that two out of every three women having an abortion suffer health complications and 10 percent of women are left sterile after having an abortion, with estimates as high as 20 percent among adolescent girls.

Abortion is also the leading cause of maternal mortality in Russia, accounting for more than 25 percent of all maternal deaths in the early 1990s (Popov and David, 1999). The vast majority of these abortion deaths (some studies suggest as much as 90 percent) are due to illegal abortion (Davanzo and Grammich (2001:27). High levels of illegal abortion are a major factor accounting for the 1995 Russian maternal mortality ratio of 53 deaths per 100,000 births, which was approximately 7 times higher than in the United States (NCHS, 1999:17). The USAID reproductive health strategy currently includes helping Russia convert from reliance on abortion as a primary means to prevent unwanted births to the use of safe and effective methods of modern contraception.

METHODOLOGY FOR THE ASSESSMENT

The team considered the goals and objectives for USAID's overall WIN strategy as well as WIN project documents in organizing this assessment (see appendix A, Scope of Work). In addition to evaluating the performance and accomplishments of the project to date, the following expected results for the project were used to guide the assessment of project impacts to date:

- a reduction in overall abortion rates with significant reduction in repeat abortions;
- an increase in contraceptive use among sexually active women;
- an increase in the number of women exclusively breastfeeding;
- an increase in the number of hospitals providing rooming-in to mothers;
- an increase in the number of hospitals offering family-centered maternity care as a birthing option;
- guidelines, protocols, and standards defining new approaches to women's and infant health services and practices developed; and
- a decrease in perinatal mortality in project sites.

In gathering information for this assessment, the team relied upon interviews with senior officials from the Ministry of Health in Moscow and health officials in Perm and Veliky Novgorod oblasts. Interviews with project administrators, service providers, and clients in WIN project sites were also an essential feature of this assessment. The team also met with directors and senior staff of medical schools in Perm and Veliky Novgorod (see appendix B).

Another essential feature of the assessment was the conduct of interviews with WIN project and USAID/Russia staff and other donor representatives. Interviews were conducted with staff from the prime contractor for the project, JSI, and the three subcontractors affiliated with the WIN project. In addition, interviews with leaders of USAID/Russia-funded projects working in other aspects of maternal and infant health were included in the team's schedule.

The team visited project facilities in all three WIN project areas, including women's consultation centers, maternity hospitals, pediatric polyclinics in all project areas, and family planning centers in Perm and Berezniki cities in Perm oblast. There are no family planning centers in Veliky Novgorod. These visits were particularly important as they allowed the team to observe program innovations, interview clients, and meet doctors and midwives who had been trained through the project. Unfortunately, there was little opportunity for observing care being provided in facilities that are not involved in the project.

The WIN project's extensive monitoring and evaluation system was a critical resource for the assessment. Much of the information about WIN project performance was drawn from these materials. In addition, the team reviewed a voluminous array of project documentation as well as other relevant research and reports (see appendix C).

II. THE PROMOTION OF FAMILY-CENTERED MATERNITY CARE AND EVIDENCE-BASED MEDICINE IN THE WIN PROJECT

The WIN project is making an important contribution in Russia by promoting family-centered maternity care (FCMC) practices based upon international evidence of efficacy (evidence-based medicine) and training in family planning counseling. These new interventions have not been commonly implemented by Russian doctors and midwives, nor have they been institutionalized in Russian medical training or practice.

FCMC includes mother-friendly care and baby-friendly hospital practices promoted by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF). Practices that have been found to be ineffective or harmful (such as routine perineal shaving, intravenous infusions, and bottle feeding) are avoided, and practices known to be safe and useful (such as constant support for women throughout labor and birth) are provided. A summary definition of family-centered maternity care is provided in appendix D.

MOTHER-FRIENDLY CARE

Mother-friendly care includes classes educating pregnant women on how to promote a healthy pregnancy, how to prepare for active participation during labor and birth, and to orient them to other aspects of FCMC. These are different from what most women anticipate during childbirth in a Russian hospital. Women are not shaved and do not have enemas on admission to the labor and delivery suite. The woman is encouraged to bring her husband or another family member or friend to the hospital to accompany and support her during labor. Constant psychological and physical support are also provided by a midwife who has received special training in measures to comfort women during labor and to make labor more efficient. The woman may eat and drink, intravenous infusions are not used routinely, and she is encouraged to be active and change positions frequently during labor.

Women labor and give birth in a private room, usually in a regular hospital bed (without stirrups) and employ whatever positions they want to use. Squatting is a particularly efficient position for giving birth, whereas lying flat on one's back with feet and legs in stirrups can cause fetal distress and results in excessive perineal tearing.

Pain medications and episiotomies are used only as needed, and thus are employed relatively rarely. Narcotics and similar drugs administered by injections or intravenous infusions cross the placenta to enter the bloodstream of the fetus and may depress the neurological and respiratory function of the newborn at birth and during the first several days of the baby's life. Pain-relieving drugs are detoxified by the mother's liver much more effectively than by the liver of the fetus or newborn, so the effect is much stronger in the baby than the mother. High total doses resulting from the cumulative effect of the mother receiving several pain shots during labor may cause the newborn to respond poorly to the extrauterine environment. Even low doses may have a negative effect on the baby's ability to breastfeed effectively and reduce the newborn's ability to respond to its mother during the important early period of maternal-infant bonding. In addition, new studies have raised the concern that fetal exposure to these drugs may affect the brain in a

way that makes the individual more susceptible to later drug addiction. Epidurals have less impact on the newborn, but reduce the effectiveness of contractions, often making it necessary to give other drugs to strengthen the contractions and increasing the need for either a cesarean section or use of forceps to deliver the baby.

Despite receiving less pain medication than most women who give birth in Russian hospitals, women interviewed by team members during postpartum hospitalization in WIN-affiliated hospitals were very positive about the care they had received. Many of them had used a birthing ball during labor. Sitting on a birthing ball provides a counter pressure that seems to ease one of the most intense forms of labor pain.

BABY-FRIENDLY CARE

The baby-friendly hospital practices promoted by WHO are designed to promote breastfeeding and maternal-infant bonding. These practices affect the care provided to both the mother and the baby after the baby is born. The baby is placed on the mother's abdomen almost immediately after emerging and becomes inoculated with microorganisms that are the normal flora of the mother's skin. The mother and father are given a period of privacy with their baby soon after the birth. Most mothers breastfeed their babies at that time.

All women can have rooming-in, even those who had cesarean deliveries, and the babies are not swaddled. Swaddling restricts the baby's respiratory volume and limits the mother's interaction with her newborn.

The lactational amenorrhea method (LAM) of postpartum contraception is explained, with clear information on conditions that must be present for breastfeeding to prevent conception, including 12 or more breastfeeds per day, one of which must be at night, and no use of bottles or pacifiers. Women are encouraged to begin another method of contraception when the baby starts to take other foods, when the mother has her first postpartum menstrual period, or at 6 months after the birth.

These practices provide effective contraception for up to 6 months after the birth, prevent infections, enhance maternal/infant bonding, and save babies' lives. The evidence documenting these benefits is irrefutable and has been demonstrated in the United States, as well as in less-developed countries (Enkin et al., 2000). WHO and a coalition of other organizations have promoted these practices throughout the world for many years, including in Russia since 1992. The Russian Ministry of Health disseminated guidelines to support breastfeeding and rooming-in throughout the country in 1998. Hospitals that meet stringent criteria may apply for WHO designation as a baby-friendly hospital. Two hospitals involved in WIN have achieved that status, and two more expect to do so by the end of 2001. Standards for designation as a WHO baby-friendly hospital are rigorous and this is a major accomplishment.

However, some baby-friendly practices contradict longstanding Russian medical beliefs and hospital practices and are opposed by some physicians. Some of the necessary changes are not allowed according to rules established by the Russian Ministry of Health (through the government's sanitary-epidemiology guidelines). These breastfeeding/rooming-in guidelines distributed in 1998 contained some advice that was adverse to

effective breastfeeding, including encouraging mothers to give their infants other foods at 3 months or even earlier, giving infants bottles containing water, and expecting infants to breastfeed on a rigid schedule.

Despite the new guidelines, most maternity hospital staffs have not been instructed in how to accomplish the necessary changes. Many pediatricians still think it is better to observe newborns in a central nursery for the first 24 hours and to provide infant formula in bottles during that time. In addition, many mothers are judged too sick to keep their babies with them.

WIN conducted a quality improvement workshop during which an interdisciplinary group of staff from all categories of facilities that provide care to mothers and babies reviewed the evidence on elements of care that support breastfeeding. They worked together to identify practices that are barriers to breastfeeding and actions to remove those barriers. The result was a set of evidence-based guidelines to promote breastfeeding in the context of the maternal and infant health care system in Russia, such as closing maternity hospital nurseries, getting rid of bottles and pacifiers, and teaching mothers how to breastfeed. This led to the development of new national breastfeeding guidelines that were presented by the Russian minister of health at a WHO executive board meeting in early 2001 (see a description of the maximizing access to quality [MAQ] methodology in section III, Findings and Conclusions).

The baby-friendly hospital approach of WHO and the USAID WIN project complement each other. While WHO established the standards for a baby-friendly hospital and evaluates applicant hospitals against those standards, the WIN project has identified barriers to reforming practices that are embedded in the Russian health care system and provides follow up to improve and reinforce baby-friendly practices until they become a true part of the hospital culture.

APPLICATION OF EVIDENCE–BASED MEDICINE IN FAMILY–CENTERED MATERNITY CARE

Family-centered maternity care is a powerful teacher of the concept of evidence-based medicine, validating the benefit of limiting routine use of treatments and procedures to those that have been stringently evaluated and found to be safe and effective. Each element of FCMC has been objectively evaluated through multiple randomized controlled trials (RCTs) conducted in countries throughout the world and has been found to produce substantial benefits, such as

- shorter, less painful labor;
- less need for cesarean sections and use of forceps;
- reduced postpartum infections and other maternal morbidity, including significant problems that may persist for the woman’s entire life;
- fewer women who find it difficult to adjust to motherhood;
- fewer babies that are abandoned by their mothers; and

- reduced rate of infant infection and deaths.

Most Russian obstetricians are initially skeptical of these methods, which are opposite to what they had been taught and practiced based on Russian studies. However, those involved with the WIN project soon see that FCMC is safe and has produced results that have made converts of both doctors and midwives. Teaching the value of evidence-based medicine may be one of the broadest benefits of this project. Russian doctors want to practice world-class medicine and are being converted to this standard through the WIN project.

III. FINDINGS AND CONCLUSIONS

PROJECT DESIGN

The WIN project appears to be well on its way to achieving most of its original objectives. Project interventions related to the introduction of exclusive breastfeeding, FCMC, and evidence-based medical practice have been effectively introduced and enthusiastically embraced at most WIN project sites. However, family planning counseling activities have been slower in getting started. This situation is not the result of any inherent flaw in the original design of the WIN project, but stems from unforeseen logistical impediments that delayed the implementation of the project's family planning component (see discussion of administration and management).

While JSI is responsible for overall project management and implementation (including monitoring and evaluation), all four of the main project partners have well-defined roles. JHU/CCP is responsible for the development of the information, education, and communication (IEC) component. URC has concentrated on quality assurance and EngenderHealth on training in family planning counseling. The work carried out under WRHP formed the foundation for the WIN project, and the partners were able to initiate work on the project without any significant delay.

Considering the project design, scope, and results expected, the project has a very limited budget. By the standards of donor-funded projects in other countries, expectations for the project should be more narrowly defined and commensurate with available funding and the implementation period for the project. Expectations related to strengthening nongovernmental organizations, domestic violence, and orphans may be drawing attention away from the family planning component of the project, which needs to be strengthened.

One project objective that may be difficult to attain is a major reduction in first-time and repeat abortions. Achieving a rapid rise in family planning use sufficient to significantly reduce abortions over the three-year implementation period of the WIN project may have been unrealistic. This is partly due to the length of time required to implement training programs, institute change in clinical practice, and measure change in reproductive behavior (e.g., accounting for the time to conceive, diagnose pregnancy, and obtain an abortion). There are also methodological problems involved in measuring short-term trends in abortion that make it difficult to discern programmatic impacts (e.g., resulting from family planning counseling).¹

¹ The abortion-to-live-birth ratio (the only statistic that can be used by the WIN project since no population [denominator] data are available for producing abortion rates) is not able to capture definitive trends in abortion since it is affected by shifts in the use of abortion and changes in the number of live births. For example, it was reported that women who live in other districts sometimes bypass their local clinic/hospital in order to have their babies at a facility that provides FCMC. An increase in the number of births at a WIN hospital could increase the number of births and thereby decrease the abortion-to-live-birth ratio even without change in the incidence of abortion in the immediate area served by the hospital. Use of the abortion-to-live-birth ratio may also cause confusion due to high ratios for groups of women with low pregnancy rates, such as very young girls and older women. Other problems include incomplete reporting of legal abortions (especially mini-abortions conducted by the end of the sixth week of pregnancy), abortions performed in private facilities, and lack of information on illegal abortions. It should also be

CONCLUSION

The overall project design has proven effective in meeting many of the initial goals for the WIN project. Sound project conceptualization, planning, and management have been key elements in the success of the project. However, the project is attempting to achieve a broad array of objectives in a short period with a very modest budget. Expectations established for this project have been set very high, and in terms of reducing first-time and repeat abortions, are probably unrealistic.

ADMINISTRATION AND MANAGEMENT

Shortly after the WIN project contract was first awarded, a 1–week planning meeting took place in Moscow in June 1999 with representatives of the principal partners: JSI, EngenderHealth (then AVSC), JHU/CCP, and URC, and representatives from the FRONTIERS Project of the Population Council, for the purpose of drawing up a three-year project implementation plan. This plan has been revised as needed to adjust for changing circumstances.

JSI is performing very effectively in its role as WIN project coordinator. Each partnering organization brings comparative expertise to the project that complements the overall effort. Having these four organizations working together as a consortium appears to be working well. This success can be attributed to the superior leadership abilities of the JSI resident project director; good working relations between project staff, consultants, and host country counterparts; effective management of the project by USAID/Russia; and the relatively small size of the consortium.

It became clear during the assessment that the JSI chief of party for the WIN project was the key driving force for the project's success to date. She combines an excellent technical background with an extremely adroit ability to manage people and to move the project forward. Her management of the project has been critical to its success.

Unfortunately, at the start of the project, for reasons beyond the control of JSI and USAID/Russia, JSI had no chief of party to manage the project, which was instead managed from the JSI/Washington office until a project director could be found. JSI's current project director began working for the project in November 1999, 5 months after project startup. While the JSI interim project leadership was quite adequate, the lack of a resident project director created some initial confusion and delayed the development of team cohesion.

JHU/CCP and EngenderHealth both had WIN project advisers who were resident in Moscow, had worked with the USAID–funded WRHP, and had separate project offices. In addition to long-term advisers, JSI, EngenderHealth, and JHU/CCP use a variety of short-term national and international consultants as needed. URC's relatively small quality-of-care component does not include a resident adviser, and has been implemented using short-term international and national consultants.

noted that the use of abortion is declining nationwide. Thus, without a control group, falling abortion-to-live-birth ratios in WIN project areas should not necessarily be taken as evidence of program impact.

While JSI and EngenderHealth have shared office premises since the outset of the project, JHU/CCP has maintained separate quarters. In the absence of other justifications, the team believes that the separate office structure for project partners was allowed to continue because WIN project partners had already established Moscow offices and there was no resident JSI project director at the outset of the project. A single WIN office would probably have promoted more effective project cohesion and coordination.

While no major problems of administrative coordination between JSI and the three subcontractors in the project were identified, it is unfortunate that EngenderHealth has not been able to recruit a new resident adviser for the WIN project over the past year. For reasons not understood by the team, the EngenderHealth resident adviser left the project in January 2001 and has never been replaced. Since that time, EngenderHealth has implemented its contractual obligations using short-term international and national consultants, and JSI has taken a more active role in the family planning component of the project. Not having an adviser primarily responsible for family planning appears to have inhibited the implementation of this crucial project component.

The USAID/Russia Division of Health in the Office of Social Sector Restructuring has provided excellent support for the project. It was reported to the team on several occasions that USAID staff could be counted upon to deal quickly and effectively with implementation problems that arose during the first two years of the project. It was noted that USAID/Russia staff made a point of attending meetings outside the American Embassy on short notice when required by the needs of the project.

CONCLUSION

The administrative and management structure for the WIN project is sound. The project has been distinguished by effective project implementation by JSI and its partner agencies, the enthusiastic participation of Russian health professionals (both at the federal and oblast levels), and productive collaboration between staff at the Division of Health, USAID/Russia, the government of Russia, and the WIN project partners.

WORKING RELATIONSHIP WITH THE RUSSIAN MINISTRY OF HEALTH

The WIN project is working with the government of Russia and the USAID Mission through two committees: an executive committee, composed of key officials of the Ministry of Health and the Ministry for the Press, Television and Radio Broadcasting and Mass Media, that reviews and approves project activities; and a technical advisory committee comprised of seven Russian experts in a variety of fields representing maternal and child health, obstetrics and gynecology, nutrition, quality of care, and public opinion research.

While knowledgeable about the WIN project, the team did note that senior officials at the Ministry of Health in Moscow want to know more about project achievements, particularly as they can be documented through quantitative measurement of change in maternal and infant morbidity/mortality and the analysis of cost savings resulting from the introduction of WIN project interventions. This documentation should be provided to senior officials as soon as it becomes available. There is clearly considerable scope for replicating WIN project innovations in other areas of the country.

CONCLUSION

The executive and technical advisory committees appear to be giving good leadership and direction to the project. Also impressive was the support for the project at both the federal and oblast levels.

IMPACT OF FAMILY-CENTERED MATERNITY CARE (FCMC)

People in Russia appreciate and are genuinely enthusiastic about changes brought about through the FCMC component of this project. Doctors and midwives are overwhelmingly positive about what they have learned and the resulting changes in how they take care of women. Women and their family members are happy about their birth experiences and grateful for the care they receive, which is very different from what is usually available. Doctors in charge of the services say that the WIN innovations have transformed how doctors and midwives relate to their patients, and the changes “have been like a breath of fresh air, both for providers and for women” (Chief of Women’s Consultation in Perm).

In addition, maternal and child health (MCH) leaders in all three cities reported financial benefits due to less use of medicines and supplies for procedures that are now used less frequently, such as sterile suture materials, analgesic and anesthetic drugs, baby formula, antibiotics, and intravenous solutions. Hospitals in Perm and Veliky Novgorod reported savings of about 100,000 rubles per year (about \$3,500 per year) as a result of FCMC. This money is now available for other uses. The neonatologist who coordinates WHO’s Mother and Child Health Care Programme in Russia thinks the cost savings may be one of the most important benefits of the project. The money saved is available for providing drugs and services that can have a direct impact on improving infant health.

Americans who visit maternity services affected by the project have also been favorably impressed, including the U.S. consul in St. Petersburg (who visited a WIN project maternity hospital in Veliky Novgorod). WIN project services are being talked about in the three cities, within the health professional community, and by women who have used the services. Some women who are supposed to use other hospitals are now seeking alternatives and bypass the closest hospital in order to have their babies at a maternity hospital affiliated with the WIN project. Heads of maternity hospitals in other oblasts have reported that they want to join the project.

Problems that may have arisen during the implementation of the project were discussed during the site visits. The team was especially concerned that women would not like the idea of avoiding use of pain medications during labor. Many physicians were highly skeptical about some innovations when they were first discussed. However, with the exception of the director of one maternity hospital in Veliky Novgorod, the staffs at all other facilities have become proponents of the new methods, convinced by strong evidence documenting the safety, effectiveness, and benefits of these practices as well as results they have seen and experienced.

Physicians identified “an overall change in the health care providers’ attitudes towards women” as perhaps the most important benefit of the WIN project. The WIN interventions can provide a healthier start in life for babies and lead to stronger ties between mothers and their babies. Two of the hospitals visited reported that the number of babies being abandoned at the hospital by their mothers had declined since they began

to provide this kind of care (see table 23 in appendix E). The director of health for Berezniki also identified doctors and midwives who are starting to “work closely with the mothers” as the most important change.

Service providers are also learning the benefits of avoiding the unnecessary use of invasive procedures. They are impressed and increasingly interested in the importance of basing care on evidence of efficacy. This project may be providing effective lessons in health care reform at the implementation level, without labeling it as such.

CONCLUSION

The FCMC component of the WIN project has been enthusiastically received by federal and oblast officials, service providers, and (most importantly) mothers in a relatively short period. This is a considerable achievement that bodes well for the future transformation of maternity care practices throughout Russia.

