



USAID
FROM THE AMERICAN PEOPLE

Institutionalizing Best Practices in Maternal and Child Health



Institutionalizing Best Practices in Maternal and Child Health (IBP-MCH)



FINAL TECHNICAL REPORT

Asta-Maria Kenney
Natalia V. Vartapetova
Kristin Eifler
Anna V. Karpushkina

November 2012



Financial support for this document was provided by USAID/Russia under the terms of Prime Contract No. **GHS-I-00-07-00002-00**. The views expressed herein are those of the authors and do not necessarily reflect those of USAID.

The USAID/ Russia Institutionalizing Best Practices in Maternal and Child Health project is implemented by John Snow Inc. and the Russian Institute for Family Health.

Acknowledgements

Many hands and many voices contributed to this document. Certainly, special thanks is due to every speaker, panelist, trainer and participant at the Institutionalizing Best Practices in Maternal and Child's Health project Final Dissemination Conference "US-Russia Forum: Bilateral Collaboration to Improve Women's and Infants' Health" held in Moscow in May 2012. The presentations, the discussions, and the obvious enthusiasm of all made the achievements enabled by the IBP-MCH interventions really come alive.

Special acknowledgement is due to the excellent cohort of the Project partners, trainers and consultants. Without them the Project implementation would not have been possible.

Many thanks to Dr. Gennady Sukhikh, Director of the Kulakov Federal Center on Obstetrics, Gynecology and Perinatology, for his multi-faced support.

Most definitely, special thanks are also due ACOG for its consistent commitment and support, and especially to Dr. Richard Waldman and Elaine Mielcarski for their many extra efforts.

Thank you to USAID/Russia for its ongoing support of the IBP-MCH vision and strategies. Special thanks especially to Larissa Petrosian (Project Manager in the Office of Health and IBP-MCHs Cognizant Technical Officer), Alyssa Leggoe (Deputy Director of the Office of Health) and William Slater (Director of the Office of Health) for their many extra efforts on IBP-MCH's behalf.

In addition to sincere thanks, a round of applause is also due the IBP-MCH staff for the determination, skill and dedication with which they implemented this project and to encourage them and wish them all the best as they move forward as the Institute for Family Health.

Table of Contents

Acknowledgements.....	3
Table of Contents.....	4
Acronyms & Abbreviations	5
Executive Summary.....	6
Background and Introduction	18
Project Accomplishments	24
Task 1: Partnerships with Federal District Centers/Institutes	24
Task 2: Operationalizing and Disseminating MCH Guidelines and Best Practices.....	41
Task 3: Optimizing the Delivery of MCH/RH Care at the Regional Level (Regionalization)	50
Task 4: Improving Access to Appropriate Family Planning, Prenatal and Postnatal Care for High-Risk Women.....	54
Task 5: Sustainability Plan.....	59
Management, Monitoring & Evaluation	67
Management.....	67
Monitoring and Evaluation (M&E)	67
Status of Expected Results.....	69
Lessons Learned and Solutions for Resolving Constraints.....	82
Annex 1: Project Deliverables	85
Annex 2: Audit/Assessment Results.....	88
Annex 2: Results of Family Planning Audits	91
Annex 3: Trainings Conducted	93
Annex 4: Workshops and Seminars Conducted.....	97
Annex 5: Number of Service Delivery Points in Project Regions Providing MCH/RH Care and Number of Networks of Care Established.....	102
Annex 6: Conferences Conducted by the Project	104
Annex 7: Presentations by Project Staff and Experts at National and Subnational Conferences	106
Annex 8: List of Professional Publications by Project Staff.....	114
Annex 9: Mass Media Coverage.....	116
Annex 10: Maternal Mortality Ratio	117
Annex 11: Infant Mortality Rate	118
Annex 12: Abortion Rates and Ratios	119
Annex 13: FP/RH Counseling Visits in Project Regions	121
Annex 14: Perinatal Mortality Rate.....	122
Annex 15: Early Neonatal Mortality Rate	123
Annex 16: Essential Newborn Care (ENC).....	124
Annex 17: Antenatal Care	125

Acronyms & Abbreviations

ACOG	American College of Obstetricians & Gynecologists
AIDS	Acquired Immunodeficiency Syndrome
AC	Antenatal care
ANC	Antenatal care
BEST	Best Practices at Scale in the Home, Community and Facilities (USAID initiative)
BF	Breastfeeding
DC	District of Columbia
DMPA	Depot medroxyprogesterone acetate (injectable contraceptive)
EBM	Evidence-Based Medicine
EmOC	Emergency Obstetric Care
ENC	Essential newborn care
FCMC	Family-Centered Maternity Care
F/M	Female/male
FP	Family planning
GHI	Global Health Initiative (USAID initiative)
GOR	Government of the Russian Federation
HIV	Human immunodeficiency virus
IBP-MCH	Institutionalizing Best Practices in Maternal & Child Health project
IFH	Institute for Family Health – Information & Research
IUD	Intrauterine device
JSI	John Snow Inc
KHMAO	Khanty-Mansiysk Autonomous Okrug
LAM	Lactational Amenorrhea Method
M&E	Monitoring & evaluation
MCH	Maternal & Child Health
MCHI	Maternal and Child Health Initiative (USAID project)
MCHI II	Maternal and Child Health Initiative II (USAID project--precursor to IBP-MCH)
MOHSD	Ministry of Health & Social Development
MPWG	Multi-Partners Working Group
NA	Not available
N/A	Not applicable
NGO	Nongovernmental organization
NR	Newborn Resuscitation
Ob-gyn	Obstetrician-gynecologist
PC	Pediatric care
PMTCT	Prevention of Mother-to-Child Transmission of HIV
RCC	Resuscitation Counseling Center
RH	Reproductive health
RLMS	Russia Longitudinal Monitoring Survey
STI	Sexually transmitted infection
T&R	Training & Resource
USAID	United States Agency for International Development
USG	United States Government
WIN	Women and Infants' Health Project (USAID project)
YANAO	Yamalo-Nenezkiy Autonomous Okrug
y.o.	years old

Executive Summary

Since 1999, the US Agency for International Development (USAID) has supported work to improve maternal and child health and reproductive health (MCH/RH) in the Russian Federation, aiming to reduce mortality rates among women and children and bring them closer to levels in Europe and other developed countries. Some of the most important challenges in modernizing MCH/RH services were:

- To update clinical practices in line with Evidence-Based Medicine (EBM) by reducing over-medicalization of care (unnecessary and sometimes harmful medications, tests, scans, etc.) and promoting low-cost, effective practices;
- To make services more responsive to clients' and families' needs, rather than to the government and health workers, for example by allowing family members to visit in the hospital and play a role in delivery and newborn care;
- To build modern management skills among managers of a health system that is more decentralized than in Soviet times.

The *Institutionalizing Best Practices in Maternal and Child Health* (IBP-MCH) project built on the work of prior years by expanding modern, evidence-based approaches to MCH/RH to additional regions* and bringing a new emphasis on collaboration with two Federal Research Institutes⁺ to strengthen their leadership capacity to deliver, disseminate and advocate for best practices in MCH and family planning/reproductive health (FP/RH) at the Federal and regional levels. The project ran from October 2008 to September 2012, but work really only started in March 2010 for reasons explained in the full report.

John Snow Inc (JSI) was selected by USAID to implement the project in close partnership with the Institute for Family Health (IFH), a Russian woman-owned nongovernmental public health research and consulting organization. Having implemented three prior USAID-funded MCH/RH projects in Russia, the two organizations had an abundance of experience and an established reputation to build on.

Website

More information about the project and copies of materials are available on the Institute for Family Health (IFH) website:

<http://www.ifhealth.ru> &

<http://www.ifhealth.ru/en>

The goal of the IBP-MCH project was to decrease maternal and infant morbidity and mortality in selected Federal Districts[#] and USAID set out five tasks designed to achieve this. This Executive Summary presents key accomplishments for each of these tasks, followed by selected project results and the lessons learned.

* For purposes of simplicity, the term "region" is used in this report to include all administrative divisions, including *oblasts*, *krais*, *okrugs*, autonomous republics and independent cities.

⁺ There are five Federal Research Institutes in MCH around the country—referred to as Federal Centers in this report—that are responsible for developing guidelines and policy for the Ministry of Health and Social Development (MOHSD) at the Federal and regional levels and to serve as methodological and organizational centers for the regions in their Federal Districts.

[#] Federal Districts oversee and facilitate the work of Federal agencies across the vast territory of the Russian Federation.

- Initial Care and Resuscitation of Newborns Training Course

Particularly noteworthy accomplishments were adoption by the Kulakov Center of:

- Russian *Medical Eligibility Criteria for Contraceptive Use*, marking the first time that the Center had endorsed a policy on family planning—a groundbreaking development in an overtly pronatalist environment where political leaders see family planning as promoting population decline; and
- The *Guide on the Essentials of Evidence-Based Care*, effectively signaling the acceptance of the leadership in the MCH/RH community of EBM and their desire to adopt and promote it in their work.

Key to winning adoption of these policies was the way the project worked: with various working groups under the leadership of the Kulakov Center. Each group included not only national experts—who had traditionally developed national policy, based on their expert opinion—but also brought in health professionals from the regions, including experts from areas where prior USAID projects had worked on MCH/RH. When a topic was selected, the group reviewed the best international evidence compiled by project staff, along with Russian evidence, and participated actively in drafting the new policy and, later, advocating for its adoption. This participatory process built understanding of the new policy as well as developing a network of supporters.

Two of the Federal policies mentioned above, however, were developed without project input, in response to demands from regions that had seen the impact of evidence-based policies on the quality of care and health outcomes. They provide the clearest evidence that the Ministry and the regions have begun to internalize the approaches promoted by USAID projects over the years. Both the MOHSD’S 2010 order on *Sanitary-Epidemiological Requirements for Health Care Organizations* and its 2011 Methodological Letter on the *Organization of Maternal Health Care for Implementation of New Technologies* radically reshape the way Russian Federal policy regulates maternal and newborn care and infection prevention and control. Under these policies, hospitals providing maternity care nationwide will go from closed institutions providing highly medicalized care to settings where partners and family members are present and involved in delivery and newborn care; where mother and baby “room in” together; and where childbirth is treated as a natural event—to cite just a few of the major changes.

To ensure that providers and managers all over the country would be aware of these new policies, the project also worked with the Federal Centers and partner regions to advocate for and disseminate these (and other) evidence-based policies and practices around the country. Conferences, seminars, publications and websites were among the dissemination mechanisms used.

Resource Center Established

The Kulakov Center made significant progress in recognizing its role as a resource center for MCH professionals. As it became familiar with EBM, it expanded its library into a modern information center with access to electronic resources and the major international medical databases. And as Center staff also came to appreciate the value of incorporating practical skills into training, it opened a Simulation Training Center with a mock delivery room, newborn resuscitation department and obstetric anesthesiology and resuscitation department.

Federal Centers’ Service Provision is Changing

The project also sought to help the two partner Federal Centers—which see their role primarily as service providers at the highest level—introduce modern, evidence-based approaches to MCH/RH in their own hospitals. However progress was slow for a number of reasons, including the reluctance of Kulakov Center staff to participate in project trainings, depriving them of the many behavior-change strategies built into those trainings. The audits/assessments conducted by the project to assess the quality of perinatal care at

the two Centers illustrated the wide gap between the Centers' practices and international standards, with the Kulakov Center performing at 36% of standard and the Urals Institute at 34%.

Collaboration with the American College of Obstetricians and Gynecologists (ACOG) Succeeds

A very important element of the collaboration between the project and the Federal Centers—as well as other MCH/RH leaders—was the project's role in facilitating a flourishing relationship with the American College of Obstetricians and Gynecologists (ACOG), the leading group of professionals in the US providing health care for women.

The partnership started with a visit by Russian counterparts to the ACOG office in Washington, DC, in 2010, when ACOG generously provided the project and its Russian partners with free access to its web resources and gave the project permission to translate its guidelines and other key materials into Russian and disseminate them through the IFH web site. This proved enormously valuable for the development of clinical protocols, guidelines and training programs under the project. IFH also created a special section on its website with news and information about ACOG and the US-Russian collaboration.

At the heart of the collaboration with ACOG were professional exchanges between the US and Russia to strengthen the capacity of the Federal Centers and the regions:

- On three occasions, ACOG members volunteered their time to travel to Russia and provide lectures at conferences for key counterparts on the provision of obstetric and gynecological (ob-gyn) care and approaches to improving the quality of care and health outcomes in the US. The American visitors also had the opportunity to see Russian health facilities to better understand the realities of service provision in Russia and to engage with counterparts on important issues.
- There were five highly productive study tours in the other direction, for Russians to visit the US. Most of these visits were to ACOG's Annual Clinical Meetings, where the Russian delegates learned a lot on a variety of ob-gyn topics and were impressed by the sheer size of the conference (with about 6,000 participants), the breadth of the scientific program, the high level of discussion which was entirely evidence-based, practical skill-building sessions, and the fact that a nongovernmental organization arranged such a major event.
- The highlight of the collaboration, however, was the 2012 conference, *US – Russia Forum, Bilateral Collaboration to Improve Women's and Children's Health*, which drew 250 participants from 26 regions of the Russian Federation and from other countries. It featured 10 leading US experts with distinguished clinical, research and academic backgrounds who represented ACOG. All of them donated their time and several were sponsored by private sector partners. The conference addressed the prevention of maternal mortality, contraception, neonatal care, women's cancers, quality and safety in MCH care and other topics. It was a unique opportunity for leaders in the Russian MCH community to hear state-of-the-art US presentations and to engage in discussions with American counterparts.

The initiative with ACOG quickly became a successful activity under the MCH section of the health working group of the US-Russian Bilateral Presidential Commission, with study tours organized by the project featuring prominently in the Commission's 2010 report. By the end of the project, in 2012, the *US – Russia Forum* (see above) was held under the umbrella of the health working group of the Commission and the successful US-Russian links were formalized by the signing of a collaboration agreement between the Kulakov Center and ACOG at the conference, in the presence of participants and the media.

Task 2: Operationalization and Dissemination of Approved MCH Guidelines and Best Practices

Under this task, the project rolled out seven training courses to modernize MCH/RH practices on ob-gyn, neonatology and other MCH/RH topics in line with evidence-based guidelines in 10 partner regions*, with the assistance of the two Federal Centers. The partner regions included five new to the project and five that had participated in the prior project but had not yet received a full package of inputs. Each region signed an agreement with the project, committing itself to rolling out project interventions in the region, to cost-share, to help with organizational activities, etc. These agreements were designed to leverage project resources and to build sustainability for project interventions in partner regions.

Training and Follow-up Conducted

A total of 26 training courses were conducted for 869 participants on Antenatal Care, Breastfeeding, Emergency Obstetric Care, Family-Centered Maternity Care, Family Planning, Newborn Resuscitation and Pediatric Care—more than originally planned. The courses were based on international evidence on the provision of MCH/RH care and were at the heart of project efforts to modernize services and approaches. The results of pre- and post-tests administered at these trainings showed that they had a significant impact on participants' knowledge. Across all courses, participants' scores rose from an average of 43% at the pretest to an impressive 82% at posttest.

Most of the training courses conducted were updated versions of those from the prior project, but two new courses were developed and conducted.

- A five-day course on *Essential Newborn and Infant Care* took the project into new territory, by expanding its work beyond the early neonatal period to address the entire first year of life. It was designed for medical practitioners providing both inpatient and outpatient care to infants and addressed topics related to the major causes of infant mortality. It seeks to combat the perception that most infants are sick and need continuous medical care and medication and to reverse the situation where health workers consider themselves responsible for the health of the population in their catchment areas, placing primary responsibility for infants in the hands of parents.
- A new five-day course on *Initial Care and Resuscitation of Newborns* was designed for different medical specialties, as well as nurses and midwives, working in inpatient settings and seeks to reduce the leading causes of morbidity and mortality among newborns, such as asphyxia and infections. There was strong interest in this course from the regions, but time and funding constraints at the end of the project stood in the way of rolling it out beyond two regions.

All the project's courses were very practical and were generally held in health facilities, so practicum could be conducted on site. They used modern interactive teaching techniques, such as discussions, case studies, role plays and practice on models to ensure that participants came away with the actual skills needed on the job. They also brought together multi-disciplinary teams of providers, including midlevel staff, so as to foster a team approach to service provision. Moreover, to help providers make the paradigm shift in approach embodied in the project's training courses, formal training courses were only a starting point, with a series of follow-up visits and other support provided over an extended period after the course.

In addition to these core trainings, the project also provided 27 workshops and seminars on many different topics for 677 participants, contributing to these professionals' improved knowledge, attitudes and skills. These included trainings on regionalization of perinatal care, medical-social care for high-risk women, workshops to develop protocols and guidelines, adolescent reproductive health and other topics.

*Khanty-Mansiysk Autonomous Okrug (KHMAO), Kurgan, Leningrad, Chelyabinsk, Moscow City, Moscow Region, Sverdlovsk (Yekaterinburg), Tyumen, Vologda and Yamalo-Nenezkiy Autonomous Okrug (YANAO.)

Exchange Visits between Regions Foster Change

Another strategy to bring about change was to use every opportunity to help regions learn from each other. The project sponsored four exchange visits allowing visiting regions to see first-hand what modern care looks like in more advanced regions and to learn from another region's practical experience. Professional meetings and conferences, as well as working groups on clinical protocols/guidelines and training materials, were also valuable fora for exchanges. And experienced trainers from more mature regions helped conduct trainings in newer regions and served as technical resources for these regions.

Audits/Assessments Show Impact of Training and Follow-up

To assess the quality of care provided, and to help partners learn to monitor and improve care themselves, the project worked with partners to conduct audits/assessments, measuring performance against standards. Performance on neonatal care was strongest, with providers in regions that had been in the prior project performing relatively well, at 66-96% of standard, and those new to the project were not far behind, at 59-73% of standard. The family planning audit tool was new for the project and showed that the overall service delivery capacity of the facilities assessed stood at between 53% and 87% of standard. There were substantial differences between regions on almost all measures, with quality of service provision, for example, ranging from 69% in Chelyabinsk to 30% in Tyumen. The audit of perinatal care found that the Moscow Region Perinatal Center scored 32% of standard and a sample of health facilities in Kurgan Region scored 40%, pointing out the difficulty of implementing the sweeping changes advocated by the project.

"Unintended Results"

The project left a legacy of some informal networks in the regions that are expected to carry its work forward through professional development and networking. One group is a *Network of IFH Friends in the Regions*. This is a group of critical thinkers who stay connected with IFH and among themselves to keep up with new information, analyze it and consider its implications for services. A second group is a *Coordinators' Club* of the most active regional leaders and coordinators who discuss critical issues related to their professional work. This group is entirely independent of IFH and the project. The third group is very different because it is comprised of women's groups, most of them informal and internet-based, that wanted to create "*consumer groups*" to provide woman-to-woman support, to help women identify quality health care providers and to make providers more responsive to women's needs. To do that, they sought information and assistance from the project.

Task 3: Utilize experience on optimizing the delivery of MCH/RH care at regional (oblast) level to promote the GOR's three-tiered system of MCH care

The project worked to strengthen regionalization of perinatal care, supporting the MOHSD's agenda on this topic. The Ministry's decree on regionalization provided only the broad framework for regionalization—three levels of care, equipment required at the various levels and staffing—so project partners were open to more concrete guidance from the project.

Federal Guidelines and Regional Policies on Regionalization Adopted

One of the needs articulated by the regions was for guidelines on regionalization to give them a better understanding of what is involved, so this became a priority for the project. Project staff identified best practices from other countries and convened workshops to share these as well as the experience of regions from past projects that had made progress on regionalization. A working group then developed the guidelines over a period of many months and, in 2012, the *Guidelines on Regionalization of Perinatal Care* were finalized and endorsed as official policy by the Kulakov Center. Among the topics addressed—many of them new to Russia—are the rationale for regionalization; identification of a risk strategy, Counseling Centers at tertiary level facilities, transportation and staff training. The Guidelines also helped regional partners

develop and adopt a total of 26 policies on the regionalization of perinatal care.

Model Regionalized Systems of MCH/RH Care Emerging

Beyond the guidelines, the project sought to develop model regionalized systems of MCH/RH care, while recognizing that this is a long, complex and expensive undertaking that also entails overcoming some major political hurdles. Partner regions made good progress but were only able to make limited changes over the short life of IBP-MCH. Most of the work was conducted on a one-on-one basis with partner regions and through small workshops, with exchange visits to Tyumen Region producing valuable benefits from its experience in implementing regionalized perinatal care.

A key approach was to assist in the development of Emergency Care Counseling Centers—generally called Resuscitation Counseling Centers in Russia—as a critical element of an effective regionalized system of care. Established at the tertiary level, these centers support lower level facilities and coordinate transportation and preparation for care in emergency situations. Project staff helped partner regions understand the role of these centers, their scope of work and appropriate staffing and equipment needs. Unfortunately, by the end of the project, information about the establishment of these centers was only available from the five regions that had participated in the prior project—not from new ones—but four of these regions had established a total of seven Counseling Centers.

Regionalization Brings Results

While the project was not expecting to have concrete results of regionalization efforts from partner regions, Tyumen, which had been working for a number of years to build an effective system, was able to show some compelling results. There was a clear shift of higher risk deliveries away from the lowest level of the health system to higher levels, as shown by the percent of premature births managed at Level I (the lowest level) declining from 22% to 7.5% between 2005 and 2010, with corresponding increases in management of such cases at Levels II and III. As this shift took place, perinatal mortality in Level I facilities declined by 30% between 2007 and 2010 and maternal mortality dropped. While it would be misleading to claim that this is directly attributable to the regionalization of care, the results are encouraging.

Task 4: Improve MCH outcomes among high-risk women through improving access to appropriate family planning, prenatal and postnatal care, in 1-2 regions in the Urals Federal District

The project also sought to improve access to MCH care among high-risk women in two regions in order to improve MCH outcomes among hard-to-reach populations who often account for a significant share of maternal and infant morbidity and mortality and child abandonment. Like the work on regionalization of care, this work supported a priority of the MOHSD to provide better-coordinated medical and social assistance to vulnerable groups. This work was also at the heart of the project's efforts to improve services for vulnerable, high-risk women and adolescents, putting tools into place and, through meetings and training, building sensitivity among service providers about how to identify and serve these vulnerable groups more effectively.

“High-Risk” Women Defined

The first step was to work with counterparts to define high-risk women, with the definition agreed upon combining international definitions with that of a “difficult life situation” under Russian law. It included women in poverty; who are alone; unemployed; homeless; victims of family violence; seriously ill; with a disability; and/or dependent on alcohol and/or drugs.

Assessment of Current Practices Pinpoints Gaps

Then, to better understand the issues, project staff developed a tool to assess current practices in the provision of health and social services related to family planning, prenatal and postnatal care to high-risk

women and potential avenues of cooperation between health and social services as well as barriers to cooperation. The assessments, conducted in two regions, identified a number of important gaps. Most significantly, health care facilities did not assess women's social risk factors and were not aware of available social support for high-risk women; conversely, social workers did not assist high-risk women to get appropriate health care. In fact, leading specialists in the regional health and social services departments often met for the first time at a project event!

Algorithms on Medical and Social Care Developed

The assessment results guided development of a standardized questionnaire for use by health and social workers in women's and children's health care facilities and in social facilities, to help them assess women's social risk factors in the prenatal and postpartum period and to provide guidance in planning support for those in difficult life situations. Testing of the questionnaire validated its utility in identifying high-risk women—and also pointed to the types of support most often needed by these women. This included improved housing conditions, financial support, family planning counseling and free contraception as well as several other needs. It also highlighted the importance of working with health and social workers to create an environment where women would be treated with respect, as clients, and where they would feel “safe” and confident that their confidentiality would be respected.

This testing shaped the final *Algorithms on Medical and Social Care for High-Risk Women*, produced in 2012. They include 25 screening questions for health and social workers to use to identify risk factors, such as migrant status, family violence and smoking, with appropriate recommendations for medical-social care in each situation—including for women without any risk factors. Also included is guidance on use of the algorithms in a sensitive, non-judgmental manner that respects the client's confidentiality as well as resource materials with the most essential information on nutrition, prevention of child abandonment and family planning.

Medical and Social Workers Trained

A three-day training course was developed based on the algorithms, and a total of 98 ob-gyns, social care specialists, psychologists and midwives participated in such trainings. Participants not only learned to use the algorithms, but learned why it is important to link health and social services, the need to be sensitive to women's reluctance to discuss their social problems and the responsibility to treat women with respect to combat stigma and discrimination against high-risk women. Test scores among trainees rose from 81% at the pretest to 97% at the posttest, demonstrating the impact of the training.

The project's landmark work was presented at a number of professional meetings and conferences and published in professional journals, spreading information about this important new topic and a number of regions expressed strong interest in introducing the algorithms in their own settings.

Task 5: Sustainability Plan

Consistent with its name, the *Institutionalizing Best Practices in MCH* project sought to institutionalize and sustain best practices in MCH/RH in order to advance the project goal of decreasing maternal and infant morbidity and mortality in the areas where it worked. Efforts to build sustainability ran through all aspects of the project's work and were based on the provisions in the contract and the approved Sustainability Plan.

New Federal Policies will Sustain New Practices

In the Russian environment, where policy plays an especially large role and is rigorously enforced, providers are reluctant to embrace new practices that are not officially endorsed through policy. Thus the project's legacy of eight new evidence-based Federal policies on MCH/RH that support modern practices throughout the country on contraception, premature birth, newborn resuscitation, infection prevention and control and other critically important topics is a huge step to sustainability. In addition, the wide dissemination of new

policies, undertaken jointly with the Kulakov Center, undoubtedly contributed to their adoption in clinical practice all over the country.

The project's work to build understanding and support for EBM through its working groups and at the highest levels of the MCH system was one of its most important contributions to sustainability. So long as the medical leadership relies on international projects to provide that evidence, MCH care will not keep pace with the rapid progress taking place around the globe. The single most crucial skill to transfer to counterparts in policy-making positions to shape clinical policy and practice in the long run is how to find, evaluate and use the best evidence. The Kulakov Center's endorsement of the *Guide on the Essentials of Evidence-Based Care* was extremely important, signaling the acceptance of the leadership in the MCH/RH community of EBM and their desire to adopt and promote it in their work. However, much work remains to build capacity to actually use EBM.

Capacity-Building to Make Change Beyond the Project's Life

The project placed a strong emphasis on building the capacity of Federal and regional leaders to carry forward the new international approaches introduced through the project. From the beginning, these key partners were involved in all details of implementation so as to build their capacity to expand and strengthen the project's work all over their territories and after the end of the project. The project helped them learn about new program management approaches, most importantly policy-making using EBM; modern training techniques; supportive supervision; use of various quality improvement and monitoring tools; and other topics.