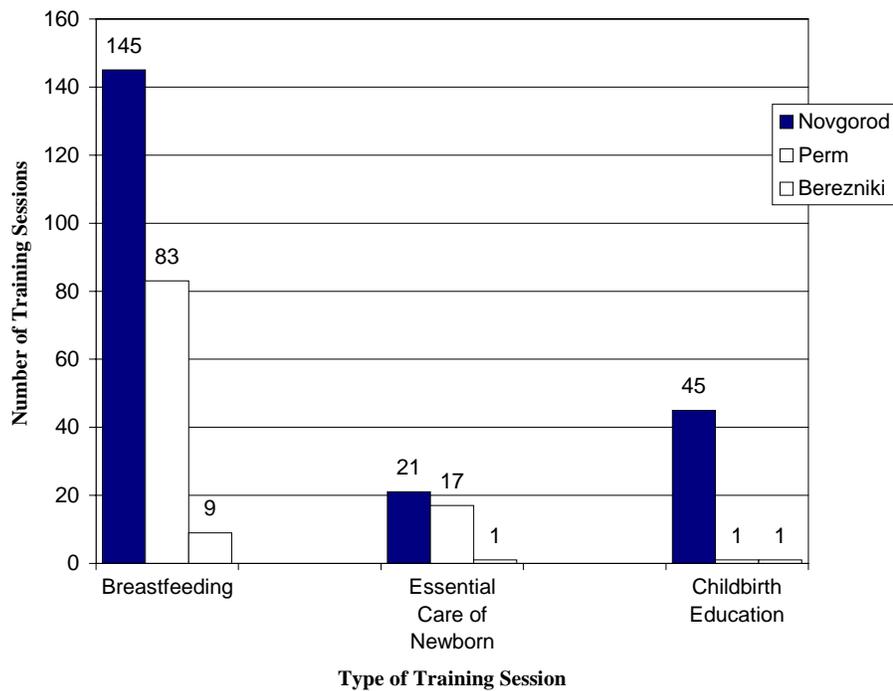
TRAINING IN FAMILY-CENTERED MATERNITY CARE

According to information compiled by the WIN project’s monitoring and evaluation system, the project has had considerable impact in terms of training service providers in family-centered maternity care. Much of the training provided by the WIN project has focused on breastfeeding. A total of 237 training sessions on breastfeeding have been conducted under the auspices of the project (which constitutes 71 percent of all maternal and child health sessions undertaken by the project). Instruction centered on the essential care of the newborn and childbirth education has not been as frequent. Project staff in Veliky Novgorod has conducted more training sessions than in other project sites (see figure 1, following page). Fewer training activities have been conducted in Berezniki, largely since this site joined the project one year later than Veliky Novgorod and Perm.

It should be pointed out that the training categories employed by the WIN project’s monitoring and evaluation system may not be strictly exclusive. For example, it is likely that instruction in the care of the newborn includes considerable information on breastfeeding. It would be useful for the WIN project to consider providing more clearly demarcated maternal/infant health training categories in the future.

FCMC training of trainers was conducted in Veliky Novgorod and Perm in the fall of 2000 and for staff of the maternity hospitals in Berezniki in the summer of 2001. Each of these sessions is extensive, including a meeting with authorities of the hospital to finalize agreement about the practices to be taught and benchmarks for monitoring quality, 5 days of didactic training for the staff of the labor and delivery unit, and 6 days of clinical training in the labor and delivery suite. Oblast and city MCH leaders, obstetricians, and sanitary epidemiologists attend the first day of the didactic course, in addition to the maternity hospital staff, who will participate in the complete cycle of training. Two American certified nurse-midwives (CNMs) conducted each of these training sessions in partnership with an Italian or British obstetrician. The Italian obstetrician works with WHO and the British obstetrician is a leading research scientist based in Oxford. Both are thoroughly committed to evidence-based maternity care.

Figure 1
Number of Training Sessions Conducted by the WIN Project
 (from project inception to September 2001)



Many inputs other than training are also entailed. Implementation of FCMC requires changes in the physical arrangement and equipment of the entire maternity unit, including

- providing space and equipment for childbirth education classes in which women learn exercises and positions that they may want to use during labor,
- removing the equipment and space previously used for administering enemas and shaving women during admission to the labor and delivery suite,
- disassembling large delivery rooms designed for several women to be delivered on operating tables (with stirrups) and removing the unnecessary equipment,
- reorganizing the physical layout to provide private labor and delivery rooms that are large enough for the laboring woman to ambulate and space for a family member to participate,
- reorganizing postpartum rooms to accommodate rooming in, and
- closing the newborn nursery.

Accomplishing these changes requires extensive communication and negotiation with diverse individuals and groups who have authority and influence in the operation of the hospital.

CONCLUSION

FCMC training activities scheduled for the first years of the WIN project appear to have been successfully implemented. These efforts have been critical in achieving much of the project's success to date.

TRAINING IN FAMILY PLANNING COUNSELING

Project inputs related to family planning have focused on

- training to improve the quality of contraceptive information, education, and counseling, as well as the quality of the clinical aspects of contraceptive care provided in family planning centers and within the context of routine antepartum, intrapartum, postpartum, postabortion, and well-baby pediatric care; and
- development of IEC materials and programs directed at the public.

EngenderHealth has major responsibility for the training component while JHU/CCP is collaborating in the management of the IEC component.

Presently, family planning training information is not compiled by the project's facility-based monitoring and evaluation system, but is obtained directly from activity reports submitted by WIN partner agencies to JSI's Moscow office. In the future, it would be better to have family planning training information fully integrated into the project's monitoring and evaluation system so that all training activities (not just maternity and infant health training) are routinely reported.

Family planning training has focused primarily on the provision of instruction for obstetricians/gynecologists, pediatricians, midwives, and nurses who work at the family planning centers, women's consultation centers, maternity hospitals, and pediatric polyclinics that are most closely involved in the project in Perm, Berezniki, and Veliky Novgorod and training of trainers to enable selected individuals to conduct similar training in other facilities. The following family planning training activities had been conducted under WIN as of the end of October 2001: updating training curriculum and materials, training of trainers workshops, and seminars for health care providers.

Updating Training Curriculum and Materials

A series of activities led to the development or updating of training curricula and materials, including a comprehensive set of Russian-language family planning/reproductive health slides, trainers' manuals, and training participant handbooks that support three kinds of courses:

- family planning information, education and counseling (for midwives and nurses),
- postpartum family planning (for personnel from maternity hospitals), and
- counseling and clinical skills for IUD insertion and removal (for physicians).

Training of Trainers Workshops

A 2–day workshop for four key local reproductive health/family planning trainers was held in April 2001 and a 5–day training of trainers for 12 health care providers was held in September 2001. Trainers who participated in the September 2001 training of trainers conducted their own course in family planning counseling for physicians, midwives, and nurses in Perm health care facilities on October 2, 2001.

Seminars

Training was conducted for the transfer of knowledge and skills to health care providers who staff facilities directly involved in the project, including

- five seminars in family planning and other reproductive health issues for 250 obstetricians and gynecologists, midwives, and nurses from the WIN project sites,
- four courses in postabortion care for 78 health care providers,
- a seminar in postpartum family planning for 20 health care providers from maternity hospitals in Veliky Novgorod, and
- a seminar in family planning information, education, and counseling for 18 midwives and nurses from WIN project-affiliated facilities in Perm.

Additional courses have been planned, including three courses in counseling and clinical skills for IUD insertion and removal for 60 obstetricians/gynecologists, which will occur between November 2001 and January 2002.

Although each course has specific content and objectives, all training activities are designed to communicate a client-centered focus, to change health care providers' attitudes and behavior (particularly with regard to client–provider interaction), and to develop the knowledge and skills required for effective communication. WHO curricula serve as the basis for much of this training. While knowledge updates are effective in increasing correct information about family planning methods, follow-up training in counseling is necessary to change providers' attitudes towards the women they serve and improve actual job performance.

Unlike the other subcontractors, EngenderHealth has not had an in-country project director since January 2001. The family planning counseling training component of the project was slow to start. Many of the planned training sessions were not completed until October 2001 or will be conducted between November 2001–January 2002—less than 6 months before the original end date for the project. Nevertheless, the team perceived considerable enthusiasm for the family planning counseling training that had occurred by the time of this assessment. Although Russian doctors also appreciate training to update their knowledge of contraception, most already have adequate information on contraceptive methods and know that they should provide family planning counseling.

However, until now, they reported that no one had actually taught them how to communicate with women and counsel them effectively.

CONCLUSION

The family planning counseling training provided through the WIN project has been well received to date. However, it was difficult to draw definitive conclusions about the project's family planning training component since much of this training has not yet taken place. While this essential project component has been a little slow to begin, much of the project's planned family planning training is to be implemented over the coming year.

MAXIMIZING ACCESS TO QUALITY (MAQ) METHODOLOGY

Staff of URC's Quality Assurance Project conducted a 1-day workshop, "Maximizing Access to Quality Health Care (MAQ)," for members of the WIN executive committee and technical advisory committee and a week-long training program, during which multidisciplinary teams of senior professionals from all three project sites were introduced to health care quality-improvement methodology. Participants then used the method, which relies on a team-based systems approach to problem solving, to outline breastfeeding guidelines for the WIN project. Each team created a flow figure to describe the care a childbearing woman and her newborn would receive in their facilities and the clinical elements provided at each step in the flow of care. The resulting description of the care being provided was reviewed in light of randomized controlled trial evidence about the effects of various elements of care on breastfeeding. This process helped the team identify changes that should be made in their procedures. This resulted in lists of needed adjustments that were taken to the oblast medical leaders, were approved in all three oblasts, and led to the development of stronger national guidelines. Quality improvement principles emphasized during this training include a focus on the customer (patient or client). Trainees learn that customer satisfaction is associated with quality.

URC has undertaken the improvement of the quality of health care in Russia through other contracts, including redesigning the system of care for neonates with respiratory distress syndrome (RDS) and improving care for women with pregnancy-induced hypertension (PIH). Although these activities were not implemented through the WIN project, the project has benefited from them since the professionals involved in WIN are also responsible for the care of neonates with RDS and women with PIH. The Russian physicians who have been involved seem intrigued by the methodology and want to learn more about methods for improving quality in health care. URC's primary agent for this work has provided excellent leadership. He speaks fluent Russian, understands the medical/health care environment and culture, and is widely respected by the Russian physicians he has worked with on this project. He has involved an American nurse-midwife, who has very competently led the FCMC element of the WIN project for JSI as a member of the team that conducted the work on improving care for women with PIH, and thus helped to integrate the URC work into the WIN project.

CONCLUSION

Introducing MAQ methodology through training directed at program administrators and service providers has clearly been instrumental in achieving the goals and objectives of the WIN project. URC has effectively implemented this project component.

INFORMATION, EDUCATION AND COMMUNICATION (IEC) ACTIVITIES

IEC plays a crucial role in the WIN project, with primary emphasis on the promotion of breastfeeding and family planning. Fortunately for the project, the JHU/CCP long-term adviser, who speaks fluent Russian, was the IEC adviser on the USAID–financed WRHP. She brings lessons learned from WRHP and over 20 years of experience working with IEC activities in publishing, radio, television, and community relations, with much of that time spent in Russia.

One of the inherent difficulties of IEC activities in the public sector is the long lead time required from the initial conceptualization to designing and testing, to approving the printed materials or radio/television spots by both USAID and the Russian government. To date, the period from conceptualization to approval has averaged about 6 months. This long approval process and the sensitive nature of broadcasting family planning messages in Russia shows the difficulties with IEC. In addition, the project does not finance the placement of radio and television spots. Because of the difficulty of obtaining quality airtime for public service announcements, it is necessary to have the continuous involvement of a senior IEC adviser who understands how to work within the system.

The WIN project has had several accomplishments in IEC to date. A campaign on breastfeeding was launched in the spring of 2001 and continued through the summer. Through the cultivation of television and radio personnel in project sites, the public service announcements on breastfeeding were aired repeatedly on both television and radio in all three cities. Project staff estimates that the announcements were aired about 1,000 times in Veliky Novgorod, about 600 times in Berezniki, and 500 times in Perm. The WIN project transferred ownership of these public service announcements to the Ministry of Health (MOH), which allows the MOH to request free airtime under current broadcasting rules. As a result, and because the spots are first rate, the television breastfeeding spots were also shown nationally during prime time.

An intensive effort has been made to cultivate journalists by giving interviews on breastfeeding, finding subjects for their stories, or giving them articles to print. Local community activities, such as celebrations for breastfeeding mothers, poster contests, teas for girls and grandmothers, and press conferences on breastfeeding have been ongoing at all project sites. The project also set up breastfeeding hotlines in Perm and Veliky Novgorod. The hotline numbers have been widely advertised. At present, the operators receive about 50 calls a month asking for information on various aspects of breastfeeding.

Under the auspices of the WIN project, brochures have been developed on breastfeeding, postabortion care, and condom use. Additional brochures on family planning methods (developed by WRHP) have also been reprinted and distributed by the WIN project. The print runs have ranged from 60,000 for the breastfeeding brochure to 220,000 for the brochure on condoms.

During the summer of 2001, logos and slogans for the upcoming family planning campaign were pretested, as were three separate concepts for television spots. These television spots have now been developed, and at the time of the assessment, were ready to start the clearance process.

In addition to the breastfeeding and family planning campaigns, the project has developed nongovernmental organization (NGO) directories in Veliky Novgorod and Perm that will be used to inform medical personnel about the local NGOs that provide assistance on a variety of issues of concern to families, covering such topics as substance abuse, family planning, and mental health.

CONCLUSION

It appears that the IEC efforts for breastfeeding have moved forward successfully. It is anticipated that IEC activities for family planning will be well financed and given priority attention during the remainder of the project, perhaps by encouraging the Russian Family Planning Association to help promote these efforts.

MATERNAL MORTALITY, ABORTION, AND INFERTILITY

U.S. and Russian officials and health professionals interviewed during the assessment expressed their belief that abortions are an important cause of maternal mortality and morbidity, especially postabortion infections that result in secondary infertility. About one fourth of all maternal mortality in Russia is thought to be due to abortions, and the vast majority of those deaths were due to abortions described as “other” (i.e., other than legally induced). The death rate from legally induced abortions fell by half between 1985 and 1995, by which time legal abortions were making only a small contribution to overall maternal mortality (NCHS, 1999:17). Maternal deaths attributed to abortion decreased further, by almost one fifth, during the last five years.

Research conducted throughout the world has found that legal, medically induced abortions are less likely than full-term births to result in serious complications and deaths. If women who are now having abortions were denied this service and either obtained illegal abortions or carried their pregnancies to term, the number of maternal deaths in Russia would increase significantly.

Legal abortions are widely available through the government health system. The team tried but was unable to learn much about the occurrence of illegal abortions in Russia. Most persons reported that illegal abortions primarily involve women who are not married, are socially and/or economically distressed, perhaps especially young girls and others who want to hide their pregnancies from family, friends, and the community. Assuming that illegal abortions are relatively uncommon yet result in a significant number of deaths, it is likely that some are self-induced or performed by untrained persons.

Many people think that secondary female infertility caused by postabortion morbidity (i.e., infection) is a serious problem. The EngenderHealth in-country consultant (a physician who works at the Russian Academy of Medical Sciences) stated that half of all Russian couples have secondary infertility, 70 percent of which is due to complications of abortion. However, she also stated that about half of all infertility in the country is due to women and half to men. That ratio seems wrong, if a major cause is complications of a procedure performed on women. It was also reported that 30 percent of women who have abortions in Perm become infected, but the doctors who reported this do not think it is their fault. The team was repeatedly told that it is because the women originally are “in poor condition.”

The same explanation is given for the high rate of hospitalization during pregnancy. It was reported that at least three fourths of all pregnant women are hospitalized prior to labor; the explanation is that they are “in poor condition.” At Maternity Hospital Number 21 in Berezniki, the team learned that “almost every woman is admitted to a hospital 2 or 3 times during pregnancy,” and the Director of Health for Berezniki stated that only 10–12 percent of the babies born in that oblast are healthy at birth. Sixty percent of the pregnant women were said to be anemic. However, due to physiologic hemodilution during pregnancy, low hematocrits (within limits) are normal for pregnant women. It is not clear whether service providers are defining women with hematocrits that are low for nonpregnant women but normal for pregnant women as being in poor condition. It is also uncertain what criteria are being used to diagnose a case of postabortion infection.

CONCLUSION

Reducing maternal deaths due to abortions will require reduction in the total number of abortions and an understanding of why some women undergo abortions outside the regular health care system; how, where, and by whom these abortions are performed; and how and why they result in deaths. Before any intervention is considered as a means for reducing infertility resulting from postabortion infections, much more information is needed, including tightly controlled collection of data on the incidence of such infections using accepted case definitions, and population-based information on the epidemiology of infertility in Russia.

DOMESTIC VIOLENCE

The WIN project has developed a relationship with a young Russian lawyer who directs the Perm Center Against Violence and Human Trafficking. This organization will conduct a study on the awareness of health personnel regarding violence against women. Five hundred health personnel will complete questionnaires and 10 will be extensively interviewed. The results are scheduled to be published.

The project has also developed cue cards for use in training health care providers on domestic violence. The JHU/CCP *Population Report on Domestic Violence* was translated, adapted, and edited for a Russian audience. JHU/CCP is using nonproject funds to sponsor two fictional scripts on domestic violence for Russia’s most popular television serial, “New Adventures of Cops,” with an estimated viewing audience of over 80 million in Russia and an audience in other countries with large Russian-speaking populations. The project is also translating the JHU/CCP *Population Report on Essentials of Contraceptive Technology* for distribution in Russia.

CONCLUSION

The work of the Perm Center Against Violence and Human Trafficking and its director are very impressive. Such efforts are clearly worthy of continued USAID support in the future. However, it is not apparent that the WIN project is the best mechanism for channeling USAID resources for work on domestic violence. Projects that become too multifaceted can become unfocused with respect to goals and objectives. A future, independent project dealing exclusively with domestic violence and human rights, funded at considerably higher levels, is worthy of future consideration.

IV. FUTURE PROGRAMMATIC NEEDS AND OPPORTUNITIES IN REPRODUCTIVE HEALTH AND INFANT CARE

STRENGTHENING FAMILY PLANNING SERVICES

Lack of Adequate Access to Free or Low-Cost Contraceptives

The federal government used to provide free contraceptives to women in economic need, but this source ended when the government terminated support for family planning in 1999. USAID does not provide contraceptive supplies in Russia and the United Nations Population Fund (UNFPA) has only provided a limited supply in support of adolescent services. It should be kept in mind that in a country where young doctors are paid the equivalent of \$25 per month as a starting wage and young nurses receive the equivalent of \$12 per month, it seems unlikely that many young couples would be able to afford the cost of contraception.

The importance of providing affordable contraception may be currently demonstrated by an operations research study being conducted by EngenderHealth and the Population Council/Frontiers Project in Perm oblast. This study compares the effect of providing family planning counseling and information to women immediately after an abortion with the effect of providing family planning counseling and information plus a 3-month supply of free contraception of the woman's choice. It appears that the provision of free contraception has generated a very rapid rise in family planning acceptance over a 6-month period (see table 28 in appendix E). Final results from this study are not expected until the third quarter of 2002.

CONCLUSION

Lack of access to affordable contraceptives contributes to unwanted pregnancies that are terminated by abortion. With the federal Duma having cut off support for family planning in 1999, a U.S.–Russia subcommittee on reproductive health should be established to raise, inter alia, the level of discussion about access to affordable high-quality contraception.

Need for Better Information on the Demand for Sterilization

It was reported that Russian MOH and health care providers, as well as the general population, are against male and female sterilization and that Russia is “not ready” for sterilization. Federal MOH guidelines allow female sterilization if a woman has at least two living children or is at least 35 years of age, or if there are preexisting medical indications that recommend the procedure, regardless of age and parity.

The following information pertaining to female sterilization is based on findings from the household and facilities surveys conducted by the WIN project in Perm, Berezniki, and Veliky Novgorod oblasts in 2000.

Women between 35–39 had given birth to approximately 1.6 children, on average; women between ages 40–44 had given birth to approximately 1.8 live-born children (David et al., 2000:26). Approximately 14 percent of women having abortions in these three areas in 2000 were between the ages of 35 and 44 (David et al., 2000:14), and

nearly 30 percent of women of all ages having either abortions or births in these facilities did not want to have another child (David, 2001:16).

Approximately 1.5 percent of married or sexually active 15–44 year-old women interviewed for the WIN household survey conducted in 2000 had been sterilized, as had about 0.3 percent of their husbands (David et al., 2000:58). About half of all women interviewed had negative attitudes towards female sterilization based on concerns about safety. However, a much higher percentage had negative attitudes about abortion based on safety concerns. About 80 percent had negative attitudes towards mini-abortions based on safety concerns, and about 90 percent had negative attitudes about abortions performed after 6 weeks (David et al., 2000:79). In addition, women were much more likely (over 70 percent) to have a negative attitude towards sterilization based on concerns about cost, compared with only about 50 percent who expressed negative attitudes about either mini or regular abortions on that basis (David et al., 2000:79).

Three percent of recently delivered mothers (interviewed during the facility survey) knew what method of postpartum family planning they planned to use and reported that they planned to use sterilization (David et al., 2000:56).

Based on these findings, a significant number of women meet the legal criteria for sterilization and may be interested in terminating their childbearing. Care providers' assumptions that such women would not want sterilization may constitute a barrier to a method that is widely used in many other countries, which could free such women from years of less than perfect contraception, punctuated by occasional abortions. Even less appears to be empirically known about the potential demand for male sterilization in Russia.

CONCLUSION

Given the high percentage of women who want to limit rather than space their childbearing and the ready access most Russian women have to clinical services, there would appear to be considerable potential demand for sterilization if the method were more readily available and promoted. Russian men, if better informed about the advantages of male sterilization, might also have more interest in this method than is commonly assumed.

COMBINING FAMILY PLANNING WITH PREGNANCY, DELIVERY, AND WELL-BABY HEALTH CARE

The WIN project promotes the idea that reproductive health includes maternity care and family planning and that each of these services can be mutually reinforcing. IEC materials on family planning are displayed and provided to women in all aspects of maternity care and in the pediatric clinics that are part of the project, just as IEC materials on breastfeeding, good nutrition for pregnant and breastfeeding women, and the importance of good parenting for children are displayed in family planning clinics. The chief of the women's consultation in Berezniki stated that she would like to have reproductive health conceptualized "like a cycle." When the woman is pregnant and receiving maternity care, the doctors and midwives should prepare her for postpartum contraception. While she is using contraceptives, the doctors and midwives should prepare her for her next pregnancy (i.e., by giving her folic acid and iodine as well as diagnosing and treating anemia).

Preconceptual care, as it is termed in the United States, could be quite important in Russia and should be provided in association with family planning. It could also focus on information and services needed for diagnosis of pregnancy as early as possible in order to avoid late abortions and understand how important it is for women who are sexually active and interested in conceiving to avoid binge drinking, which is an important cause of fetal alcohol syndrome.

ROUTINE PEDIATRIC HOME VISITS DURING INFANCY

Pediatricians and pediatric nurses make numerous routine home visits to mothers and their babies during the entire year of infancy—at least four during the first month, two nurse visits and one pediatrician visit during the second month, and regular nurse visits at least once a month thereafter, with the pediatrician visiting as needed. Each pediatrician in the polyclinic is responsible for all babies in a specified catchment area, and they may get to know the mothers very well. The same is true for nurses, who have more regular and longer term visiting schedules with mothers and who are more likely to focus on preventive aspects, whereas the pediatricians are expected to focus primarily on pathology. Although these visits focus on the health of the baby and not the mother, since the WIN project began, some nurses and doctors have begun counseling women about LAM. Some also discuss the need for family planning in a general way, but mainly in relation to LAM. The team observed some confusion and inconsistency among pediatric nurses about when women who are breastfeeding become vulnerable to conception and need to start another method of contraception to avoid becoming pregnant while their child is still an infant. The nurses have an outline that lists the subjects the nurse is supposed to cover during each of the regularly scheduled home visits.

CONCLUSION

Repeated home visits provide an excellent opportunity for a nurse to get to know a woman and her problems. They may well be in the best position to provide timely family planning information and referral to postpartum women, who are often too focused on their birth experience and new baby to focus adequately on family planning information provided during postpartum hospitalization. Pediatric nurses need better training in LAM and could incorporate keeping track of the criteria for LAM (exclusive breastfeeding, with no bottles and no pacifiers; at least 12 breastfeeds/day, including one at night; less than 6 months postpartum, and no menses) and referring women for family planning in a timely manner for these home visits.

ADOLESCENT REPRODUCTIVE HEALTH

In 1997, the literacy rate of the adult population in the Russian Federation was 98.4 percent. The majority of adolescents in Russia attend high school through graduation. While most Russian adolescents are healthy, there are alarming increases in the use of tobacco, alcohol, and illicit drugs. A WHO survey conducted in the mid-1990s found that 19.4 percent of boys and 9.7 percent of girls aged 15 smoke at least once a week (WHO/EURO, 1997). Based on data from a substance abuse register, the incidence of drug abuse among adolescents is almost 2.5 times greater than among the general population, and substance abuse is 8.8 times greater (Ministry of Health, 1998). While the team did not have access to information on the initiation of sexual activity among

adolescents, the Ministry of Health reported in 1998 that 1 out of 10 abortions was performed on women under age 19, and that more than 2,000 abortions involved girls under 14 years of age.

The team observed health care being provided to adolescents, mostly young girls, in various clinic settings, including services related to pregnancy and delivery. One of the more innovative activities reviewed during this assessment was a pilot healthy lifestyle school approach being used in high schools in Veliky Novgorod. Under this program, which is not part of the WIN project, city health and education authorities have joined forces to teach an up-to-date program of health education, including sex education, in the high schools. This is especially interesting when one considers the strong resistance, dating from Communist days, to formal education on sexuality. The pilot program, which builds on an earlier ongoing program in St. Petersburg, conducts a 1-week intensive health education program in various grades in each high school. The course is conducted by a group of highly motivated and well-selected physicians and other health personnel, who go to each of the schools to teach small classes of students on a broad variety of health themes, using an interactive approach.

Prior to the start of the program, information was collected from the students to determine what they wanted to learn, the parents of the students were briefed about the course and its proposed content, and permission was sought from parents to permit their children to attend the course, where family planning and contraception is taught as part of the overall program beginning in the ninth grade. During the site visit, one class was observed where sexually transmitted diseases (STDs), including human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), was being taught. In another class, menstruation was the theme. What was most noticeable about the program was the articulateness of the teachers and the productive interaction between students and teachers. The course is designed to interact with and educate students about real-life health issues of interest to them, and to teach how positive decisions about a healthy lifestyle can have long-term implications for health.

After the week of healthy lifestyle classes, girls (but not boys) that attend the course are invited and expected to attend a special clinical service that provides physical examinations for the girls. The team was not enthusiastic about this aspect of the program. Of the 1,300 girls who had physical examinations, 20 percent reported that they were sexually active and had speculum vaginal examinations as part of their overall physical examinations. The genital examination for the other 80 percent of the girls included visual examination of the external genitalia and palpation of the vagina and uterus through rectal examination. The examinations are conducted by a midwife who also looks at the girl's arms and legs for signs of injected drug use and asks about use of alcohol and tobacco. Of the 1,300 girls examined through this program last year, one case of syphilis and two benign tumors were found, and the affected girls were referred for treatment. This is a very small return for the expense and other costs involved in subjecting a very large number of mainly virginal young girls to these examinations. In contrast, examination of 260 girls who came to the same clinic on a walk-in basis in October 2001 led to identification and treatment of 10 cases of syphilis and 10 cases of gonorrhea.

CONCLUSION

The Veliky Novgorod healthy lifestyle school is an interesting pilot effort that may offer a model that could be replicated in other oblasts. The program might also serve as a cornerstone for future USAID support for adolescent reproductive health care. However the availability of a walk-in clinic where young girls and boys would feel comfortable would be more appropriate than mass physical examinations of young adolescent girls tied to the healthy lifestyle course.

OPPORTUNITIES FOR ENHANCED NGO INVOLVEMENT

It is unclear what scope may exist for further NGO involvement in the WIN project or any follow-on effort. The NGO sector is still relatively underdeveloped in Russia, no doubt a legacy of the Soviet period when most social services were provided through public sector channels. Clinical health services are still dominated by and will continue to function primarily through the public sector.

USAID/Russia is supporting an NGO strengthening project implemented through the Centre for Development and Population Activities (CEDPA). Unfortunately, the team was not able to learn much about CEDPA's activities in Russia or to focus on how the NGO-based social welfare advocacy agendas that CEDPA typically supports might further the aims of a project oriented to enhancing maternal and infant health services.

Other than the development of the two NGO directories for Perm and Veliky Novgorod oblasts, there is little direct NGO involvement in the WIN project. The one impressive exception is the work of the Perm Center Against Violence and Human Trafficking. There is certainly scope for increasing support for this NGO and its sister organizations combating human rights abuses in Russia. However, whether the WIN project, or a follow-on project centered on maternal and child health and family planning is the proper mechanism for such support, is another matter. There is considerable danger in loading too many activities and objectives (not to mention partner organizations) into one project vehicle.

CONCLUSION

There is currently not much NGO involvement in the WIN project. It is doubtful whether this component could be significantly strengthened during the remaining implementation period for the WIN project.

COORDINATION WITH OTHER USAID PROJECTS AND DONORS

From the meetings the team had in Moscow with USAID, WHO, UNICEF, the Russian MOH, the Russian Academy of Medical Sciences, and a variety of individuals in the two WIN project oblasts (see appendix B, Persons Contacted), it appears that WIN project staff has made a strong effort to ensure that the goals, objectives, and progress of the project are well known. The team noted the coordination between the WHO baby-friendly hospital program and the WIN project. It was also learned that UNICEF has begun to support adolescent service centers, including reproductive health (in a pilot approach), and this program would appear to complement WIN project activities. Another positive feature is that the vice president of the Russian Academy of Medical Sciences and director of the Obstetrics, Gynecology and Perinatology Research Center

was well versed on the project. He is also the head of the Russian Family Planning Association (RFPA), an organization that has encouraged the publication and distribution of family planning brochures produced by the WIN project.

There is a positive link between the operations research on abortion and family planning being conducted by the FRONTIERS Project. While the research has been delayed, the findings should be useful for the WIN project and the MOH. The team also discussed with the country director for Population Services International (PSI) the activities being supported by USAID/Russia and undertaken by PSI to promote condom use as part of the HIV/AIDS prevention strategy in selected oblasts, and the work that PSI is doing with NGO partnering.

The team also met with the regional director for the American International Health Alliance (AIHA) to review the ongoing project activities and explore the possibility of forging future linkages between AIHA and the WIN project. At the outset, it was noted that the current WIN project director was formerly a key staff member of AIHA. AIHA has incorporated elements of family-centered maternity care into its work with Russian hospitals, with particular emphasis given to neonatal resuscitation efforts. There is room for more collaboration with AIHA, but this will require an active effort to brief the large number of medical personnel who benefit from AIHA exchanges about the work of the WIN project.

CONCLUSION

USAID should conduct a bimonthly meeting of directors and key personnel of projects that USAID finances in health to ensure that there is effective coordination. The WIN project should review the UNICEF pilot project for the provision of adolescent services to see if there might be a useful link to a future WIN project in additional oblasts. Additionally, if the PSI work is to be expanded, USAID and the MOH should initiate these PSI activities in WIN project oblasts in order to increase collaboration between projects that relate directly to much of the same target population.

V. WIN PROJECT MONITORING AND EVALUATION

ELEMENTS OF WIN PROJECT MONITORING AND EVALUATION

A comprehensive evaluation system is currently being implemented by the WIN project. Pre- and post-intervention household and facility surveys are utilized along with a facility-based monitoring system that tracks key indicators over the three-year life span of the project.

Many of the project's principal objectives are being assessed through the use of household and facility-based surveys. Baseline indicators for the WIN project were collected in 1999 and 2000 by the All Russia Centre for Public Opinion and Market Research (VCIOM) in the three cities participating in the WIN project.

For the *Women and Infant Health Project Household Survey 2000*, information was obtained from 3,900 women of reproductive age in Veliky Novgorod, Perm, and Berezniki (1,300 in each city). The sampling frame was based on electoral rosters. Electoral districts (ELDs) served as primary sampling units for the survey. The household survey obtained information on such topics as fertility, abortion, maternal and infant health, contraceptive knowledge and use, family planning counseling, and STDs. Results from the baseline household survey were published in December 2000.

For the *Women and Infant Health Project Facility Survey 2000*, providers and clients in 20 health centers participating in the WIN project were interviewed. This included 497 providers and 1,304 women of reproductive age (15–44 years of age) obtaining care in maternity hospitals, women's consultation centers, and children's polyclinics in Veliky Novgorod, Perm, and Berezniki. Baseline indicators pertaining to abortion, antenatal care, delivery and postpartum care, and contraceptive counseling were collected. Particular attention was given to obtaining respondent information useful for assessing change in health-seeking behavior and client satisfaction over the life of the WIN project. Results from the baseline facility survey were published in January 2001.

The household and facility surveys designed for the WIN project will be repeated in order to measure change in essential performance indicators for the project. This effort will be essential in order to assess project achievements in the client (catchment) populations served by the health facilities affiliated with the WIN project.

The WIN project's facility-based monitoring and evaluation system became fully operational by July 2000. Since that time, quarterly monitoring of quantitative indicators has been routinely maintained for WIN project activities (e.g., facility-based training activities), process indicators, and outcome measures. This information complements the quarterly performance reports that have been routinely compiled by JSI since the inception of the project. Quantitative monitoring reports for five quarters (from July–September 2000 through July–September 2001) were available at the time of this assessment.

The WIN project's facility-based monitoring and evaluation system is generally reporting essential performance and outcome measures in a timely fashion. However, a few

problems were noted that should be addressed by the WIN project staff responsible for maintaining this system.

The project's monitoring and evaluation system may be collecting more information than is actually necessary for efficient project management. For example, some indicators of infant health (e.g., atopic dermatitis) may not be essential to track in the future. The system should be reviewed in relation to economizing on the volume of information currently being recorded in health facilities and transmitted to JSI in Moscow.

Information on training should be upgraded to ensure that planned training activities are accurately recorded and that family planning training (much of which has yet to occur) is included in the reporting system. Also, as noted previously, the training categories employed by the project's monitoring and evaluation system may not be strictly exclusive. For example, it is likely that instruction pertaining to the care of the newborn includes considerable detail on breastfeeding. It would be useful for the WIN project to consider providing more clearly demarcated maternal/infant health training categories in the future.

Steps need to be taken to ensure that family planning performance data from women's consultation centers in Veliky Novgorod are reported in a timely fashion. During the period of this evaluation, no information on family planning use was being reported by women's consultation centers in Veliky Novgorod even though clinic-based service providers are compiling these data.

PROJECT PERFORMANCE AS ASSESSED THROUGH QUANTITATIVE INDICATORS

For the purposes of this midproject assessment, it was not possible to make extensive use of baseline household and facility survey data to measure short-term change in WIN project activities. Instead, reliance was placed on the project's monitoring and evaluation system, which compiles quarterly clinic-based information from administrative offices and health facilities affiliated with the WIN project; that is, oblast health care authorities, maternity hospitals, women's consultation clinics, gynecological units at maternity hospitals, children's polyclinics, and family planning centers. (This information has been tabulated and is presented in appendix E.)

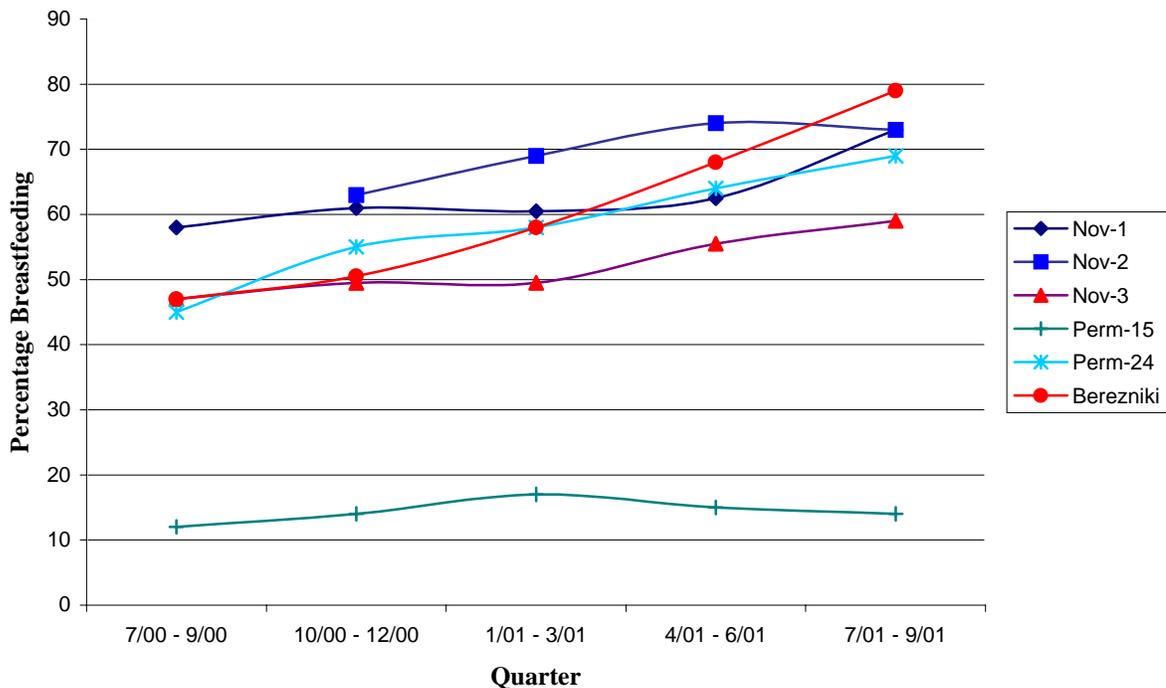
It is important to note that WIN project activities (e.g., training and service innovations) often commenced prior to the initiation of data collection by the project's monitoring and evaluation system. Therefore, estimates shown in appendix E for the first quarter (July–September 2000) reflect the impact of project activities that had been ongoing over the previous year.

FAMILY-CENTERED MATERNITY CARE (FCMC) INNOVATIONS

Service statistics compiled by the WIN project clearly indicate that many of the project's essential FCMC components are being effectively implemented. This is particularly true in the case of exclusive breastfeeding. As of July–September 2001, the majority of mothers in most project facilities were exclusively breastfeeding at 6 months (see figure 2). The one notable exception is Perm–15, where only 13.7 percent of all of mothers were

exclusively breastfeeding at 6 months by the fifth quarter of the project's reporting period (July–September 2001).

Figure 2
Percentage of Mothers Exclusively Breastfeeding at 6 Months
 (by Quarter from July 2000 to September 2001)
 (Reports from Children's Polyclinics)



The WIN project does appear to have been successful in promoting greater use of exclusive breastfeeding in maternity hospitals. All maternity hospitals participating in the project (including the maternity hospital in Perm–15) report that at least 90 percent of all mothers were exclusively breastfeeding during their hospital stays (averaging about 3 days). Maternity hospitals in Novgorod–2, Perm–2, and Berezniki (which only introduced WIN project innovations during year two of the project) reported that exclusive breastfeeding during hospital stays is now nearly universal (see tables 5 and 6 in appendix E).

Other FCMC elements being promoted by the WIN project also appear to be taking hold in health facilities. With the notable exception of Veliky Novgorod–1, nearly all mothers are now rooming-in with their babies, rather than relying on nurseries for early life support (see figure 3, following page). This is a remarkable departure from the practices of the recent past. As can be seen in figure 4 (following page), the percentage of mothers with family support during labor and delivery, while still below 50 percent in all participating maternity hospitals, is steadily rising in most instances. The only exception appears to be the maternity hospital in Perm–9, where only 4.8 percent of mothers had any family support as of July–September 2001.