At the regional level and below, counterparts were selected among senior officials in regional and city health departments, academic institutions, professional associations and heads of regional or municipal facilities that set the trends in their regions and/or had oversight responsibility for other health facilities. The project made these counterparts' responsibilities very clear from the beginning, through agreements stipulating that they would disseminate project practices in their regions. Then the project built these leaders' understanding and commitment to best practices through working groups and workshops and by giving them the tools to advocate for the best practices and to monitor their implementation. The broad geographic reach achieved by the project, as well as the encouraging assessment results, attest to the success of this strategy.

The project also developed a cadre of skilled trainers, including eight in the Federal Centers, to enable the Centers and partner regions to support and roll out the new practices after project assistance ends. In addition, best practices were institutionalized in medical, nursing and midwifery schools to ensure that future cohorts of health professionals will embark on their medical careers equipped with the best information and skills; and that those already working will receive up-to-date information through continuing medical education courses.

Investment in MCH/RH Promoted

To encourage partners to invest resources in improving MCH/RH care the project's agreements with partners required them to make contributions in cash and in kind in return for project assistance. They made a broad range of contributions, such as upgrading health facilities to provide individual rooms for women; purchasing equipment; and procuring free drugs and contraceptives for vulnerable populations. The groundwork was laid for partners to invest in further improvements in the future.

Information Disseminated to Advocate for Change

Project staff's experience in Russia over many years showed that broad dissemination of evidence-based MCH/RH policies and best practices is crucial to create a climate of understanding and acceptability, to build demand for the new approaches and to speed up their adoption. The project conducted numerous conferences and seminars—and supported partners in organizing many others—where best practices and the

latest policies were disseminated to broad audiences in project regions and all over the Russian Federation. Key events were a two-part mid-term conference, organized in collaboration with the Federal Centers, to disseminate international approaches and best practices, and the high-profile end-of-project conference, the *US – Russia Forum*, with the opportunity to hear from 10 US speakers.

Other dissemination mechanisms included the IFH bulletin, *Family Health*; the IFH website that drew an ever-increasing audience; 14 articles written by staff in professional journals; and mass media coverage.

Institute for Family Health can Spread Best Practices in the Future

Last, but by no means least, IFH itself, being a Russian nongovernmental organization (NGO), was a central part of the sustainability strategy to spread best practices in MCH/RH beyond the life of the project and to leverage funds from a variety of sources. During the period of the project, IFH signed five contracts with Russian local authorities, including two on MCH that effectively leveraged funds for activities that expanded the reach of the project's work and others related to HIV prevention, also an important element of MCH/RH.

Selected Project Results

- Maternal mortality declined by 9.7% in project regions from 19.6 maternal deaths per 100,000 live births to 17.7 between 2007 and 2010.
- The infant mortality rate in project regions fell more sharply than the national rate—by almost 29% (from a rate of 8.3 infant deaths per 1,000 live births to 5.9) in the same time period.
- The abortion rate fell 22% in project regions (from 37.8 to 29.5 per 1,000 women of reproductive age) in 2008-2010.
- Since 2007, the number of FP/RH counseling visits reported by project-assisted facilities more than doubled across the five “old” project regions from 2007 to 2010, with an increase of 115%.
- The perinatal mortality rate (the number of deaths and stillbirths in the first week of life per 1,000 live births) decreased by 17% in IBP-MCH regions, from 8.3 to 6.9 in 2007-2010.
- The early neonatal mortality rate (deaths in first 28 days of life per 1,000 live births) decreased 26.3%, from 2.8 to 2.0, in partner regions between 2007 and 2010.
- A total of 967 medical and paramedical practitioners, including social service practitioners,(915 women and 52 men) were trained in evidence-based MCH/RH clinical guidelines across the IBP-MCH regions.

Lessons Learned and Solutions for Resolving Constraints

Most of the lessons learned come from working with the Federal Centers, which was a major new priority area for project staff, while there are fewer lessons from working with the regions, where project approaches had already been fine-tuned over a decade. There are also some initial conclusions from the project's work on regionalization and on medical-social care, but more time and experience would be needed to draw firm conclusions on these two topics.

- Enormous progress was made in adoption of evidence-based federal policies, but more work is needed to build capacity on EBM, so counterparts can modernize policy and practice without support from international projects.
- The Kulakov Center has the potential to provide leadership for the MCH field, given considerable continued technical assistance. Developing that leadership role in other Federal Centers will be more difficult.
- Changing clinical practices at the Federal Centers will take time and substantial technical assistance.

- There are other leaders in MCH around the country who are interested in bringing about change and who could potentially play leadership roles: MCH research institutes, regional policy makers, medical schools and other opinion-leaders.
- The collaboration with ACOG was highly productive and merits continuation. A program of exchange visits could be maintained at modest cost and would bring continued benefits.
- Family planning needs to be better mainstreamed into the broader health system to improve access to services. The recent Russia Longitudinal Monitoring Survey (RLMS) also suggests that more attention should be given to postpartum and postabortion counseling on family planning.
- Work on introducing evidence-based care for infants in the first year of life got off to a good start, but needs more time to build momentum.
- Work is needed to combat the climate of secrecy that surrounds health statistics in Russia and the tendency to present data that are politically correct. Data-based decision-making remains to take root.
- The regionalization of perinatal care is moving forward rapidly. However, some fundamental problems need to be tackled before effective systems of regionalization can be put into place, e.g. the dearth of adequately trained physicians and other health professionals for the tertiary level.
- Strengthening the linkages between medical and social care is a promising avenue to improve services for high-risk women during pregnancy and after delivery.

How the IBP-MCH Project Supported USAID's Global Health Initiative (GHI), BEST* and USAID FORWARD

The *Institutionalizing Best Practices in Maternal & Child Health* (IBP-MCH) project was designed to improve maternal and infant health outcomes, with its work centering on institutionalizing best practices in Russian policy and practice. Consistent with the *USAID FORWARD* initiative, John Snow Inc (JSI), the implementing organization, contracted with a Russian NGO, the Institute for Family Health (IFH), to take the lead in project implementation, enhancing the project's credibility in the Russian environment as well as building sustainability. In addition, the Ministry of Health and Social Development's (MOHSD) lead organization on maternal and child health (MCH) issues, the Kulakov Center, was a close and critical partner in modernizing federal policy on MCH and family planning/reproductive health (FP/RH) as well as in promoting international approaches throughout the country. Project staff were seen as valuable partners for MOHSD in improving MCH and reproductive health in the Russian Federation.

In line with GHI and BEST*, the project's implementation approaches addressed the principal causes of mortality and morbidity and promoted evidence-based interventions to address those causes. Scale-up was built in from the beginning through various strategies, including collaboration agreements with partner regions that provided for them to scale-up, at their own expense, best practices pioneered by the project in carefully selected facilities in each region. Project monitoring tools ensured quality during scale-up.

The project's approaches showed positive results in terms of key health outcomes in project regions:

- The maternal mortality ratio declined by almost 10%, from 19.6/100,000 live births in 2007 to 17.7 in 2010;
- The infant mortality rate fell by almost 29%, from 8.3 infant deaths/1,000 live births in 2007 to 5.9 in 2010;
- The abortion rate declined 22% from 37.8 abortions per 1,000 women aged 15-49 in 2008 to 29.5 in 2010.

While aiming to improve health outcomes, project staff recognized that to institutionalize those changes, and to strengthen the management of MCH services, the project also needed to work to improve the health system. Key activities included:

- Strengthening MCH leadership at the national, Federal District and regional levels by working with the MOHSD, partner Federal Districts and regions to adopt evidence-based policies and then support their implementation at scale;
- Improving the integration of family planning and MCH care by integrating family planning into existing MCH services; and better integrating maternal and infant care by training multi-disciplinary teams of providers to establish networks of care within and between health facilities to provide seamless care for clients;
- Building a system of regionalized MCH care to enhance the chances of survival for mothers and infants by establishing a three-tiered system of care, with expensive equipment and highly specialized medical expertise concentrated in a limited number of health facilities, and setting up systems to channel women and infants to the appropriate level of care;
- Improving resource-use by reducing the over-medicalization of care that characterized the Soviet health system as a result of not following Evidence-Based Medicine (EBM);
- Promoting objective use of data to monitor and evaluate MCH services and outcomes.

The project brought a culture of knowledge-sharing and evaluation to its Russian partners, as envisioned in *USAID FORWARD*. Its reliance on EBM as the foundation for effective policies and practices was crucial to improving health outcomes; its data-driven approaches to evaluate and improve quality of care through assessments/audits were something new in a Russian environment; its emphasis on participatory decision-making was crucial to acceptance of new approaches; and its dissemination of Russian achievements and results in improving MCH/RH care and adopting new evidence-based policies built momentum for change around the country.

* *Best Practices at Scale in the Home, Community and Facilities* is an action plan for smart integrated programming in family planning, maternal and child health and nutrition under USAID's Global Health Initiative.

Background and Introduction

Structure of this Report

This Final Report on the USAID *Institutionalizing Best Practices in Maternal and Child Health* (IBP-MCH) project responds to the contractual requirement for a report that “highlights accomplishments against the implementation plan, gives the status of the expected results, addresses lessons learned during implementation, and suggests solutions for resolving constraints identified” as well as addressing and demonstrating “how Russian partners will continue activities beyond the completion of the project to ensure project sustainability.”

The structure of this document reflects those priorities:

- It starts with an *introduction*, including some background on the environment in which the project worked;
- The bulk of the report is devoted to summarizing *project accomplishments*, including project sustainability;
- There is a concise overview of project *management, monitoring and evaluation*;
- There is a section on the *status of expected results*;
- At the end are *lessons learned and solutions for resolving constraints*.

Annexes are provided with more detailed information and data.

Legacy of the Soviet Health System

Strengthening health care in the Russian Federation and other countries of the former Soviet Union presents very different challenges from working in most other countries.

The Soviet health system was entirely financed and operated by the government and promised universal access to free care. There was widespread infrastructure and an abundance of health workers—most of them working in narrow specialties—providing excellent access to care. However, the system was also characterized by central planning and control and heavy regulation. Health workers adhered rigidly to regulations and health facilities and health authorities were required to meet targets. Initiative at the individual or institutional level was stifled.

Soviet medical science developed in isolation from the mainstream of international scientific information. Even today, many medical practices in the Russian Federation remain informed by a “unique Soviet” approach or represent Western standards of 50 or more years ago, and there are numerous clinical diagnoses unknown in the rest of the world. A widespread lack of knowledge of clinical epidemiology and minimal access to the

Internet and international journals and publications, coupled with limited English language skills, kept health professionals from acquiring information about international standards, research and approaches. Professional cultural norms were governed by a closed system of decision-making at the very top of the system, an absence of open discussion and a rigid management culture averse to decentralization and a team approach. Medical education, too, was antiquated and emphasized theoretical information at the expense of practical skills.

Clients were passive recipients of services, were given little information about their health, and were expected to follow doctors’ orders without question. In effect, the system was more responsive to the wants and directives of government than to the needs of clients.

In this environment, virtually all women received prenatal care and delivered in a hospital. Yet key maternal and child health (MCH) indicators—most notably maternal and infant mortality rates—lagged behind those of Western Europe and even behind some less developed countries, calling into question the content of care. Mortality related to direct obstetrical causes and abortion were major factors in the elevated levels of maternal mortality.

Most women and children were considered to be sick and received highly medicalized care. Women were often hospitalized during the prenatal period, they had to make numerous prenatal visits, even during a healthy pregnancy; they received many medications, tests, scans and specialist referrals; and they generally spent over a week in the hospital for delivery. Care for infants and children was similarly over-medicalized. In addition, there were strict regulations on infection prevention and control that meant that maternity hospitals were closed to family members, women were separated from their newborns during their hospital stay, women and infants had to wear sterile hospital garb, and hospitals were regularly closed for disinfection and “rest.”

Thus, a key challenge was to demedicalize care. This, in turn, called for introducing evidence-based medicine (EBM) to demonstrate that better results could be achieved with less medical approaches. However, EBM was an alien concept to virtually all health professionals and there was widespread skepticism that studies of sub-national population groups could provide sufficiently reliable evidence for decision-making. The complex web of laws and regulations also presented a major challenge because changing providers’ practices meant changing a whole array of regulations. Failure to capture one of the policy changes needed to allow providers to practice according to new, evidence-based standards exposed providers to punishment by one of the various supervisory bodies and inspection teams that governed—and continue to govern—their professional lives.

Abortion was legal and widely available, with no stigma attached to its use, and women obtained numerous abortions over their lifetimes. But the techniques used were often antiquated, accounting for high levels of deaths and complications. Modern contraception—with the exception of the IUD—was virtually unknown and there was widespread skepticism, even among obstetrician-gynecologists (ob-gyns), about its safety and effectiveness, especially the hormonal methods. Doctors provided IUDs to women who faced medical or social risks if they should become pregnant, but the concept of couples choosing to use contraception or of health workers providing counseling to help them decide which method to use was unknown. Complicating the task of making contraception more widely available was a sharp decline in the population of the Russian Federation, from 148 million in 1992 to an estimated 142 million now. In response, the Government adopted strong pronatalist policies, including payments to women for childbearing, and policy makers fear that making contraception more available will accelerate the population decline.

Considerable progress has been made in the last 20 years and health indicators for the Russian Federation—including maternal and infant mortality rates and use of modern contraception—are improving steadily, although they still lag behind Europe.

The health system, too, has undergone changes during this time. An initial shift to a more decentralized system, where regions had considerably more autonomy, gave way, in 2000, to some reassertion of central control. “Federal Districts” were created to oversee and facilitate the work of federal agencies across the vast territory of Russia. Under the umbrella of the Federal Districts, there are five federal scientific research centers—often referred to as Federal Centers or research institutes—in the field of MCH: in Moscow, St. Petersburg, Ivanovo, Rostov-on-Don and Yekaterinburg. These Federal Centers are responsible for developing guidelines and policy for the Ministry of Health and Social Development (MOHSD) at the federal and regional levels and are intended to serve as methodological and organizational centers for the regions in their respective Federal Districts.

These were the kinds of challenges that the U.S. Agency for International Development (USAID) took on in the Russian Federation, when it began to support work on family planning/reproductive health (RH) and MCH. The Ministry of Health (now the MOHSD) was preoccupied at the time with the short-fall in health financing since the end of the Soviet Union and there was little interest in international experience. So USAID focused its interventions on regions that were open to change. Gradually, the number of regions recognizing the value of more modern approaches and adopting them grew—but the

Ministry remained closed to these ideas. It wasn't until the start of the current project that MCH leadership at the MOHSD changed and the door was opened to collaboration at the national level.

Introduction to the project

Since 1999, USAID has supported four projects to improve maternal and child health and strengthen health systems in the Russian Federation:

- The *Women and Infants' Health Project* (WIN) (June 1999 – September 2003) worked in two regions*, pilot-testing new approaches to integrated family planning and MCH programming;
- The *Maternal and Child Health Initiative* (MCHI) (October 2003 - September 2006) was designed to scale up WIN's successes, working in 16 regions, with a focus on urban areas;
- The *Maternal and Child Health Initiative II* (MCHI II) (October 2006 - December 2009) added an additional 10 regions, while expanding the work done in 10 "old" regions, and reached beyond urban areas into rural areas;
- The *Institutionalizing Best Practices in MCH* (IBP-MCH) project (October 2008 to September 2012) continued the work at the regional level—in 5 new regions and 5 "old" ones—but placed a new emphasis on collaboration with two Federal Districts (see page 19 for an explanation of Federal Districts), to strengthen their capacity to deliver, disseminate and advocate for best practices in MCH and family planning/reproductive health at the regional and federal level.

John Snow Inc (JSI) and the Institute for Family Health (IFH) were close partners in the implementation of these projects. JSI managed the first two, and, in response to a call for the identification of an indigenous Russian "legacy" organization under the first MCHI project, in 2006, a group of former JSI staff established IFH, a woman-owned nongovernmental public health research and consulting organization. IFH managed the MCHI II project, but in challenging times for NGOs, in the IBP-MCH project, it became a subcontractor to JSI—albeit one with a high level of responsibility and visibility in project implementation.

The goal of the IBP-MCH project was to decrease maternal and infant morbidity and mortality in target Federal Districts through five intermediate results:

- MCH best practices based on newly-developed MCH protocols adopted by the MOHSD related to major causes of maternal and infant morbidity and mortality operationalized by key partners in target Federal Districts and corresponding regions. (Note that this language is from the contract modification in March 2010. In the original contract, this result read: MCH best practices related to major causes of maternal and infant morbidity and mortality adopted by target Federal Districts and corresponding regions;)
- Decreased abortion rates in regions within the selected Federal Districts;
- Increased modern contraceptive prevalence among women of reproductive age within the selected Federal Districts;
- Strengthened capacity of key federal and regional entities to deliver, disseminate and advocate for best practices in MCH and reproductive health at the regional and federal level; and
- Strengthened capacity of health care providers including obstetrician-gynecologists, pediatricians, family doctors, midwives, nurses, including in rural areas, to deliver quality reproductive health and MCH services and counseling.

* For purposes of simplicity, the term "region" is used in this report to include all administrative divisions, including *oblasts*, *krais*, *okrugs*, autonomous republics and independent cities.

These expected results were to be achieved through five explicit Tasks which were modified during the life of the project, as can be seen in Table 1 below. Each of these tasks included one or more “deliverables” to be presented to USAID for approval. A list of deliverables is included as Annex 1.

Table 1: Tasks Established for the IBP-MCH Project under the Original and Modified Contract

	Original Contract	Modified Contract (effective March 2010)
Task 1	Establish Partnership to Create Federal District-Level Hub on MCH Best Practices in two Federal Districts	Establish Partnership with Federal-Level Centers to Support their Leadership Role in Operationalizing MCH Best Practices in two Federal Districts
Task 2	Dissemination of Basic Package of MCH Protocols and Guidelines	Operationalization and Dissemination of Approved MCH Guidelines and Best Practices
Task 3	Disseminate recommendations on optimizing delivery of MCH/RH care at regional (oblast) level	Utilize experience on optimizing the delivery of MCH/RH care at regional (oblast) level to promote the GOR’s three-tiered system of MCH care
Task 4	Develop an integrated model of family planning and social services in up to three regions within the two selected Federal Districts	Improve MCH outcomes among high-risk women through improving access to appropriate family planning, prenatal and postnatal care, in 1-2 regions in the Urals Federal District
Task 5	Sustainability Plan	Sustainability Plan

As implied by the shift in tasks presented in Table 1, the project had two distinct phases:

- The first centered on the scope of work outlined in the original contract and lasted almost 18 months, although there was very limited progress for reasons outlined below.
- The second phase started in March 2010, when JSI’s contract was modified with a revised scope of work, and ran until September 2012.

The delays at the beginning of the project were due to changes in leadership and policy at the MOHSD that led USAID and the Ministry to review project priorities. While this process was under way, the Mission asked JSI not to move forward with full contract implementation and, by June 2009, JSI notified the USAID Contracting Officer of delayed implementation of its contractual obligations. Full start-up of activities took place in March 2010 and, since that was already the mid-point of the project, the project was later extended from three years to four. Most of the activity reported here took place in the two-and-a-half years of this second phase of the project.

While USAID was engaged in discussions with MOHSD about the project, project staff, in consultation with USAID, provided the new team at MOHSD with information about past project activities and copies of materials developed under those projects. These were forwarded by the Ministry to the Federal Center for Obstetrics, Gynecology and Perinatology named for V. Kulakov—hereafter referred to in this report as the Kulakov Center—which is the Ministry’s lead agency on MCH issues, for review. While there was never any formal outcome of those reviews, they led to informal discussions between senior staff at the Kulakov Center and project staff, paving the way for collaboration under the progressive leadership of the Center’s new Director, Dr. Gennady T. Sukhih.

The March 2010 contract modification contained a number of changes, but the most significant was to emphasize collaboration with Federal District entities even more strongly than in the original scope of

work and to call for dissemination and operationalization of newly developed MCH protocols (*poryadok*) under review by the MOHSD at that time. The modified scope of work also reduced the project’s technical focus areas from five to three, as can be seen in Table 2. However, while it removed the integration of family planning with prevention of sexually transmitted infections (STIs) and prevention and treatment of HIV as well as the integration of family planning into social services from the focus areas, it left them to be covered, most significantly under Task 4.

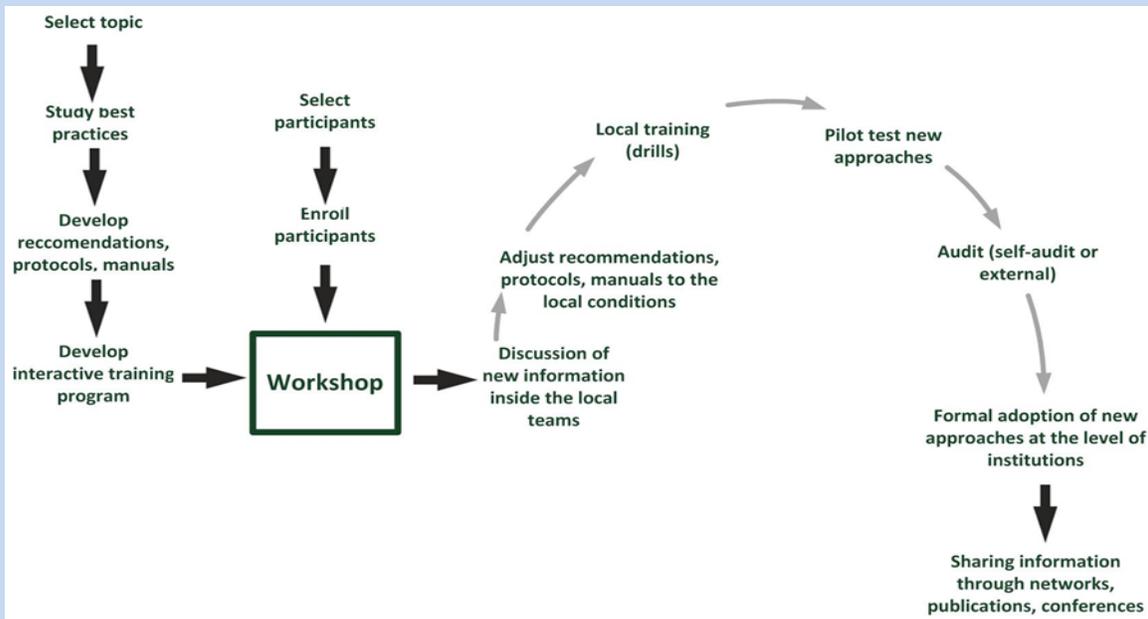
Table 2: IBP-MCH Project Technical Focus Areas under the Original and Modified Contract

Original Contract	Modified Contract (effective March 2010)
<ul style="list-style-type: none"> • Family planning • Maternal and infant health • Integration of family planning with STI/HIV prevention and treatment • Integration of family planning into social services • Effective organization of delivery of MCH care 	<ul style="list-style-type: none"> • Family planning • Maternal and infant health • Effective organization of delivery of MCH care

IBP-MCH Model for Introducing and Institutionalizing Evidence-Based Best Practices *

The project's main focus was on the introduction and institutionalization of evidence-based best practices already proven to be effective in reducing maternal and infant mortality and morbidity and improving reproductive health. The process used was the following:

- *A topic was selected*—an area of practice that needed improvement (e.g. neonatal resuscitation.) This was usually done in consultation with leading Russian research institutions and partner regions.
- The IFH team then *studied international best practices* on this topic.
- A working group of leading Russian specialists met to review the international evidence and to *develop recommendations, clinical protocols/guidelines or manuals* to improve providers' practices.
- IFH developed an *interactive training program* to introduce the new evidence-based best practices. These were usually five-day workshops designed not only to convey knowledge but also to provide opportunities for participants to practice the new skills under the watchful eyes of the trainers
Training participants were carefully selected, with the assistance of regional authorities. Criteria emphasized participants' interest in new approaches, their opportunities to implement them, and their potential to pass them on to others in the course of their work.
At the end of each workshop, participants developed their own action plans. They usually *presented the new information* to their colleagues at the health facility and *engaged them in discussion*.
- Each institution *adjusted the new practices* to its own context and *trained its staff*.
- Based on the training, the new *approach was pilot-tested* and the effectiveness of implementation was *audited/assessed* by local staff or outside experts using the project's audit/assessment tools.
- The organization *formally adopted* the new practice in the form of a protocol.
- Since participants were connected through an informal IFH network, they *shared information* with colleagues, made presentations at conferences, published articles in specialized journals and/or trained others in their region. This contributed to spreading the new practice.



* Adapted from: *Final Performance Evaluation, USAID Maternal and Child Health Project, Evaluation Report*, International Business & Technical Consultants, Vienna, Virginia, for USAID/Russia, June 13, 2012

Project Accomplishments

Task 1: Partnerships with Federal District Centers/Institutes

Under Task 1 (in the revised scope of work), the project was charged with establishing partnerships with two Federal Centers, the Kulakov Federal Center on Obstetrics, Gynecology and Perinatology (the Kulakov Center) in Moscow, which is the MOHSD's lead agency on MCH; and the Federal State Research Institute for Maternity and Infancy in Yekaterinburg (the Urals Institute.) The purpose of the partnerships was to help the Centers disseminate and operationalize evidence-based clinical guidelines and best practices in 10 project regions and foster sustainability of evidence-based practices in MCH.

Key Accomplishments—Task 1

- Close partnerships were developed with two Federal Centers, particularly the Kulakov Center, which is the MOHSD's lead agency on MCH;
- This collaboration led to the adoption of eight new evidence-based policy documents (see Table 12) at the federal level, effectively institutionalizing modern, evidence-based practices in maternal and newborn care and family planning/reproductive health for the entire Russian Federation. This modern policy framework will facilitate the task of spreading best practices around the country;
- Landmark accomplishments were adoption by the Kulakov Center of:
 - The *Guide on the Essentials of Evidence-Based Care*, effectively recognizing the value of Evidence-Based Medicine; and
 - The *Russian Medical Eligibility Criteria for Contraceptive Use*, bringing the Center into the politically sensitive field of family planning/reproductive health for the first time;
- Development of *Adolescent Reproductive Health Guidelines*;
- The Kulakov Center opened a Simulation Training Center and began to offer practical skills training for providers;
- The project facilitated formal and informal exchanges between the American College of Obstetricians and Gynecologists (ACOG) and leaders in the Russian MCH community. This culminated in a major conference, *US-Russia Forum: Bilateral Collaboration to Improve Women's and Children's Health*, in 2012 and the signing of a collaboration agreement between ACOG and the Kulakov Center, formalizing their close relationship.

Task 1 also envisioned exchanges between international experts from the American College of Obstetricians and Gynecologists (ACOG) and staff from the Federal Centers as a mechanism for capacity-building.