Figure 3
Percentage of Mothers Rooming-In in Maternity Hospitals
 (by Quarter from July 2000 to September 2001)

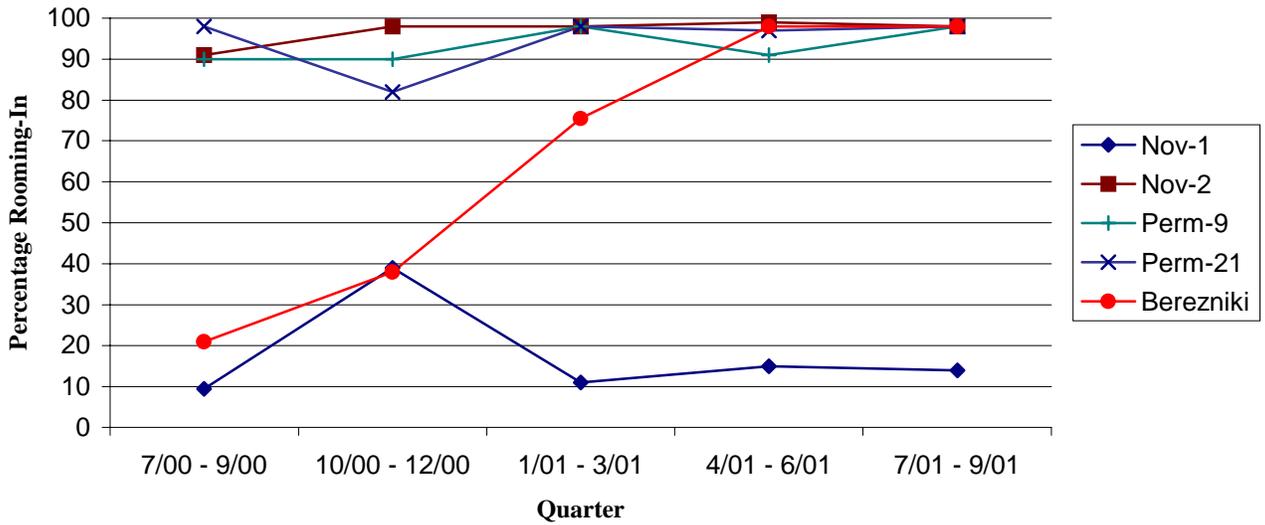
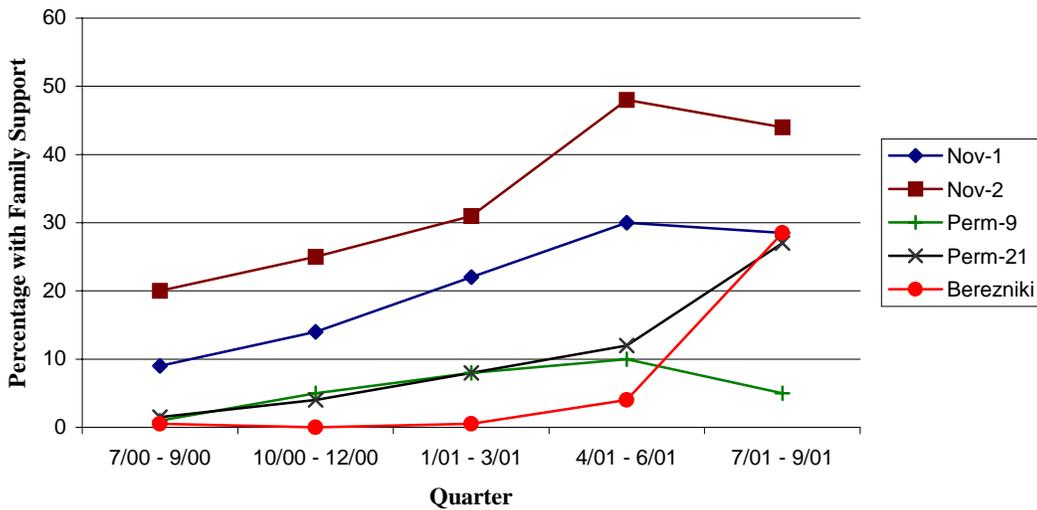
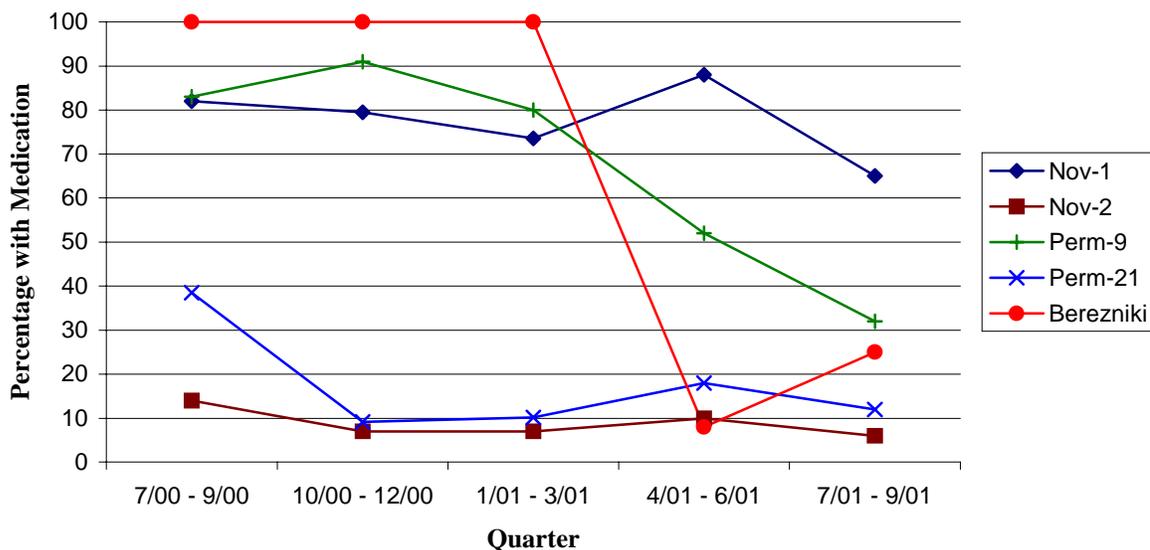


Figure 4
Percentage of Mothers with Family Support during Labor and Delivery
 in Maternity Hospitals (by Quarter from July 2000 to September 2001)



Reliance on pain medications appears to be declining in many WIN project sites (see figure 5, following page). Since July–September 2000, the most pronounced declines in the use of pain medications have occurred in maternity hospitals situated in Berezniki and Perm–21. However, the maternity hospital in Veliky Novgorod–1 continues to rely heavily on pain medications. In the most recent reporting period, 64.4 percent of mothers were given pain medications in the Veliky Novgorod–1 maternity hospital, compared with less than 25 percent in all other WIN–affiliated maternity hospitals.

Figure 5
Percentage of Mothers Receiving Pain Medication during Labor and Delivery
in Maternity Hospitals (by Quarter from July 2000 to September 2001)

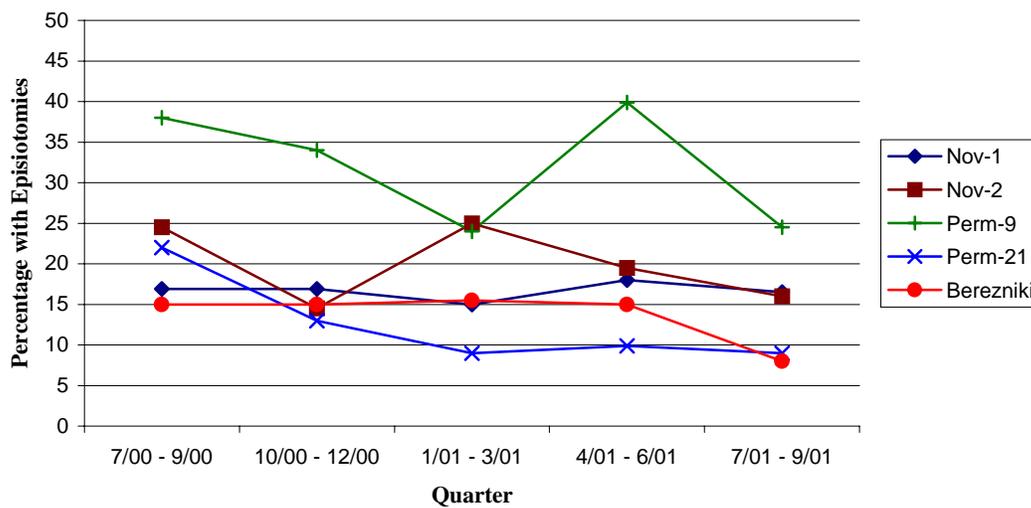


As noted earlier, the project aims to reduce the use of systemic pain medications (narcotics or similar drugs administered by injection or intravenous infusion) because these drugs cross the placenta to enter the bloodstream of the fetus and may depress the neurological and respiratory function of the newborn at birth and during the first several days of the baby’s life. Epidurals have less effect on the newborn, but reduce the effectiveness of contractions and increase the need for either a cesarean section (C–section) or use of forceps to deliver the baby.

The incidence of episiotomies for vaginal deliveries has declined in many WIN project sites, most notably in the Perm–21 maternity hospital (see figure 6, following page). An episiotomy is a surgical procedure in which the vaginal outlet is enlarged by making a cut, usually from the bottom of the vaginal opening towards the rectum.² As of July–September 2001, only 8.7 percent of all mothers in Perm–21 and just 7.9 percent in Berezniki had to undergo any type of episiotomy procedure during delivery. The only maternity hospital not reporting any decline in episiotomies is in Veliky Novgorod–1.

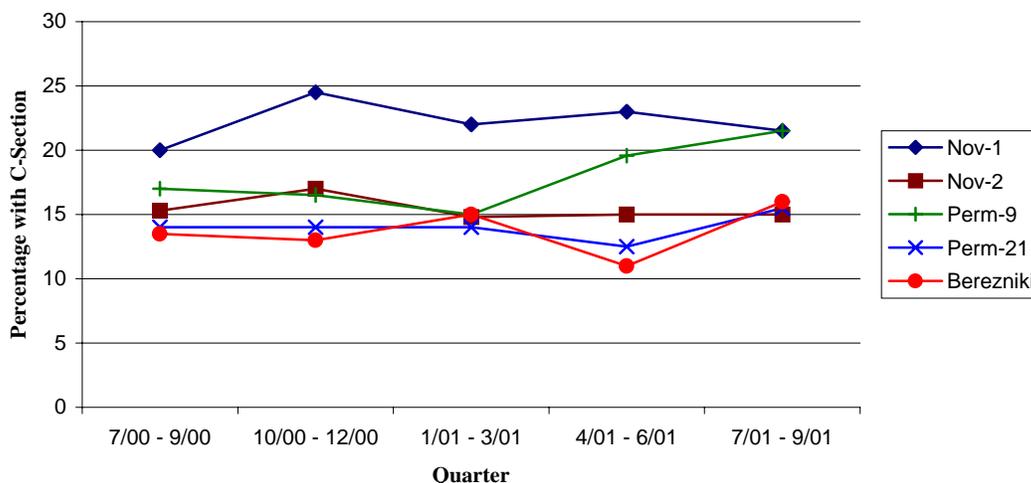
² Although an episiotomy may be needed to hasten delivery in situations in which the mother or fetus is in danger or to provide space for the birth of a very large infant or for application of forceps or vacuum traction equipment if the woman cannot push the baby out without assistance, the cut itself is painful, even with local anesthetic (which may or may not be used), as are the stitches needed to repair the wound, a task that takes priority over the mother’s interest in her newborn during the period just after the birth. Routine or liberal use of episiotomy causes more problems than it prevents, including excessive bleeding, tears that extend from the episiotomy into the anus or rectum, and discomfort and sometimes infection during the period of wound healing (Enken et al., 2001). A significant proportion of women who have resultant damage to the anus or rectum experience long-term problems, such as anal incontinence or pain during sexual intercourse (Haadem et al., 1987: 53–56).

Figure 6
Episiotomy Incidence Rate among Vaginal Deliveries
in Maternity Hospitals (by Quarter from July 2000 to September 2001)



As shown in figure 7, C-section levels do not appear to have declined substantially in any WIN project site. Fifteen to 23 percent of all mothers were having C-sections in participating maternity hospitals during the most recent reporting period, with the highest C-section rates being reported from the maternity hospital in Veliky Novgorod-1 (21.6 percent) and Perm-9 (21.3 percent). It was reported to the team that cesarean rates are increasing in Russia. If that is true, the lack of an increasing trend in WIN project sites may be considered a measure of success.

Figure 7
Percentage of Mothers with C-Sections
in Maternity Hospitals (by Quarter from July 2000 to September 2001)



MEASURES OF INFANT HEALTH

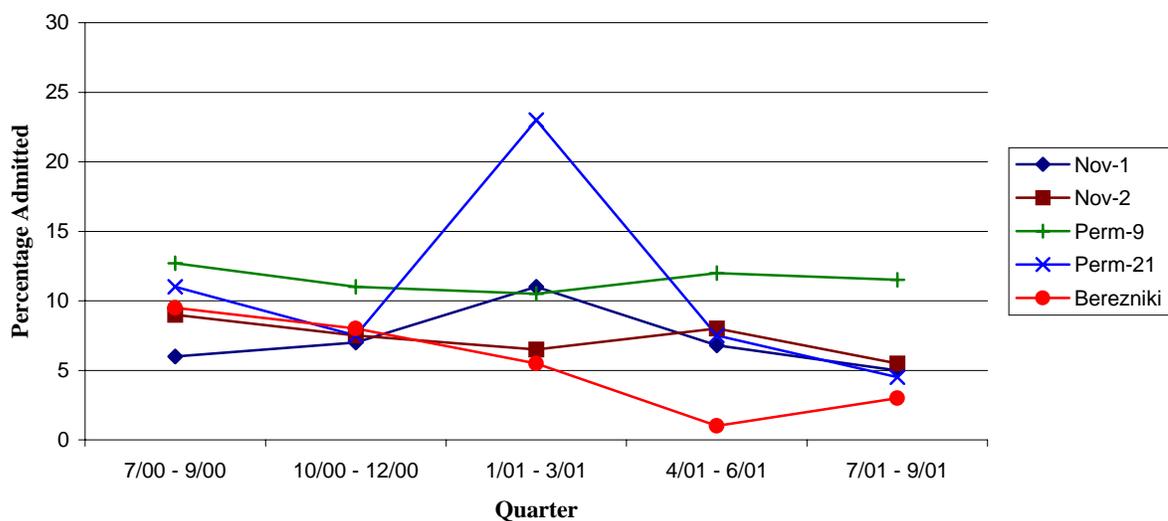
Given the increased use of exclusive breastfeeding and the introduction of other FCMC practices in affiliated WIN project health facilities, evidence of improved infant health and survival was examined. The WIN project's monitoring and evaluation system tracks

numerous indicators of infant morbidity as well as levels of perinatal, neonatal, and infant mortality. These measures are reported every quarter.

It is worth noting that many of these morbidity and mortality indicators may fluctuate considerably in the short term (e.g., due to seasonality of some infectious diseases) so that it may be difficult to attribute trends directly to the presence of WIN project activities. In addition, it is probably unrealistic to expect long-term trends in such measures as perinatal and infant mortality to become apparent when assessing the small number of infant deaths occurring by quarter within three small to medium-sized Russian cities.

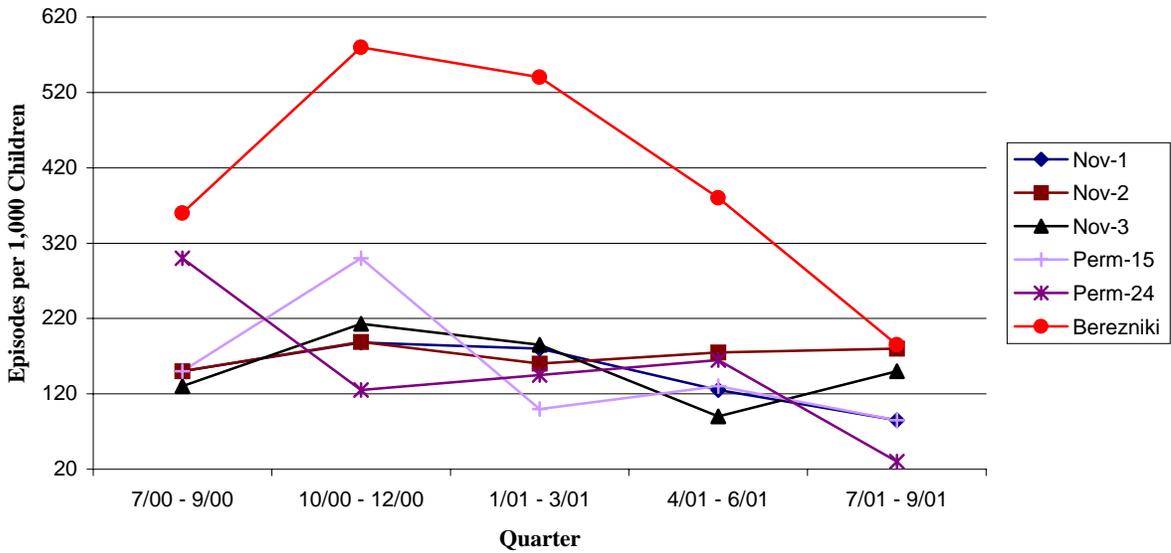
With the above caveats in mind, the question of whether the WIN project seemed to be making a difference in the health of Russia’s infants was addressed. While the evidence presented in appendix E often seems to offer little more than random fluctuation, there are indications that the WIN project may be making a substantial contribution. For example, the percentage of infants admitted to intensive care in maternity hospitals has fallen at most project sites (see figure 8). The most notable declines have occurred in Perm–21 and Berezniki, two project areas that have high exclusive breastfeeding immediately following birth as well as at 3 and 6 months postpartum.

Figure 8
Percentage of Infants Admitted to Intensive Care
in Maternity Hospitals (by Quarter from July 2000 to September 2001)



Upper respiratory tract infections have also fallen rapidly in many children’s polyclinics, especially in Perm–24 and Berezniki (see figure 9, following page). In Perm–24 there were only 35 episodes of upper respiratory tract infection per 1,000 children as of July–September 2001 compared with 298 episodes per 1,000 children a year earlier. This polyclinic primarily serves children born to mothers in Perm–21 maternity hospital, a WIN project facility that has attained high levels of exclusive breastfeeding.

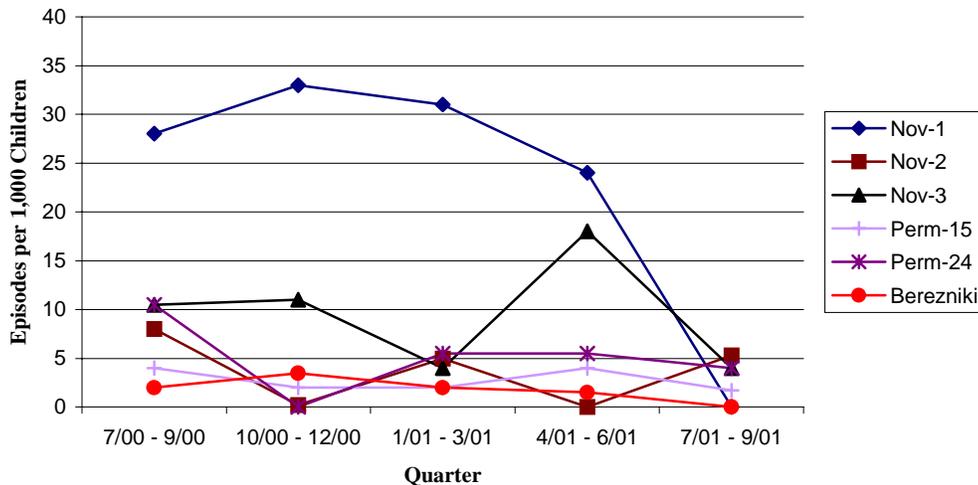
Figure 9
Incidence of Upper Respiratory Tract Infections among Infants Aged 0–5 Months in Children’s Polyclinics (by Quarter from July 2000 to September 2001)
 (Episodes per 1,000 Children)



However, this success was not replicated in all project areas. For example, the children’s polyclinic in Veliky Novgorod–2 reported a slight rise in upper respiratory tract infection since July–September 2000, despite reporting high levels of exclusive breastfeeding over the same period.

Figure 10 also reports that the incidence of pneumonia has fallen in many project sites, again most consistently among children being served by the Perm–24 polyclinic. Owing to the relatively small number of pneumonia cases reported per quarter, incidence trends in some project sites are not convincingly distinct.

Figure 10
Incidence of Pneumonia among Infants Aged 0–5 Months in Children’s Polyclinics (by Quarter from July 2000 to September 2001)
 (Episodes per 1,000 Children)



Another encouraging trend is that the percentage of infants with jaundice has fallen substantially in some project sites, particularly in maternity hospitals situated in Veliky Novgorod–1 and Veliky Novgorod–2 (see figure 11). However, linking this encouraging trend to the growth of exclusive breastfeeding is somewhat problematic since the incidence of jaundice has not fallen substantially in Berezniki, a project area that has experienced a rapid increase in exclusive breastfeeding over the past year. More time may be needed to observe the impact of exclusive breastfeeding in Berezniki.

Figure 11
Percentage of Infants with Jaundice in Maternity Hospitals
 (by Quarter from July 2000 to September 2001)

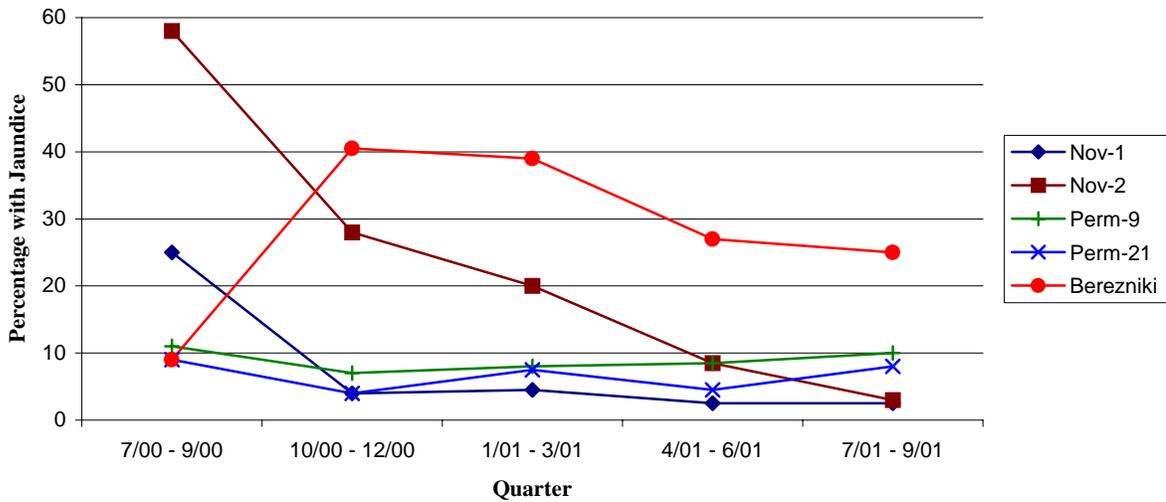
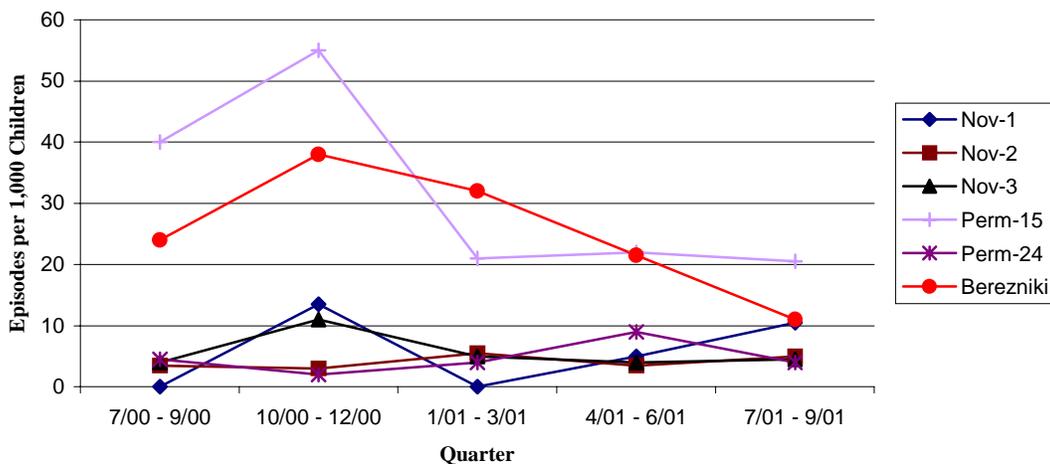


Figure 12 below indicates that the incidence of ear infections (otitis) has fallen by about 50 percent in facilities previously reporting high infection rates (i.e., Perm–15 and Berezniki). It is not possible to distinguish clear trends in other project sites reporting significantly lower rates of ear infection.

Figure 12
Incidence of Ear Infections (Otitis) among Infants Aged 0–5 Months
in Children’s Polyclinics (by Quarter from July 2000 to September 2001)
 (Episodes per 1,000 Children)



Other infant morbidity indicators, such as the incidence of diarrhea, anemia, and atopic dermatitis, do not show consistent trends over the WIN project’s 15-month reporting period (from July 2000–September 2001). As noted previously, additional time may be needed for definitive morbidity and mortality trends to emerge, especially in project sites such as Berezniki that have only recently implemented many FCMC interventions.

LEVELS AND TRENDS IN INFANT MORTALITY

The WIN project’s monitoring and evaluation system tracks quarterly change in several infant mortality measures, the most important being the perinatal mortality rate, the neonatal mortality rate, and the infant mortality rate. These mortality rates are derived from clinic records sent to the office of the oblast health authority.

Perinatal mortality rates are compiled by gynecological units in each maternity hospital. These rates are presented in table 1 for the facilities participating in the WIN project. In addition, urban, rural, and all oblast infant mortality estimates are compiled by the oblast health authority. Since WIN project sites in Veliky Novgorod, Perm, and Berezniki are city based, the relevant mortality rates for this evaluation are urban estimates. Perinatal, neonatal, and infant mortality rates for the urban areas of Veliky Novgorod, Perm, and Berezniki are presented in table 2 (following page).

Table 1
Perinatal Mortality Rate by Quarter
(Late Fetal Deaths and Deaths in the First 7 Days of Life per 1,000 Live Births)
 (Reports from Gynecological Units)

	7/00–9/00	10/00–12/00	1/01–3/01	4/01–6/01	7/01–9/01
Veliky Novgorod–1	5.2	11.2	11.1	19.8	12.2
Veliky Novgorod–2	3.0	5.6	8.0	10.5	5.2
Perm–9	15.3	8.7	23.3	11.8	8.0
Perm–21	6.2	17.0	6.2	2.8	4.8
Berezniki	10.1	5.2	14.3	7.1	20.8

It should again be noted that there is some uncertainty whether infant mortality statistics in Russia are necessarily based upon internationally agreed definitions. It is the team’s understanding that preterm infants that do not survive a full 7 days after birth are not always considered to be live births and there is some confusion whether late fetal deaths are always included in measures of perinatal mortality. (The standard internationally accepted definition of the perinatal mortality rate is the number of late fetal deaths and deaths in the first 7 days of life per 1,000 live births.)

Table 2
Urban Perinatal, Neonatal, and Infant Mortality Rates

Urban Perinatal Mortality Rates (Late Fetal Deaths and Deaths in the First 7 Days of Life per 1,000 Live Births) by Quarter (Compiled by Oblast Health Authorities from Service Statistics)					
	7/00–9/00	10/00–12/00	1/01–3/01	4/01–6/01	7/01–9/01
Veliky Novgorod	20.2	10.3	10.9	13.3	
Perm	7.4	6.2	6.1	5.6	7.6
Berezniki	0	17.0	-	7.0	23.3
Urban Neonatal Mortality Rates (Deaths in the First 28 Days of Life per 1,000 Live Births) by Quarter (Compiled by Oblast Health Authorities from Service Statistics)					
Veliky Novgorod	6.1	2.1	1.8	6.7	
Perm	5.0	4.4	4.4	4.0	4.6
Berezniki	0	9.8	-	2.3	9.5
Urban Infant Mortality Rates (Deaths from 0–11 Months per 1,000 Live Births) by Quarter (Compiled by Oblast Health Authorities from Service Statistics)					
Veliky Novgorod	12.3	4.1	1.8	8.9	
Perm	12.0	10.6	9.6	9.7	9.6
Berezniki	7.2	9.8	-	2.3	16.5

Unfortunately, it is difficult to discern systematic patterns in these data. As can be seen in table 1, the perinatal mortality rate fluctuates considerably by quarter with no definitive trends to be observed. This indistinct result is no doubt due to the low number of perinatal deaths reported by quarter in WIN project sites.

Urban estimates shown in table 2 indicate that perinatal mortality appears to have fallen from 20.2 to 13.3 in Veliky Novgorod over the 12-month reporting period from July 2000 to June 2001. However, there is no change in perinatal mortality in Perm and a suggestion of some increase in Berezniki, although the time series in this instance is not complete. The neonatal mortality rate (defined internationally as the number of infant deaths in the first 28 days of life per 1,000 live births) does not appear to have changed appreciably in any area, although considerable quarterly fluctuation can be noted, especially in Veliky Novgorod. The infant mortality rate (infant deaths in the first year of life per 1,000 live births) appears to have fallen in Veliky Novgorod and Perm between the first and last quarters of the reporting period (from 12.3 to 8.9 in Veliky Novgorod and 12.0 to 9.6 in Perm), while no consistent trend can be discerned for Berezniki.

In general, considerable fluctuation in these quarterly mortality rates makes the identification of definitive trends difficult. This instability likely arises from the small number of perinatal, neonatal, and infant deaths that occur on a quarterly basis in the three project cities. Greater clarity pertaining to levels and trends in infant mortality could be achieved if these demographic statistics were simply reported on an annual basis rather than quarterly.

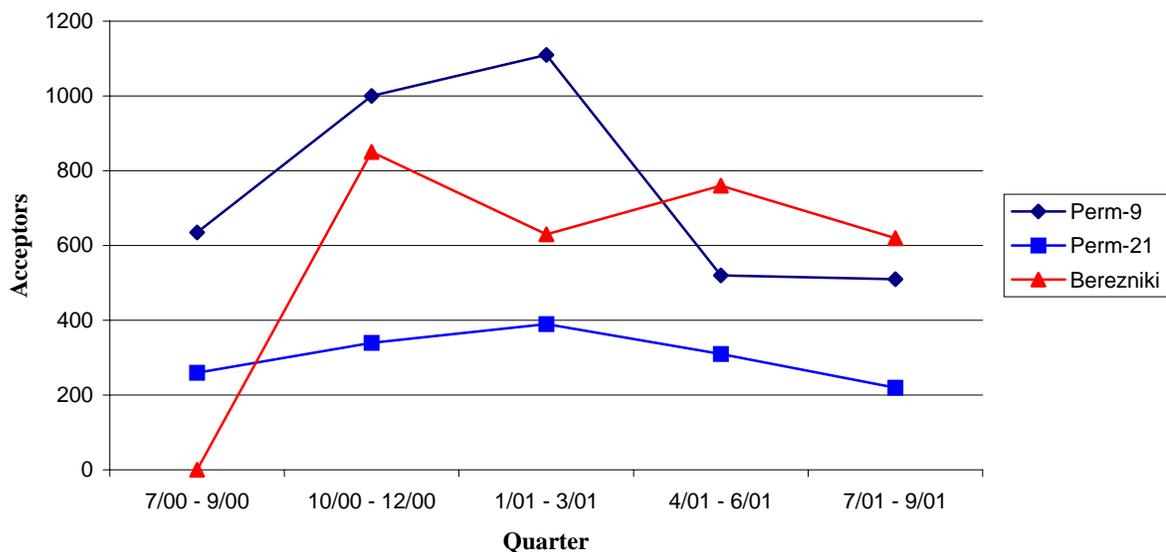
FAMILY PLANNING ACCEPTANCE AND USE

The WIN project's monitoring and evaluation system compiles quarterly information from family planning centers on new family planning acceptors and users (new acceptors plus continuing users). The family planning centers are the principal source of family planning services in Perm and Berezniki, although family planning counseling is also provided in women's consultation clinics and maternity hospitals.

Veliky Novgorod oblast does not have separate family planning centers. Family planning services are instead offered through women’s consultation clinics. Unfortunately, these clinics have not been submitting quarterly information on family planning use to the WIN project’s monitoring and evaluation system. In addition, family planning performance data from women’s consultation clinics in Berezniki are also not routinely reported to the project’s monitoring and evaluation system in Moscow. Therefore, family planning data compiled by the WIN project at the time of this assessment were not complete. This issue is in need of further attention by WIN project staff.

Reports from family planning centers in Perm and Berezniki indicate that the number of new family planning acceptors has not risen significantly over the reporting period of the project (see figure 13). In fact, the Perm–9 family planning center actually reports a drop of nearly 50 percent in family planning acceptors during the last three quarters (January–March 2001 through July–September 2001). Other centers in Perm–21 and Berezniki do not appear to have significantly increased their level of family planning activity during the life of the WIN project. The main methods being accepted in family planning centers are pills and condoms, with IUDs, injectable contraceptives, and emergency contraception (morning-after pills) being far less frequently utilized (see table 24 in appendix E).

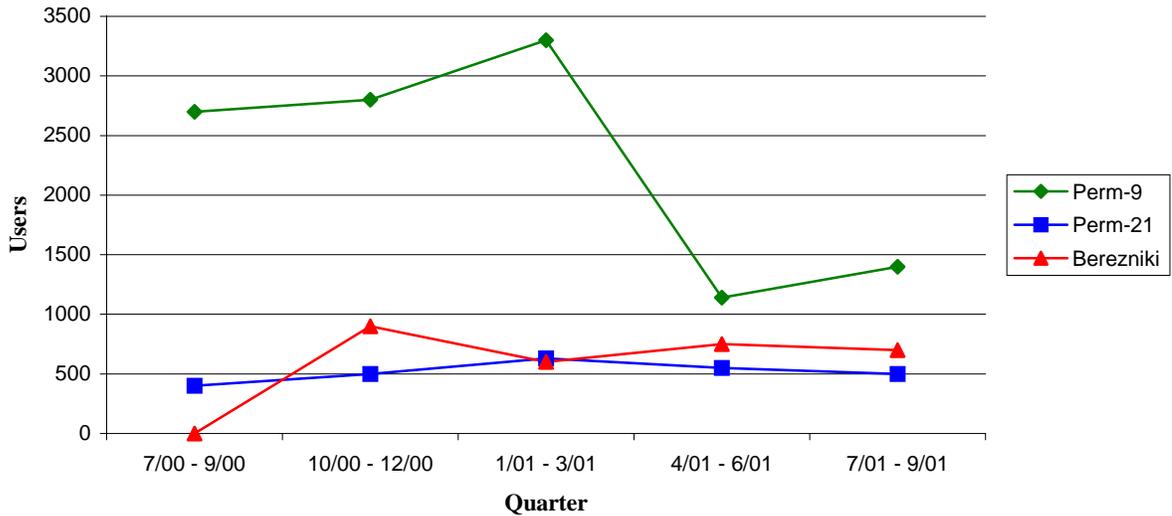
Figure 13
Total Number of New Family Planning Acceptors in FP Centers
 (by Quarter from July 2000 to September 2001)



As can be seen in figure 14 (following page), the number of users (new acceptors plus repeat users) presents a pattern similar to that recorded for new family planning acceptors. Family planning use is either flat or, in the case of the family planning center in Perm–9, substantially lower over the 15–month reporting period under review.

Continued use of contraception in the project’s study areas is a critically important indicator of project performance. These findings clearly point to the need to strengthen the provision of family planning counseling and services during the last year of the WIN project.

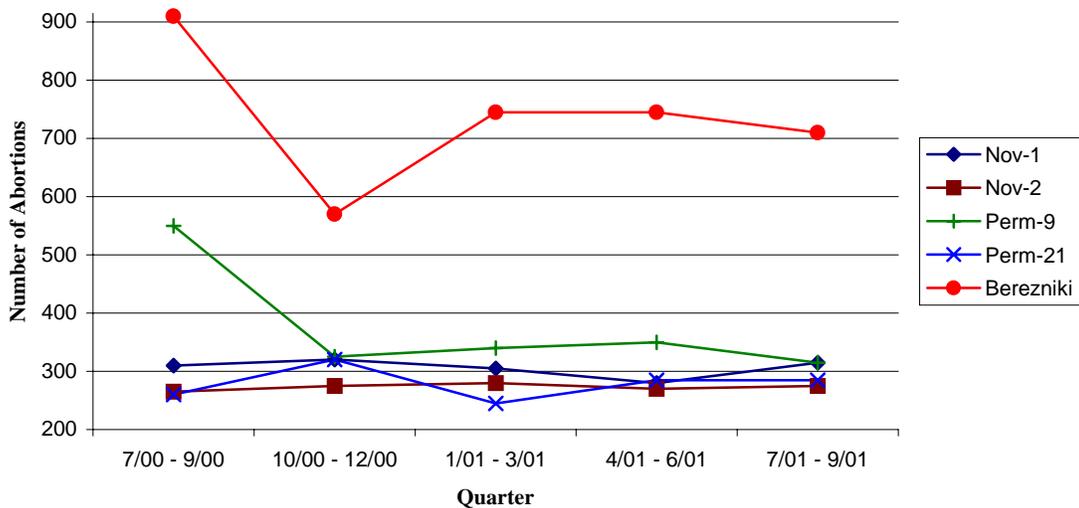
Figure 14
Total Number of New Family Planning Users (New Acceptors and Repeat Users)
in FP Centers (by Quarter from July 2000 to September 2001)



LEVELS AND TRENDS IN ABORTION

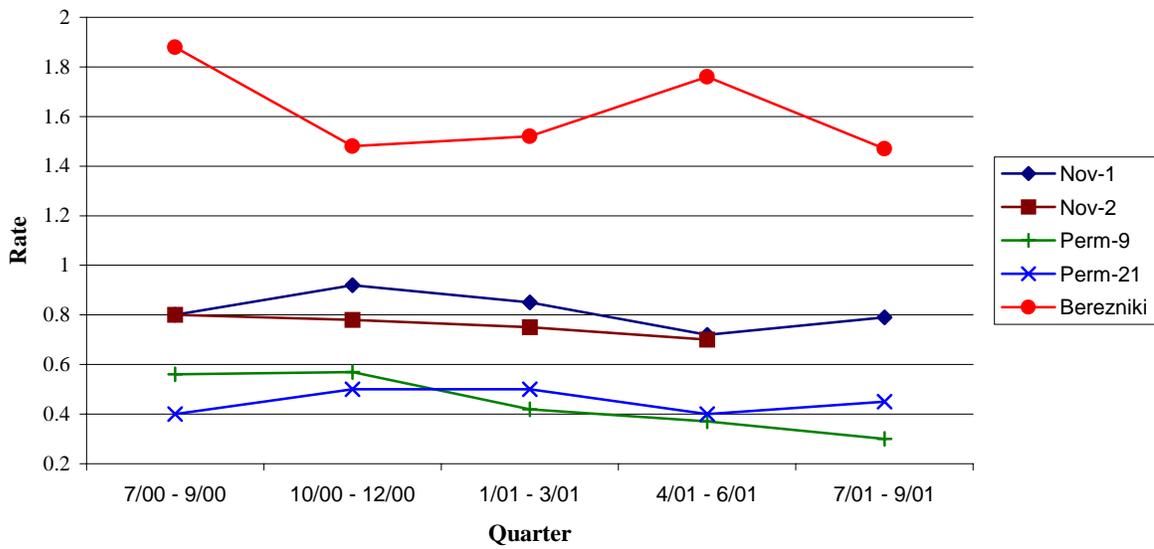
Reports from the gynecological units of maternity hospitals affiliated with the WIN project indicate that there have been some modest reductions in the number of abortions performed in Perm-9 and Berezniki, but little in the way of decline elsewhere (see figure 15). It should be noted that more abortions are still performed in Berezniki than in other project sites, but at least the absolute number of cases is falling. The percentage of abortions that are late term (between 16–22 weeks) has also not changed appreciably during the project’s 15-month evaluation period (see table 26 in appendix E).

Figure 15
Number of Abortions as Reported by Gynecological Units of Maternity Hospitals
(by Quarter from July 2000 to September 2001)



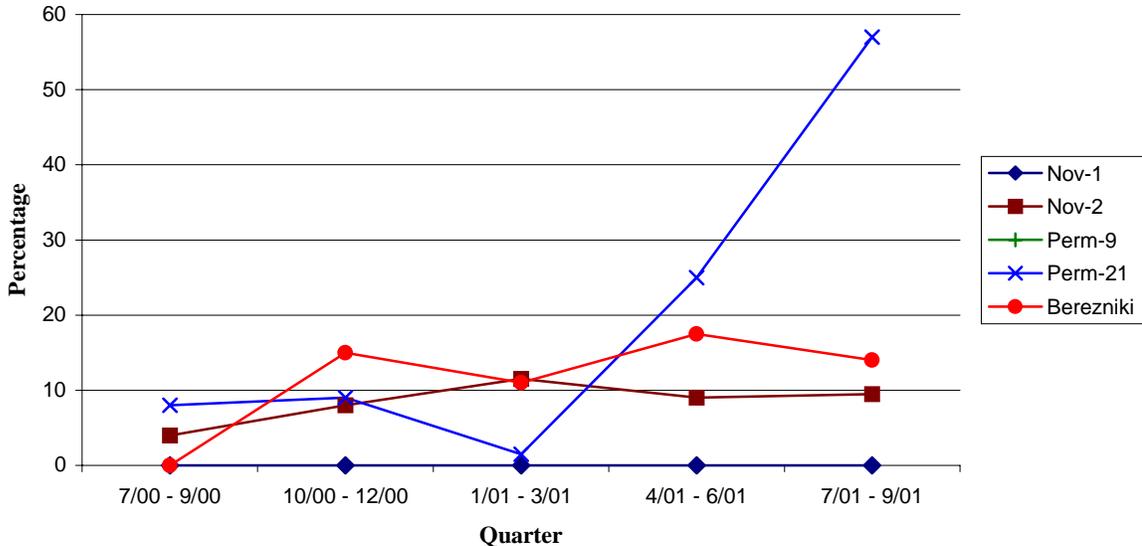
The abortion ratio (the number of abortions per 100 live births) has declined in Perm-9, Berezniki, and Veliky Novgorod-2, but remains essentially unchanged in other sites (see figure 16). As noted previously, the abortion ratio is determined not just by the number of abortions performed but also by the number of births occurring, and it is not a totally reliable indicator of abortion trends.

Figure 16
Abortion Ratio: Abortions per 100 Live Births as Reported by
Gynecological Units of Maternity Hospitals (by Quarter from July 2000 to September 2001)



As is evident in figure 17 (following page), the WIN project does appear to be achieving some success in increasing the percentage of women who accept family planning methods after having an abortion. For example, in the gynecological unit of the Perm-21 maternity hospital, the percentage of abortion clients accepting family planning rose from just 8 percent in July–September 2000 to 57 percent in July–September 2001. This impressive rise, which has not been matched in other areas, may partly be due to the provision of free contraception as part of an operations research study (being conducted by EngenderHealth and the FRONTIERS Project) investigating the role of family planning counseling and use in reducing abortion levels.

Figure 17
Percentage of Women Who Accept Family Planning Following an Abortion
as Reported by Gynecological Units of Maternity Hospitals
(by Quarter from July 2000 to September 2001)



VI. RECOMMENDATIONS

It is recommended that the WIN project be funded for an additional year to take advantage of and to consolidate the success of the project as implemented in the three current sites, and that a follow-on project be designed to further strengthen the WIN model and expand the reach of project innovations into every region of the country. This should be done in part by institutionalizing key program elements and adding new family planning activities that can be implemented through the personnel and facilities involved in the WIN project. It is also recommended that an intensified effort to combat HIV/AIDS be a centerpiece of USAID's future health programming in Russia. To this end, the introduction of an affordable, high quality, branded condom through an expanded social marketing effort should be a priority over the coming years.

The strategy for extending the reach of the WIN interventions, both in a fourth-year extension and in a follow-on project, should rely heavily on full utilization of extant Russian systems to disseminate new knowledge, practices, and standards throughout the medical/health care system. Instead of replicating the project on an oblast-by-oblast basis in a manner that is extraneous to these long-standing systems, the project should document and report the success of the demonstration projects in a manner that will draw positive attention from national obstetrics/gynecology, pediatrics, and midwifery leaders and work to incorporate project innovations into the basic education and routine refresher training for service providers throughout the system.

Specific recommendations for the final year of the WIN project and a follow-on project are presented in the following sections.