The approved implementation plan for the revised scope of work articulated the project's overall approach to working with the Federal Centers, adopting a two-fold emphasis. First, working *within* the Centers to strengthen their capacity to deliver, disseminate, advocate for, and ensure the quality of up-to-date MCH/RH services/practices and policies. And second, working hand-in-hand with them *in the regions* to implement and disseminate best policies and practices. Implementing this two pronged approach, the project focused on the following areas:

- Promotion of evidence-based care;
- Implementation of best practices;
- Development of training and resource capacities of the two Federal Centers;
- Collaboration with ACOG.

This task represented a new focus area compared to prior projects and was an area of major accomplishment, as can be seen in the text box at left. The modern policy framework put into place at the federal level for MCH/family planning/reproductive health through the project promises a substantial degree of sustainability for the project's work.

Building links with two partner Federal Centers

Project staff began working with the Kulakov Center in 2003 in an effort to involve its senior staff in project activities and to win political

support for the project's work. After the death of the former Director, Vladimir Kulakov, in 2007, the MOH appointed Dr. Gennady T. Sukhih as Director, and the MCHI II team developed links with him and

his newly appointed team. Starting in 2008, project staff were invited to take part in all significant events conducted by the Center, opening the door to effective collaboration under the new project. Project staff had also worked with the Urals Institute since 2004, gradually building their support for modern, evidence-based approaches to MCH/RH care.

Early in 2009, with a new mandate under IBP-MCH to work with the Federal Centers, a series of meetings were organized with the Centers, regional health authorities and USAID to identify which Federal Centers should participate in the new project. As a result, the Kulakov Center and the Urals Institute were chosen as partners for project implementation. Memoranda of Understanding were drafted and working groups established in both Federal Centers to collaborate with the project and coordinate activities. During the period when project activities were largely suspended, project staff continued to meet Kulakov Center representatives, building relationships, engaging in dialogue on a variety of topics and, at the request of Dr. Sukhih, advising on protocols under development at the Center. By late 2009, project staff were meeting with counterparts at the Kulakov Center on a weekly basis—in sessions such as the Center’s “journal club” and “Scientific Thursdays,” discussing various technical issues informally and making presentations on results and materials from the most significant professional journals and events. Project staff used these meetings to review and discuss international clinical protocols, review project training materials, help prepare Kulakov Center conferences and other matters. Numerous topics were discussed, including the management of normal labor and delivery, care for the newborn in the delivery room and on the postpartum ward, premature delivery and others.

In March 2010, as soon as the new scope of work for the project was finalized, the collaboration with both Centers was formalized through agreements outlining the technical areas of collaboration and the support to be provided by the project and the partners. Project staff began attending all meetings and conferences held by the Kulakov Center as well as all conferences of the Urals Institute. Soon they were invited to every significant national conference or major event on MCH/RH issues as presenters, with prime slots in plenary sessions and workshops. The Kulakov Center staff also began facilitating work with the Russian Society of Obstetricians and Gynecologists, which had long been challenging. For the first time, the MOHSD showed genuine interest in the project’s work and the highly visible collaboration with the Ministry and the influential Kulakov Center, along with their public recognition of the project’s contribution, conferred great credibility on IFH as an organization and on project staff.

Of the two partner Federal Centers, the Kulakov Center was the major focus because, in addition to its responsibility for the regions in Russia’s Central Federal District, it is the lead institution under the MOHSD responsible for MCH/RH nationwide. Moreover, its director, Dr. Sukhih, was eager to collaborate with the project and his senior staff exercised great influence in their capacities as the Russian Federation’s Head Ob-Gyn, Head Neonatologist, Head Reproductive Health Specialist for Youth, and heads of other technical areas.

The influence of the Urals Institute is more limited, since its jurisdiction, while large, covers only six regions. However, the Institute’s Director, Dr. Vladislav Kovalyov, participated in project activities as a member of various working groups, developing protocols and guidelines. And the Deputy Director, Dr. Nadezhda Bashmakova, who also served as Head Ob-Gyn for the Urals District, actively supported and promoted project activities at the national and district levels. The Urals Institute also invited project staff when they conducted national and regional events. However, it never developed a cadre of senior staff interested in implementing the new practices and its political influence, even in Yekaterinburg City and surrounding Sverdlovsk Region, where it is located, was strictly limited. The reality was that leading maternity hospitals serving Yekaterinburg City and Sverdlovsk Region proved more progressive than the Institute and moved more quickly.

Promotion of Evidence-Based Care

In February 2010, as the revised IBP-MCH scope of work was being finalized, it was decided to organize a Multi-Partners Working Group (MPWG) headed by Dr. Sukhih and coordinated by the project to develop and update guidelines and other project materials. From that point, the MPWG evolved into a highly effective group working on MCH/RH policy and it soon expanded to include several thematic subgroups, enabling it to address a number of different topics simultaneously (see text box below.) As a result of the MPWG' work and other initiatives, eight new evidence-based policy documents were adopted as policy for the entire Russian Federation. (See Table 12 for a list of policies developed with project assistance.)

Guide on the Essentials of Evidence-Based Care

In tackling its policy agenda, the project faced the major challenge of increasing the understanding of the Russian ob-gyn community about Evidence-Based Medicine (EBM) as the foundation of modern medical practice and encouraging doctors and managers to adopt evidence-based protocols and practices, instead of relying on expert opinion. Although in the past, the Federal Centers had shown little interest in EBM, by the time the IBP-MCH project started, the two partner Centers were open to learning more about EBM and how to use it to improve MCH and RH policy and practice.

At the Centers' request, the first task taken on by the MPWG was to develop a guide on EBM for use by medical practitioners and managers to support dissemination of EBM in everyday practice and in medical education. After a lengthy process of meetings and consultations, with MPWG members drafting sections of the document, the *Guide on the Essentials of Evidence-Based Care* was finalized, endorsed by the Kulakov Center, printed in 2011, and distributed to health professionals, academics and policy makers through conferences and workshops. The *Guide* explained the rationale for EBM, with a special focus on MCH/RH, its importance and how to use it in practice. It was used and promoted at all IBP-MCH events as an effective tool to implement evidence-based practices in all aspects of MCH care.

As a result of working on this guide, Dr. Sukhih took on the task of promoting EBM in many different fora, such as the major annual All-Russian Scientific Forum *Mother and Child*, giving EBM credibility and visibility as a critical topic for the Russian MCH community. And he recognized the project as a pioneer in developing evidence-based protocols and guidelines for Russia and as a key partner in promoting EBM in MCH/RH.

Multi-Partners Working Group

A highly successful approach adopted by the project was to work with a Multi-Partners Working Group (MPWG) to develop modern, evidence-based federal policies. Establishment of a working group comprised not only of national experts but also of health professionals from the regions was a sharp departure from past practice, when only top national experts were involved in policy development. The MPWG brought together experts from the Kulakov Center, senior staff from the Urals Institute, leaders from key Russian MCH/RH institutions, experts from regions where prior USAID projects had worked on MCH/RH, as well as project staff.

The project facilitated the policy development process by providing the group with the best available international evidence, translated into Russian, and ensuring that partners from past USAID projects were included in the group to allow the MPWG to learn about *Russian* evidence and experience in implementing international approaches. Using evidence about best practices as the foundation for policy was something very new for federal-level policy makers. The project worked with MPWG members to actually *draft* sections of policies under development—and not only to review project drafts—so as to build their understanding of EBM and their support for the final policy.

The process of reviewing the evidence and participating in drafting policies was critical to building support for adoption of MPWG-developed documents as official federal policy. It also promoted sustainability by building a cadre of high-level supporters for the project's work—and more importantly, for evidence-based policy-making.

Protocol on Premature Birth

Building on the successful work developing the *Guide on the Essentials of Evidence-Based Care*, the Federal Centers and the project agreed to work with the MPWG to develop and update clinical guidelines and protocols. The MPWG choose a *Protocol on Premature Birth* as the first priority. IBP-MCH presented its own protocol as a model and reviewed the evidence behind the document. After several months of discussion and some small changes, the protocol was finalized, endorsed by the Kulakov Center in 2010 and then by the MOHSD in 2011, and published in the professional journal *Obstetrics and Gynecology* (#4, 2011.) This was the first Russian protocol on the topic and presented only evidence-based practices demonstrated to increase the effectiveness and efficacy of care. Prior to that, several medical schools had developed clinical recommendations, but they were not evidence-based and often contradicted each other on key topics, such as appropriate medications and indications for hospitalization.

National Medical Eligibility Criteria for Contraceptive Use

It wasn't long until project staff were able to broach the sensitive topic of family planning with Kulakov Center leaders. In a highly significant development, an MPWG working group, including 42 nationally and internationally recognized specialists in obstetrics, gynecology, breast health, oncology, endocrinology, andrology, sexology and public health, developed Russian eligibility criteria for contraceptive use, including the needs of socially vulnerable populations like adolescents and women living with HIV. The project began by preparing a package of evidence-based information, drawing heavily on the World Health Organization's eligibility criteria and those of the US Centers for Disease Control and Prevention, ACOG and the Royal College of Obstetrician-Gynecologists. The working group's document was discussed at a Kulakov Center conference, placed on the IFH website for comment and then endorsed by the Russian Society of Obstetricians and Gynecologists as well as the Russian Contraception Society, before being endorsed by the Kulakov Center. The only significant departures from international recommendations are to conform to Russian law and methodology: immediate postpartum IUD insertion is not recommended and voluntary surgical sterilization is limited to those over 30 or with at least two children. Recognizing the importance of the new *Medical*

The project "contributed to the movement to break away from the traditional approach and to adopt a new approach based on seeking out relevant data, international standards, and best practices as the basis for improving health outcomes."

*Final Performance Evaluation,
USAID Maternal and Child Health Project,
Evaluation Report, International Business &
Technical Consultants, Inc, Vienna, Virginia, for
USAID/Russia, June 13, 2012*



Photo: A working group discusses the National Medical Eligibility Criteria for Contraceptive Use

Eligibility Criteria, Bayer Health Care and Richter-Gideon, two leading contraceptive manufacturers, reprinted it in bulk for distribution through their own networks to most ob-gyns in the country.

Evidence of Institutionalization

Two important new federal policies adopted by MOHSD in recent years were developed independently of the project, demonstrating that the Ministry and the regions have begun to internalize the approaches promoted by USAID projects over the years.

- The MOHSD's Federal Service for Protecting Consumers Rights and Human Wellbeing (Rospotrebnadzor), in 2010, issued a landmark order modernizing infection prevention and control policy for maternal and newborn care for the entire Russian Federation (Sanitary-Epidemiological Regulations and Norms 2.1.3.2630-10 # 58, *Sanitary-Epidemiological Requirements for Health Care Organizations*, May 18, 2010.) It embodied international standards promoted by USAID projects for over a decade. This major change was the result of growing momentum from regions that had participated in previous projects and seen the positive results of using modern infection prevention and control standards. The regions showed Rospotrebnadzor that the new approaches were more effective, leading to the removal of a host of ineffective and often expensive old requirements and adoption of effective, modern policies. Now visitors are allowed into maternity hospitals and departments, partner-assisted deliveries are permitted, patients can wear their own clothes instead of sterilized hospital garb, and separate wards for "infectious" and "noninfectious" patients have been abolished—among a host of other positive changes included in the order.
- Another case is an important Methodological Letter issued by MOHSD in 2011 with new clinical recommendations on the *Organization of Maternal Health Care for Implementation of New Technologies* (#15-4/10/2-6796 13.o6.2011, <http://www.minzdravsoc.ru/docs/mzsr/letters/199>.) The letter adopted the provisions of the project's protocol on normal delivery, including key concepts such as partner presence, individual delivery rooms, rooming-in, breastfeeding, the partograph, newborn thermal protection and appropriate hand-washing. (Unfortunately, active management of the third stage of labor was omitted.) This landmark policy completely reshaped the way Russian federal policy regulated maternal and newborn care, making it largely consistent with project recommendations.

Initial Care and Resuscitation of Newborns Training Course

The MPWG, with project assistance, developed a one-week course entitled *Initial Care and Resuscitation of Newborns*, endorsed by the Kulakov Center, to implement new MOHSD recommendations on that topic. The program was based on one piloted by the project in Leningrad Region; then modified during a workshop with 15-20 leading neonatologists, selected project regions and the two Federal Centers; and further modified after presentation in draft form at a major conference in November 2011 at the Kulakov Center. The course is designed for neonatologists, ob-gyns, midwives, *feldshers** and emergency care workers and teaches evidence-based practices that decrease newborn mortality and morbidity using a practical algorithm on neonatal resuscitation. It covers asphyxia and its prevention, respiratory support, heart compression, support for preterm and very small babies, the organization of neonatal care and other topics. It also includes guidelines on neonatal resuscitation and builds practical skills by using simulators. It was strongly promoted by the Russian Federation's former Chief Neonatologist and Deputy Director of the Kulakov Center, Dr. Elena Baybarina, who was subsequently appointed head of MCH for the MOHSD.

*Similar to nurse-practitioners in the US.

Guidelines for Prevention of Healthcare-Associated Infections in Maternities

The project worked with the lead organization for infection control in health care, the Federal Service for Protecting Consumers Rights and Human Wellbeing (Rospotrebnadzor), along with the Kulakov Center and the Urals Institute, to update guidelines on infection prevention and control in maternities. These built on Rospotrebnadzor's new 2010 infection prevention and control order on maternal and newborn care (see text box on page 28), providing more in-depth information for maternity hospitals and departments.

Project staff identified the Australian *Guidelines for Prevention and Control of Infections in Health Care* as a model, obtained approval to use them and translated them into Russian. These were then enriched with the latest information from the Centers for Disease Control and Prevention and the British National Institute for Health and Clinical Excellence. The Russian guidelines were finalized in consultation with expert ob-gyns, epidemiologists, microbiologists and others; presented at the National Rospotrebnadzor Conference; and posted on the IFH website for comment. As the project ended, they awaited formal Rospotrebnadzor approval. The new guidelines cover the concept of infection control; standard precautions; creating a safe environment for women and children; staff health and safety; sterilization and disinfection; medical waste; monitoring and evaluation and other topics. Rospotrebnadzor invited project staff to present the guidelines to a broad audience of specialists from almost all Russian regions at the September 2012 *National Conference on Effective Prevention Strategies for Populations at High Risk of HIV*. In addition, recognizing the value of the guidelines for monitoring health facilities' compliance with infection prevention and control policies all over the country—a large part of its responsibilities—toward the end of the project, Rospotrebnadzor asked the project to develop checklists for each section of the guidelines. Unfortunately, time did not allow for this to be done under the project.

Protocol on Preeclampsia, Eclampsia

This important new protocol was developed by a working group co-chaired by Dr. Sukhih of the Kulakov Center and Dr. Natalia Vartapetova, IBP-MCH Chief of Party, and involving leading specialists in ob-gyn, anesthesiology, internal medicine and other topics from the Kulakov Center and the Urals Federal District, other experts who had worked with IFH and others. Key topics covered include the definition of preeclampsia; its clinical classification; general principles of management; delivery; and eclampsia. The protocol makes important changes in the diagnostic criteria, it simplifies treatment (which formerly entailed an average of about a dozen drugs) and modernized the classification of preeclampsia and eclampsia. It was developed over a period of about a year, discussed at a national conference at the Kulakov Center and at the All-Russia Conference on *Mother and Infant*, and endorsed by the Kulakov Center in 2012.

Environmental Considerations

The project addressed the environmental compliance provisions in the contract in many aspects of its work—training, protocols/guidelines, information support and M&E—but especially through the *Guidelines for Prevention of Healthcare-Associated Infections in Maternities*, which incorporate modern, effective practices in infection prevention and proper waste disposal and are now official policy for the Russian Federation (see at left.)

Project staff developed a checklist for health care waste management and identified key weaknesses in providers' practices relative to World Health Organization standards. Based on results, they gave special priority to working with Rospotrebnadzor to address waste handling; proper waste segregation; safe epidemiological and ecological disposal; reusing or recycling general waste to the extent possible; and monitoring healthcare waste management practices.

Guidelines on Regionalization of Perinatal Care

These important guidelines, approved by the Kulakov Center, are discussed under Task 3.

Other policy documents developed

Project staff also worked with expert working groups—sometimes including the Kulakov Center and sometimes not—to develop or update a number of other important policy documents which, however, were never formally adopted as federal policy, for a variety of reasons. For example, the *Essential Newborn and Infant Care Course* moved slowly because it wasn't a high priority for the Kulakov Center since it was outside their field; time ran out on the *Adolescent Reproductive Health Guidelines*; and some equipment manufacturers voiced concerns about the course on low birth weight babies.

Three of the documents developed, in particular, bear mentioning:

Essential Newborn and Infant Care Training Course

A new topic addressed by the project, with MPWG partners, in response to numerous requests from regions, was a training course on care for newborns and infants in the first year of life—a topic that also addressed language in the USAID contract to “expand... consideration of infant morbidity and mortality beyond the early neonatal period.” The course seeks to link neonatologists and nurses in hospitals with pediatricians and nurses working in polyclinics and focuses primarily on healthy babies, with only brief discussion of complications. Contents include breastfeeding and infant feeding, danger signs and how parents should respond, the number of pediatric visits (based on Russian *prikazes** and world experience), growth monitoring, Sudden Infant Death Syndrome and immunization. A key perspective embodied in the course is that parents have a primary role in caring for their child—a significant departure from the traditional Russian practice where health workers were considered responsible. To help providers make this radical shift—which doctors find very challenging—the course emphasized the development of counseling skills through theoretical study and plenty of practice in role-plays. The course was developed with a working group, including regional leaders in neonatology and pediatrics, consultants from 1st Moscow State Medical University and project staff and trainers. Once completed, it was provided in two project regions and there was strong interest from other regions, but time and funding constraints at the end of the project stood in the way. While much progress was made, more time will be needed to identify visionaries who are ready to take the lead on this topic—an indispensable first step for building broader momentum.

Adolescent Reproductive Health Guidelines

Another MPWG thematic work group, comprised of many specialties, worked with the project for two years to develop *Adolescent Reproductive Health Guidelines* based on an MOHSD's monitoring and evaluation tool as well as on guidelines from other countries, most significantly from ACOG. The guidelines were designed for a broad audience: pediatricians, ob-gyns, andrologists, urologists and health managers. They address adolescent growth and development, contraception, STIs, HIV, education on human sexuality, sexual assault, healthy lifestyles, special considerations in providing services to adolescents, counseling techniques for youth and other topics. While the guidelines themselves were finalized, time ran out at the end of the project to give them visibility through conferences or other means and to advocate for their adoption.

Guidelines on Care for Very Low Birth Weight Infants

Guidelines were developed on care for very low birth weight infants, including a volume with the guidelines and another with tools such as growth tables and weight charts and resource materials on neurological development and other topics. Topics covered include delivery; the first steps after birth,

*A *prikaz* is a Government decree or order.

such as Continuous Positive Airway Pressure (CPAP) and surfactant; prevention of neurological and other diseases and handicaps; rehabilitation, developmental care, growth, nutrition, home care, etc. in the first year of life. The guidelines also reinforce the importance of a regionalized system of care as a critical part of survival. They were printed and disseminated, even though the Kulakov Center did not endorse them, since there was demand from the field for evidence-based guidance on this topic.

Other policy documents developed to respond to interest in the field were:

- Protocol on Normal Delivery
- Protocol on Gestational Hypertension
- Protocol on Labor Dystocia
- Protocol on Shoulder Dystocia
- Protocol on Induction of Labor
- Protocol on Post-term Pregnancy
- Protocol on Breech Presentation

The progress made on federal policy is a lasting legacy of the project that will greatly facilitate the task of spreading modern practices around the country. In the past, regions were often reluctant to embrace the new practices promoted by the project because they contradicted federal policy, but now this obstacle has been removed in many key areas of MCH. Moreover, the leadership of the Kulakov Center is committed to further adoption of modern, evidence-based policies. If these policies are widely implemented, they could have a significant impact on reducing maternal and infant mortality and morbidity.

The quality and safety of care

An important aspect of the project's work with the Federal Centers was to introduce them to concepts and tools related to quality of care, encouraging them to begin applying them in their own facilities as well as to improve the care provided by facilities in their districts. A critical part of this was to help them develop their own protocols to guide the quality of care in their own health facilities, such as protocols they adopted on premature birth and preeclampsia.

Project staff also sought to introduce the Federal Centers to use of MCH audit/assessment tools to evaluate and improve the quality of care. Staff worked with the Centers to review and refine the project's perinatal care tool used in prior projects and understand the assessment methodology. The tool includes observation of providers' practices, medical chart reviews and interviews with medical personnel and clients. After discussions with the Federal Centers, the project was invited to conduct assessments in their maternity hospitals. The results of these audits are discussed under *Implementation of Best Practices* on page 31. As a prelude to discussion of the assessment findings, project staff oriented senior staff from the Federal Centers to the concept of quality of care and basic principles of quality improvement. This was done informally with the Kulakov Center over many months of meetings and more formally in the Urals Federal District, where a two-day workshop entitled *Modern Approaches to Quality Management in Medical Services: Risk Management* was held in Yekaterinburg in December 2010. Theoretical approaches to quality management, medical audit and standardization of services were discussed and a very practical introductory training course was conducted on the perinatal assessment tool to encourage self-monitoring by individual health facilities in line with modern quality improvement approaches. As a result, the Urals Federal District formed a working group to implement the tool in medical facilities. The Urals Institute reported using the tool for assessments in Chelyabinsk, Kurgan, Surgut (KHMAO) and Tyumen, but it is not clear if it was used by Kulakov Center staff.

The project was unable to work with the Federal Centers explicitly on reducing maternal and perinatal mortality because the MOHSD made it known that it should avoid dealing directly with maternal mortality. The Ministry had other priorities and was not ready to listen to new ideas. More progress was made in the regions (see page 47) where project staff were able to work with Tyumen to analyze “near-miss” cases.

Disseminating and operationalizing evidence-based clinical guidelines and best practices

The revised scope of work in the IBP-MCH contract called for disseminating and operationalizing evidence-based clinical guidelines and best practices based on ob-gyn and neonatology guidelines (*porjadoks*) developed and under review by the MOHSD in early 2010. It also stated that training materials and recommendations developed under the previous *Maternal and Child Health Initiative II* project could only be used after review by the Federal Center(s) to ensure their consistency with the MCH guidelines under review by the MOHSD. However, Dr. Sukhih at the Kulakov Center recognized that the *porjadoks* amounted to *standards* of care and did not provide the detailed guidance needed to modernize clinical practices. He also recognized the importance of providing evidence-based guidance to the MCH/RH field in order to improve health outcomes. So he requested that the project move forward with its work using its existing guidelines, training courses and other materials, while the MPWG moved ahead, step by step, in the development of modern, evidence-based policies for the Russian Federation.

The project not only worked with the Federal Centers on *developing* evidence-based policy, but it also supported them in *promoting and disseminating* evidence-based policies and practices around the country as a core element of advocacy for these policies and practices. Project staff participated in and/or helped organize about 25 national and major regional conferences, either conducted or cosponsored by the Federal Centers. Often, this involved working with Center staff—or in some instances MOHSD staff—to plan the events. Project staff also helped speakers from the Federal Centers prepare important speeches, presentations and workshops for these events. For example, project staff helped Dr. Sukhih prepare major presentations on “Obstetrics, Gynecology and Neonatology: Implementing Best Practices” for the IVth Regional Scientific Forum *Mother and Child* in the Urals in 2010; on “Evidence-Based Medicine: Pro and Contra” for the XIth All Russian Scientific Forum *Mother and Child 2010*; and on “Russian-American Collaboration in Maternal and Child Health and Next Steps” at the IBP-MCH end-of-project conference. They helped Dr. Baybarina, the Head Neonatologist at the time, to prepare important presentations on “Protocols for Premature Delivery” for the Vth Regional Scientific Forum *Mother and Child* in 2011 and for the end-of-project conference; and Dr. Vera Prilepskaya, Deputy Director for Science at the Kulakov Center, with her presentation on the Russian *National Medical Eligibility Criteria for Contraceptive Use* at the end-of-project conference.

The Kulakov Center also disseminated selected information about the project’s activities, including the end-of-project conference, *US – Russia Forum: Bilateral Collaboration to Improve Women’s and Infants’ Health*. See its website, <http://ncagip.ru/news>.

Implementation of Best Practices

The project’s two partner Federal Centers see themselves primarily as service providers at the highest level. However, at the beginning of the project, they had very little exposure to modern international approaches to MCH/RH and the care they provided was far removed from international best practices. The approved Implementation Plan for the project outlined a set of activities to build improved understanding of best practices and update providers’ practical skills in these facilities. Specifically, the following activities were envisioned:

- Participation in the Kulakov Center’s internal meetings and workshops to discuss the best practices (already discussed under Task 1;)
- Regular clinical audits at the Kulakov Center to ensure implementation of best practices;

- Trainings for Center staff on best practices;
- Involvement of the Federal Centers in training courses and follow-up visits for the regions (addressed under Task 2, page 44.)

After discussions with the Kulakov Center about approaches to improving the quality of care, Dr. Sukhih requested that the project conduct an audit of basic perinatal care practices at the Center to evaluate the practices used against modern international recommendations. The audit was conducted in early 2009 and involved observation of providers' practices, medical chart reviews and interviews with medical personnel and clients. Key findings were that clients were very satisfied with the quality of obstetric care they received and most would recommend the Center to their friends and family; that infection control procedures were relatively good, although some routine "preventive" practices were ineffective and wasteful of resources; postpartum antibiotic-use was inappropriate; the "warm chain" was not properly maintained; a number of practices used during labor did not meet international standards; there were no protocols for perinatal care; and there was insufficient information support.

As a follow-up to the audit, a work plan was developed to strengthen the Center's technical capabilities and a number of meetings and consultations were held with Center staff on various perinatal care topics. Due to the Kulakov Center staff's reluctance to participate in the project's standard training programs—which they considered unnecessary and time-consuming—the project made regular presentations at the Center on modern evidence-based practices at meetings and workshops. However, project staff knew very well that would not be enough to bring about radical change.

A follow-up audit was conducted in early 2011 to identify progress toward best practices and found that change was very slow in coming. The total score rose from 27% of standard at baseline to only 36% at endline. (See Annex 2.a for details.) On the positive side, rooming-in was more common, though not yet the norm; a modern Basic Labor Management Protocol had been developed; there was less overuse of medication; active management of the third stage of labor was being practiced; and hand-washing kits were available where needed. However, many of the new practices promoted by the project were not being followed. For example, there were still no individual delivery rooms; rooming-in for the baby was not the norm; partners attended only about 10% of deliveries; the "warm chain" was still not being followed; essential newborn care was not being properly implemented; personnel didn't wash their hands before and after each patient; counseling on breastfeeding, newborn care and contraception was not provided; printed informational materials were not available; and informed consent for care was not being discussed or obtained.

Project staff discussed these results with the staff responsible but did not suggest how to move forward, since they had already provided the inputs needed for the Center to make the necessary changes. Instead, they recommended use of the audit tools to monitor progress—and simply offered assistance where needed.