RECOMMENDATIONS FOR A FINAL YEAR OF THE WIN PROJECT

The following changes for a fourth and final year of the WIN project are recommended. The goal should be to provide the additional inputs needed to make the important, successful innovations that have already been introduced strong enough to continue, thrive, and be replicated and institutionalized through processes that are part of the indigenous Russian system. If USAID does not continue to work in this area at the end of the fourth year of the WIN project, these innovations should be capable of continuing on the strength of their inherent effectiveness and attractiveness to Russian maternal and child health professionals.

1. Continue support for Perm/Berezniki and Veliky Novgorod to ensure that the program has a solid base to continue after project assistance ends in these oblasts.
2. Address needs for additional training or follow up to strengthen and improve implementation of the project in the existing sites, such as filling the request for an additional week of clinical precepting in FCMC methods expressed by the director of maternity hospital number 2 in Veliky Novgorod.
3. Expect and train pediatricians and pediatric nurses who make home visits to infants (and their mothers) throughout the infant's entire first year of life to provide family planning education and counseling to the mothers, help them recognize when they

are no longer breastfeeding in a way that suppresses ovulation, and refer them to a women's consultation or family planning center for care at that time.

4. Bring all women's consultations, maternity hospitals, and children's polyclinics in Perm and Veliky Novgorod oblasts into the project, thus providing improved WIN services to the entire population (rural as well as urban) of both oblasts. These services are now directly offered to only the women who reside in specific districts within the three project cities. The regional maternity hospital in Perm City should receive priority attention for implementation of this recommendation.
5. Disseminate information about WIN project interventions to obstetricians, gynecologists, pediatricians, midwives, and nurses throughout Russia by writing and publishing papers in influential professional journals and giving presentations at appropriate professional meetings.
6. Brief leaders of the relevant professional associations (i.e., the organization of obstetricians/gynecologists, the organization of pediatricians, and the organization of midwives) on the project and its accomplishments to date and provide an opportunity for them to visit one or more of the sites to see the new practices in action.
7. Support a careful analysis of the financial costs and benefits of utilizing the WIN innovations compared with either prior costs in the same facilities or costs for services in facilities that have not implemented these changes.
8. Convene a seminar to bring these methods to the attention of the organizations and institutions that influence the basic (preservice) education and training of obstetricians/gynecologists, pediatricians, and midwives, and to MCH leaders from oblasts throughout the country. The timing should be planned so that data from the postintervention household and facilities surveys will be available for use during the seminar.
9. Review the project's monitoring and evaluation system to identify modifications that might make the system more responsive to project requirements and easier to manage. This review should include an assessment of current indicators being measured by the system to ensure that all information is essential and meaningful for program implementation. For example, some indicators of infant health (e.g., atopic dermatitis) may not be essential to track in the future. Information on training should be upgraded to ensure that planned training activities are accurately recorded and that family planning training (much of which has yet to occur) is included in the reporting system. In addition, steps need to be taken to ensure that family planning performance data from women's consultation centers in Veliky Novgorod are reported in a timely fashion. During the period of this evaluation, no information on family planning use was being reported by women's consultation centers in Veliky Novgorod even though clinic-based service providers are compiling these data.
10. Write a guide on how to initiate and implement the project in a new oblast. This guide should be made widely available in order to promote the initiation of WIN project activities in oblasts not currently participating in the project.

11. USAID should conduct a bimonthly meeting of directors and key personnel of projects that USAID finances in health to ensure that there is effective coordination.
12. Continue to support the IEC component of the project, with special attention given to family planning.
13. Provide contraceptive commodities to support family planning training.
14. Create a core group of best trainers from both regions, including obstetricians/gynecologists and midwives who could serve as clinical preceptors to care providers who are learning new methods. This group of trainers should be conceptualized as a training center, even though they work in a variety of facilities. Negotiate to give the training center a role in the government health care scheme so that trainers can be paid for their work.

RECOMMENDATIONS FOR A NEW FIVE-YEAR PROJECT

A follow-on five-year project should start in June 2003 and end in May 2008 to permit nondisruptive transition from the current to a new project. The continuing leadership of the present JSI WIN project director will be very important to project success.

1. Expand the WIN model to one oblast in each of the seven federal regions. This would require replication in five new oblasts, in addition to continuation of the project in Perm and Veliky Novgorod oblasts. A process should be used in which oblasts that would like to be chosen for participation in the project have an opportunity to indicate their interest. The WIN project director and at least one other key consultant to the current project (possibly the nurse-midwife) should visit oblasts that indicate an interest in participating in order to identify the best prospect in each region.
2. Consider the potential risks, costs, and benefits of replicating the project in the city of Moscow. The FCMC practices introduced through WIN are appreciated and becoming better known through spontaneous word-of-mouth promotion by women in Perm, Berezniki, and Veliky Novgorod. Successful implementation of these methods in one or more hospitals in Moscow might bring them to the attention of national policy makers (in government) and trendsetters (in society), and could help to move the medical establishment towards greater appreciation of evidence-based medicine, especially if the obstetrics and pediatrics departments of Moscow Medical University were to become involved.
3. Establish a nationwide executive committee to ensure coordination and exchange of ideas. There should be two executive committee members from each oblast that participates in the project, in addition to individuals that should be part of the committee because of their national roles. Also provide a mechanism to rotate membership in a way that will facilitate adding new members as needed.
4. Explain the healthy lifestyle school in Veliky Novgorod to the executive committee and provide an opportunity for members to participate in a site visit. Organize a subcommittee to focus on how to introduce healthy lifestyle schools in other oblasts

that are participating in the project and want to do so. Build in funding to replicate the Veliky Novgorod healthy lifestyle school as part of the project in at least three additional oblasts. The clinical care part of this project should not be replicated. The subcommittee should also look at UNICEF's new initiatives in the provision of health services designed for adolescents to see if there could be scope for collaboration.

5. Provide contraceptive commodities to support family planning components of the project.
6. Include a strong communications component in the project, with special attention given to IEC for family planning. If PSI's work is to be expanded, USAID and the MOH are encouraged to initiate these activities in WIN project oblasts in order to increase collaboration between projects that relate directly to much of the same target population.
7. Strengthen the healthy lifestyles component of the antenatal education component of the project to give stronger emphasis to education and interventions that have been proven effective in
 - reducing smoking by pregnant women (increasing the proportion of women who give up smoking while pregnant and reducing the number of cigarettes per day for women who continue to smoke),
 - avoiding excessive alcohol consumption, and
 - protecting pregnant women from domestic violence.

All aspects of the healthy lifestyles component of antenatal education for pregnant women should be based on evidence of efficacy.

8. Support a partnership between the U.S. Centers for Disease Control (CDC) unit responsible for control of STIs and the venereology control units at the federal level and in the oblasts that participate in this project in order to solve problems with the interface between MCH services and the venereology authorities in the Russian Federation.
9. Conduct a high-profile national meeting with cosponsorship by the National Academy of Medical Sciences on evidence-based medicine and its application to maternity care. CDC should play a role in this, as well as the Cochrane Collaboration, which is based in Oxford, England (Oxford and Perm are also sister cities).
10. Work with the Russian midwifery education leaders to develop a didactic and clinical training curriculum. In addition, provide opportunities for leaders to develop the midwifery competencies needed to support FCMC for use in basic (preservice) midwifery schools and to be provided through the continuing education (refresher training) programs provided through each oblast.

11. Conduct focus group research with

- appropriate samples of fertile (menstruating) women from each oblast participating in the project who are 35 years of age or older and have at least one living child,
- married men between the ages of 20 and 40, and
- obstetricians/gynecologists, pediatricians, midwives, felchers, and nurses to ascertain their knowledge and attitudes regarding male and female sterilization.

Based on the findings of this research, develop an approach for possibly implementing a family planning contraceptive sterilization component for men and/or women during the second year of the project.

12. Include representatives from one higher level medical school and one midwifery school in each participating oblast in the local executive committee and form a subcommittee of the project-level executive committee to explore how to introduce WIN methods into basic education and refresher training of obstetricians/gynecologists, pediatricians, and midwives.
13. Strengthen the attention given to men in the program, especially in the IEC component.
14. Have URC conduct a quality assurance workshop to develop guidelines for postabortion care, including family planning counseling and services.

THE RAPID SPREAD OF HIV/AIDS IN RUSSIA

Finally, it is imperative to note that the team is very concerned about the current rise of HIV/AIDS infection in Russia as the epidemic begins to move beyond intravenous drug users. UNAIDS has recently reported that Eastern Europe has the most rapid rate of increase in new HIV/AIDS infections in the world. In Russia, 75,000 new cases of HIV infection were reported by early November 2001 compared with 56,000 cases in 2000 (Bellaby, 2001). Russia's health system is not giving adequate attention to HIV prevention. The WIN project provides training to obstetricians/gynecologists and midwives, two categories of health workers who play critical roles in managing STDs. Significantly greater resources will need to be directed toward the prevention and treatment of STDs (most critically HIV/AIDS) in the future.

Therefore, in addition to the expansion of the WIN follow-on project, USAID should devote a significant amount of its health assistance efforts in Russia to providing subsidized contraceptives, especially condoms, in order to reduce the spread of HIV infection and to reduce the need for abortions. USAID should finance condoms on a mass scale, as well as the development and implementation of a social marketing of condoms program to promote a quality branded condom at an affordable price, supported by a nationwide campaign targeting the 15–24 year age group.

APPENDICES

A. SCOPE OF WORK

B. PERSONS CONTACTED

**C. BIBLIOGRAPHY OF SIGNIFICANT DOCUMENTS AND
REFERENCES**

D. DEFINITION OF FAMILY-CENTERED MATERNITY CARE

E. WIN PROJECT PERFORMANCE INDICATORS

APPENDIX A
SCOPE OF WORK
(from USAID)

SCOPE OF WORK

USAID/Russia

ASSESSMENT OF WOMEN AND INFANTS HEALTH PROGRAM

TASK IDENTIFICATION

USAID/Russia invites a team of experts in women's/maternal/reproductive/infants' health to conduct an assessment of its women and infants health program in the fall of 2001.

BACKGROUND

Historically, women throughout the former Soviet Union have had limited access to modern family planning methods, often relying instead on abortion as a method of fertility control. Abortion rates in the Europe and Eurasia Region are the highest in the world. In Russia, high rates of maternal mortality and morbidity are due, in large part, to Russian women's almost exclusive reliance on repeated abortions as a method of fertility control. There are more than two abortions for every live birth, and a high percentage of maternal deaths are due to complications from abortions. To address these problems, USAID/Russia implemented the Women's Reproductive Health Project (WRHP) from 1994 to 1999. The project's successes included marked reductions in abortion rates and increased access to safe, voluntary family planning for 4 million women.

Although the successes of the WRHP were numerous, maternal and infant mortality rates continued to range from two to ten times higher than in other industrialized countries. Barriers exist to evidence-based medicine, client-centered approaches, and preventive health practices. Accordingly, as the reproductive health program ended, USAID began working with government and non-government experts and stakeholders to develop a follow-on strategy. The strategy still included family planning, but put it in the context of the broader aspects of women's and infants' health. The Women and Infants' Health Project's (WIN, planned for June 1999 to June 2002) overall goal is the reduction of maternal and infant mortality and morbidity by improving the effectiveness of selected women and infant health services by providing training and technical assistance in "safe motherhood," such as reproductive health, postpartum care, postabortion care, breastfeeding, and prevention of sexually transmitted infections (STIs). The interventions were guided by the following principles: use of evidence-based medicine to enhance clinical practice; use of quality assurance methods involving both providers and clients in the provision of quality services; promotion of a client-oriented focus and continuity and consistency in client-provider communications and across service levels.

The goals and accomplishments of both the WRHP and the WIN Project are detailed below.

The USAID/Russia Women's Reproductive Health Project (1994-1999)

The USAID/Russia Women's Reproductive Health Project (WRHP) began in 1994 and came to a successful close in 1999, with over four million women in Russia enjoying access to modern family planning information and services. Impact survey data, collected in 1999, showed that abortion rates steadily declined in project areas while remaining relatively constant at control sites. Modern contraceptive use among younger women increased over time and there was a widening gap evident among these women in terms of use between the project and control sites. Women served by the project were better informed about contraception, resulting in improved attitudes toward family planning and increased understanding of the safety and effectiveness of modern methods of contraception.

Major Program Elements of the WRHP included:

- **Creation of Demonstration Service and Training Centers** in six sites (Ivanovo, Yekaterinburg, St. Petersburg, Tver, Novosibirsk, and Vladivostok) to provide hands-on training in modern family planning technologies for health care personnel. Following the completion of the demonstration sites, several of the master trainers were used in a roll-out project to train health care workers in eight more sites: Yaroslavl, Penza, Tomsk, Omsk, Cheboksary, Moscow, Tyumen, and Perm.
- **An Information, Education and Communication campaign** to provide accurate and comprehensive information on modern family planning methods to potential family planning clients, health professionals, and the general public.
- **Sufficient Contraceptive Supplies** were provided to meet the needs of the demonstration and training centers for a period of one year, plus provision of supplies for trainees to take back with them to initiate training and supply activities in their home oblasts.
- **Policy work** was undertaken with regional policy-makers and key government officials to gain support for reproductive health activities.
- **Pharmaceutical Training and Liaison** to supply accurate information to women who by-pass physicians and purchase oral contraceptives in pharmacies. Pharmacists were trained to provide family planning counseling to their customers to ensure proper information.
- **Project Impact Measurement** through three surveys to provide baseline data and impact data on key project activities. The surveys included two project sites (Ivanovo and Yekaterinburg) and one comparison site (Perm).

Cooperating Agencies and Activities

AVSC provided training in clinical and counseling skills in four demonstration sites — Ivanovo, Ekaterinburg, St. Petersburg, and Tver and roll-out training in eight additional oblasts (Yaroslavl, Penza, Tomsk, Omsk, Cheboksary, Moscow, Tyumen, and Perm).

JHPIEGO trained a smaller group of physicians in training-the-trainer skills. These physicians also developed a series of curricula of various lengths for different audiences.

JHPIEGO also worked with the Ministry of Health to develop new service delivery guidelines on modern contraceptives.

John Snow, Inc./SEATS/MotherCare developed the demonstration and training sites in Novosibirsk and Vladivostok. Besides training in modern contraceptives, the MotherCare project included training in exclusive breast-feeding and LAM (lactational amenorhea method) and developed two baby-friendly maternity hospitals in each site.

The Futures Group, Inc./RAPID conducted seminars in Ivanovskaya, Sverdlovskaya (Yekaterinburg), and Leningradskaya (St. Petersburg) oblasts for policy makers on the benefits of family planning.

The Futures Group, Inc./SOMARC provided liaison support for the project with the pharmaceutical companies and trained pharmacists on modern contraceptives and provision of quality services. The project also worked with the Chemical Pharmaceutical Institute in St. Petersburg to develop a curriculum on family planning.

Johns Hopkins University/Center for Communication Programs developed educational and informational materials for both women and physicians. Working with the Russian Family Planning Association, they developed brochures and a video for youth and conducted a mass media campaign.

The U.S. Centers for Disease Control and Prevention (CDC) provided logistics support for contraceptive shipments. These shipments were designed to ensure some contraceptive choice would be available to women following counseling training.

Working with VCIOM, the All-Russia Center for Public Opinion and Marketing, CDC also conducted two surveys to measure the impact of the program. The surveys, completed in the demonstration sites of Ivanovo and Yekaterinburg, and the comparison site of Perm, provided baseline information at the beginning of the project and a final impact of the activities in relation to contraceptive use and changes in abortion patterns.

Achievements

In partnership with Russian counterparts, the WRHP completed the following activities:

- Trained over 6,500 health practitioners in fourteen sites;
- Developed national service delivery guidelines for family planning;
- Completed a national family planning curriculum and institutionalized the training of physicians in reproductive health; and
- Strengthened counseling skills among all providers trained in reproductive health service delivery.

Women and Infant Health (WIN) Project (June 1999-June 2002)

Activity Goal, Strategic Objectives, and Intermediate Results

USAID has identified a limited number of strategic objectives for Russia. All health activities, including the WIN strategy, contribute to Mission Strategic Objective 3.2.: “Improved effectiveness of selected social benefits and services.”

The WIN strategy identified as its own strategic objective *the reduction of maternal and infant morbidity and mortality by improving the effectiveness of selected women and infant (WIN) health services, with special emphasis on reducing repeat abortions and unwanted pregnancies, in selected sites.*

Under its strategic objective, the WIN strategy identified the following intermediate results: *increasing: 1) access, 2) demand, and 3) quality of selected women and infants’ health services,* as well as a series of sub-intermediate results for each.

The WIN Project provides the bulk of the effort under the WIN strategy, and as such, contributes to the following WIN strategy sub-intermediate results:

IR1: Increased Access to WIN services

- IR 1.1: Supportive Policy Environment
- IR 1.2: Broadening Services Provided
- IR 1.3: Increased Points of Selected Service Delivery

IR 2: Increased Demand for WIN Services

- IR 2.1: Increased Consumer Knowledge of Services and Benefits and Risks of Key Health Behaviors

IR 3: Increased Quality of WIN Services and Practices

- IR 3.1: Increased Choice of Practices/Methods
- IR 3.2: Increased Dissemination of Best Practices
- IR 3.3: Increased Professional Technical Competence
- IR 3.4: Improved Provider/Client Relations
- IR 3.5: Increased Continuity of Care
- IR 3.6: Increased Appropriateness and Acceptability of Services

The WIN Project was designed to achieve the following:

- Provide family-centered maternity care that encourages exclusive breastfeeding and rooming-in;
- Provide high quality prenatal and postnatal care;
- Increase training on neonatal resuscitation;

- Increase family planning counseling and services during the post-abortion and postpartum period;
- Integrate sexually transmitted infection services into reproductive health care; and
- Train health care workers in recognizing and counseling women who are victims of violence and providing adequate referrals.

Implementation:

Under the TASC/IQC mechanism in the USAID/Washington Global Bureau's Population, Health and Nutrition Center (G/PHNC), **John Snow, Inc (JSI)** was awarded a contract to implement the WIN Project in Russia. JSI is implementing the WIN Project in selected sites in two oblasts: Perm and Berezniki cities in Permskaya oblast; and Velikiy Novgorod city in Novgorodskaya oblast.

Subcontractors under the JSI WIN Project include **AVSC International, Johns Hopkins University, Center for Communication Programs (JHU/CCP) and University Research Corporation (URC)**. Together, under the JSI contract, these organizations are providing training and technical assistance in maternal and newborn health and nutrition, including the promotion of exclusive breastfeeding; family planning services for postpartum and post-abortion clients; domestic violence; essential care of the newborn; and family-centered maternity care as a component of antenatal, delivery and postpartum care.

An important aspect of the project includes developing a close collaborative relationship with the Russian government and recognized health care experts and providers to enhance the important role of the Russian government and health care providers--both at the federal and local level--in supporting as well as disseminating project results. To achieve this collaboration, the WIN Project is working with the USAID Mission and Russian government representatives through two committees: 1) an executive committee that reviews and approves project activities and 2) a technical advisory group that is involved in actual project implementation and results.

Other:

The **FRONTIERS** Project of the Population Council (with AVSC as a subcontractor) is supporting operations research to improve post-abortion family planning counseling. The results of the operations research will be used to provide program managers and policy decision-makers with the information needed to improve existing services and plan for the future.

The **POLICY Project** of the Futures Group International and the Center for Development and Population Activities (CEDPA) is implementing activities that support the strengthening of women's non-governmental organizations (NGOs) to improve their knowledge and advocacy skills in family planning and reproductive health. The creation of a network of such NGOs responds to the need for an improved policy environment in the area of reproductive health.

The **All-Russia Center for Public Opinion and Market Research** known as VCIOM (a national survey organization that implemented several surveys under the WRHP in collaboration with CDC) was subcontracted by JSI to conduct baseline survey research.

Activities that the WIN Project is undertaking include:

- Maximizing Access and Quality (MAQ) workshops for the executive and technical advisory committees, with up to four additional workshops for the project sites.
- At selected sites, develop and implement action plans for needed training and technical assistance for increasing family planning, with special emphasis on postpartum and abortion counseling; integration of STI services; prenatal education and prepared childbirth; violence against women; healthy lifestyles; and adolescent reproductive health.
- At selected maternity hospitals, develop and implement action plans to link facilities with women's consultations and polyclinics; introduce family-centered maternity care; and train staff in neonatal resuscitation, early initiation of breast-feeding; promote rooming-in and other practices that facilitate breast-feeding and encourages contact between the newborn and other family members.
- Conduct research on women's and adolescents' attitudes toward family planning (with particular emphasis on post-abortion and postpartum counseling), sexually transmitted infections (STIs), prenatal care and prepared childbirth, violence against women, healthy lifestyles, and reproductive health in general as a basis for developing informational, educational, and communication materials. Establish post-abortion and postpartum family planning counseling in each of the selected sites.
- Increase Dissemination of Best Practices by linking selected Russian professional associations (obstetric/gynecology, pediatrics, and midwives) with U.S. counterparts.
- Develop new standards and guidelines on selected practices, based on experience in project sites, in coordination with professional associations and executive and technical advisory committees. Work with professional associations for distribution of new standards and guidelines.
- Provide training in family planning (with particular emphasis on post-abortion and postpartum counseling), STIs, prenatal care and prepared childbirth, violence against women, healthy lifestyles, and reproductive health in general.
- Restructure services to be more "client centered."
- Create linkages between maternity hospitals, women's consultations, and polyclinics.
- Use results from operations research work completed by the FRONTIERS Project.
- Develop new practice standards and guidelines under the quality assurance component implemented by URC.

Related Projects:

USAID/Russia supports several activities in its health portfolio with components that are relevant to the WIN Project. These include:

American International Health Alliance AIHA Community-Based Primary Health Care Partnerships:

Women's Health Initiative

As part of AIHA's Women's Health Initiative, the following four Women's Wellness Centers have been established in Russia: Savior's Hospital for Peace and Charity in Moscow in partnership with Magee Women's Hospital in Pittsburgh, Pennsylvania; Central City Hospital in Dubna in partnership with La Crosse, Wisconsin; Hospital 122 in St. Petersburg in partnership with Jewish Health Systems of Louisville, Kentucky; and Essentuki Maternity Hospital in Essentuki in partnership with Iowa Health Systems in Des Moines, Iowa. The Women's Wellness Center model was developed by AIHA to provide a comprehensive range of clinical and educational services in ambulatory care facilities throughout the former Soviet Union and in Central and Eastern Europe. The Centers serve as models for comprehensively addressing and managing the unmet health care needs of women through an effective mix of health promotion, education, early diagnosis, treatment and follow-up. Services provided by the Centers may include family planning, prenatal care, sexually transmitted infections (STIs), cancer screening, including pap smears and clinical breast exams, mental health education, substance abuse education, chronic disease screening, health issues affecting older women including hormone replacement therapy, healthy lifestyles including nutrition, and adolescent health programs. Two new Women's Wellness Centers will be established in Russia this year: in Khabarovsk, in partnership with Lexington, Kentucky, and in Snezhinsk with Livermore, California. Maternal and Child Health and reproductive health are also a focus for several of the seven new partnerships in Russia.

Neonatal Resuscitation Initiative

In response to the crucial situation and critical needs of newborns in Russia as well as many other countries in the NIS, AIHA partnerships initiated training in neonatal resuscitation techniques, a cost-effective clinical approach with great life-saving potential. Several partnerships formalized this training by opening Neonatal Resuscitation Training Centers (NRTCs), including: Moscow (Moscow/Norfolk, Virginia); Samara and Tver were replicas of the Moscow/Norfolk NRTC; Ulan-Ude (Buryatia/Rhineland, Wisconsin); and Chelyabinsk (Chelyabinsk/Takoma, Washington).

The AIHA neonatal resuscitation training course provides health care professionals with a set of basic skills in newborn care which are standard practice in delivery rooms across the United States, Western Europe and other areas of the world. This training enables practitioners to assist infants when they experience difficulty breathing on their own through techniques of thermal management, infant positioning, suctioning and stimulation while using minimal equipment. Proper or effective neonatal resuscitation skills in delivery rooms and birth houses serve to not only decrease infant mortality rates, but also to reduce the number of developmental disabilities that can occur as a result of blood and oxygen deprivation in the first minutes of life. The training centers are responsible for disseminating knowledge and conducting monthly training

courses in neonatal resuscitation, as well as gathering statistics from those medical institutions that have had personnel trained at the center. This statistical information serves to evaluate the impact of this training in the region. The NRTCs also serve as reference centers and provide training for medical professionals from other regions as well. In fact, the Moscow center serves as a national referral center and training site.

In support of AIHA's expanded efforts in neonatal resuscitation in Russia, Ministry of Health Order No. 372, regarding the "elaboration of initial and critical/intensive care of the neonate in the delivery room", dated December 1995, was approved by the Russian Ministry of Health. The order increased the degree of neonatal resuscitation implementation in Russian hospitals, which led to significant reductions in the areas of mortality and the incidence of Central Nervous System abnormalities in newborns.

Reductions in neonatal mortality have been demonstrated in a number of health care facilities in Moscow and Samara, Russia since the implementation of the Neonatal Resuscitation Program. For instance, between 1994 and 1998, neonatal mortality fell from 11.5 to 10.7 at Maternity Hospital No. 1, from 34 to 16 at Maternity Hospital No. 13, and from 13.2 to 7.7 at Municipal Hospital No.13 Nursery in Moscow. Infant mortality reductions in Samara went from 16.4 per 1000 live births to 8.9 per 1000 live births from 1994 to 1997.

Quality Assurance Project in Tver Oblast: This activity focuses on development and dissemination of quality improvement concepts, techniques, and activities; development and testing of a core set of quality indicators; targeted quality improvement demonstrations; training of health professionals and policy makers in the principles and application of quality improvement activities. The U.S. implementing partner is the University Research Corporation (URC) through its G/PHNC Quality Assurance Project. The Tver activity has completed two demonstration projects on pregnancy-induced hypertension and neonatal respiratory distress syndrome. The main Russian counterpart for this project is the Central Research Institute for Health Care Organizations and Information of the Ministry of Health of the Russian Federation (CRI). Experience from this activity is used under WIN since URC is also a subcontractor to JSI.

USAID/Russia's Assistance to Russian Orphans (ARO) Program, implemented by Holt International Children's Services and Charities Aid Foundation (CAF) in Western Russia, and by Mercy Corps International (MCI) and the European Children's Trust and the World Association of Children and Parents in the Russian Far East, provides technical assistance to NGOs and their partners in the government sector aimed at child abandonment prevention and the development of community-based child welfare services, including the promotion of family-based care for orphans as an alternative to institutionalization. Certain grantees' work (e.g. protocol development for newborns with disabilities) links closely to WIN.

Health Communications: The MEASURE Communication Project (Population Reference Bureau and Academy for Educational Development) helps the Mission in analyzing and presenting project results and communicating project experience to the international donor community and other audiences. In the area of reproductive health, the key topic addressed is the impact of improved use of family planning services on contraceptive prevalence and abortion rates. The impact evaluation is to be based primarily on time series analyses of data from two CDC reproductive health surveys. The technical analysis has been completed and the draft report has been submitted for review.

Other Related Projects:

Maternal and Child Health has long been a priority area under the U.S.-Russia Health Committee of the US-Russia National Commission (previously known as the Gore-Chernomyrdin Commission).

Several activities under the Health Committee complement and are closely related to the WIN Project. Although USAID may not be the sole funder, USAID/Russia seeks to promote linkages between these research and on-going activities, given that the WIN Project provides a mechanism to introduce and demonstrate the effectiveness of other activities and outcomes (e.g. recommendations from research). The activities include:

CDC and UNICEF have led efforts to strengthen the policy environment for increasing the consumption of fortified foods. The project included trainings in micronutrient malnutrition with the goal of preventing disease among the Russian population by improving food and water quality through micronutrient enrichment, including iodine, iron, flouride and selenium.

Congenital Syphilis Study Project: CDC worked with the Russian NGO “SANAM” and the Ministry of Health to assess the nature of congenital syphilis in five Russian regions.

Study of Women of Reproductive Age and Alcohol Intake: In the summer of 1999, the National Institute of Health/the National Institute of Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) began a survey of women of reproductive age in the St. Petersburg area. The purpose of the study is to assess the knowledge, attitudes and behavior and practices of these women concerning alcohol and substance abuse, nutrition, contraceptive use and other health behaviors, all useful information in developing strategies for promoting healthy behaviors, particularly those around alcohol use.

Fetal Alcohol Syndrome Project: Following a visit by a U.S. team concerned with fetal alcohol syndrome (FAS), Russian FAS specialists visited the U.S. in October 1998 on a study tour. Under joint collaboration between NIAAA and Moscow scientists will be developed a training program for Russian physicians in the diagnosis and referral of children affected with FAS, as well FAS incidence and prevalence rates among children in Moscow will be established.

Expected Results:

By the end of this activity the following results were defined in the WIN strategy to be accomplished in the target oblasts:

- 1) A reduction in the overall abortion rate--with a significant drop in repeat abortions and abortions following a birth.
- 2) An increase in the use of modern contraceptives among sexually active women.
- 3) An increase in the number of women exclusively breast-feeding.

- 4) An increase in the number of hospitals offering rooming-in to mothers.
- 5) An increase in the number of hospitals offering family-centered maternity care as a birthing option .
- 6) A decrease in perinatal mortality (early neonatal death-first 7 days of life) in targeted hospitals .

Over time, the constellation of results has evolved, and the team should review the results in the WIN Strategy in comparison to those currently listed.

The WIN Project will be evaluated using a suite of methods: pre-and post-intervention household and facility surveys, and a routine monitoring system to track key indicators within participating facilities. The evaluation is designed to assess the effectiveness and impact of the project in the sites established in three cities.

Progress to date:

The first year of program implementation included two baseline surveys, one at the community level and the other in health facilities; the formation of national level Executive and Technical Advisory Committees, comprised of leading Russian experts, which provide oversight and guidance for WIN, as well as Technical Working Groups in Perm and Novgorod, which provide a similar function at the oblast level; and the development and production of numerous communication materials; and training courses focused on the topics of maximizing access to quality services, family-centered maternity care (FCMC), exclusive breastfeeding, essential care of newborns, and contraceptive technology updates.

In the second year of program implementation, the project is focusing on publishing the baseline reports; continuing training for health professionals including training on antenatal care; developing curricula and protocols; designing and conducting a mass media campaign on breastfeeding; developing family centered maternity care (FCMC) model sites; and conducting operations research.

PURPOSE OF THE ASSSIGNMENT

The purpose of the assessment is to review the WIN Project in Russia which is at a mid-term point, assess the project's performance and progress to date and the appropriateness of the project design, identify factors impeding effective implementation and advise the USAID Russia Mission on any needed redirection of strategies or priorities which would suggest the expansion or extension of the project. In addition, the assessment team will provide suggestions for the future direction of Russia's programs in order to assure a comprehensive and consistent women's/reproductive/maternal/infant health strategy, determine new areas for technical assistance.

The team members will, through interviews, data collection and review of the information sources, provide answers to the following list of questions:

I. PROJECT DESIGN and IMPLEMENTATION:

- To what extent has the WIN Project achieved the project's overall goals as outlined in the WIN Strategy?
- What is the likelihood of achieving all of the IRs? What additional steps may need to be taken in order to achieve the IRs? How will achievement be monitored/captured?
- Is the WIN Project realistic, or is it too overly ambitious? Are there too many concepts to be implemented at once?
- How can the project best achieve a broad roll-out within the pilot oblasts and to other regions in Russia? In other words, how can WIN's successes best be institutionalized nationwide?
- Are there specific components of the program, e.g., interventions, models, tools, that lend themselves better to such roll-out and replication? Are there key lessons learned or success stories that could form the basis for a targeted approach to dissemination and replication?

II. ADMINISTRATIVE STRUCTURE:

- Is the overall administrative and implementing structure to manage and carry out project objectives working effectively? (Executive Committee and Technical Advisory Committee at the national level, and Oblast Coordinating Committees at the oblast level and technical working committees in each facility).
- How effective has the communication between the contractor and the sub-contractors been?
- How effectively has USAID managed the WIN Project from its side, and what have been the barriers?

III CONTRACTOR'S AND SUBCONTRACTORS' ACTIVITIES:

- How appropriate are the activities for accomplishing the program's strategies and IRs?
- How could the activities be strengthened?
- Could other activities be more appropriate?

IV. SERVICE DELIVERY:

- Are all relevant areas of service delivery being adequately supported? How can service delivery be further improved?
- What is the quality of service delivery? Clinical? Counseling? How is the quality being monitored and measured? How can service delivery be improved?

- To what extent are family planning services (clinical and counseling) being integrated into pre-natal, postpartum and post-abortion care? How can these services be more integrated?

V. TRAINING:

- Is the training adequate? Is there “refresher” training?
- To what extent are trainers from the previous WRHP being used?
- Are data available on how the training has impacted service delivery?
- Will “roll-out training” be possible in the future without provision of a financial incentive to trainers? How could the WIN Project or USAID promote or facilitate such activities?

VI. IEC/BEHAVIOR CHANGE COMMUNICATION:

- Are “behavior change” programs under the WIN Project integrated with service delivery programs?
- Are the programs done in conjunction with the local officials?
- Will the materials that are being produced by the WIN Project be replicable at a low cost in the future when USAID is no longer involved?
- What results have there been to date from the IEC campaign? How is the impact being measured?
- Do all of the service sites in the target oblasts have adequate materials? Are plans being made for the materials to be distributed in other oblasts?
- What effect has the IEC program had on public awareness of the advantages of “exclusive breastfeeding”? How will the results affect the next planned campaign, on family planning?

VII NGO INVOLVEMENT:

- Have activities involved non-governmental counterparts for implementation? Has this been effective?

VIII. FAMILY PLANNING:

- How is the WIN Project incorporating family planning into its programs?
- Does the program respond to U.S. congressional “priorities” of lowering the abortion rates? Should there be more emphasis in the program on reducing abortion rates?

- With the current emphasis in Russia on the adverse effect of a decreasing population on “national security” how can the family planning programs better justify their existence? In particular, how can international programs deflect the notion that the West promotes family planning to further reduce the birth rate?

IX. GENDER BALANCE/EQUITY:

- Has the project identified areas of gender bias that negatively affect women’s health programs? Has it developed strategies to address these biases (e.g. provider bias against modern methods of contraception)?
- Have the project’s programming efforts focused on increasing male participation in prenatal, nutrition, delivery, postpartum, contraception , post-abortion care and STI programs?

X ADOLESCENTS:

- What are the project’s efforts towards reaching young adults? Should USAID/Russia increase its assistance in the area of adolescents and reproductive health?

XII. DATA COLLECTION/RESULTS DISSEMINATION:

- Given the availability and status of baseline data how realistic are the WIN Project’s goals?
- Do the assessment tools (baseline surveys, community diagnoses, training needs assessment, etc.) allow WIN to determine and prioritize elements of demand, access and quality of care? Has use of these tools facilitated program planning and evaluation?
- How will they help USAID/Russia with its future programming in women’s/reproductive/infant health?
- How should WIN’s programmatic results be disseminated to USAID and others in international health?

XIII. HOST GOVERNMENT INVOLVEMENT:

- Is there high-level government support for the WIN Project?
- Is there close collaboration, decision making and information sharing between the Project’s partners (MOH, USAID and contractors)?

XIV. COORDINATION WITH OTHER USAID PROJECTS AND OTHER DONORS:

- How effective has the WIN Project been in coordinating with other maternal/infant/reproductive health initiatives within USAID (AIHA, fetal alcohol, congenital syphilis and assistance to orphans, POLICY), and with other donor organizations ?
- How could such coordination be improved in the future?

XV. SUMMARY AND FUTURE DIRECTIONS:

- How can the results of this assessment, the lessons learned from the WRHP and those learned to date from the WIN project provide a clear guidance to USAID/Russia's future work in the maternal/infant/reproductive health?
- Should the WIN strategy be revised?
- Should the WIN project's scope be expanded and/or the timeline for the project extended? What recommendations can be made about funding levels for either and extension or expansion of the Project?
- Should there be additional programmatic components or sites or both?
- What are the key lessons learned that the Mission should focus on for future efforts?

INFORMATION SOURCES

USAID/Russia in conjunction with the USAID Bureau for Europe and Eurasia's (E&E) Health Reform and Humanitarian Assistance Division in Washington and the USAID Global Bureau's PHN Center (G/PHN) will provide the review team with a package of documents at least one month prior to the beginning of the review. These documents should be reviewed prior to departure from the U.S. and serve as reference materials in country. Each team member might also be responsible for collecting and reviewing additional documents and reports during the field phase of the review. Copies of such documents should be provided to USAID/Russia upon completion of the trip.

METHODOLOGY

The overall methodology for the health program review is a combination of reviewing documents, conducting briefing sessions and interviews (both in Russia and in Washington), making site visits, and compiling a final report. Where feasible and as determined by USAID/Russia, the evaluation team will begin its work in Washington, D.C. by both reviewing available documents and meeting with appropriate USAID/W staff, and other donors, contractors and grantees working in Russia on similar projects. All team members will travel to Russia from the U.S. to meet with USAID/Russia and the WIN Project staff before visiting project sites in Perm and/or Novgorod Oblasts, as well as during mid-assessment meetings as needed. All team members will exit Russia from Moscow to allow for outbriefs and meetings with USAID/Russia and others as appropriate.

DELIVERABLES

During the exit debriefing, the team will present to USAID/Russia staff a comprehensive outline of the final paper, including a list of major findings, conclusions and recommendations, a table of contents for the report, a draft executive summary, a list of in-country contacts, and a list of source materials.

The report will be finalized by the Team Leader in the United States and presented to USAID/Russia within two weeks after the completion of the evaluation for comment. The contractor (POPTECH) will then prepare the final copy of the report for distribution.

The assessment report, along with tables and annexes, should not exceed fifty (50) pages.

The report should follow a format as follows:

- Table of Contents.
- Executive Summary stating purpose, findings, conclusions and recommendations (not to exceed three pages). (The Executive Summary should be appropriate for broader dissemination, and as such be translated into Russian.)
- Body of the report including a description of the justification for the assessment, the environment in which the team operated, a statement of the methodology used, and a lengthy description of the major findings, conclusions and recommendations.
- Annexes to include the evaluation Scope of Work, lists of persons consulted, background supplemental materials useful for a fuller understanding of the report, a bibliography of significant documents used to consult, and a list of acronyms.

TEAM COMPOSITION AND PARTICIPATION

The following summary descriptions indicate the experience and skills that team members will ideally possess.

All team members should have a comprehensive understanding of USAID's policies and strategic planning processes, especially as they relate to PHN (population, health and nutrition) programs. Problem-solving skills and the ability to work independently as well as within a team structure is necessary. Previous experience on USAID assessment or evaluation teams within the former Soviet Union is essential. Russian language skills are preferable.

The ideal team will have three members, with the following skills:

Maternal and Infant Health Expert: S/he must have comprehensive knowledge in maternal and infant (or child) health program implementation.

Evaluation Specialist: S/he must have expertise in project monitoring and evaluation including data collection, preferably in reproductive/maternal/infant health.

Reproductive Health Specialist: S/he must have extensive experience in reproductive health program design, management and implementation. S/he must have knowledge of IEC/Behavior Change Campaigns, and the design and implementation of training programs to improve the counseling and clinical skills of physicians and other health professionals.

Translator/Logistics Coordinator: S/he should be able to assist with logistics, including in-country travel, scheduling appointments, and coordinating necessary meetings.

SCHEDULE AND LOGISTICS

RESPONSIBILITIES OF USAID/RUSSIA

Kerry Pelzman, Chief, USAID/Russia Health Division, Office of Social Sector Restructuring, will oversee and approve all aspects of the assessment. A member of the Health Division may accompany team members on any or all visits in-country.

USAID/Russia will be responsible for obtaining country clearances prior to travel subsequent to a request from the contractor with the pertinent information.

USAID/Russia will assist in scheduling appointments for team members with host government officials, USAID/Russia contractors and cooperating agencies (CAs, other donor organizations and others doing work in Russia) related to this SOW, although the team may reschedule or propose additional meetings as needed. All meetings scheduled by team members relating to this SOW should be cleared through USAID/Russia.

RESPONSIBILITIES OF THE CONTRACTOR

The contractor will be responsible for all pre-trip travel arrangements and logistics including visas, insurance, etc.

The contractor will be responsible for coordination, issuance and dissemination of the final report.

IN-COUNTRY MEETINGS

While in Russia, the team will meet with the following individuals and groups as appropriate:

- USAID program staff on a regular basis to update on the progress of the assessment as requested by USAID.
- Host country government officials at the national, regional and local levels.
- USAID/Russia contractor and grantees implementing health activities in-country.
- Donor representatives, international organizations, PVOs and other partner organizations working in program areas relevant to the program review (World Bank, Soros, UNFPA, UNAIDS, UNICEF, DIFD, etc.).
- Health service providers at selected sites, including demonstration oblasts.

SCHEDULE

The following is the proposed schedule for the team's visit. The team will be expected to work six-day workweeks, including travel days. Preliminary dates are from week of October 22 through week of November 19.

Week One

Monday, Tuesday, Wednesday

Individual documents review within the U.S. Team conference calls as necessary.

Thursday and Friday

Team Planning Meetings in Washington (two days)

Friday evening

Depart for Russia

Saturday

Arrive in Russia

Sunday

Free day

Week Two

Monday

Team meeting at USAID/Russia, WIN

Tuesday

Team meetings in Moscow with other donors, organizations, etc.

Wednesday

Travel to Perm Oblast; afternoon meetings

Thursday, Friday, Saturday morning

Meetings in Perm

Saturday afternoon

Travel to Moscow; team debrief

Sunday

Free day

Week Three

Monday

Meetings/team debrief in Moscow

Tuesday, Wednesday, Thursday

Travel to Novgorod, meetings in Novgorod, travel to Moscow

Friday, Saturday

Team debrief in Moscow

Sunday

Free day

Week Four

Monday

USAID debrief; delivery of first draft of report

Depart for the U.S.