At the Urals Institute, the project conducted a two-day workshop on best practices in MCH in fall 2010 and a session on medical audit in the winter, so it wasn't until January 2011 that the Institute was ready for an initial audit. This showed that the facility was providing care largely in line with old practices and approaches. Its score on the perinatal care audit was 34% of standard (see Annex 2.a for details.) Among the issues identified were: no protocols had been developed or implemented at the facility; partner deliveries and non-medical pain management were still rare; active management of the third stage of labor was not properly performed; essential newborn care was not fully implemented; the "warm chain" was not followed correctly; hand-washing kits were not available where needed and personnel didn't routinely wash their hands before and after each patient; exclusive breastfeeding and rooming-in were still not implemented; and counseling on breastfeeding, newborn care and contraception were often not provided. After reviewing the results of the audit, Institute staff participated in a course on breastfeeding and went on to develop a solid work plan to improve their work in that area.

The project provided a number of trainings for the two partner Federal Centers' staff on best practices (see more detail in Annex 3.a):

- The Kulakov Center received very limited training because, as noted above, its staff did not want training courses. Nevertheless, the project managed to conduct the following trainings:
 - An abbreviated introductory training for 35 senior staff on Family-Centered Maternity Care in 2010—only three days instead of the usual 11 required to fully understand the new approaches and to practice the skills;
 - A two-day course on EBM in MCH care for 25 staff in 2012.
- A total of 17 Urals Institute staff participated in seven training courses provided for Sverdlovsk Oblast health facilities, including:
 - Breastfeeding
 - Family-Centered Maternity Care
 - Antenatal care
 - Family planning
 - Training of trainers on family planning
 - Neonatal care and resuscitation and
 - Emergency obstetric care.

They also received a two-day workshop on best practices in MCH in 2010 and two trainings on clinical audit: one on the importance of medical audit and on the project's audit tool; the other on risk management, including medical audit and "near miss" case review.

Possibly as important as formal training programs in promoting best practices was participation by staff from both Centers in MPWG meetings, where they reviewed the evidence behind modern clinical practices during the process of developing Russian protocols, guidelines and training courses; and study tours.

At the end of the project, it was evident that much more work was needed to update practices at the two Centers to provide modern, evidence-based care. Accustomed to setting policy and practice for the Russian Federation without the benefit of international experience, they were reluctant to change. They continued to use mostly old non-evidence-based practices; most staff remained skeptical of EBM, preferring to rely on "Russian local science;" their services were commercialized; and their organizational and management capacity badly needed to be strengthened.

Development of training and resource capacities of two federal centers

Recognizing the need for the Federal Centers to play a leadership role in improving and modernizing MCH policies and practices in their Federal Districts, the Project Implementation Plan set out the following agenda for development of a Training and Resource (T&R) Center at the Kulakov Center and a resource group at the Urals Institute:

- Jointly develop a concept, strategies and plan of activities for T&R;
- Assist in establishing a T&R Center and a resource group, including training methodology and materials, trainers and models;
- Involve ACOG and JSI expertise in the activities of a T&R Center through consultations, training sessions and materials and information support.

Since project staff considered it imperative that any training, technical assistance and dissemination of information provided by the Federal Centers through resource centers/groups should promote *effective* practices and policies and contribute to improved health outcomes, the project's major emphasis was on building their understanding and commitment to *evidence-based approaches* to MCH/RH as a precondition for training and assisting colleagues in the field.

To help give the Centers a vision of the role they could play as training and resource centers, while at the same time building their expertise on technical topics, modern training methodology and supervision methods and quality improvement approaches, the project involved the staff from these Centers in training, follow-up visits, audits, conferences and other project activities. As a result, seven strong trainers were identified at the Kulakov Center and one at the Urals Institute, who worked as co-trainers with project staff and experts and are available for future training and technical support.

The Kulakov Center made significant progress in recognizing its role in providing training for the MCH field to help health workers improve their knowledge and skills. In 2009 it established a resource center with a library of Russian and foreign books and dissertations. As the Center's understanding of EBM evolved (with project assistance), they expanded the library into a modern information center with access to electronic resources and the major international medical databases. In addition, due to a great

The US-Russia Bilateral Presidential Commission

The importance of the collaboration that evolved over the life of the IPB-MCH project between ACOG, the Federal Centers and other leaders in the MCH community in Russia cannot be overstated. It became a successful activity under the MCH section of the health working group of the US-Russia Bilateral Presidential Commission. Study tours organized by the project feature prominently in the *Joint Report 2009-2010 Results of the US-Russia Presidential Commission* (US Department of State, 6/14/2010) and provided an opportunity for Dr. Gennady Sukhikh, Director of the Kulakov Center, to hold discussions with US officials working on MCH issues in the context of the Bilateral Presidential Commission.

In 2012, these US-Russian links on MCH were formalized through the signing of a collaboration agreement between the Kulakov Center, represented by Dr. Sukhikh, and ACOG, represented by its President, Dr. James Breeden, at the end-of-project conference. After the signing, Dr. Sukhikh called for continued US – Russian collaboration to contribute to valuable exchanges of knowledge, practices and technologies for the benefit of mothers and children.



Photo: Dr. Breeden and Dr. Sukhikh signing the collaboration agreement between the Kulakov Center and ACOG

extent to the project's advocacy, Center staff also came to appreciate the value of incorporating practical skills into training. In October 2011, they opened a Simulation Training Center with a mock delivery room, newborn resuscitation department and obstetric anesthesiology and resuscitation department. It is equipped with new diagnostic equipment, manikins and simulators to train doctors on practical skills in delivery techniques, newborn resuscitation, anesthesia and emergency care (<http://ncagip.ru/structure/83/1966>.)The IBP-MCH project donated four pieces of training equipment to the Center to enhance its capabilities not only in maternal and newborn care but also in cancer detection, in response to the Center's request for assistance from the project in that area.*

Both Federal Centers regularly turned to the project for evidence-based publications and for assistance in preparing informational materials for pregnant women.

The collaboration with ACOG (more detail below) played an important role in helping staff at the two Federal Centers understand how they could provide more effective leadership and support to the ob-gyn community. They gained exposure to a host of functions, such as board certification procedures for ob-gyns, development and updating of clinical standards and guidelines, provision of updates for doctors on the latest clinical evidence, continuing medical education events, publication of professional journals, maintenance of a specialized library and electronic resource center, production of educational materials for doctors and patients, promotion of a code of ethics, advocacy in the political arena, support in lawsuits, etc. A number of these functions could potentially be undertaken by resource centers/groups in the Russian setting.

Collaboration with the American College of Obstetricians & Gynecologists (ACOG)

From the beginning, both Federal Centers expressed strong interest in establishing relations with professional entities in the US and the project involved ACOG in this collaboration. With over 55,000 members, ACOG is a private, voluntary, nonprofit membership organization and is the leading group of professionals in the US providing health care for women. It works primarily in four areas: serving as a strong advocate for quality health care for women; maintaining the highest standards of clinical practice and continuing education for its members; promoting patient education and stimulating patient understanding of and involvement in medical care, and increasing awareness among its members and the public of the changing issues facing women's health care. It was clear that ACOG could offer abundant ideas and expertise to Russian counterparts, helping them envision a new leadership role for the ob-gyn community, understand how American doctors provide maternity and newborn care, family planning and reproductive health services and demonstrating the continuous learning and quality improvement that underlies medical practice in the US.

The collaboration with ACOG began in summer 2009 under the predecessor project (MCHI II), with a study tour to the US by a Russian delegation from both Federal Centers and partner regions. The trip included a short visit to ACOG headquarters in Washington, DC, where the group was oriented to the role of a professional association in the US, received an overview of ACOG's work and visited the resource center. The approved project Implementation Plan laid out a plan to build on this first step, including:

- Provision by ACOG of free access to its web resources;
- Translation into Russian by the project of the most important information, such as

*A model to practice reading of obstetric ultrasound imaging, with both normal and abnormal conditions; a baby simulator to teach infant care; a breast model that allows ultrasound identification of cysts of different sizes and depths and differentiation between cysts and dense masses; and another breast model to use as a teaching tool with women, for them to practice breast palpation techniques and detect various abnormalities.

guidelines and “Points of View,” and posting them on the IFH web-site (see *Free Access to ACOG Resources*, below);

- Involving ACOG in training courses at the Kulakov Center and in the Urals Federal District;
- Russian participation at ACOG meetings and participation by ACOG representatives in MCH/RH meetings in Russia to discuss the most important MCH/RH issues;
- Taking advantage of ACOG’s close links with the Royal College of Obstetrician-Gynecologists and joint activities related to maternal mortality and near-miss case audits, to ask to join these activities and learn more about the tools used;
- Exploring opportunities to assist the MOHSD and the Kulakov Center in their desire for information about cervical and breast cancer.

The depth and extent of the resulting collaboration between leaders in the US and Russian MCH communities, especially the Kulakov Center, was remarkable.

Free access to ACOG resources

During a visit by Russian counterparts to the ACOG office in Washington, DC, in June 2010, ACOG generously provided the project and its Russian partners with free access to its web resources and gave the project permission to translate its guidelines and other key materials into Russian and disseminate them through the IFH web site. The project has translated a number of ACOG resources into Russian, for example to develop the *Adolescent Reproductive Health Guidelines*, other clinical protocols and guidelines, and a training program for health and social providers on support to high-risk women. Project staff also adopted ACOG’S Code of Ethics to promote important ethical principles to Russian ob-gyns through the *Guide on the Essentials of Evidence-Based Care*.

The IFH website created a special section devoted to collaboration with ACOG (<http://www.ifhealth.ru/section1371>) which carried news and information about ACOG and the US-Russian collaboration, which is expected to continue.

Participation by ACOG representatives in MCH/RH meetings in Russia

On three occasions, ACOG members volunteered their time to travel to Russia and provide lectures and consultation to their Russian counterparts as part of the project’s capacity-building activities for the Federal Centers and regions. In addition to giving lectures at major conferences, the American visitors saw health facilities to better understand the realities of service provision in Russia and to engage with counterparts on important issues.

- In late 2009, Dr. Richard N. Waldman, then President-Elect of ACOG, along with Elaine Mielcarski, Fellow of the American College of Nurse Midwives, visited Yekaterinburg and made presentations at the Congress of the Urals Society of Obstetricians and Gynecologists, stressing the importance of family-friendly obstetrical and neonatal services. They repeated the presentations at the Kulakov Center, adding an update on the H1N1 epidemic in the US and the increased risk of severe forms in pregnant women. At both sites, they engaged in productive discussions with the leadership of the Federal Centers.
- In March 2011, a distinguished three-person ACOG delegation travelled to Russia to conduct three conferences entitled *Perinatal Care in the USA: the Role of Professional Medical Associations* at the Kulakov Center in Moscow, in Tyumen City and St. Petersburg. The visiting delegation included Dr. Waldman, ACOG President; Douglas Laube, a

“It’s a pleasure to observe the partnership between the Russian and American people.”

Director of the USAID/Russia Health Office, speaking at the project’s US – Russia Forum

Past-President of ACOG, Chair of the Department of Obstetrics and Gynecology at the University of Wisconsin and, at that time, a Fellow at USAID in Washington; and Dr. Nancy Chescheir, Professor at the University of North Carolina Medical School; as well as Elaine Mielcarski, a member of the American College of Nurse-Midwives. The conferences drew a total of over 450 participants from the two Federal Centers and 18 regions (both those participating in the project and others), with many participants paying their own expenses to participate. Key topics at these conferences were maternal mortality, prevention of premature birth, developing guidelines for perinatal care and team communication. The presentations, focusing on US approaches, triggered a host of questions and lively discussion and it was clear that participants were impressed with the systematic data-based approaches used in the US to improve maternal and newborn care.

- 2012 marked the high point of the collaboration with ACOG, with 10 US representatives identified by ACOG traveling to the project's end-of-project conference, the US – Russia Forum, *Bilateral Collaboration to Improve Women's and Infants' Health*, in May (see text box below for details.)

US – Russia Forum *Bilateral Collaboration to Improve Women's and Infants' Health*

The IBP-MCH end-of-project conference, the *US – Russia Forum*, adopted an innovative format. It was held under the umbrella of the health working group of the US-Russia Bilateral Presidential Commission and featured 10 leading US experts with distinguished clinical, research and academic backgrounds who represented ACOG. All of them donated their time and several were sponsored by private sector partners. The conference was a unique opportunity for leaders in the Russian MCH community to hear outstanding US presentations and to engage in discussions with American counterparts.

The importance of the event was demonstrated by the stellar speakers at the opening session: Dr. Oleg Filippov, Deputy Head of MCH for MOHSD; Charles North, USAID/Russia Mission Director; Dr. Vladimir Serov, Chairman of the Russian Society of Ob-Gyns; Joel Lamstein, President of JSI; Dr. Richard Waldman, Past President of ACOG; and Dr. Gennady Sukhih, Director of the Kulakov Center, who hosted the first day of the conference at the Center. The event began with the signing of the collaboration agreement between ACOG and the Kulakov Center—see page 34 for details.

The conference was devoted to technical sessions featuring state-of-the-art presentations by US speakers and their Russian counterparts, enabling conference participants to learn about and discuss current US and international approaches to MCH services, burning issues and key project accomplishments. Topics included:

- Preventing maternal mortality
- Contraception
- Prevention of preterm birth
- Neonatal care and management of premature infants
- Prevention, screening and treatment of women's cancers (breast, cervical, ovarian and uterine cancer)
- Medical and social care for women in difficult life situations
- Formal communication
- Quality and safety in MCH care
- Approaches to training

Two important new resources for health care providers were presented and discussed during the conference. These were the *National Medical Eligibility Criteria for Contraceptive Use* and the *Initial Care and Resuscitation of Newborns Training Course*, both major new publications developed by interdisciplinary working groups led by the Kulakov Center and IFH and endorsed by the Center. The project's *Algorithms on Medical and Social Care for High-Risk Women* were also presented and discussed.

The Russian delegates commended the high level of the presentations and the friendly and democratic tone of communication with the audience. Both Russian and American colleagues were impressed by the innovative format as well as the content of panel discussions.

The conference drew over 250 participants from ³⁸36 regions of the Russian Federation and other countries, including regional healthcare authorities, representatives of social care departments, chief doctors of perinatal centers, leading specialists of maternal health care facilities and medical education faculties.

Russian participation in ACOG meetings

There were five highly productive study tours for Russian counterparts to the US, including visits to ACOG events or meetings with ACOG:

- In May 2010, a 15-person Russian delegation from the Kulakov Center, the Urals Institute, Leningrad and Irkutsk regions, Moscow City and IBP-MCH staff participated in ACOG's 58th Annual Clinical Meeting in San Francisco. The group learned a lot on a variety of topics and was impressed by the sheer size of the conference (with about 6,000 participants), the breadth of the scientific program, the high level of discussion which was entirely evidence-based, the practical skill-building sessions, the scope of ACOG's work and the fact that a nongovernmental organization arranged such a major event. The visit also included a trip to Boston, where the Russian delegation visited JSI headquarters and learnt about the organization and its work in the US and around the world.
- Shortly afterwards, in June 2010, seven people, including the Director of the Kulakov Center, Dr. Sukhih, and other Center staff, along with a representative from Medical Corporation *Medlife* in Perm and IBP-MCH staff, went to Washington, DC, where they visited ACOG headquarters and were welcomed by ACOG President, Dr. Waldman. They learned about the College's everyday work, its scientific work, continuing medical education, support to members and its wealth of resources. It was clear that both parties were interested in extending their professional collaboration and concrete next steps were discussed. The group also attended the World Congress *Women Deliver*, a high-profile event that drew global leaders from the health and political spheres, business people and others. The conference sought to attract adequate investment in women's health to decrease maternal and neonatal mortality, to ensure universal access to reproductive health care, and to combat HIV. During their trip, the Russian group also had a chance to learn about the research undertaken by the National Institutes of Health and the National Institute of Child Health and Human Development, which was particularly impressive to Dr. Sukhih, and they visited the JSI Washington office to hear about some of its centrally-funded projects working in MCH.
- In the spring of 2011, and again in 2012, a total of 17 Russians attended ACOG's 59th and 60th Annual Clinical Meetings in Washington, DC, and San Diego, California. The groups were drawn from the Kulakov Center, the Urals Institute, leading Sverdlovsk Region maternity hospitals, the Moscow Perinatal Center and project staff. The meetings provided valuable clinical updates and impressed participants in much the same way as the first group in 2010.
- In late 2011, there was a one-week study tour for 10 staff members from Maternity #4 in Moscow—the largest maternity hospital in the city, with 8,000 births a year—to Syracuse, New York. The facility's Head Doctor recognized that initiating the sweeping changes in practice promoted by the project would be extremely challenging in a large hospital and she wanted to give her leadership team a concrete vision of what they should be aiming for. Along with IBP-MCH Chief of Party, Dr. Vartapetova, they identified private funding for almost all costs from Proctor and Gamble and "Soglasie," a large insurance company. Dr. Richard Waldman of ACOG and his wife, Elaine Mielcarski, who had visited Russia and understood the needs of Russian health providers, arranged a program tailored to the needs of

"The practices and experience learned by our medical providers and St. Joseph's Hospital Health Center are very valuable. We are sure that the knowledge they gained, the methods of treatment and international standards will be successfully implemented in our maternity hospital."

*Head Doctor,
Maternity # 4 in Moscow,
on the results of the study tour*

a Russian group—and also included abundant hospitality and social events. The group spent most of the time at St. Joseph’s Hospital Health Center in Syracuse, New York, but also visited Strong Memorial Hospital in Rochester, a referral and teaching hospital. The group observed the provision of modern evidence-based care in ways that are woman- and family-centered, while still having systems in place for medical interventions to ensure the safety of mother and baby when needed. Both parties benefited greatly from the experience and were eager to repeat it. As the project ends, plans are in progress for another group from Maternity #4 to visit Syracuse, if funding can be found.

Addressing cervical and breast cancer

Cervical and breast cancer received considerable attention at the end-of-project conference (see text box on page 38), with US experts from the University of Alabama at Birmingham (the President of the US Society of Gynecological Oncology), Drexel University College of Nursing and Health Professions and a leading medical imaging practitioner from California making presentations that triggered considerable interest and discussion with the audience. Topics included prevention and treatment of ovarian cancer; new prevention and treatment approaches to uterine cancer; an update on HPV and cervical cancer prevention; screening for breast cancer; and advances in screening for breast cancer.

The project also gave anatomical models, complete with instructional materials on their correct use, to the Kulakov Center’s new Simulation Training Center to facilitate teaching practical skills to doctors in detection of breast and uterine cancers (see page 36.)



Photo: Dr. Natalia Vartapetova, IBP-MCH Chief of Party, presenting a certificate donating training equipment to the Kulakov Center’s Director, Dr. Gennady Sukhikh.

Collaboration with the Royal College of Obstetrician-Gynecologists

While the collaboration with the Royal College of Obstetrician-Gynecologists was not nearly as close as that with ACOG, the British organization played an important role in honing the expertise of project staff on issues related to maternal mortality and giving Russian counterparts a better understanding of other countries’ approaches to reducing maternal mortality.

IBP-MCH staff received regular information on maternal mortality and “near miss” case audit, as well as the latest achievements in MCH, from the Royal College of Obstetrician-Gynecologists. This was then disseminated at national and regional conferences in Russia.

The project Chief of Party, Dr. Vartapetova, and Dr. Alexey Kholin from the Kulakov Center attended the conference *Saving Mothers’ Lives* in March 2011 in London. The conference was organized by the Centre for Maternal and Child Enquiries and was marked by the launch of a report on the factors underlying maternal deaths in the UK between 2006 and 2008. The conference was extremely valuable in pointing out the importance of maternal mortality audits and “near miss” case reviews in setting future directions for MCH services. It also afforded an opportunity for the Russian representatives to share best practices and the results of audits of clinical practices with representatives of other professional associations.

Task 2: Operationalizing and Disseminating MCH Guidelines and Best Practices

Key Accomplishments—Task 2

- 26 training courses on seven MCH/RH topics were conducted for 869 participants in partner regions—more than planned; the average pretest score rose from 43% to 82% at posttest;
- 27 other workshops and seminars were held for 677 participants;
- A new course on pediatric care, addressing the major causes of mortality and morbidity in the first year of life was developed and successfully implemented;
- Four highly productive exchange visits took place between regions, allowing “older” regions to support newer ones by demonstrating their accomplishments in implementing new perinatal care practices;
- Audits/assessments showed improved quality of care in project-assisted sites.

Under Task 2 in the revised scope of work, the project was to assist the two Federal Centers in rolling out selected MCH guidelines and practices on obstetrics/gynecology, neonatology and other topics in 10 partner regions. A wide range of health care providers were to be trained in approved MCH best practices and guidelines and a cadre of Russian experts was to be developed in the selected regions to serve as trainers. The process of integration of MCH/RH best practices in health care facilities, for example through follow-up control visits by experts and setting up a quality control system, was to be documented and demonstrate how the MCH/RH guidelines would be institutionalized in target Federal Districts. Task 2 also called for a process of region-to-region exchanges and peer-to-peer leadership among health care providers from regions across Russia to disseminate and learn from each other about MCH/RH.

The starting point for work in the regions was to discuss with the two Federal Centers the criteria for selection of regions where the project should work, to identify regions that met the criteria, and then visit them to discuss what the project had to offer and ascertain their level of interest, commitment and willingness to cost-share. Based on these discussions and visits, as well as prior experience, the project agreed with USAID to work in 10 regions, half of them new to the project and half that had been involved previously:

Table 3: IBP-MCH Project Regions

Federal District	“Old” Regions	New Regions
Urals Federal District	Khanty-Mansiysk Autonomous Okrug (KHMAO) Kurgan Tyumen	Chelyabinsk Sverdlovsk (Yekaterinburg) Yamalo-Nenezkiy Autonomous Okrug (YANAO)
Northwestern Federal District	Leningrad Vologda	
Central Federal District		Moscow City Moscow Region

The main criteria in the selection of these regions were maternal, perinatal and infant mortality rates, abortion rates, high level political support, the interest and commitment of MCH leaders, the influence of the region on others in the Russian Federation and readiness to cost-share, combined with the recommendations of the MOHSD, the Federal Centers and USAID. With the new regions participating in IBP-MCH, the total number of regions where JSI and IFH have helped USAID work to improve MCH/RH since 1999 is 30.

The project signed agreements with the regions before proceeding with activities, to ensure smooth collaboration and make clear the responsibilities of both parties. In order to build sustainability, the project required partner regions to make a number of counterpart contributions. Typically, they

contributed the time of senior officials for working group meetings and for management and oversight of project activities; they assumed responsibility for organizing trainings and workshops; they provided office space and the venues for trainings and meetings; they paid salaries while staff participated in workshops and meetings; they contributed funds for travel and lodging for their staff to participate in events; and they provided free mass media coverage for the project.

The process of getting signed agreements with regional partners proved more time-consuming than in past projects, while partners in regional health departments obtained the political approvals needed. In addition, changes in leadership in Chelyabinsk and Sverdlovsk regions slowed things down there and the last region, Yamalo-Nenezkiy Autonomous Okrug (YANAO), was only able to sign in October 2011.

Training and Quality Improvement

Training

The plan was for the “old” regions that had participated in the prior project to receive training and technical assistance on topics not yet covered under that project or where they still needed help to perform up to standard. New oblasts, meanwhile, would receive a set of core trainings on key best practices. Tyumen and Vologda would serve as training sites, with support from project staff.

Table 4: Number of Training Courses Conducted and Number of Participants, by Training Topic

Training Topic	Number of Courses	Number of Participants
Antenatal Care	4	159
Breastfeeding	4	127
Emergency Obstetric Care	3	106
Family-Centered Maternity Care	5	183
Family Planning *	5	151
Newborn Resuscitation **	3	79
Pediatric Care ***	2	64
Total	26	869

* Includes a training for 24 trainers (ob-gyns and midwives) on family planning

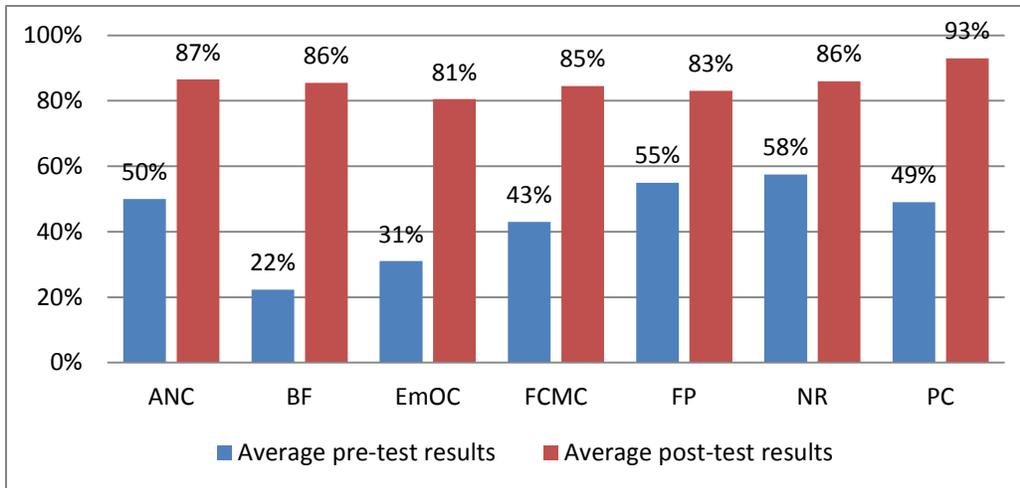
** Initial Care and Resuscitation of Newborns training course

*** Essential Newborn and Infant Care training course

The approved implementation plan envisioned 19 core training courses on seven different MCH/RH topics. As can be seen in Table 4 above, a total of 26 courses on seven topics were conducted for 869 participants (see Annex 3.a for details.) These trainings include only those on topics specifically mentioned in the implementation plan for Task 2. The success of the trainings is indicated by the increases in the participants’ average test scores which rose from 43% across all these trainings at pre-test to 82% at post-test. See Figure 1 below for details by course.

In addition to these trainings, the project also provided 27 workshops and seminars on many different topics for 677 participants, contributing to these professionals’ improved knowledge, attitudes and skills (see Annexes 3.b and 4 for details.) These include trainings on regionalization of perinatal care, medical-social care for high-risk women, workshops to develop protocols and guidelines, adolescent reproductive health and other topics.

Figure 1: Average Pre- and Post-test Scores, by Course



Most of the seven standard courses conducted were very similar to those conducted under MCHI II, although they were updated in the early months of the project to reflect the latest evidence and to incorporate key points from the *porjadoks*. The *Essential Newborn and Infant Care* training course, however, was new and was developed in the early months of the project. It addresses one of the areas of emphasis in the IBP-MCH contract, namely to expand consideration of infant

“Everything was very regulated. Now everything is possible.”

Director of the Sverdlovsk Regional Clinical & Diagnostic Center for MCH

mortality and morbidity beyond the early neonatal period. The *Initial Care and Resuscitation of Newborns* course was also new. All the courses were very practical and were generally held in health facilities, with practicum conducted at that site.

Highlights of each course are as follows:

- *Antenatal Care* is a five-day course that aims to expand the knowledge of health professionals on modern approaches to care for pregnant women, preparation for childbirth and promoting healthy lifestyles. It includes discussion of preparing women and couples for postpartum family planning decisions and addresses effective practices on STI- and HIV prevention as well as PMTCT. It is designed for ob-gyns, midwives and others. There is a special emphasis on improving clinical skills in identifying and caring for high-risk groups. Training methods include presentations, discussions, small group work, video films, case studies and role plays.
- *Breastfeeding* is a six-day course on the principles of breastfeeding, common problems and how to address them for ob-gyns, neonatologists, pediatricians, midwives, nurses and others working in inpatient and outpatient settings. It covers nutrition for breastfeeding women, feeding recommendations for underweight babies, complementary feeding, care for newborns whose mothers do not have enough milk, the Lactational Amenorrhea Method of family planning and other topics. It follows MOH policy on feeding of infants born to women living with HIV, barring breastfeeding in these cases. To address health providers’ unfamiliarity with counseling skills, there is a strong emphasis on this topic, including role-plays to develop practical skills.
- *Emergency Obstetric Care* is a five-day course for ob-gyns, pediatricians, anesthesiologists and resuscitation specialists, midwives and nurses that addresses the key causes of maternal mortality such as hemorrhage, hypertension and sepsis, and also includes key emergency care practices for newborns. It covers adult and newborn resuscitation, management of eclampsia,

postpartum hemorrhage, coma, anaphylactic shock and other conditions. It incorporates role-playing and the use of simulators to improve trainees' skills, along with other interactive teaching methods.

- *Family-Centered Maternity Care* is an 11-day introductory course to modern approaches to perinatal care for ob-gyns, neonatologists, midwives and others working in inpatient settings.

It covers 16 protocols, including pain relief, active management of the third stage of labor, medications during the first and second stages of labor, the partograph, partner deliveries, newborn care, skin-to-skin contact, newborn resuscitation, maternal resuscitation, fetal heart monitoring, family planning, PMTCT, working as a team and other topics. The second week of the course is practicum.

- *Family Planning* is a week-long course that covers the rationale for family planning in a pronatalist environment, its contribution to improving maternal and child health and reducing abortion; provision of the range of contraceptive methods available in Russia; prevention of STIs and HIV; and contraception for special populations like adolescents, women postpartum and postabortion, and those living with HIV. It places a strong emphasis on counseling, so as to move providers away from the old model of recommending a method to clients, and help them begin to support clients in making their own voluntary and informed choices about contraception. In addition to this free-standing family planning course, family planning is also included as an integral part of courses on antenatal care, breastfeeding, Family-Centered Maternity Care and pediatric care to show how services should be integrated into a range of maternal and child health care. One of the family planning courses conducted was a one-week training of trainers from five regions in the Urals Federal District.
- *Initial Care and Resuscitation of Newborns* is a new five-day course for neonatologists, pediatricians, ob-gyns, nurses and midwives in inpatient settings. It is designed to reduce asphyxia, breathing problems, problems resulting from meconium aspiration, and infections, which are leading causes of mortality and morbidity. Participants practice their skills with manikins and there is plenty of opportunity for group discussion. There was strong interest in this course from the regions, but time and funding constraints at the end of the project stood in the way of rolling it out beyond two regions.

“The project has changed the way we think.”

*Staff member at
Maternity Hospital #3, Tyumen City*

Key Accomplishments on Family Planning/Reproductive Health

The project's work on this topic went well beyond training service providers. Key accomplishments were:

- Adoption of Russian *National Medical Eligibility Criteria on Contraceptive Use* as official federal policy;
- Developing a job aid for providers on the new *Medical Eligibility Criteria*;
- Updating job aids on contraceptive counseling for providers;
- Development of *Adolescent Reproductive Health Guidelines* with the Kulakov Center and other partners;
- Development and implementation of a family planning assessment tool;
- Trainings on family planning for front-line health workers and inclusion of family planning as a component of other courses;
- Development of a family planning training team in Sverdlovsk Region;
- Assessing the needs of high-risk women for family planning and making the topic a core element of the *Algorithms on Medical and Social Care for High-Risk Women*;
- Publishing and distributing two editions of IFH's *Family Health* bulletin on family planning topics;
- Disseminating family planning information and conducting master classes at major conferences and workshops;
- Disseminating family planning information through the IFH website.

- *Essential Newborn and Infant Care* is a new five-day training course developed to strengthen the knowledge and skills of medical practitioners providing both inpatient and outpatient care to infants on topics related to the major causes of mortality in the first year of life. It is designed for pediatricians, family doctors, pediatric and visiting nurses, medical school faculties and health administrators, as well as other specialists who provide care for newborns and infants. It focuses primarily on healthy infants, with only brief discussion of complications. It emphasizes linkages between the maternity or hospital and polyclinic and covers normal physical and neurological development, to combat the perception that most infants are sick and need continuous medical care and medication; the number of visits (under Russian *prikazes* and international practice); growth monitoring; nutrition; immunization; danger signs and how parents should respond, Sudden Infant Death Syndrome and other topics. It gives considerable attention to counseling and involving parents in observing and caring for their child, which is a new—and difficult—topic for most health workers who have been trained to consider themselves responsible for the health of the population in their catchment areas.

As articulated in the Implementation Plan, staff from the Federal Centers partnered with the project in these trainings, with their experts serving as co-trainers, to gain expertise in the subject matter and to learn modern, participatory, competency-based training techniques. They also participated in follow-up visits, although this proved challenging in light of the sensitive relations between the Centers, the regions and individual health facilities. Experts from regions that partnered with past USAID projects

Institutionalization in the Regions

The project's partner regions adopted 100 new policies supporting implementation of best practices promoted by the project in their territories:

- 71 on Evidence-Based MCH/RH Quality of Care and Service Delivery;
- 26 on regionalization of perinatal care; and
- 3 on linkages between medical and social care.

(See details in Table 13 and text following the table.)

also played an important role as trainers on many of these courses, strengthening their training skills, promoting them as resource persons for new regions, and relieving project staff in Moscow of the need to conduct repeated standard training courses.

Project staff knew from experience that the modern practices taught in the training courses represented such radically new approaches that one training course—no matter how good—would not suffice to change providers' ingrained behaviors. Thus, each training course was reinforced by project staff and/or experts through supportive supervision to promote practical implementation of the new information and skills. During the follow-up visits, providers' practices and skills were evaluated, feedback was given and, when necessary, short refresher trainings were provided. Other support mechanisms were

also used to follow up on training, including e-mail communications, provision of additional information on specific topics, etc.

Key tools to measure and improve performance were formal audits/assessments (the same as those used in the Federal Centers), entailing observation of providers' practices, medical chart reviews and interviews with medical personnel and clients. These assessments helped counterparts work from the very beginning with the project's data-based approach to improving the quality of care and sought to build the capacity of staff at the local level to assess how they are performing on their own, without top-down supervision.

Two assessment tools—on Perinatal Care and Essential Newborn Care—were developed, based on existing audit tools, and tailored to each region’s needs. A new tool was developed on family planning, including interviews with the head of the health facility, the ob-gyn and with women, and was applied in three regions. (See more detail on page 81.)



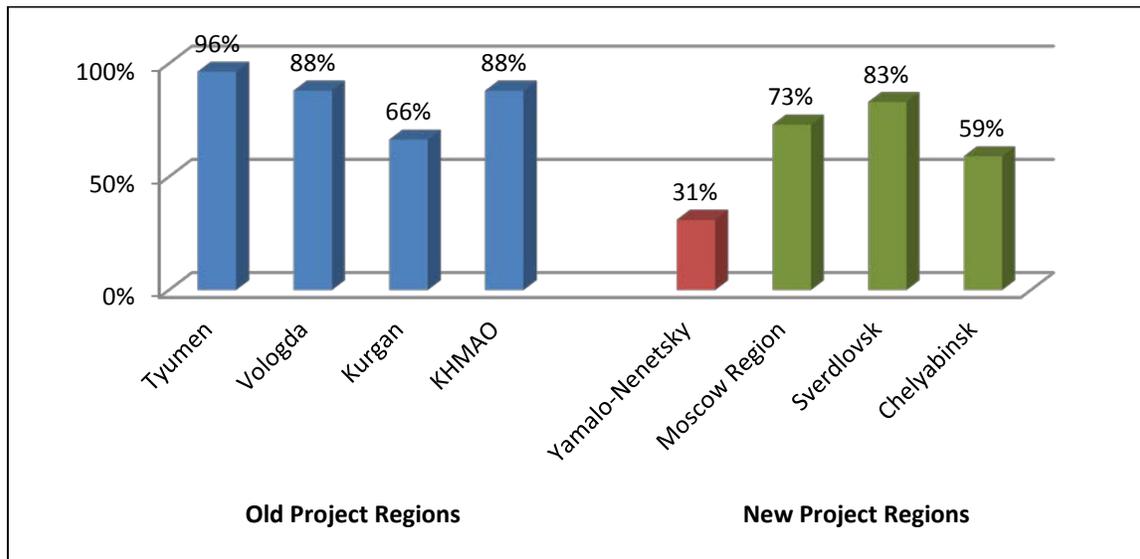
Photo: Specialists strengthening their practical skills at a course on Initial Care and Resuscitation of Newborns

The *Essential Newborn Care* assessments showed that providers in regions that had been in the project for some time performed at quite high levels relative to standards, while those new to the project were not far behind. Most facilities had high scores, especially on breastfeeding, rooming-in and staff training. At the same

time, many facilities continued to apply outdated and ineffective practices. Tyumen Region maternities scored the highest overall, at 96%, with Vologda and KHAMAO following at 88%. YANAO, the last region to join the project (in 2011) received its audit *before* project interventions and scored only 31%. The contrast between YANAO’s score and those of other regions highlights how radically the quality of care changed from old practices to new ones. (See Figure 2 and Annex 2.b.)

Figure 2: Correct Implementation of Essential Newborn Care Practices in Partner Regions

Average percentage score at sites assessed in the regions



N.B. All assessments took place after project interventions—except in Yamalo-Nenetsky where it was conducted before any interventions.

The audits on *perinatal care* showed that all facilities were in need of improvement. On average, providers assessed in Kurgan performed at 40% of standard. They scored best on the “warm chain” (newborn thermal protection) and the availability of emergency kits and protocols for obstetric bleeding; and were weakest in continued use of some ineffective/harmful old practices in the postpartum period and in basic neonatal resuscitation. The Moscow Regional Perinatal Center attained

an average score of only 32%, with its strongest performance being in relatively low use of ineffective/harmful practices in delivery management and the postpartum period. Its weakest areas were in the lack of emergency kits and protocols for obstetric bleeding and implementation of the “warm chain.” The scores of the Federal Centers’ clinical facilities are discussed under Task 1, on page 32.

The *family planning* audit tool was new for the project and showed that the overall service delivery capacity of the facilities assessed stood at between 53% and 87% of standard. This included measures on staffing, quality of counseling, availability of free contraceptives, information support for the population and other items. There were substantial differences between regions on almost all measures, with quality of service provision, for example, ranging from 69% in Chelyabinsk to 30% in Tyumen (see Annex 2.c.i.) The quality of contraceptive counseling, as described by providers interviewed, is summarized in a graph in Annex 2.c.ii. The data show that most providers are providing appropriate counseling for women on various methods, especially for progestin-only contraceptives, IUDs, and the Lactational Amenorrhea Method (LAM.) Results were not so strong on postabortion counseling and DMPA (injectable contraceptive), with weaknesses on postabortion counseling concentrated around understanding when to prescribe combination oral contraceptives after abortion and, with respect to DMPA, generally weak knowledge of the method.

Consistent with the project’s goal of decreasing maternal and infant mortality, maternal and perinatal mortality were routine topics of discussion with regional specialists at trainings and workshops. Project staff promoted open evaluation of the possible causes of death, discussions with multi-disciplinary groups to investigate the real causes of death, and avoiding blame and punishment so as to learn lessons from each event. It also helped regions appreciate the connection between a regionalized system of care and reductions in maternal and perinatal mortality. The project also included the BABIES Matrix in the Essential Newborn and Infant Care Training Course. With the subject of maternal and infant deaths remaining highly sensitive in Russia, the approach of “near miss” case review was more acceptable to partner regions.

The project helped Tyumen Region include analysis of “near misses” in its routine system for monitoring and evaluating maternity care and it also provided limited advice to former partners in Irkutsk and Kemerovo regions who were interested in the topic. The high level of interest in this



Photo: A modern delivery room in the Yekaterinburg Perinatal Center

approach is demonstrated by the selection of implementation of “near miss” case analysis as the main subject for doctoral theses by leading regional obstetricians.

Networks of care established

Approved MCH guidelines and best practices were rolled out in both urban and rural areas of partner regions. Whenever possible, the project involved inpatient facilities along with their associated outpatient women's consultations—which are also the focal point for family planning provision*—and pediatric polyclinics. In each region, the project trained staff from the regional maternity hospital along with its women's consultation and children's polyclinic, as well as other maternity hospitals and associated outpatient facilities in the main urban centers. In rural areas, some district hospitals also participated, along with their women's consultations and pediatric polyclinics.

IBP-MCH worked with a total of 202 health facilities, including 67 maternity hospitals and at least 84 women's consultations, nine family planning centers and 42 children's polyclinics that benefited from training, follow-up, resources and other interventions on evidence-based best practices. These facilities made up 67 "networks" of care across rural and urban areas, encompassing a maternity hospital, women's consultation, family planning center (where they exist) and children's polyclinic. The facilities were linked by referral systems and supervisory systems. (See Annex 5 for details.)

Region-to-region exchanges

The concept behind region-to-region exchanges was to foster the operationalization and dissemination of MCH/RH guidelines and best practices by sharing practical experiences and lessons learned between peers in project-assisted regions. The visits were an important complement to the project's working groups and training courses that were the foundation for promoting new practices to regional partners, but which sometimes seemed a bit theoretical to regions new to the project. Exchange visits gave new partners the opportunity to see best practices in action and to discuss the changes with peers who had already implemented them. In addition to giving participants exposure to real-life changes, the visits also promoted sustainability by encouraging regions to look to each other for innovations, resources and technical assistance, building mutual support networks to improve their policies and services. The exchanges were very valuable, with participants expressing their appreciation and a desire for more such opportunities.

In consultation with USAID and the Federal Centers, Tyumen and Vologda Regions were designated as training sites for the project because of their ability to demonstrate best MCH practices in action; their willingness to share their knowledge, skills and experience; their ability to pay their experts while sharing their expertise with other regions; and their ability to provide free space for meetings and to take responsibility for organizing visits from other regions.

There were a total of four exchange visits between regions for 167 participants:

- A two-day exchange and training visit to Tyumen Region in October 2010 by 25 senior officials from Chelyabinsk, Kurgan, Sverdlovsk and Tyumen regions, KHMAO and YANAO, as well as representatives of the Kulakov Center and the Urals Institute. Tyumen shared its experiences, results and lessons learned in implementation of best MCH/RH practices.

*Family planning centers now exist only in some regions. Mostly, family planning centers and cabinets have been absorbed into other women's health care facilities and are no longer separate entities.

- A one-day exchange visit in March 2011, also to Tyumen, by 75 visitors from 15 regions from as far afield as the Republic of Karelia and Sakhalin. Project regions that participated were Chelyabinsk, Kurgan and Moscow Region as well as Moscow City, KHMAO and YANAO. This exchange was held in conjunction with the ACOG conference, *Perinatal Care in the USA: the Role of Professional Medical Associations* (see pages 37 and 38) and had a similar agenda to the October visit to Tyumen, but with the addition of a focus on regionalization of care. Many of the regions participating in this visit attended with their own funds. In addition, as a result of the trip, the heads of Chelyabinsk and Kirov regions decided that leading specialists from their regions would benefit from gaining a better understanding of Tyumen Region’s experience, so they organized another visit, financed with their own funds.
- A one-day visit to Surgut City (KHMAO) was conducted in May 2011 by 47 professionals from Chelyabinsk, Kurgan, Moscow, Sverdlovsk, Tyumen and Vologda regions, as well as Moscow City, KHMAO, YANAO and the Komi Republic. This exchange was conducted in conjunction with the conference on *Modern Strategies to Improve the Quality of Care to Women and Children* (see page 64) and centered on the experiences, results and lessons learned in implementing best practices in KHMAO.
- A one-day visit to Sverdlovsk Region was conducted in December 2011 by 20 senior officials from Chelyabinsk, Kurgan, Leningrad, Moscow, Tyumen and Vologda regions, as well as Moscow City, KHMAO, YANAO and the Republics of Komi and Tatarstan. Like the other visits, this one centered on the observation of modern practices in Sverdlovsk Region.

“Unintended Results” of the Project

The project left a legacy of some informal networks in the regions that are expected to carry forward the project’s work through professional development and networking.

One group is a *Network of IFH Friends in the Regions*. This is a group of critical thinkers who stayed connected with IFH and among themselves to keep up with new information, analyze it and consider its implications for services. They received e-mail updates from the project; asked questions and received answers; sought to develop their own evidence-based materials and sought feedback from IFH. They even met from time to time independently of the project. They had internalized what the project had taught them and wanted to stay connected with IFH and each other to keep improving and modernizing care on their own.

Another group is a *Coordinators’ Club* of some of the most active regional leaders and coordinators. Members discuss critical issues related to their professional work. This group is entirely independent of IFH and the project.

The third group is not comprised of health professionals, but of women’s groups, most of them informal and internet-based. The women wanted to create “*consumer groups*” to provide woman-to-woman support, to help women identify quality health care providers and to make providers more responsive to women’s needs. To do that, they sought information and assistance from the project.

Vologda Region did not play as large a role as expected in hosting visits because, even though it is a model for many modern approaches to MCH care, it is far away from the regions where most of the project’s work was being conducted (in the Urals Federal District) and because many of the more affluent regions considered Vologda, a poor region, not to be a relevant example to follow. On the other hand, KHMAO and Sverdlovsk Region stepped up to share their experiences with other regions.

Before each study tour, project staff worked with officials in the region on the design of the visit, to ensure that they addressed priority concerns, that time was used effectively, that key materials were available for the visitors and that all organizational arrangements were in place. The visits concluded with wrap-up sessions where the visiting regions met to review lessons learned, to decide on next steps

and to ensure that they returned home with all needed materials and technical resources to move forward.

In addition to exchange visits, the project used every opportunity to help regions learn from each other in other ways. It encouraged and supported its partner Federal Centers to use their professional meetings and conferences to involve people from surrounding regions—and this took place frequently, as can be seen from the list of conferences and seminars in Annex 7.

Another example is involving experienced trainers from more mature regions in conducting trainings in newer regions. This allowed the trainers to go beyond the standard curriculum, sharing first-hand information on lessons learned and practical solutions to challenging situations. They were also able to describe the process of project implementation in their home regions and share their own experiences.

The MPWG thematic subgroups that worked on developing and updating clinical guidelines, training materials and other national policy documents, under the leadership of the Kulakov Center and the project, were also a forum for regional exchanges. They allowed regional partners to discuss their results in implementing best practices in Russia alongside the international evidence.

The project also always invited its regional coordinators and heads of MCH services to participate in project events, knowing that this was a valuable opportunity for them to share experiences, both formally and informally, and to build bridges across regions. It was very clear by the end of the project, that informal networks such as these were a positive “unintended result” of the project’s work (see text box on page 48) with potential to sustain project efforts.

Task 3: Optimizing the Delivery of MCH/RH Care at the Regional Level (Regionalization)

The revised scope of work for Task 3 called for collaboration with the selected Federal Centers to facilitate the exchange and application of experience on optimizing the delivery of MCH/RH care at the regional level (regionalization), consistent with MOHSD policy. The project was charged with drawing on experience in a few regions (Vologda, Irkutsk and Tyumen) under the MCHI project.

Work on this Task was facilitated by the high priority accorded by the MOHSD—and consequently also by the regions—to the development of regionalized systems of care. However, the Ministry’s decree #808 on regionalization provided only the broad framework for regionalization—three levels of care, equipment required at the various levels and staffing. So project partners were open to more concrete guidance from the project.

The Project Implementation Plan presented the following key tasks to be accomplished, with the involvement of the Federal Centers and the Federal Institute for the Organization and Informatization of Health Care.

- Organize a workshop in each of two regions to build regional capacity to plan for regionalization: defining the three levels of care and the number of health facilities needed at each level, the scope of services at each level, equipment and staffing, transportation pathways and training needs.

Key Accomplishments—Task 3

- Development of *Guidelines on Regionalization* which served as a “roadmap” for partners;
- A very successful exchange visit for guests from 15 regions to Tyumen Region to learn from its experience in implementing regionalized perinatal care;
- Good progress in Kurgan Region toward implementation of three levels of care;
- Strong results from past project partners already implementing regionalized care:
 - Increased percentages of premature births taking place at higher levels of the health system;
 - Reduced perinatal mortality rates;
 - Reduced maternal mortality rates.

- The project will facilitate exchanges and application of experience and lessons learned in other regions such as Tyumen and Vologda.

The project worked with USAID and its two partner Federal Centers to select two regions—Kurgan and Leningrad Regions—for targeted technical assistance to build frameworks for a three-tiered (regionalized) system of MCH care. These two regions requested assistance on regionalization from the project and represented two different models of MCH service delivery in which to implement regionalization, allowing for learning opportunities from these different models.

One of the first steps was to join with University Research Corporation, the Kulakov Center and others for a two-day international conference on *Regionalization of Perinatal Care* held in Tver in spring 2010. The conference focused on current Russian and foreign experience in perinatal care, with IBP-MCH project staff and experts making presentations on “Basic Steps in Building a Regionalized Perinatal Care System in IBP-MCH Project Pilot Regions,” and particularly the experience of Perm Krai.

To help with the work on regionalization, early in the project, staff assisted Vologda Oblast to finalize its order on regionalization of care, based on best practices and evidence-based protocols (Order No. 750 on *Levels of Care for Pregnant, Intrapartum and Postpartum Women and Neonates*, July 8, 2010.) This designated which health facilities should provide which level of care, identified just one facility in each major city as a Level III provider, identified the medical conditions requiring transfer to another level, specified how equipment should be allocated, etc. The order served as a valuable model for other regions participating in the project and, to facilitate such sharing with a broad audience, staff assisted oblast officials in making the order available on the Internet at: http://www.volmed.org.ru/doc/index.php?type_doc=4&action=show_full&id=929&cat_id=7.

Guidelines on Regionalization of Perinatal Care and Regional Policies

One of the needs articulated by the regions early on was for guidelines on regionalization to give them a better understanding of what is involved, so this became a priority for the project. To start, project staff reviewed the experience of the US, Canada, Australia and Europe to identify best practices in other countries. Then workshops were held in St. Petersburg and Yekaterinburg in 2011, with representatives of the two Federal Centers, Kurgan and Leningrad regions and other selected partner regions. Some regions from past projects that had made progress on regionalization (Irkutsk, Kazan and Vologda) also participated to share their experiences and lessons learned. These workshops addressed the positive impact of regionalization on health outcomes; the key challenges in implementing regionalization of perinatal care in Russia; international models and systems of regionalization; and the main components of an effective regionalization system, including the definition of perinatal risk, transportation systems, audit and client counseling. They led to the formulation of the basic concept and structure of Russian guidelines and a working group that began drafting them. Drafts were then refined in intensive e-mail exchanges and small working group meetings.

The *Guidelines on Regionalization of Perinatal Care* were finalized in 2012 and endorsed by the Kulakov Center. They cover the following topics, most of them new for Russia:

- The rationale for regionalization
- Policy documents needed to develop a regional policy (19 Federal documents plus examples of policies from “old” project partner regions)
- The “passport” for the region, i.e. the number of doctors, nurses, hospitals, ambulances, telecommunications, etc. in place
- Identification of a risk strategy (drawing on ACOG’s classification of risk groups, e.g. twins, preterm birth, birth anomaly, and other conditions)
- Monitoring delivery at the appropriate level of care

- Auditing the effectiveness of the system (e.g. percentages of births that are preterm at various levels of care, time of transportation, etc.)
- Establishment and functions of Counseling Centers at Level III
- Transportation for mothers and babies in emergencies (vehicles, who accompanies the patient, medications needed in the ambulance, etc.)
- Training of medical staff at all levels on a continuing basis and education of the population to understand the purpose of a regionalized system.

The guidelines also cited examples from experience and results in Irkutsk, Komi Republic, Perm, Vologda and Yekaterinburg.

Work on the Guidelines was valuable not only in its own right, but to give partners a clearer idea of what is involved in developing a regionalized system of care. It also helped them develop appropriate regional policies.

Over the life of the project, partner regions adopted a total of 16 “basic” policies incorporating regional versions of Federal decree #808, defining the three levels of care in the region, in addition to federal facilities, and listed health facilities at the two referral levels. Ten “additional” policies on regionalization were also adopted, addressing neonatal resuscitation and care as well as emergency care counseling and monitoring. The project considers the number of policies adopted to be a major accomplishment and a keystone for sustainability in the future. (Table 10 provides information by region.)

Progress in Kurgan and Leningrad regions

From the early days of the project, IBP-MCH staff worked closely with Leningrad and Kurgan regions to help them define the three levels of care, consistent with the broad framework set out in MOHSD’s decree #808, the number of health facilities needed at each level of care, the scope of services at each level, equipment and staffing plans, transportation pathways and training needs.

IBP-MCH staff met leading MCH specialists in Kurgan Region in late 2010 to discuss the quality of MCH services in the region and approaches to providing care to high-risk women and neonates. This was followed by training in spring 2011 to help the region move toward regionalized care and to hold a meeting to assign levels of care to medical facilities in the region. Representatives from Kurgan Region also took part in a region-to-region exchange visit to Tyumen in 2011 where they learnt first-hand about Tyumen’s experience in successfully implementing its regionalization protocol. As a result of this and other technical assistance from project staff, by the end of the project, Kurgan Region had made good progress in developing—and starting to implement—a written plan for regionalization. The plan included opening a Regional Perinatal Center, the only Level III facility in the region (now operational); strengthening maternity hospitals in larger population centers around the oblast to function as Level II facilities; and gradually closing the smallest Level I maternities.

In Leningrad, IBP-MCH staff visited the region to study the organization of health care. They found many Level I facilities in small towns scattered throughout the region, a few Level II facilities, but no regional perinatal center. Moreover, there was a major problem with St. Petersburg City perinatal centers often refusing to provide emergency care to patients from the region because of the difficulties inherent in financing care across administrative boundaries, since St. Petersburg and Leningrad Region are independent regions. Although the project helped Leningrad Region strengthen and upgrade Level II facilities in Gatchina and Vyborg to a higher level, the fundamental challenge of access to a Level III facility was not solved and will be extremely challenging to resolve in the absence of health financing reform.