Tuesday, Wednesday, Thursday

Team Leader will complete report

TEAM PLANNING/DEBRIEFING MEETINGS

Team planning meetings will be held in Washington for two days before departure for Russia with key E&E Bureau and G/PHN staff who have been substantially involved with USAID Russia health programs to gain an appreciation of the USAID Mission's health portfolio.

Upon arrival in Russia, the team will meet with the Director of the Office of Social Sector Restructuring and the Chief of the Division of Health. During the briefing meetings, the team will review the Scope of Work and team responsibilities; refine the team schedule as necessary and address and resolve outstanding issues and questions. Individual or small group meetings with other USAID/Russia staff will be scheduled as appropriate.

A debriefing meeting will be held with USAID/Russia staff prior to the team's departure from Russia.

APPENDIX B
PERSONS CONTACTED

PERSONS CONTACTED

U.S. Agency for International Development/Washington

Paul Holmes, Regional Health Advisor, Bureau for Europe and Eurasia

Mary Jo Lazear, Health Advisor, Bureau for Europe and Eurasia

Willa Pressman, Country Coordinator, Bureau for Global Programs, Field Support and Research,
Center for Population, Health and Nutrition, Office of Field and Program Support

USAID/Russia

Carol Peasley, Director

George Deikun, Deputy Director

Earle Lawrence, Director, Office of Social Sector Restructuring

Kerry Pelzman, Chief, Health Division

Larissa Petrosysan, Project Management Assistant, Health Division

Charles North, Program Office

WIN Project Resident Staff

Natalia Vartapetova, MD, Head of the WIN Project Representative Office, JSI Resident Advisor

Natalia Kisseleva, MD, WIN Project Coordinator, JSI

Michelle Berdy, Senior Program Officer, WIN Project Resident Advisor in Russia, JHU/CCP

WIN Consultants

Pauline Glatleiter, CNM, MN, Midwifery Care of California, JSI Consultant to WIN

Irina Savelieva, MD, Health, Department of International Research Programs, Russian Academy
of Medical Sciences, and WIN Consultant on Family Planning, EngenderHealth Consultamt to
WIN

Ludmilla Romanchuk, WIN Breastfeeding Consultant and WHO Baby-Friendly Hospital
Program

Ludmilla Shmarova, WIN Breastfeeding Consultant and WHO Baby-Friendly Hospital Program

M. Rashad Massoud, MD, Senior Quality Assurance Advisor, URC Consultant to WIN

Rimma Potemkina, MD, Leading Researcher, National Research Center for Preventive Medicine
of the MOH and WIN Evaluation Consultant

John Snow, Inc., Washington

Abul Hashem, Project Director

Will Gerard, TASC/IQC

EngenderHealth

Inna Sacci, New York (telephone interview)

Russian National Academy of Medical Sciences

Vladimir Kulakov, MD, Vice President of the Russian Academy of Medical Sciences and
Director, Obstetrics, Gynecology and Perinatology Research Center

Russian Ministry of Health

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APPENDIX C

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APPENDIX D

DEFINITION OF FAMILY-CENTERED MATERNITY CARE

DEFINITION OF FAMILY–CENTERED MATERNITY CARE

FCMC is evidence-based medicine applied to the care of pregnant women and their newborns. Practices that have been found to be ineffective or harmful (such as routine perineal shaving, intravenous infusions, and bottle feeding) are avoided, and practices known to be safe and useful (such as constant support for women throughout labor and birth) are provided. FCMC includes mother-friendly care and the baby-friendly hospital practices promoted by WHO.

MOTHER–FRIENDLY CARE

- Is designed to meet the informational, social, emotional, comfort and support needs of normal pregnant women and their families during pregnancy and childbirth;
- Emphasizes education and preparation to enable the pregnant woman to take a knowledgeable, active role in promoting her own health and that of her fetus and baby;
- Encourages involvement of the pregnant woman’s family members or other persons of her choice in her preparation for childbirth and motherhood and invites their supportive presence during labor and birth;
- Avoids unnecessary use of invasive, uncomfortable and/or restrictive procedures;
- Encourages women to be active during labor—to sit up, walk, assume any comfortable position, change positions frequently, and avoid the supine and lithotomy positions; and
- Manages birth as a process requiring cleanliness but not sterility.

BABY–FRIENDLY HOSPITAL PRACTICES

- Designed to promote breastfeeding, maternal-infant bonding, and lactational amenorrhea, and to reduce newborn infections;
- Provided to the mother and baby after the baby is born;
- Promoted worldwide by WHO; and
- Key elements include
 - skin-to-skin contact between mother and baby,
 - rooming-in,
 - exclusive breastfeeding for first 6 months of life,
 - breastfeeding on demand,
 - no bottles,
 - no pacifiers, and
 - expert assistance to prevent and solve breastfeeding problems.

Every element of FCMC has been objectively evaluated through multiple randomized controlled trials (RCTs) conducted in countries throughout the world and has been found to produce substantial benefits:

- reduced incidence of infant morbidity and mortality;
- shorter, less painful labors;
- less need for cesarean sections and use of forceps;
- reduced postpartum infections and other forms of maternal morbidity, some of which are associated with significant problems that may persist for the woman's entire life;
- fewer women who find it difficult to adjust to motherhood; and
- fewer babies who are abandoned by their mothers.

APPENDIX E

WIN PROJECT PERFORMANCE INDICATORS

WIN PROJECT PERFORMANCE INDICATORS

BREASTFEEDING

Table 1: Number of Infants Aged 0–2 Months Seen in Children’s Polyclinics by Quarter (Reports from Children’s Polyclinics)					
	7/00-9/00	10/00-12/00	1/01-3/01	4/01-6/01	7/01-9/01
Veliky Novgorod-1	103	96	136	121	119
Veliky Novgorod-2	262	236	263	231	257
Veliky Novgorod-3	179	185	144	181	146
Perm-15	491	424	434	479	460
Perm-24	381	364	365	343	335
Berezniki	501	475	477	453	481

Table 2: Percentage of Mother’s Exclusively Breastfeeding at 3 Months by Quarter (Reports from Children’s Polyclinics)					
	7/00-9/00	10/00-12/00	1/01-3/01	4/01-6/01	7/01-9/01
Veliky Novgorod-1	67.0	72.9	68.4	71.9	84.0
Veliky Novgorod-2	69.8	77.0	77.9	85.7	77.4
Veliky Novgorod-3	61.5	57.3	63.2	71.3	75.3
Perm-15	16.7	19.1	24.7	32.4	43.7
Perm-24	55.6	63.2	68.5	77.3	81.2
Berezniki	62.9	66.5	72.1	81.5	85.7

Table 3: Number of Infants Aged 0-5 Months Seen in Children’s Polyclinics by Quarter (Reports from Children’s Polyclinics)					
	7/00-9/00	10/00-12/00	1/01-3/01	4/01-6/01	7/01-9/01
Veliky Novgorod-1	178	152	196	206	194
Veliky Novgorod-2	384	377	388	364	372
Veliky Novgorod-3	282	274	222	272	242
Perm-15	698	576	662	1087	1613
Perm-24	581	574	533	547	544
Berezniki	747	725	789	690	735

Table 4: Percentage of Mother’s Exclusively Breastfeeding at 6 Months by Quarter (Reports from Children’s Polyclinics)					
	7/00-9/00	10/00-12/00	1/01-3/01	4/01-6/01	7/01-9/01
Veliky Novgorod-1	57.9	61.2	59.7	63.1	72.7
Veliky Novgorod-2	-	63.7	68.0	73.9	73.1
Veliky Novgorod-3	47.5	49.3	49.5	55.9	58.7
Perm-15	11.7	14.1	16.3	14.4	13.7
Perm-24	44.2	54.5	56.5	64.5	69.5
Berezniki	46.7	50.3	57.0	67.5	78.5

Table 5: Percentage of Mother’s Exclusively Breastfeeding on Day of Hospital Discharge by Quarter (Reports from Maternity Hospitals)					
	7/00-9/00	10/00-12/00	1/01-3/01	4/01-6/01	7/01-9/01
Veliky Novgorod-1	98.2	90.7	88.8	90.5	83.2
Veliky Novgorod-2	94.2	92.4	95.4	96.5	96.6
Perm-9	83.2	82.8	89.9	92.4	94.5
Perm-21	96.9	98.3	97.7	96.0	97.6
Berezniki	95.1	88.9	96.3	98.1	97.3

Table 6: Percentage of Mother's Exclusively Breastfeeding Immediately Postpartum and During Hospital Stay by Quarter (Reports from Maternity Hospitals)					
	7/00-9/00	10/00-12/00	1/01-3/01	4/01-6/01	7/01-9/01
Veliky Novgorod-1	83.7	85.3	78.4	79.9	69.9
Veliky Novgorod-2	79.3	87.8	91.1	91.5	89.1
Perm-9	72.8	72.7	77.6	81.1	85.1
Perm-21	93.6	96.6	88.4	95.6	95.0
Berezniki	21.9	30.6	58.1	93.9	89.5

MATERNAL HEALTH CARE PRACTICES

Table 7: Number of Infants Born Alive in Maternity Hospitals by Quarter (Reports from Maternity Hospitals)					
	7/00-9/00	10/00-12/00	1/01-3/01	4/01-6/01	7/01-9/01
Veliky Novgorod-1	381	353	357	399	405
Veliky Novgorod-2	329	353	370	376	384
Perm-9	972	571	802	924	998
Perm-21	641	639	481	701	619
Berezniki	489	386	484	423	475

Table 8: Percentage of Mother's Rooming In by Quarter (Reports from Maternity Hospitals)					
	7/00-9/00	10/00-12/00	1/01-3/01	4/01-6/01	7/01-9/01
Veliky Novgorod-1	8.9	38.0	11.2	14.8	13.6
Veliky Novgorod-2	91.2	97.5	97.6	98.9	97.4
Perm-9	89.5	90.0	98.5	90.9	98.9
Perm-21	99.1	82.6	97.7	96.0	99.0
Berezniki	21.9	35.2	75.8	97.6	98.7

Table 9: Percentage of Mother's with Family Support during Labor and Delivery by Quarter (Reports from Maternity Hospitals)					
	7/00-9/00	10/00-12/00	1/01-3/01	4/01-6/01	7/01-9/01
Veliky Novgorod-1	8.9	14.4	22.3	30.4	27.5
Veliky Novgorod-2	19.8	24.2	31.1	47.6	43.6
Perm-9	0.6	4.7	7.2	10.3	4.8
Perm-21	1.9	3.7	6.7	13.0	25.0
Berezniki	0.6	0.0	0.4	3.8	27.9

Table 10: Percentage of Mother's Given Pain Medication during Labor and Delivery by Quarter (Reports from Maternity Hospitals)					
	7/00-9/00	10/00-12/00	1/01-3/01	4/01-6/01	7/01-9/01
Veliky Novgorod-1	82.9	78.9	73.8	86.2	64.4
Veliky Novgorod-2	14.0	6.4	6.6	10.0	4.9
Perm-9	84.9	92.3	80.0	52.2	32.4
Perm-21	37.6	8.6	10.1	17.6	12.2
Berezniki	100.0	100.0	99.5	6.4	24.8

Table 11: Percentage of Mother's with Episiotomies among All Vaginal Deliveries by Quarter (Reports from Maternity Hospitals)					
	7/00-9/00	10/00-12/00	1/01-3/01	4/01-6/01	7/01-9/01
Veliky Novgorod-1	16.4	16.5	14.7	18.4	16.9
Veliky Novgorod-2	24.5	14.2	25.3	19.0	16.0
Perm-9	38.0	33.8	24.3	39.9	24.2
Perm-21	21.8	13.0	8.7	9.5	8.7
Berezniki	14.6	14.6	15.2	14.9	7.9

Table 12: Percentage of Mother's with C-Sections by Quarter (Reports from Maternity Hospitals)					
	7/00-9/00	10/00-12/00	1/01-3/01	4/01-6/01	7/01-9/01
Veliky Novgorod-1	20.0	24.6	22.3	23.2	21.6
Veliky Novgorod-2	15.5	16.6	14.6	15.1	14.9
Perm-9	17.1	16.3	14.4	19.5	21.3
Perm-21	13.8	13.9	13.8	12.7	16.0
Berezniki	13.1	12.7	14.8	11.1	16.3

INFANT HEALTH

Table 13: Percentage of Infant's Discharged with Mothers by Quarter (Reports from Maternity Hospitals)					
	7/00-9/00	10/00-12/00	1/01-3/01	4/01-6/01	7/01-9/01
Veliky Novgorod-1	98.2	79.3	76.2	74.9	83.2
Veliky Novgorod-2	98.8	92.4	95.4	96.5	96.6
Perm-9	85.3	97.0	97.6	98.3	98.9
Perm-21	94.7	98.3	97.5	96.0	97.7
Berezniki	85.9	95.6	97.9	98.1	98.9

Table 14: Percentage of Infant's with Jaundice by Quarter (Reports from Maternity Hospitals)					
	7/00-9/00	10/00-12/00	1/01-3/01	4/01-6/01	7/01-9/01
Veliky Novgorod-1	25.2	3.7	4.2	3.0	2.5
Veliky Novgorod-2	58.1	28.3	19.7	8.5	3.4
Perm-9	11.1	6.1	7.5	8.5	9.8
Perm-21	8.1	3.9	6.9	4.6	7.3
Berezniki	8.0	40.4	38.6	26.5	25.1

Table 15: Percentage of Infants Admitted to Intensive Care by Quarter (Reports from Maternity Hospitals)					
	7/00-9/00	10/00-12/00	1/01-3/01	4/01-6/01	7/01-9/01
Veliky Novgorod-1	6.0	6.5	11.2	7.0	4.9
Veliky Novgorod-2	9.1	7.1	6.5	8.0	5.2
Perm-9	13.0	10.5	10.1	11.6	11.4
Perm-21	10.6	7.4	22.5	7.3	4.4
Berezniki	9.6	8.0	5.4	0.7	2.9

Table 16: Incidence of Diarrhea per 1,000 Infants Aged 0-5 Months by Quarter (Reports from Children's Polyclinics)					
	7/00-9/00	10/00-12/00	1/01-3/01	4/01-6/01	7/01-9/01
Veliky Novgorod-1	16.9	46.1	5.1	4.9	0.0
Veliky Novgorod-2	41.7	53.1	10.3	24.7	32.3
Veliky Novgorod-3	21.3	29.2	40.5	3.7	49.6
Perm-15	8.6	16.4	10.6	7.0	9.7
Perm-24	31.1	5.2	13.1	9.1	11.0
Berezniki	13.4	15.2	9.5	10.1	12.2

Table 17: Incidence of Anemia per 1,000 Infants Aged 0-5 Months by Quarter (Reports from Children's Polyclinics)					
	7/00-9/00	10/00-12/00	1/01-3/01	4/01-6/01	7/01-9/01
Veliky Novgorod-1	16.9	19.7	25.5	4.9	20.6
Veliky Novgorod-2	10.4	15.9	10.3	5.5	2.7
Veliky Novgorod-3	70.9	21.9	22.5	3.7	33.1
Perm-15	120.3	139.9	84.6	127.1	128.6
Perm-24	0.0	122.0	135.1	138.9	22.1
Berezniki	18.7	29.0	13.5	42.0	93.9

Table 18: Incidence of Upper Respiratory Infection per 1,000 Infants Aged 0-5 Months by Quarter (Reports from Children's Polyclinics)					
	7/00-9/00	10/00-12/00	1/01-3/01	4/01-6/01	7/01-9/01
Veliky Novgorod-1	151.7	177.6	178.6	121.4	92.8
Veliky Novgorod-2	151.0	180.4	159.8	167.6	174.7
Veliky Novgorod-3	131.2	204.4	189.2	91.;9	148.8
Perm-15	147.6	299.1	96.7	129.9	91.3
Perm-24	297.6	122.0	157.6	160.9	34.9
Berezniki	354.8	591.7	548.0	373.9	181.0

Table 19: Incidence of Pneumonia per 1,000 Infants Aged 0-5 Months by Quarter (Reports from Children's Polyclinics)					
	7/00-9/00	10/00-12/00	1/01-3/01	4/01-6/01	7/01-9/01
Veliky Novgorod-1	28.1	32.9	30.6	24.3	0.0
Veliky Novgorod-2	7.8	0.0	5.2	0.0	5.4
Veliky Novgorod-3	10.6	10.9	4.5	18.4	4.1
Perm-15	4.3	1.5	1.5	4.2	1.4
Perm-24	10.4	0.0	5.6	5.5	3.7
Berezniki	1.3	2.8	1.4	1.4	0.0

Table 20: Percentage of Ear Infections (Otitis) among Infants Aged 0-5 Months by Quarter (Reports from Children's Polyclinics)					
	7/00-9/00	10/00-12/00	1/01-3/01	4/01-6/01	7/01-9/01
Veliky Novgorod-1	0.0	13.2	0.0	4.9	10.3
Veliky Novgorod-2	2.6	2.7	5.2	2.7	5.4
Veliky Novgorod-3	3.5	10.9	4.5	3.7	4.1
Perm-15	40.1	55.1	21.1	22.3	20.7
Perm-24	3.5	1.7	3.8	9.1	3.7
Berezniki	24.1	37.2	32.5	21.7	10.9

Table 21: Percentage of Infants Aged 0-5 Months with Atopic Dermatitis by Quarter (Reports from Children's Polyclinics)					
	7/00-9/00	10/00-12/00	1/01-3/01	4/01-6/01	7/01-9/01
Veliky Novgorod-1	33.7	19.7	35.7	14.6	0.0
Veliky Novgorod-2	2.6	29.2	28.4	5.5	10.8
Veliky Novgorod-3	31.9	21.9	76.6	11.0	33.1
Perm-15	44.4	81.8	55.9	60.1	48.4
Perm-24	0.0	0.0	7.5	0.0	5.5
Berezniki	10.7	11.0	16.2	7.2	21.8

FAMILY PLANNING

Table 22: Total Number of New Family Acceptors by Quarter (Reports from Family Planning Centers)					
	7/00-9/00	10/00-12/00	1/01-3/01	4/01-6/01	7/01-9/01
Veliky Novgorod-1	-	-	-	-	-
Veliky Novgorod-2	-	-	-	-	-
Perm-9	642	996	1110	527	503
Perm-21	248	332	390	299	220
Berezniki	-	860	635	770	615

Table 23: Total Number of New Family Planning Users (New Acceptors and Repeat Users) by Quarter (Reports from Family Planning Centers)					
	7/00-9/00	10/00-12/00	1/01-3/01	4/01-6/01	7/01-9/01
Veliky Novgorod-1	-	-	-	-	-
Veliky Novgorod-2	-	-	-	-	-
Perm-9	2658	2826	3322	1129	1371
Perm-21	384	496	669	552	510
Berezniki	-	892	635	770	699

Table 24: Percentage Distribution of Contraceptive Use by Method from 7/00-9/01 (Reports from Family Planning Centers)					
	Pills	IUDs	Injectables	Condoms	Emergency Contraception
Veliky Novgorod-1	-	-	-	-	-
Veliky Novgorod-2	-	-	-	-	-
Perm-9	41.7	3.2	3.9	48.7	2.5
Perm-21	34.8	10.3	3.5	50.4	1.1
Berezniki	65.3	6.1	9.0	18.4	1.3

ABORTION

Table 25: Number of Abortions by Quarter (Reports from Gynecological Units in Maternity Hospitals)					
	7/00-9/00	10/00-12/00	1/01-3/01	4/01-6/01	7/01-9/01
Veliky Novgorod-1	306	322	304	283	314
Veliky Novgorod-2	262	270	276	258	265
Perm-9	547	327	337	345	314
Perm-21	256	327	245	283	280
Berezniki	909	571	735	739	704

Table 26: Abortion Ratio (Abortions per 100 Live Births) by Quarter (Reports from Gynecological Units in Maternity Hospitals)					
	7/00-9/00	10/00-12/00	1/01-3/01	4/01-6/01	7/01-9/01
Veliky Novgorod-1	80	91	85	71	78
Veliky Novgorod-2	80	76	75	69	-
Perm-9	56	57	42	37	31
Perm-21	40	51	51	40	45
Berezniki	186	148	152	175	148

Table 27: Percentage of Abortions that are Late Term by Quarter (Reports from Gynecological Units in Maternity Hospitals)					
	7/00-9/00	10/00-12/00	1/01-3/01	4/01-6/01	7/01-9/01
Veliky Novgorod-1	4.6	7.1	1.6	1.1	0.6
Veliky Novgorod-2	1.9	3.0	0.7	4.3	-
Perm-9	0.5	7.0	10.1	3.2	7.0
Perm-21	10.6	12.8	9.8	6.4	10.7
Berezniki	6.9	5.8	8.4	9.3	8.4

Table 28: Percentage of Mothers Who Obtain a Family Planning Method Following Abortion by Quarter (Reports from Gynecological Units in Maternity Hospitals)					
	7/00-9/00	10/00-12/00	1/01-3/01	4/01-6/01	7/01-9/01
Veliky Novgorod-1	0.0	0.0	0.0	0.0	0.0
Veliky Novgorod-2	3.4	7.4	11.6	8.5	9.4
Perm-9	0.0	0.0	0.0	0.0	0.0
Perm-21	7.8	8.3	1.6	24.0	56.8
Berezniki	0.0	13.8	10.9	16.6	13.4



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