It is worth noting that, due to the project’s approach of sharing between regions, other IBP-MCH partner regions made good progress toward developing a regionalized system of perinatal care. A case in point is Sverdlovsk Region, where regional leaders developed a scope of work, training plans and protocols.

Model delivery systems of MCH/RH care functioning effectively

Establishing an effective regionalized system of care is a long, complex and expensive undertaking that also entails overcoming some major political hurdles—e.g. closing health facilities, rationalizing staffing and mobilizing resources for buildings, equipment, ambulances, etc. Kurgan, Leningrad and other partner regions made good progress but were only able to take a few steps forward over the short life of IBP-MCH.

The project chose to support the establishment of Emergency Care Counseling Centers as a crucial element for effective operation of a regionalized system of care. Generally known as Resuscitation Counseling Centers in the regions, these should be established at the tertiary level to support Levels I and II facilities and to coordinate transportation and preparation for care in emergency situations. Project staff worked with counterparts in partner regions to help them understand the role of these centers, their scope of work and appropriate staffing and equipment needs. A number of regions already had a counseling center, so the project's role in those cases was to strengthen their operation, but other regions needed to start from scratch. Unfortunately, information about the establishment of these centers was only available from some partner regions at the end of the project. Vologda and Tyumen both reported Emergency Care Counseling Centers, Kurgan reported two such centers and KHMAO three. Information from other regions was not available.

While the project was not expecting to have concrete results of regionalization efforts from partner regions, Tyumen Region, which had been working for a number of years to build an effective system of regionalized perinatal care—and which served as a model for others during the life of the project—could show some compelling results. Tyumen saw a clear shift of higher risk deliveries away from Level I (the lowest level) to Levels II and III (higher levels) of the system. This is shown by the percent of premature births managed at Level I declining from 22% to 7.5% between 2005 and 2010, with corresponding increases in management of such cases at Levels II and III (Figure 3.a). As this shift took place, perinatal mortality in Level I facilities declined by 30% between 2007 and 2010 (Figure 3.b) and maternal mortality dropped (Figure 3.c.) While it would be misleading to claim that this is directly attributable to the regionalization of care, the results are encouraging.

Figure 3.a: Percent of Births that were Premature, by Hospital Level, Tyumen Region

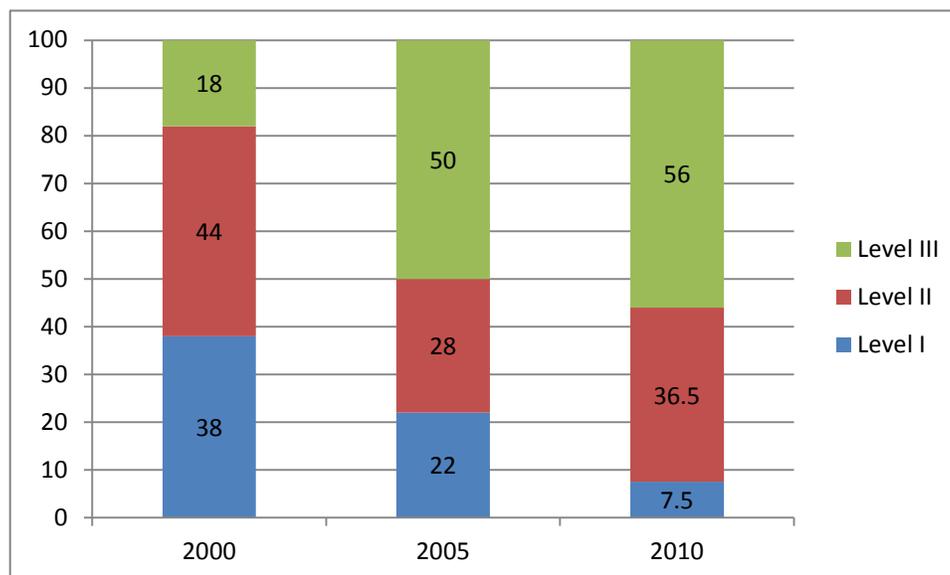


Figure 3.b: Perinatal Mortality Rate (per 1,000 live births) in Level I Maternities, Tyumen Region

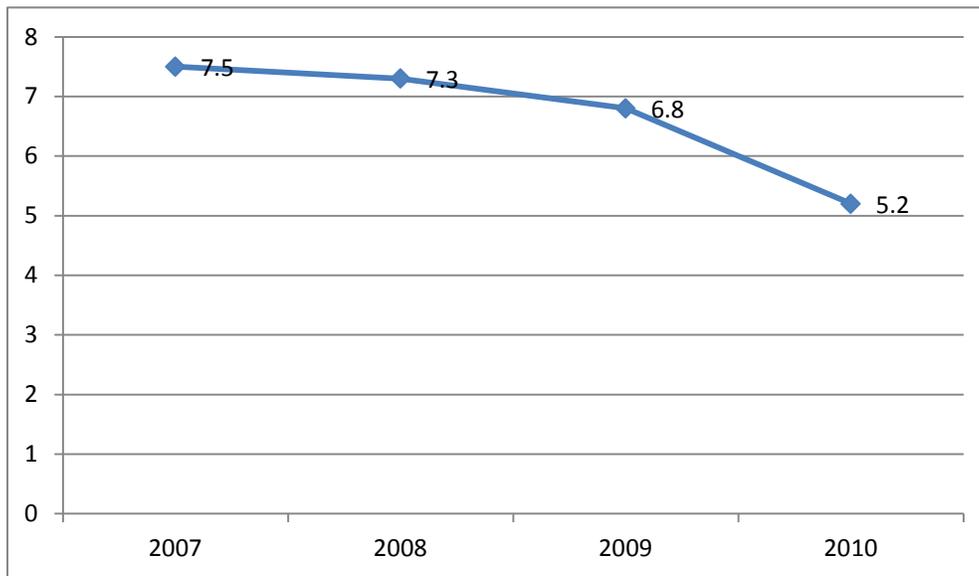
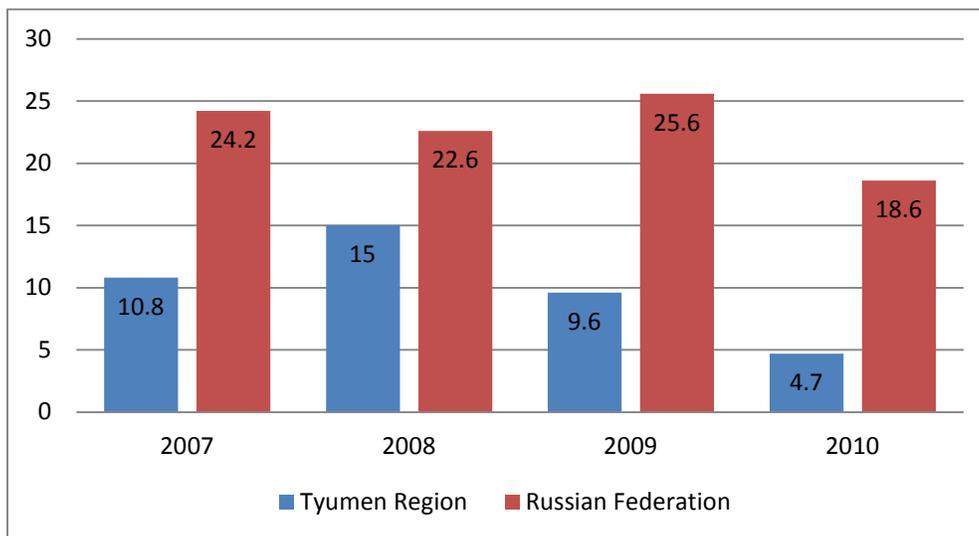


Figure 3.c: Maternal Mortality Ratio in Tyumen Region (per 100,000 live births)



Task 4: Improving Access to Appropriate Family Planning, Prenatal and Postnatal Care for High-Risk Women

Task 4 under the revised scope of work involved working with 1-2 regions to improve access to MCH care among high-risk women in order to improve MCH outcomes among hard-to-reach populations who often account for a significant share of maternal and infant morbidity and mortality and child abandonment. The work was to be consistent with the framework of MOHSD decree #389 on the provision of medical-social assistance, including through social workers in women’s consultations. The approved Implementation Plan set out the following major activities:

- Reaching consensus with key stakeholders on the definition of high-risk women;
- Developing a tool to assess current practices in the selected regions regarding the provision of family planning, prenatal and postnatal care to high-risk women;
- Assessment visits to the selected regions, followed by workshops to discuss the findings, recommendations and develop plans of action;
- Trainings on approaches to implement the plans;
- The results of the assessments were to be shared with other regions and MOHSD.

Key Accomplishments—Task 4

- Conducted an assessment in two regions of current practices regarding provision of medical-social care related to family planning, prenatal and postnatal care to high-risk women;
- Developed *Algorithms on Medical and Social Care for High-Risk Women* to help health and social workers identify high-risk women and provide them with appropriate assistance;
- Trained providers to use the *Algorithms*;
- Published two articles in professional journals about the project's work in linking medical and social services, spreading information about this important new topic.

As can be seen in the text box above, the project's accomplishments went beyond the work envisioned in the implementation plan and at the end-of-project conference a number of regions expressed strong interest in introducing the assessment tool in their own settings. The work done on Task 4 was at the heart of the project's efforts to improve services for vulnerable, high-risk women and for adolescents, putting tools into place and, through meetings and training, building sensitivity among service providers about how to identify and serve these vulnerable groups more effectively.

MOHSD Decree #389 (2007) on *Improvement of Health and Social Care in Women's Consultations* and Decree #808 (2009) on *Obstetric and Gynecologic Care* required health care providers to establish social cabinets (offices) and, as IBP-MCH was starting, regional health departments and individual health facilities were struggling to define the role of the new cabinets. So IBP-MCH's focus on this area was welcomed. To allow the Federal Centers to learn about effective integration of health and social services for high-risk women, as well as to participate in the process used to develop this program initiative, they were involved in key steps in the process and in important meetings.

"The project made it possible to bring medical and social staff together."

Participant from KHMAO speaking at the end-of-project conference

The results of the project's work on medical-social care were clearly appreciated, with regions greeting the project's tools and approaches with enthusiasm and voicing their desire to replicate these approaches.

In the early months of the project, while activities were delayed pending discussions between USAID and MOHSD, IBP-MCH staff reviewed almost 250 resources in the international literature on medical-social care for high-risk women. From this review came a list of key best practices to improve MCH outcomes among high-risk women: an effective system to assess social risks among women of reproductive age; improved access to appropriate family planning, prenatal and postnatal care through development of a plan for medical-social support, case-management and home visits; financial support and provision of temporary accommodation, food and other necessities; availability of appropriate information about social care and health care; peer support; and free contraception.

This review phase also allowed the staff to identify the most relevant international guidelines to be adapted to the Russian context. The example selected was *Pregnancy and Complex Social Factors, Guidelines for Service Provision for Pregnant Women with Complex Social Factors*, commissioned by the National Institute for Health and Clinical Excellence in the United Kingdom, developed by the National

Collaborating Centre for Women's and Children's Health and published by the Royal College of Obstetrician-Gynecologists in 2010.

An early activity was to designate KHMAO and Tyumen Region as sites for implementation of Task 4, after discussions with USAID, the Urals Institute and partner regions in the Urals Federal District. Both of these regions were interested in working on medical-social collaboration, had well-developed systems of social care, the interest and ability to reach high-risk women and were in a position to cost-share with the project by contributing staff time, office space, meeting space, equipment, etc.

Defining high-risk women

The next concrete step was to define high-risk women. Project staff were already aware of Russian federal policies and regulations that provided an appropriate legislative framework to develop models for high-risk women. They reviewed the federal orders and other legislative documents related to medical-social care for high-risk women, compiled a database of Russian normative documents and identified federal and regional stakeholders specializing in social care. Then the project worked with the heads of the health and social departments in the two project regions to establish partnerships between social and health care specialists, develop a definition of high-risk women and to plan collaboration. The definition adopted combined international definitions with that of a "difficult life situation" under Russian law ("Fundamentals of Social Care," #195, 10.12.1995) and identified women experiencing one or more of the following problems: poverty*; alone; unemployed; homeless; family violence; serious disease; disability; alcohol and drug dependency.

Assessment of current practices

Then project staff developed a tool to assess current practices in the provision of health and social services related to family planning, prenatal and postnatal care to high-risk women, including the role of social workers at women's consultations, links with social services, potential avenues of cooperation and barriers. The tool drew on federal legislative documents as well as language in the USAID contract for IBP-MCH.

The assessments were conducted in KHMAO and Tyumen Region in early 2011 and involved structured interviews with leading regional health and social services stakeholders. Key findings were that, despite the fact that MOHSD decree #389 requires medical-social assistance to women, there were a number of important gaps:

- No evaluation of social risks in health care facilities;
- No focus on the special health needs of high-risk women in health facilities and health providers were not informed about social support to high-risk women;
- No involvement of social services in assisting high-risk women to get appropriate health care;
- No effective linkages or referral systems between the social and health sectors in family planning and MCH. Many leading specialists of both departments met for the first time at project events.
- No social workers in women's consultations in Tyumen Region; and in KHMAO, only a few women's consultations had social providers on staff;
- No special standards of care for vulnerable women, those suffering from substance abuse and family violence.

Afterwards, workshops were held in the two regions with the heads and leading specialists of health and social departments to discuss the findings of the assessment and develop a plan of action. IBP-MCH

*The official definition of poverty was a monthly income below 3,500 rubles per family member.

specialists presented international best practices to support high-risk women in family planning, prenatal and postnatal care. And the regions noted that there was already some collaboration between MCH health services and social services. For example, in cases where a woman in a maternity hospital planned to abandon her child, social providers were brought in to determine why and to explore with her the option of keeping the child. Both regions also noted that they had some systems in place to support women who had experienced family violence.

The plan of action for the project that emerged from these workshops centered on developing recommendations for medical-social collaboration to provide high-risk women with effective support in family planning, prenatal and postnatal care; developing and testing a questionnaire for use by health providers in women's consultations, maternities and children's polyclinics to assess women's risk and social status; developing a training program on *Medical-Social Support for Women in Difficult Life Situations*; and conducting trainings in the two regions.

There is more detail about the results of the assessments and the plan of action in the project report *Assessment of Current Practice to Reach High-Risk Women with Appropriate Family Planning, Prenatal and Postnatal Care and Plan of Action*, April 2011.

Algorithms on Medical and Social Care for High-Risk Women

The assessment results guided development of a standardized questionnaire for use by health and social providers in women's consultations, maternities, children polyclinics and social facilities to help them assess women's social risk factors in the prenatal and postpartum period and to provide guidance in planning support for those in difficult life situation. This eventually became the *Algorithms on Medical and Social Care for High-Risk Women*.

After receiving comments from the regions on the draft questionnaire, it was revised and prepared for pretesting. The study protocol for the test was approved by the Ethical Committee at the National Research Center for Preventive Medicine, which is registered with the US Department of Health and Human Services as a review board to protect human subjects participating in research projects funded by the US Government. The testing took place in KHMAO and Tyumen Region in late 2011, in close collaboration with the regional health and social development departments, and involved interviews with 155 women who were either pregnant or postpartum (including 44 living with HIV.)

The most frequent risk factors to emerge as a result of the testing process were unemployment, migrant status, family violence and smoking. Women living with HIV had more risk factors and were more likely than the entire study population to experience most of the risk factors. Among this group, the most common risk factor by far was low-income, but migrant status, smoking and unemployment were also very important.

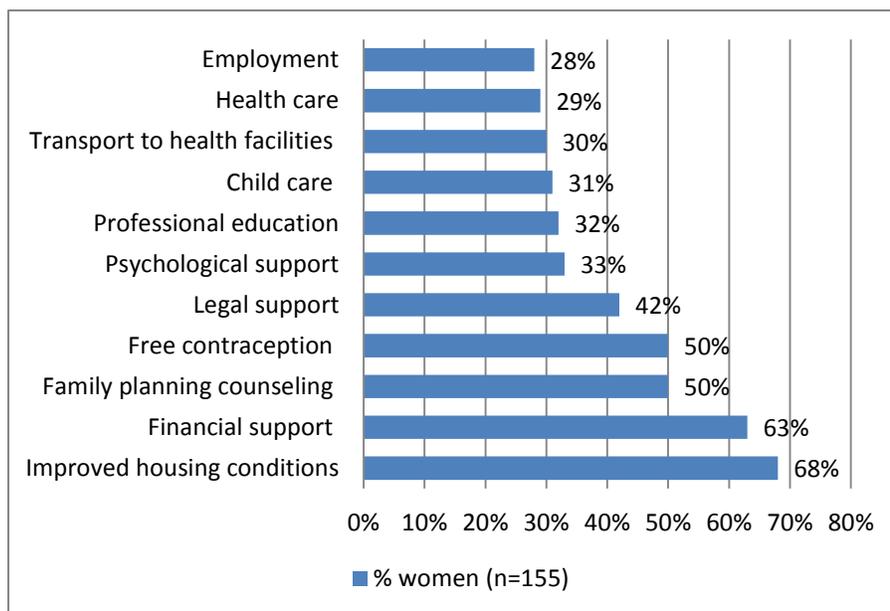
"Due to this study we identified serious social problems in several women living with HIV that we had not known about before. We provided them with comprehensive support that significantly improved their lives and the lives of their children. The questionnaire works!"

*Deputy Head of the HIV-AIDS Center
in Nijnevartovsk, KHMAO*

The testing of the questionnaire also pointed to the types of support most often needed by high-risk women (see Figure 4 on page 58.) This included improved housing conditions, financial support, family planning counseling and free contraception as well as several other needs. It also highlighted the importance of working with health and social workers on a number of sensitive topics that were later incorporated into the training. These professionals often failed to create an environment where women would feel "safe" and sure that their confidentiality would be respected. And many failed to treat the most vulnerable women as clients who deserve respectful, client-centered care. There were significant attitudinal issues that needed to be addressed.

The project report, *Testing a Questionnaire for Social Risk Factors affecting Women’s Access to Family Planning and MCH Services, Report of Main Findings* (February 2012), provides more detail on the results of the testing and the study methodology.

Figure 4: Support Needed by Women during Pregnancy and Postpartum



This testing shaped the final *Algorithms on Medical and Social Care for High-Risk Women*, produced in 2012. They include 25 screening questions, with appropriate guidance for medical-social care in each situation—including for women without any risk factors. The document also provides guidance on how to use the algorithms in a sensitive, non-judgmental manner that respects the client’s confidentiality. And it includes resource materials with the most essential information on healthy nutrition, prevention of child abandonment and family planning. A sample client record to include in the woman’s files in a health or social service facility is also provided.

Trainings on medical – social care for high-risk women

Three three-day trainings on medical-social care to high-risk women were conducted in KHMAO, Tyumen and Kurgan in early 2012 for a total of 98 ob-gyns, social care specialists, psychologists and midwives. The focus of the trainings was on the rationale for providing medical-social care to high-risk women and on use of the new *Algorithms*. The course emphasized counseling skills to sensitize providers to the importance of being sensitive to women’s reluctance to discuss their social problems and to encourage them to treat women with respect so as to combat the stigma and discrimination against high-risk women the project had observed among many providers. A training participant captured the impact of the course, saying, “I changed my attitude to women living with HIV.” Test scores also attested to the improvement in participants’ knowledge and attitudes, which rose from 81% at the pretest to 97% at the posttest across the regions.

Policy

The fact of the project’s two partner regions adopting policies on medical-social care also attests to the value they placed on this initiative and their commitment to work in this area.

- The health and social care departments of KHMAO developed regional order #163-p/118 in 2011 on coordination between health and social facilities in the region to support pregnant women and women with children in difficult life situations.

- The two departments subsequently issued a joint decree on implementation of the *Algorithms on Medical-Social Care* (#309.398-p22.06.2012)
- The health and social care departments in Tyumen Region worked to update the Memorandum of Collaboration between the two departments (#750, 10.10.2008.)

Dissemination

As in other areas of the project’s work, dissemination of information on the integration of medical and social care was an integral part of the work.

Based on the literature review early in the life of the project, staff prepared an edition of IFH’s *Family Health* bulletin on the topic of *Medical-Social Care for High-Risk Women* (3/2011.) This offered recommendations (see text box at right) and was widely disseminated at project meetings with health and social providers and through the IFH website.

<p>Recommendations to Improve Services for High-Risk Women</p> <ul style="list-style-type: none"> • Evaluate the prevalence of social factors that adversely affect MCH; • Routinely assess risk factors in women’s consultations, maternities and children’s polyclinics and identify high-risk groups needing immediate medical-social care; • Train medical and social providers in effective medical-social care for high-risk women; • Combat stigma and discrimination against high-risk women; and • Disseminate best practices in medical-social care for high-risk women. <p style="text-align: right;">Source: <i>Medical-Social Care for High-Risk Women</i>, <i>Family Health</i> bulletin, IFH, March 2011</p>

In spring 2011, after the assessment was completed, the results and recommendations were presented to Russian regions and federal stakeholders at the Surgut (KHMAO) Conference on *Modern Approaches to Improving the Quality of Women’s and Children’s Healthcare Services*. Representatives from KHMAO, Tyumen and Kurgan also shared their experiences in organizing medical and social care for high-risk women at the conference.

“The project’s algorithms are very helpful. They need to be more widely disseminated and adopted.”

Representative from Tyumen Region Health Department

At the end-of-project conference, the *US – Russia Forum*, an entire session was devoted to the topic and the *Algorithms on Medical and Social Care for High-Risk Women* were presented to the broad audience attending the conference. Representatives from KHMAO and Tyumen discussed their work and expressed their appreciation that the project had made it possible to bring medical and social staff together.

The regional representatives spoke about the encouraging early results they were seeing from the emerging collaboration. And American presenters shared examples of US approaches to reaching high-risk women and tailoring services to their needs. Project staff were also invited by Russian federal stakeholders to present the algorithms at national and international events, such as the *National Conference on Effective Prevention Strategies for Populations at High Risk of HIV* in Suzdal and the *International Forum on Women, Children and HIV* in St. Petersburg, both in the fall of 2012.

Task 5: Sustainability Plan

The project was charged with developing a sustainability plan outlining how improvements made at the Federal District and regional levels would be used to advocate for change at the Federal level and with non-participating districts. This plan was also to address how Russian experts at the Federal District and regional levels could disseminate best practices and experiences developed through the project using Federal and/or regional government funds.

Key Accomplishments—Task 5

- Developed a sustainability plan approved by USAID;
- Left behind eight new federal policies embodying evidence-based best practices on MCH/RH. This policy framework supports modern practices throughout the Russian Federation;
- Developed eight trainers from the Federal Districts, as well as trainers in partner regions, who can continue to promote modern practices;
- Institutionalized best practices in medical, nursing and midwifery schools, where they will be taught for the foreseeable future;
- Disseminated evidence-based MCH/RH policies and practices to broad audiences through numerous conferences and workshops, publications and web-sites;
- The Institute for Family Health, the project's Russian implementing partner, won two grants/contracts from Russian clients who were willing to invest in technical assistance to improve their MCH/RH programs.

See also the text boxes on page 25 and 27 about the Multi-Partners Working Group and Evidence of Institutionalization.

Consistent with its name, the *Institutionalizing Best Practices in MCH* project sought to institutionalize and sustain best practices in MCH/RH in order to advance the project goal of decreased maternal and infant morbidity and mortality in the target Federal Districts. Efforts to build sustainability ran through all aspects of the project's work, implementing the contract language and the more detailed activities described in its Sustainability Plan approved by USAID.

The approved Implementation Plan identified dissemination of project interventions, approaches, strategies and experience to broader audiences at various national and international meetings, conferences and other events to increase the overall supportive policy environment and ensure further sustainability. It also noted that the project's focus on policy and effective implementation of policy was particularly critical to institutionalizing the project's work. And it explained how conferences to be held in the middle and at the end of the project would disseminate project approaches to build

momentum for implementation of new policies and practices, while at the same time increasing the technical capacity of participants.

Finally, the IBP-MCH contract stipulated that the project's Final Report should describe "how Russian partners will continue activities beyond the completion of the project to ensure project sustainability."

To address all these interlinked approaches to sustainability, this report groups the project's activities to promote sustainability under the following strategies:

- Policy as a mechanism for sustainability;
- How Russian partners will continue project activities;
- Disseminating improvements to advocate for change;
- IFH as a Russian legacy organization.

Policy as a mechanism for sustainability

Prior USAID projects had made it abundantly clear that adoption of Federal policies that endorsed the new international approaches to MCH/RH was badly needed, since many regions were reluctant to move forward with modern practices because they conflicted with federal law and policy. It was very clear that, in a country with a highly regulated environment and powerful mechanisms to enforce laws and regulations and punish infringements, Federal policy was *the* most powerful incentive to institutionalize the project's approaches. So supporting adoption and dissemination of modern, evidence-based policies was a major priority for the project in order to encourage Federal Districts and regions nationwide to update their practices—and it had a high degree of success.

The Kulakov Center was an essential partner in this effort, since it is responsible for setting federal policy on MCH/RH and recommending its adoption to the MOHSD. However, the project approached its work with the Center with a double agenda. Of course, it wished to support adoption of as many new and effective policies as possible. However, it also worked with senior staff at the Center to demonstrate the *process* of developing good evidence-based policies, preparing them to carry on this work independently later on.

The federal policies adopted by the Kulakov Center and the MOHSD stand as a powerful testament to the success of the project's agenda in terms of actually influencing policy. The project leaves a policy legacy that supports modern practices throughout the country on contraception, premature birth, newborn resuscitation, infection prevention and control and other critically important topics. (See more detail in Task 1.) Moreover, since policy is only effective if people are aware of it and implement it, the project also supported the Kulakov Center in disseminating these policies and promoting their adoption in clinical practice.

In terms of demonstrating the *process* of developing evidence-based policies, the MPWG and its thematic subgroups played a central role. Working groups are widely recognized as a best practice in the countries of the former Soviet Union to foster effective, lasting change because they provide a forum for key players to discuss matters openly, reach agreement, and then ensure that there is a group of people who stand behind the consensus. Over the life of the project, working groups provided a forum for many important players at the federal and regional levels, as well as in academia, to become more familiar with EBM and its value in formulating policy and shaping practice. And they demonstrated the value of involving the regions and service providers—and not only top professors, as in the past—in the policy development process, allowing actual experience in the field to play a part in policy development.

The project's work to build understanding and support for EBM at the highest levels of the MCH system was arguably one of its most important contributions. The single most crucial skill to transfer to counterparts in policy-making positions in order to promote sustainability is how to find, evaluate and use the best evidence to shape clinical policy and practice. So long as they rely on international projects to provide that evidence, MCH care will not keep pace with the rapid progress taking place around the globe. Enormous progress was made on that count, with the Federal Centers and many regions learning the vocabulary of EBM and the value of looking at international evidence. The tremendous interest of the Kulakov Center in developing new evidence-based protocols bodes well for the future. However, developing the rigorous methodological skills and the English language skills to enable the Center to move forward on its own will take more time.

How Russian partners will continue project activities

The core of the project's approach to building the capacity of Federal and regional partners to continue the project's work after it ended was to strengthen leadership at the federal and regional levels to carry forward the new international approaches introduced through this and prior projects. From the beginning, these key partners were made responsible for project implementation and involved in all details of implementation so as to build their capacity to expand and strengthen the project's work all over their territories and after the end of the project.

Promoting Good Governance

Project staff devoted almost as much attention to the *process* of bringing about changes in the health system as they did to the actual changes being made. The *process* was crucial to building a base of support for the changes, to promoting sustainability—and also to demonstrating basic principles of good, accountable and responsive governance in the health sector. The project sought to move away from the old model of a few national experts setting policy and practice for the entire country, based on their opinions and experience, and coupling this with rigid enforcement mechanisms. Rather, it promoted:

- *Evidence-based decision-making* as the foundation of health policy and practice, because following the evidence dramatically increases the chances that changes will be successful—that they will improve clinical practice and health outcomes.
- *Participatory decision-making* through working groups representing a range of stakeholders from around the country to bring a variety of perspectives and experiences to the table and to build support for new approaches.
- *Decentralized decision-making*, recognizing that local decision-makers have a greater investment in improving their work when they are empowered to make changes themselves. The project gave leaders at the local level the tools to improve MCH/RH care on their own—without waiting for inspections from higher levels of the system.
- *Empowering clients/the population* by placing them at the center of decision-making about the health care they will receive and helping health care providers see their role as serving clients, rather than doing to patients what they think is needed.

The project worked with both the Kulakov Center and the Urals Institute to strengthen their role in providing leadership to the field to adopt modern evidence-based policies and practices, and considerable progress was made. As outlined under Tasks 1 and 2, the project helped them learn about new program management approaches, most importantly policy-making using EBM; modern training techniques; supportive supervision; use of various quality improvement and monitoring tools; the role of accurate data in improving the quality of care; as well as working to conceptualize and develop their capabilities in providing training and resources in their territories.

At the regional level and below, project staff identified counterparts in leadership positions and worked to develop their capacity. Counterparts were selected with a key consideration being their potential to expand the project's work on their own over the life of the project and beyond. They were usually senior officials in regional and city health departments, academic institutions, professional associations and heads of regional or municipal facilities that set the trends in their regions and/or had oversight responsibility for other health facilities. The project made counterparts' responsibilities very clear from the beginning, through collaboration agreements stipulating that they would disseminate project practices in their region. Then the project built these leaders' understanding and commitment to best practices through working groups and workshops and by giving them the tools to advocate for the best practices and to monitor their

implementation. The broad geographic reach achieved by the project, as well as the positive assessment results, attest to the success of this strategy.

For years, USAID projects have been building cadres of skilled trainers at the regional level to ensure that regions have the capacity to roll out the new practices after project assistance ends. The best trainers from regions where the project had worked in the past played an important role in training providers in other regions in this project. And efforts were under way at all times during the current project to develop more strong trainers. The project selected training participants with a view to their interest and capacity to share what they learned with others afterwards. And regional trainers helped teach many of the standard training courses and conduct follow-up visits, freeing up project staff to work on other things.

One difficulty, however, was that regions had difficulty paying for professional-standard workshops like those conducted by the project because of limitations on how Government funds could be used, so

project staff encouraged counterparts to take advantage of regularly scheduled gatherings of health workers, such as Obstetrician-Gynecologist Days, regular meetings of city and/or rayon officials, etc., to disseminate the new practices. These proved effective mechanisms for mini-trainings that could be done in all regions and the expectation is that they will continue—using the regional trainers developed under the project.

Institutionalizing best practices in medical, nursing and midwifery schools was a conscious approach to ensuring that future cohorts of health professionals will embark on their medical careers equipped with the best information and skills; and that those already working will receive up-to-date information through continuing medical education courses. Five of the project's 10 partner regions had medical schools—most notably Chelyabinsk State Medical Academy, 1st Moscow State Medical University, Urals State Medical Academy, Tyumen State Medical Academy and Surgut State University (KHMAO.) So IBP-MCH worked with academic leaders to support adoption of its materials and to update their teaching. Many health administrators and heads of perinatal centers who participated in the project also served as faculty in these academic institutions, facilitating integration of the new material.

An important measure of commitment to improving MCH/RH care is investment in these services. To promote this, the project's agreements with partners required them to make contributions in cash and in kind in return for project assistances as to promote the idea of investing to strengthening services. Details of the agreements differed from one region to another, but typically regions contributed the time of senior officials; they organized project trainings and events; provided venues for trainings and meetings; paid salaries, travel and lodging for staff attending workshops and meetings; and provided free mass media coverage. They also made other major contributions, such as upgrading health facilities to provide individual rooms for women; purchasing equipment like heating lamps for newborns and birthing balls for women; paying for printing; procuring free contraceptives for vulnerable populations and essential evidence-based drugs, such as oxytocin. The groundwork was laid for partners to invest in further improvements in the future.

Disseminating improvements to advocate for change

Project staff's experience in the Russian Federation over many years showed that broad dissemination of evidence-based MCH/RH policies and best practices was crucial to create a climate of understanding and acceptability, to build demand for the new approaches and to speed up their adoption. Project staff took advantage of every opportunity to speak at important national, subnational or regional conferences and seminars, to publish and otherwise disseminate important information and to help and encourage the Federal Districts and regional partners to do the same.

- The project conducted several major dissemination events—as well as many other lesser ones—where best practices and the latest policies were disseminated to project partners and broader audiences all over the Russian Federation. (See Annex 6 for details.)

Key events were a two-part mid-term conference, organized in collaboration with the Federal Centers, to disseminate international approaches and best practices:

- The first part was the March 2011 Tyumen conference on *Perinatal Care in the USA: the Role of Professional Medical Associations* which provided an opportunity for leaders in the Russian MCH community to hear first-hand from ACOG representatives how American ob-gyns address some key issues facing their Russian counterparts. Over 200 participants from 16 regions attended this important dissemination event.



Photo: Representatives of JSI, IFH, ACOG and Tyumen Region at the conference on Perinatal Care in the USA: the Role of Professional Medical Associations in Tyumen City, 2011

- The second part was the conference *Modern Approaches to Improving the Quality of Women’s and Children’s Healthcare Services* held in May 2011 in Surgut (KHMAO) and attended by representatives of 12 regions. A major emphasis at the conference was on dissemination of evidence-based best practices in MCH, including the *Protocol on Premature Birth*, developed by the Kulakov Center together with the project, and key information about the importance of linking medical and social services for high-risk women.
- The end-of-project conference, the *US – Russia Forum: Bilateral Collaboration to Improve Women’s and Infants’ Health*, held in May 2012, drew over 250 participants from 26 regions of the Russian Federation and other countries. It featured 10 US speakers representing ACOG as well as project partners from the Federal Centers and partner regions discussing state-of-the-art approaches to key MCH challenges in reducing maternal and infant mortality and morbidity. (See text box on page 38) Two important new resources for health care providers were presented and discussed at the conference: the *National Medical Eligibility Criteria for Contraceptive Use* and the *Initial Care and Resuscitation of Newborns Training Course*, both endorsed by the Kulakov Center. The project’s *Algorithms on Medical and Social Care for High-Risk Women* were also presented and the pilot regions shared their experience. All the materials developed over the life of the project were discussed—or at least mentioned—and made available to participants.
- Other important conferences were *Perinatal Care in the USA: the Role of Professional Medical Associations*—the same event mentioned above, but held in other cities—at the Kulakov Center in Moscow and in St. Petersburg in 2011, with over 250 participants. The Moscow conference drew national leaders in the MCH field, including national-level policy makers and leading academics, while the St. Petersburg event attracted MCH specialists and leaders from Leningrad Region and some from St. Petersburg City.
- In addition to these major dissemination events, project staff made 54 presentations and/or conducted workshops, seminars or master classes on a broad range of issues at a minimum of 28 national, subnational or regional events over the life of the project (see Annex 7.) Such events were important to reach broad audiences—including those beyond current partner regions—so as to spread information about the new approaches more widely around the country. Some examples are

a 2010 conference in St. Petersburg on *Premature Birth*, where modern, evidence-based practices were presented and discussed, and a 2011 *Therapeutic Forum* organized by the Tyumen Regional Health Department, where a variety of modern approaches to MCH/RH care were discussed, including client-centered care and interdisciplinary approaches to RH.

- Just as important as disseminating information directly, project staff worked closely with Federal District and regional partners to support them in their dissemination activities, as mentioned under Tasks 1 and 2.
- The project produced and/or reprinted 13 editions of the IFH bulletin *Family Health*, which were distributed at trainings and conferences, sent out by mail and e-mail to individual and institutional recipients all over the country and placed on the IFH website. Seven new editions were developed and produced on the following topics:
 - *Newborn care* (1/2010)
 - *Medical Eligibility Criteria for Contraception: What's New Worldwide?*(1/2011)
 - *Management of Very Low Weight Babies* (2/2011)
 - *Medical-Social Care for High-Risk Women* (3/2011)
 - *Protracted Labor* (4/2012)
 - *Shoulder Dystocia* (4/2012)
 - *Use of Oxytocin* (4/2012)

Bulletins on *Hemorrhage, Eclampsia, Cesarean Section as a Method of PMTCT, Preterm Labor, Adolescent and Youth Reproductive Health and Counseling* were reprinted and distributed.

- Project staff wrote 14 articles that were published in professional journals. In addition to being important vehicles for dissemination, these articles attest to the quality of the work done by project staff and the wide professional interest in their work (see list in Annex 8.)

In addition, there were 145 articles/reports about the project and its work in regional press, on television, radio and the Internet, reaching the general public (see Annex 9.)

- The IFH website (www.ifhealth.ru) was a critical resource to disseminate evidence-based information and materials on MCH, family planning and reproductive health—such as training manuals, model protocols/guidelines, job aids and patient education materials—as well as information about the project and the partnership with ACOG. The site was continually updated with new materials and information and was used by ever-increasing numbers of people around the country—and in 26 other countries.* Users came from 53 Russian regions—predominantly from Moscow, but also (in order of frequency) from Sverdlovsk, Tyumen, Leningrad, Chelyabinsk, Kemerovo, Irkutsk, Novosibirsk, Kurgan and other regions—demonstrating the value of the site to spread information. The number of visits to the site each month grew from around 1,000 in 2010 to about 7,400 in 2012 and the number of users rose from 445 to 1,125 in the same time period. Most users were physicians (45%), but public health executives constituted 30% and staff in medical education institutions accounted for 11.5% of users. On average, each visitor surfed at least seven pages per session, indicating that the information on the site was useful and interesting.

*The largest numbers of international users, in descending order, were from the US, Ukraine, Kazakhstan, Belarus, Belgium, Bulgaria, Moldova, Uzbekistan, France and Tajikistan.

The Institute for Family Health (IFH) as a Russian legacy organization

Last, but by no means least, IFH itself was a central part of the strategy adopted by project staff to spread best practices in MCH/RH and leverage funds from a variety of sources. Since it was established as an indigenous Russian organization in 2006—thanks to USAID assistance—IFH has been seeking out opportunities to help Russian and international partners expand the reach of new evidence-based approaches to MCH/RH care. During the period of the IBP-MCH project, it signed five contracts with Russian local authorities, including two on MCH that effectively leveraged funds for activities that expanded the reach of the project's work:

- With Sakhalin Regional Health Department to reprint IFH's MCH materials for health providers in the region;
- With Surgut City (KHMAO) to develop a clinical protocol on *Care for Infants with Extremely Low Birth Weight at Birth and during the First Year* for the Surgut Clinical Perinatal Center.

The others related to HIV prevention—also an important element of MCH and reproductive health.

IFH has been gradually building an international reputation for its expertise and, over the life of IBP-MCH:

- Representatives from Kazakhstan, Kyrgyzstan, Ukraine, the US and Uzbekistan attended six project events.
- The Chief Specialist on Clinical Issues, Dr. Oleg Shvabskiy, was invited to speak about *Programs to Prevent Drug Addiction among Teenagers* at a 2011 conference in Ashgabat, Turkmenistan.
- The Chief of Party, Dr. Vartapetova, made two visits to Ukraine in 2011 to provide technical assistance to the USAID-funded *Maternal and Infant Health Project*, which was similar to the Russian MCH projects. She assisted with assessments of perinatal care in two regions of the country, advised on the development of national policy, shared IBP-MCH's work on the regionalization of perinatal care and discussed strategies to improve perinatal care with top officials in Ukraine's Ministry of Health. Ukrainian specialists planned to draw on training materials, guidelines, clinical protocols and information and communication materials developed by IBP-MCH and prior projects.
- Representatives from the Ukraine *Maternal and Infant Health Project* and the Ukrainian Presidential Perinatal Care Initiative visited St. Petersburg in 2011 to participate in a project workshop on *Perinatal Care Regionalization* to inform their own work on regionalization.
- Project staff facilitated a visit in early 2012 of a Ukrainian delegation organized by the Ukraine *Maternal and Infant Health Project* to Irkutsk Region, a pilot region under MCHI and still a pioneer on MCH issues, to see modern perinatal care in action and to learn about their successful experience with regionalization.
- Dr. Vartapetova participated in the 2012 World Federation of Public Health Associations Congress and a JSI Maternal, Child and Neonatal Health technical meeting in Addis Ababa, Ethiopia, making presentations on best practices and results in regionalization of perinatal care.

Management, Monitoring & Evaluation

Management

The project got off to an unusually slow start. This was due to a changed environment at the MOHSD that prompted USAID and the Ministry to review the project's agenda. And in the meantime, the Mission asked JSI to hold off on full project implementation. During this waiting period, which lasted almost 18 months, project management made wise use of time to update training manuals, model protocols/guidelines and other important materials to ensure that they reflected the latest evidence; to research linkages between health and social services; to write articles for publication; and build ties with the Kulakov Center and ACOG.

True project implementation began at what should have been the half-way point in the project—when a contract modification was issued with a revised scope-of-work. The modification brought an important benefit to the project, in the form of support from MOHSD and the Kulakov Center, that paved the way for effective project implementation. However, it also presented some management challenges. Most importantly, there were only 18 months left to implement an ambitious agenda. And some of the new activities, such as the international travel associated with the partnership with ACOG, had significant cost implications; and it was also clear that the Federal Centers would do less cost-sharing than originally expected. So JSI requested a one-year project extension (to September 2012) and an equitable adjustment, which was granted shortly before the original end-date of the project. In addition, the revised scope of work necessitated a considerable volume of paperwork to prepare initial project deliverables, like the Implementation Plan, M&E Plan and a number of others, twice over: once for the original scope of work and a second time for the revised scope of work (See Annex 1 for a list of deliverables.)

A final issue was that project funding fell 7% short of budget. This left management struggling in the last six months to fund printing and dissemination of important federal policies and prompted cancellation of six trainings in the regions and three meetings to advocate for the guidelines on adolescent reproductive health, infection control and regionalization. The guidelines on adolescent reproductive health were not endorsed by the Kulakov Center and the guidelines on all three topics were not printed and disseminated as planned.

Monitoring and Evaluation (M&E)

M&E was an important concern for project management, partly to meet USAID's expectations that the project should be able to show results but also to foster evidence-based and data-based approaches to decision-making among its partners.

As a first step, the project team prepared an M&E Plan for the project that was approved by USAID. The plan was designed to produce both performance indicators and effectiveness indicators and included all contractually required indicators. It was also designed to make maximum use of existing data sources, so as to be as cost-effective as possible. Existing data sources included regional and facility-level statistics (where Russian partners were prepared to share these) and the Russian Longitudinal Monitoring Survey (RLMS), a USAID-funded survey conducted at no cost to the project.

Most performance indicators, such as the number of people trained, events conducted and the number of service delivery points benefiting from project assistance came from the project database. Whenever possible, key indicators were collected for both men and women and disaggregated by gender to reflect the project's efforts to promote equitable participation and involvement of men and women at all levels. Of the 967 participants in all the project's training courses, 95% were women and only 5% were

men (see Annex 3.c.) Despite efforts to involve as many men as possible in trainings, their low participation reflects the reality that the overwhelming majority of MCH service providers are women. However, these numbers do not take into account the essence of the changes promoted by the project to make MCH care more of a “family affair” by involving men in antenatal care, delivery, newborn care and RH decisions.



Photo: A father holding a newborn for skin-to-skin contact in Tyumen Maternity Hospital # 3

The M&E section of the Project Implementation Plan stated that joint planning would be undertaken with the Federal Centers and regional representatives to study modern approaches and tools of clinical audit, but that actual implementation of various types of audit (maternal and perinatal mortality, “near miss” and quality of care) would depend of the readiness of the regions and the Centers to do this work. (See pages 31 and 47 for details.)

In addition to data required for USAID indicators, the project made effective use of tools developed to improve the quality of care, as reported under Tasks 1 and 2. Project staff believed it was critical to apply these tools to evaluate the project’s true impact on services and to work with counterparts to encourage them to adopt the tools to help continuously improve the services they provided. The tools included facility assessments, client interviews, provider interviews and medical record reviews.

The project also conducted two important research activities in support of the integration of medical and social services (Task 4.) A qualitative assessment of current practices in providing health and social services related to family planning, prenatal and postnatal care to high-risk women was undertaken. And an elaborate testing was done of a questionnaire for use by health and social workers to identify high-risk women and provide assistance to them. The study protocol for this testing was submitted to the Ethical Committee at the Russian National Research Center for Preventive Medicine and received its approval. The results of both of these research projects were published in professional journals (see Annex 8.)

Status of Expected Results

This section of the report measures progress on all the indicators in the IBP-MCH project's approved M&E Plan, which also included indicators required in the IBP-MCH contract. The project collected data for *performance indicators*, to measure outputs (such as the number of people trained, materials disseminated and other activities) provided by the project to achieve the desired results, as well as for *effectiveness indicators* to measure outcomes and actual improvements in MCH/RH care and the health of women and infants.

In the interests of cost-effectiveness, whenever possible the project made use of data already available, such as from the ongoing RLMS and data regularly collected by the MOHSD, partner regions and health facilities. In addition, it collected a number of indicators not available from other sources but important to look at the project's work. It should be mentioned that data from Russian Government sources are not always the most accurate or reliable and Government partners are often reluctant to share them. So there are a number of gaps in the data and the quality of the data is sometimes questionable. In addition, the most recent data for most indicators relying on Government sources are for 2010, since 2011 data were not yet available as this report was being written.

Progress on project indicators is reported according to the indicator numbers in the M&E Plan. Selected other relevant data are also included.

The tables presented here include data for the entire project, including "old" project regions that participated in the MCHI II and IBP-MCH projects since 2004-2008, and new regions that only participated in the project from 2009 (See Table 5)—although work only began in earnest in 2010, as explained on pages 20 and 41. The data have been separated in this way because some regions participated in the project for such a short period of time that it is unrealistic to expect to see changes in many of their indicators.

Aggregated data for the five "old" regions and five new regions are presented in this section of the report, with disaggregated data by region appearing in Annexes 10-17.

Table 5: Project Regions

"Old" regions (2004-2008)	Vologda (2004), Tyumen (2004), KHMAO (2007), Kurgan (2007), Leningrad (2008)
New regions (2009-2012)	Moscow Region, Moscow City, Sverdlovsk, Chelyabinsk, YANAO

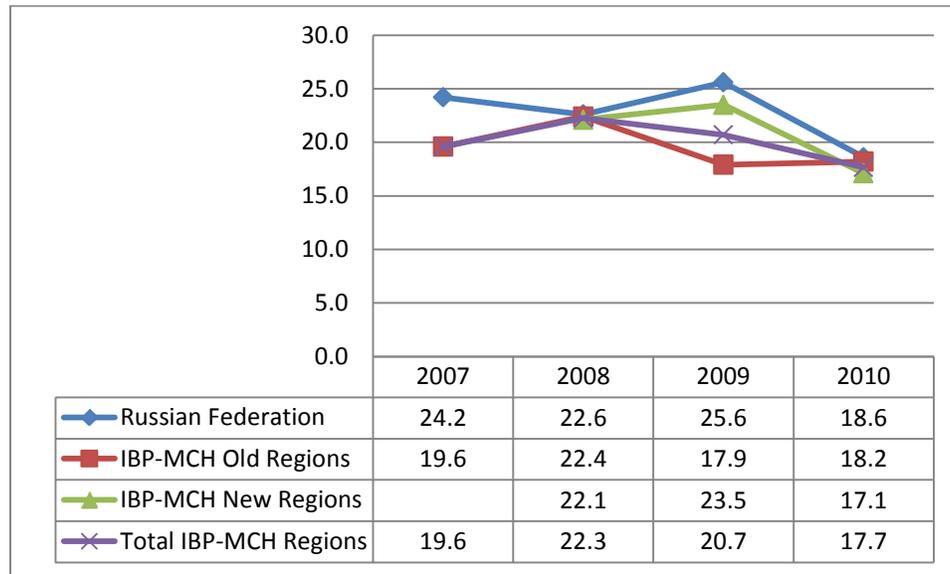
Progress toward the Project Goal: Reduced morbidity and mortality of mothers and infants

- Indicator 1: Maternal Mortality
(*Maternal mortality ratio: the number of maternal deaths per 100,000 live births*)

Maternal mortality data are extremely sensitive in the Russian Federation and these data may not present the full picture of maternal mortality due to challenges with reporting and data collection. It should also be noted that maternal mortality is a notoriously difficult indicator to affect. Due to the low number of maternal deaths overall—and particularly when data are examined by region—every case significantly influences the ratio.

Overall, IBP-MCH regions presented a downward trend in maternal deaths per 100,000 live births from 2007 to 2010—by an impressive 9.7 percent (from a ratio of 19.6 to 17.7)—and available data show lower mortality in project regions compared to the Russian Federation as whole (see Figure 5 and Annex 10.) Despite virulent flu epidemics in 2009 and 2010 that pushed up maternal deaths in many Russian regions, most project regions still saw declines relative to 2007-2008, although Vologda, Leningrad, Moscow City and Chelyabinsk experienced increases. However, while the maternal mortality ratio decreased 4.5% in Russia as a whole between 2007-2008 and 2009-2010 (the years of the flu epidemics), it fell 11.4% in project regions.

Figure 5: Trends in the Maternal Mortality Ratio 2007-2010, Russian Federation and Project Regions

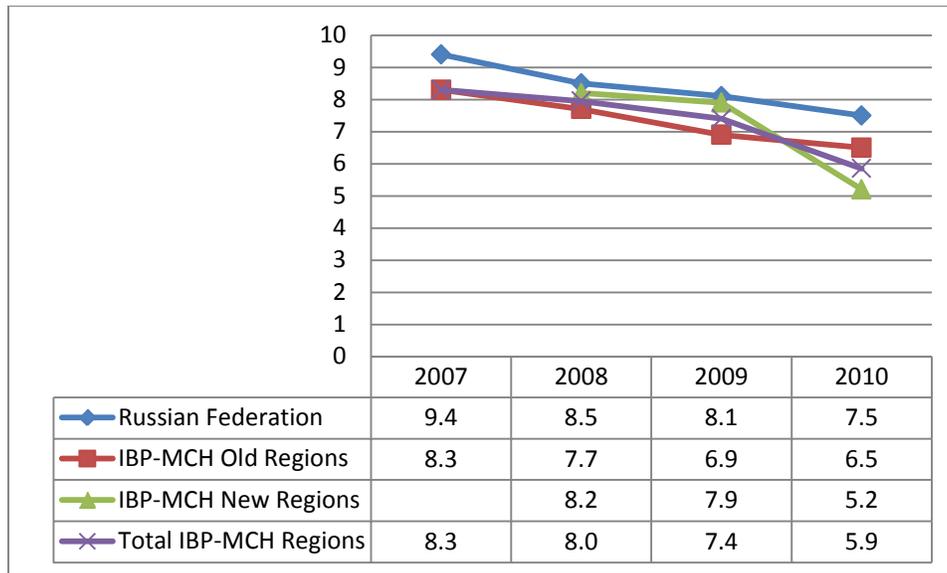


NB: The aggregated Maternal Mortality Ratio for project regions for 2007-2010 that was presented in the project's Mid-Term Report has been re-calculated to correct an error.

- **Indicator 2: Infant Mortality**
(Number of deaths of infants (0-1 years) per 1,000 live births)

Infant mortality nationally and in project regions showed a sharp downward trend from 2007. The national rate dropped almost 20%, from 9.4 to 7.5 infant deaths per 1,000 live births between 2007 and 2010, while the rate in project regions fell even more sharply—by almost 29% (from a rate of 8.3 to 5.9.) (See Figure 6 and Annex 11.) At the regional level, Kurgan had the largest decrease, at 27% (from a rate of 12 to 8.8), but it also had the highest rate among project regions. Kurgan and Chelyabinsk were the only project regions with rates higher than the national rate in 2010.

Figure 6: Trends in the Infant Mortality Rate 2007-2010, Russian Federation and Project Regions



Progress toward Intermediate Result #1: Abortion rates in regions within the selected federal districts decreased (2% annually from the baseline)

- *Indicator 3: Total Abortion Rate in participating territories*
(Number of abortions per 1,000 women of reproductive age (15-49 y.o.) in participating regions)

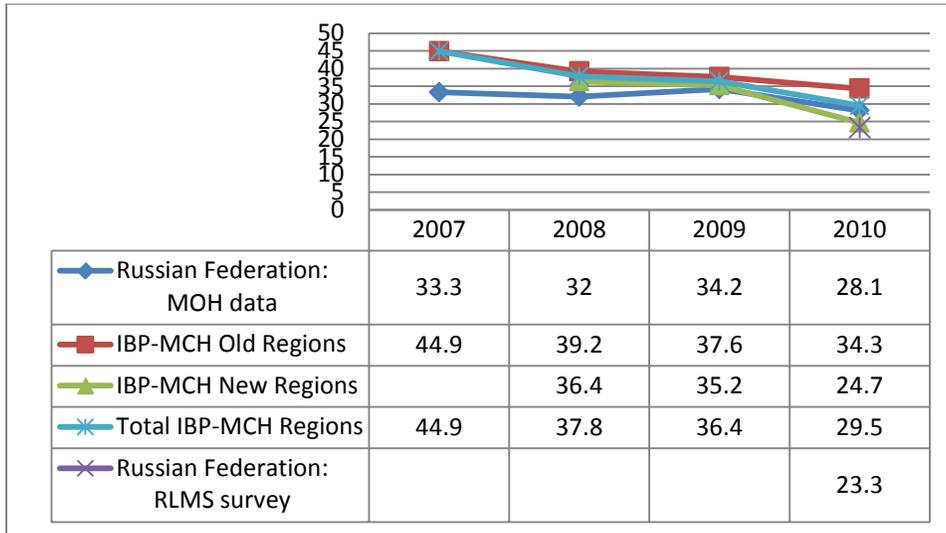
Across the Russian Federation, the number of abortions per 1,000 women decreased 16% from 33.3 per 1,000 women of reproductive age in 2007 to 28.1 in 2010 (see Figure 7 and Annex 12.a.) In regions where the project had been working for more than three years, however, the abortion rate declined a remarkable 24% from 2007 levels (from 44.9 to 34.3.) In 2008-2010, the aggregate decline across all project regions was 22% (from 37.8 to 29.5), which substantially exceeded the targeted 2% annually from baseline. The project believes its work on family planning contributed to this decline.

Overall, IBP-MCH regions had higher abortion rates than the national rate for 2010 (34.3 per 1,000 women compared to 28.1). Of these regions, Vologda had the highest rate, at 59 in 2007, but it also saw the greatest percentage decrease in abortions since then, at 29%. The data show that most regions saw the strongest decline in abortions between 2009 and 2010.

The RLMS was used for certain national-level indicators. The RLMS is a nationally sampled representative survey of approximately 4,700 households measuring a range of economic, social and health indicators. The data presented in this report are based on data collected through the FP/RH module in the 2010 round (Round 19). Responses were gathered from 3,401 women aged 14-54. Data from the RLMS indicate a general abortion rate in 2010 of 23.3.¹ The project believes, however, that this low level may be attributed in part to under-reporting of abortions in the sample.

¹Barden-O'Fallon J, Reynolds Z, Speizer IS, *Women's Health in the Russian Federation: the Russia Longitudinal Monitoring Survey 2010* [working paper WP-11-121], Chapel Hill, NC, MEASURE Evaluation, 2010

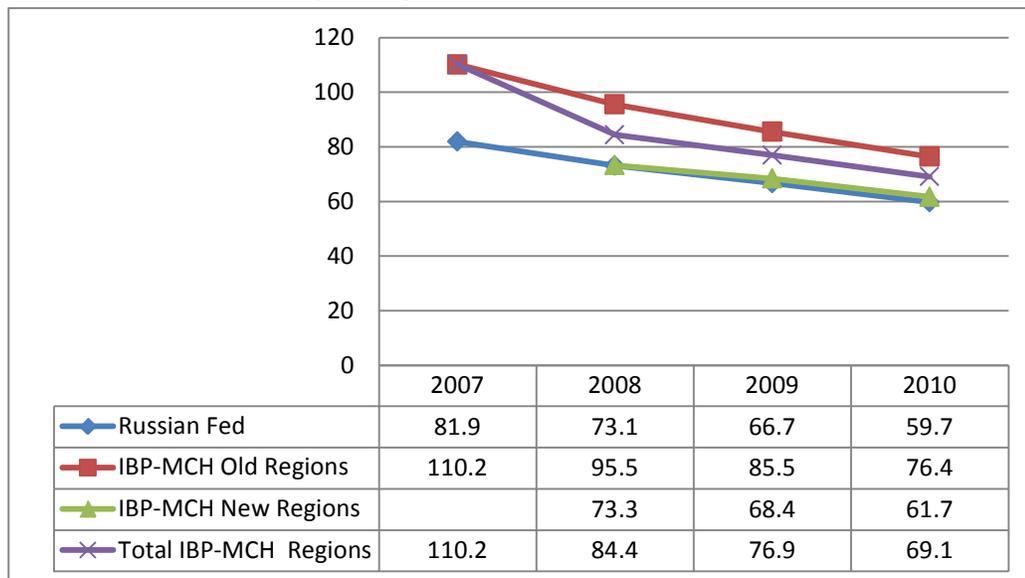
Figure 7: Trends in the Total Abortion Rate 2007-2010, Russian Federation and Project Regions



While it is not a project indicator, it is informative to look at the abortion *ratio* as well as the abortion *rate*, to understand the number of abortions relative to live births—a widely-used measure of the incidence of abortion.

In all IBP-MCH regions, the abortion ratio per 100 births decreased by 37% (from 110.2 to 69.1) between 2007 and 2010. The average rates in old project regions remained higher than those in new project regions and nationally. The data show that, although the incidence of abortions relative to births declined, it remained high, particularly in Vologda, Kurgan and Leningrad regions, where the number of abortions equaled or exceeded the number of live births (see Figure 8 and Annex 12.b.)

Figure 8: Trends in the Total Abortion Ratio 2007-2010, Russian Federation and Project Regions



- Indicator 4: Modern Contraceptive Use Rate among women surveyed
(Percent of women of reproductive age (15-49 y.o.) who report using modern contraceptives, postabortion, postpartum, last 30 days)

RLMS data show that 41% of all women surveyed in 2010 used a modern method of contraception in the preceding 30 days (see Table 6.) Of those using contraception, 84% used a modern method, i.e. 34% of all women. Of those methods, male condoms and the pill were the most frequently used across all age groups. RLMS data for postabortion and postpartum contraceptive use are framed within “provider-recommended” use, and therefore were re-analyzed to determine clients’ use of modern methods as discussed with their provider. The percentage of postabortion and postpartum clients reporting modern contraceptive use after discussion with a provider were roughly similar, at 37% and 34%, respectively.

Table 6: Modern Contraceptive Use Rate and Percent of Clients Counseled on Contraception (RLMS)

2010 Russian Federation	Modern Contraceptive Use Rate	Percent of Clients Counseled* on Contraception
Postabortion*	37%	53%
Postpartum**	34%	46%
Last 30 days, including prenatal**	41%	72%

+ Provider’s prescription is used as a proxy for counseling

* Client reported use, as recommended by provider

** Client reported use only

- Indicator 5: Prenatal, Postabortion and Postpartum clients counseled on contraception
(Percent of women interviewed who report that provider discussed contraception, by period (prenatal, postabortion, postpartum))

RLMS data were re-analyzed to better understand whether clients were counseled about contraception. The RLMS questionnaire asked about “providers’ recommendation” for the postabortion and postpartum periods. The RLMS questions for the “last 30 days” of contraceptive use discuss quality of counseling, which encompasses prenatal counseling. Overall, 72% of clients interviewed reported having been counseled on contraceptive methods in the last 30 days, whereas 53% of postabortion and 46% of postpartum clients reported having been prescribed one or more contraceptive methods (see Table 6.)

- Indicator 6: FP/RH counseling visits in project regions
(Number of counseling visits for FP/RH as a result of USG assistance)

Since 2007, the number of FP/RH visits reported by project-assisted facilities more than doubled across the five “old” project regions, with an increase of 115%. Vologda and Kurgan saw the greatest increase in the number of visits annually (112% and 99% respectively.) (See Table 7 and Annex 13.) Data for the new project regions were not available.

Table 7: Number of FP/RH Counseling Visits in IBP-MCH Regions, 2007-2010

	2007	2008	2009	2010	Percent Change 2007-2010
“Old” Project Regions	109,613	170,253	213,421	235,355	+115%

- Indicator 7: FP/RH service delivery points in project regions
(Number of USG-assisted service delivery points providing FP/RH counseling or services)

By project's end, IBP-MCH had assisted 160 FP/RH service delivery points (9 family planning centers, 84 women's consultations, and 67 maternities) across all project regions (see Annex 5.)

- Indicator 8: Training in FP/RH services
(Number of people trained in FP/RH with USG funds)

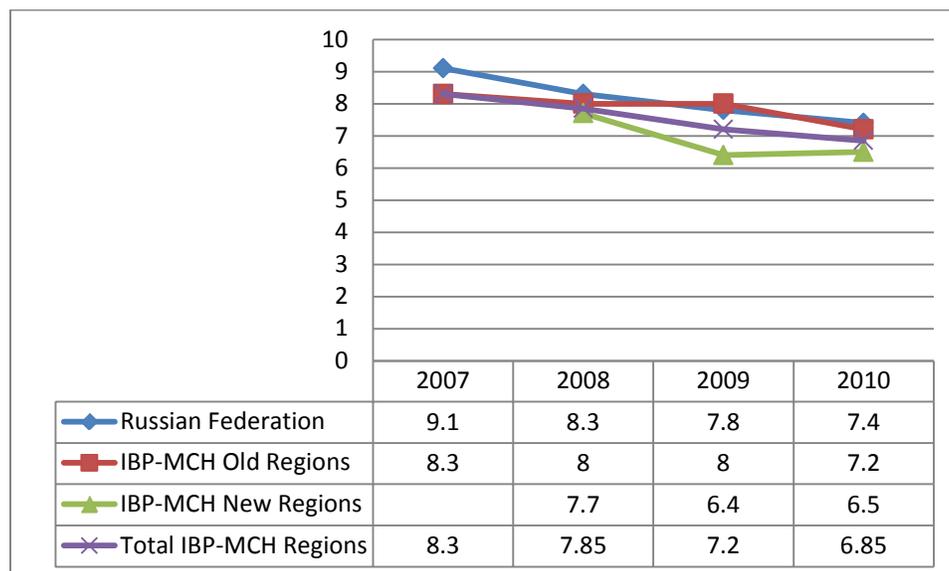
IBP-MCH trained 151 medical professionals (144 women and 7 men) in FP/RH practices in five free-standing family planning training courses (see Annex 3.a.) Family planning was also a part of courses on antenatal care, breastfeeding, Family-Centered Maternity Care and pediatric care, reaching an additional 533 health workers; and a further 150 medical practitioners also participated in a master class on family planning under the XIth All-Russia Scientific Forum on the Mother and Child. IBP-MCH also conducted other professional development sessions on FP/RH knowledge and practices at conferences and congresses.

Progress toward Intermediate Result #2: MCH best practices related to major causes of maternal and infant morbidity and mortality adopted by target regions/federal districts.

- Indicator 9: Perinatal mortality rate
(Number of stillbirths (22 weeks to birth) and deaths in first week of life per 1,000 live births)

Overall, the perinatal mortality rate in IBP-MCH regions not only decreased by 17% (from 8.3 to 6.9 per 1,000 live births) over the project period, but it was also consistently lower than across the Russian Federation (Figure 9 and Annex 14.) The rate across the Russian Federation decreased by 19 % (from 9.1 per 1,000 live births to 7.4) over the life of the project. Of all project regions, Leningrad showed the largest decline (from 8.5 to 6.5—or 24 %.)

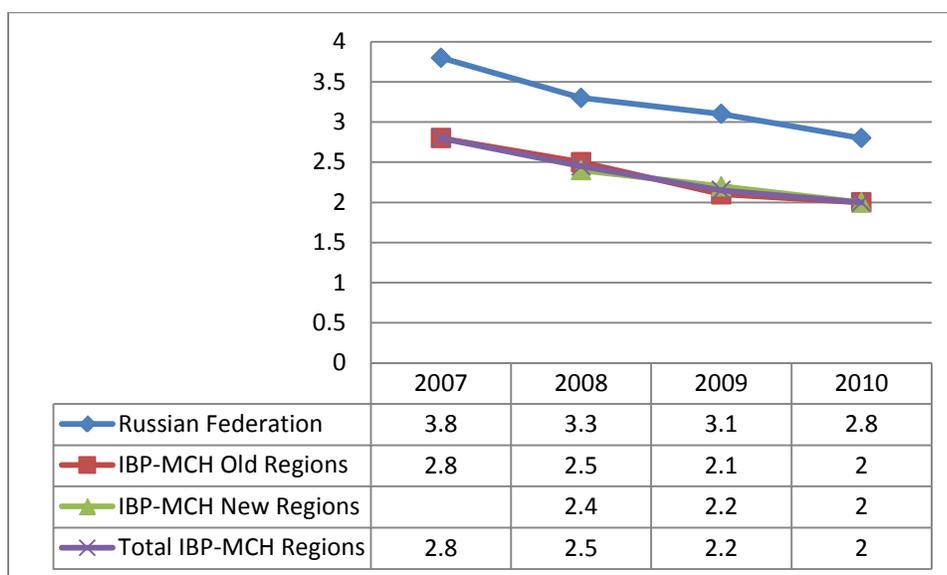
Figure 9: Trends in the Perinatal Mortality Rate 2007-2010, Russian Federation and Project Regions



- *Indicator 10: Early neonatal mortality rate*
(Number of deaths in first 28 days of life per 1,000 live births)

As with the perinatal mortality rate, the early neonatal mortality rate across the project period decreased 26.3%, from 2.8 to 2.0 deaths per 1,000 live births, and was consistently lower than the national rate (Figure 10 and Annex 15.) All project regions showed declines, with Kurgan having the steepest drop, at 34% (from 4.4 deaths per 1,000 live births to 2.9.)

Figure 10: Trends in the Early Neonatal Mortality Rate 2007-2010, Russian Federation and Project Regions



- *Indicator 11: Essential newborn care (ENC)*
(Number and percent of newborns receiving essential newborn care, by region. Numerator: Number of newborns in project facilities in region, Denominator: total number of newborns in region)

The project introduced a package of Essential Newborn Care interventions and collected data on the number of newborns receiving ENC in 2009 and 2010. Due to the timeline of the roll-out of the ENC interventions, ENC data were only collected in “old” project regions that had time for ENC practices to be introduced and implemented, along with data collection.

The data show that the number of newborns receiving ENC increased 28% between the two years (Table 8 and Annex 16.) Vologda and Tyumen regions saw the largest increases, at 35% and 41% respectively, while Leningrad, which joined at the very end of the previous project, had the smallest increase, at 5%.

Table 8: Number of Newborns Receiving ENC in IBP-MCH Regions, 2009-2010

	2009	2010	Percent Change
“Old” Project Regions	37,388	48,043	+28%

Data on the *percent* of newborns in project-assisted facilities receiving ENC were available from only three regions because data from the two other regions were unreliable. For the three regions that provided coherent data, Vologda showed a 21% increase in this percentage, Tyumen a 17% increase and Kurgan an 18% increase.

- *Indicator 12: Antenatal care (ANC)*
(Number of antenatal care visits by skilled providers from USG assisted facilities, by location)

Between 2009 and 2010, IBP-MCH regions saw a combined 11% increase in the number of antenatal care visits by skilled providers (see Table 9 and Annex 17.) The largest increase was seen in Tyumen Region (20%--from 21,323 to 25,622), while the lowest was in Vologda Region (2%--from 11,926 to 12,204.) MOHSD regulations stipulate at least 10 antenatal visits for a normal pregnancy.

Table 9: Number of Antenatal Care Visits by Skilled Providers in Project Regions, 2009-2010

IBP-MCH Regions	2009	2010	Percent Change
Antenatal Care	82,105	91,190	+11%

- *Indicator 13: Designation of levels to health facilities*
(Number of policies adopted listing health facilities as distinguished by level of facility)

Over the life of the project, a total of 16 *prikazes* with regional versions of Federal decree #808 were adopted across the project regions. These “basic” policies on regionalization defined the three levels of care in the region, in addition to federal facilities, and listed health facilities at the two referral levels. Ten “additional” policies on regionalization were also adopted, addressing neonatal resuscitation and care as well as emergency care counseling and monitoring. (See Table 10.)

Table 10: Number of Basic Policies and Additional Policies Adopted in Project Regions that Designate Levels of Care

Region	Basic Policies*	Additional Policies**
Old Project Regions		
Vologda Region	2	
Tyumen Region	2	
KHMAO	3	4
Kurgan Region	1	4
Leningrad Region	2	
New Project Regions		
Moscow Region	2	
Moscow City	1	
Sverdlovsk Region	1	1
Chelyabinsk Region	1	1
YANAO	1	
Total	16	10

* Regional versions of Federal decree#808. Some regions also developed *prikazes/orders* with detailed explanations of the three levels of care in the region, in addition to the federal policy.

** Additional policies include orders and clarifying policies on neonatal resuscitation and care, emergency care counseling centers, monitoring delivery at the appropriate level of care and transportation routes. In KHMAO, Sverdlovsk and Chelyabinsk, policies were developed for municipal centers and these are included as separate documents from those at the regional level.

- *Indicator 14: Model delivery systems of MCH/RH care established (Emergency Care Counseling Centers established at tertiary level)*

Just five regions provided data on Emergency Care Counseling Centers—generally called Resuscitation Counseling Centers (RCCs) in Russia—and four of them reported establishing seven RCCs (see Table 11). These centers, established at the tertiary level of care, support Levels 1 and 2 facilities and coordinate transportation and other services.

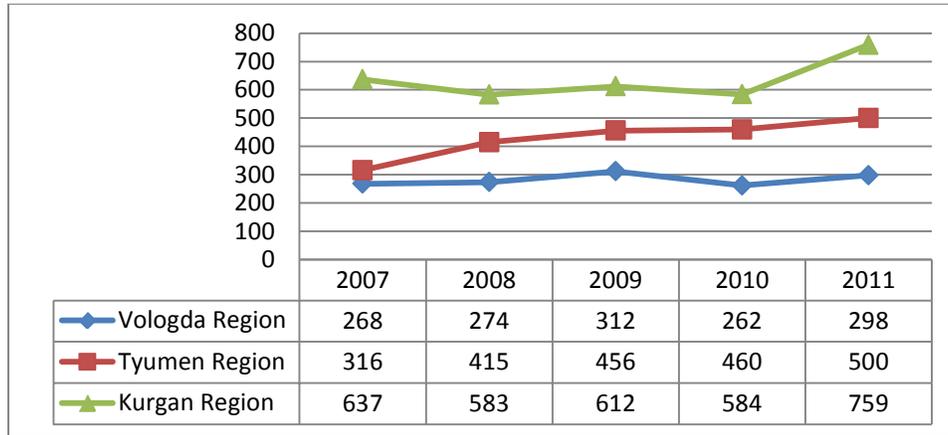
Table 11: Number of Resuscitation Counseling Centers (RCCs) Established in Selected Project Regions

Region	Number of RCCs
Vologda Region	1
Tyumen Region	1
KHMAO	3
Kurgan Region	2
Leningrad Region	0
Total	7

- *Indicator 15: Model delivery systems of MCH/RH care operational (Number of consultations provided by Emergency Care Counseling Centers to primary and secondary level facilities)*

The project measured whether model delivery systems for regionalized perinatal care were operational by the number of consultations provided by Resuscitation Counseling Centers, but unfortunately data on this indicator were only available from three partner regions. Tyumen saw a steady increase of 36% from 2007 to 2011 (from 316 to 500 consultations) and Kurgan had an increase of 16% (from 637 to 759.) The number of consultations in Vologda fluctuated over the life of the project, but followed a generally upward trajectory. (See Figure 11.) It should be mentioned that the project focused its work on the quality and content of consultations, rather than on the quantity.

Figure 11: Number of Consultations Provided by Resuscitation Counseling Centers (RCCs) to Primary and Secondary Level Facilities



Progress toward Intermediate Result #3: Strengthened capacity of key federal district and regional entities to deliver, disseminate, and advocate for up-to-date MCH/RH services/practices at the federal and regional level

- *Indicator 16: Federal entity health care providers implementing evidence-based MCH practices (Number of regional and/or federal entities/research institutes adopting and delivering up-to-date MCH/RH services and policies)*

The project worked with two Federal entity health care providers to achieve this indicator: the Kulakov Center in Moscow and the Urals Institute in Yekaterinburg. The Kulakov Center made great progress in adopting five new evidence-based MCH/RH policies: the *National Medical Eligibility Criteria for Contraceptive Use*; the *Protocol on Preeclampsia, Eclampsia*; *Protocol on Premature Birth*; *Guidelines on Regionalization of Perinatal Care*; and the training course on *Initial Care and Resuscitation of Newborns*.

While good progress was made on policy, the two Federal entities moved slowly to actually implement evidence-based practices, as described on pages 31-32. Audits conducted in 2011 showed that the Kulakov Center was performing at 36% of standard on perinatal care and the Urals Institute was at 34%. So the process of change is under way, but will take time and further support to see meaningful change.

IBP-MCH also worked with 10 partner regions to implement evidence-based services and policies. A total of 100 policies on MCH/RH were adopted by these regions (see Indicator 18, below) and they were all engaged in expanding and improving the delivery of services. Assessments conducted on various aspects of MCH/RH care show regions performing at between 53% and 87% of standard on family planning service delivery; between 25% and 50% on perinatal care, and between 56% and 97% on neonatal care (see Annexes 2.a – 2.c.)

Thus, there were a total of 12 regional and/or federal entities/research institutes adopting and delivering up-to-date MCH/RH services and policies. In addition, other regions that participated in past projects had adopted and were delivering up-to-date MCH/RH services and policies.

- *Indicator 17: Advocacy for evidence-based MCH care*
(Number of regional and/or federal entities/research institutes disseminating and advocating for up-to-date MCH/RH services/policies)

The two Federal entities, the Kulakov Center and the Urals Institute, were increasingly engaged in disseminating and advocating for up-to-date MCH/RH services and policies through conferences and seminars (see page 33), through co-training with the project trainers on courses advancing evidence-based care (see page 45), and dissemination through the Kulakov Center’s website (see page 32.)

In addition, all 10 of the project’s partner regions were actively involved, as evidenced by their broad roll-out of up-to-date services (see Annex 5) and the 100 policies they adopted (see Indicator 18.) In addition, other regions that participated in past projects were also engaged in dissemination and advocacy for up-to-date MCH/RH services/policies.

Faculties of medical schools in IBP-MCH regions also participated actively in disseminating and advocating for up-to-date services and policies. Medical schools involved during IBP-MCH were Chelyabinsk State Medical Academy, First Moscow State Medical University, Urals State Medical Academy, Tyumen State Medical Academy and Surgut State University. In addition, other medical schools that participated in past projects were also involved.

In total, 17 regional and/or federal entities/research institutes participating in IBP-MCH were involved in disseminating/advocating for evidence-based MCH/RH care.

- *Indicator 18: New effective policies*
(Number of new effective (evidence-based) MCH/RH policies adopted at the regional and federal level)

At the federal level, eight policies focusing on evidence-based MCH practices were adopted over the life of the project (see Table 12 below.)

Table 12: Federal Policies Adopted on Evidence-Based MCH Practices

Name of Policy	Details
Organization of Maternal Health Care for Implementation of New Technologies	#15-4/10/2-6796 13.06.2011, http://www.minzdravsoc.ru/docs/mzsr/letters/199
Sanitary-Epidemiological Requirements for Health Care Organizations	Sanitary-Epidemiological Regulations and Norms 2.1.3.2630-10 # 58, May 18, 2010
Guidelines for Prevention of Healthcare-Associated Infections in Maternities	Moscow, 2012, http://www.ifhealth.ru
National Medical Eligibility Criteria for Contraceptive Use	Moscow, 2012, http://www.ifhealth.ru
Protocol on Preeclampsia, Eclampsia	Moscow, 2012, http://www.ifhealth.ru
Protocol on Premature Birth	http://www.rosminzdrav.ru/ministry/61/5/1
Guidelines on Regionalization of Perinatal Care	Moscow, 2012, http://www.ifhealth.ru
Initial Care and Resuscitation of Newborns Training Course	http://www.rosminzdrav.ru/ministry/61/5/1 Moscow, 2012, http://www.ifhealth.ru

At the regional level, a total of 71 policies were adopted on evidence-based MCH/RH quality of care and service delivery over the life of the project (see Table 13 below.) A list of the policies by name is not available.

Table 13: Number of Regional Policies Adopted on Evidence-Based MCH/RH Quality of Care and Service Delivery

Old Project Regions	
Vologda Region	8
Tyumen Region	9
KHMAO	7
Kurgan Region	8
Leningrad Region	8
New Project Regions	
Moscow Region	5
Moscow City	4
Sverdlovsk Region	11
Chelyabinsk Region	7
YANAO	4
Total	71

In addition:

- 26 policies were adopted on regionalization of perinatal care (see Table 10 for details by region); and
- Three policies were adopted on linkages between medical and social care:
 - Regional order #163-p/118 of the KHMAO health and social care departments on coordination between health and social facilities in the region to support pregnant women and women with children in difficult life situations;
 - Joint decree #309.398-p of 22.06.2012 of the KHMAO health and social care departments on implementation of the *Algorithms on Medical-Social Care*;
 - Memorandum of Collaboration between the health and social care departments in Tyumen Region. #750, 10.10.2008.

Thus, in total, exactly 100 regional policies were adopted.

- Indicator 19: Implementation of evidence-based MCH practices
(Number of medical professionals trained in maternal/newborn health through USG supported programs, by provider type, gender, and training topic, level)

IBP-MCH trained 718 medical professionals (679 women and 39 men) in evidence-based maternal and newborn health practices. Topics included Family-Centered Maternity Care, breastfeeding, antenatal care, emergency obstetric care, neonatal care and resuscitation, and pediatric care. Details by training topic and gender are provided in Annex 3.a.

- Indicator 20: Training on evidence-based MCH/RH practices
(Number of medical and para-medical practitioners (including social service practitioners) within the selected federal districts trained in evidence-based clinical guidelines, by provider type, gender, and training topic, level)

A total of 967 medical and para-medical practitioners, including social service practitioners, (915 women and 52 men) were trained in evidence-based MCH/RH clinical guidelines across the IBP-MCH regions (See Annexes 3.a—3.c.) This figure includes professionals trained in the courses listed under Indicator 19 above, plus family planning courses and social-medical courses. The types of participants—doctors, mid-level staff, social workers, etc.—are identified in Annexes 3.a—3.b.)

- *Clinical Audits*

As provided in the project’s M&E Plan, IBP-MCH conducted a series of audits/assessments in MCH to improve the quality of care. The project also conducted an audit of family planning service provision. Even though the results of these audits are not required indicators in the M&E Plan, they are included in this report because of their importance. It should be noted that, while percentage scores were used to rate facilities (or groups of facilities) on various measures, these scores were used to give partners in the field and project staff a detailed picture of the strengths and weaknesses at specific sites. Relatively few facilities participated in each type of audit, so they did not constitute a representative sample and the results should not be interpreted as representative of other health facilities. The full data have been omitted from this report in the interests of space, but summary results appear in Annex 2.

The *Perinatal Care* audits were conducted in six facilities in four regions from 2008 to 2011: the Kulakov Center in Moscow, the Perinatal Center in Moscow Region, the Urals Institute in Yekaterinburg, and three hospitals in Kurgan. They examined the presence of equipment and practices related to labor and delivery, postpartum care, obstetric bleeding, the “warm chain”, infection control and basic neonatal resuscitation in the delivery room. Key results appear on pages 32 and 45-46 and in Annex 2.a.

The *Essential Neonatal Care (ENC)* audit was conducted in 19 facilities across eight regions. These audits measured the presence of up-to-date practices and the absence of outdated ones. They covered rooming-in, breastfeeding, “warm chain” management, hand hygiene, resuscitation equipment and training. Key results appear on pages 45 and in Annex 2.b.

The *Family Planning* audit tool was new for the project and was tested in five women’s consultations in three regions in 2012: City Hospital #2 in Tyumen, Kurgan City Maternity Hospital #1 and three facilities in Chelyabinsk: the State Medical Academy and City Clinical Hospitals #3 and #9. The audit assessed: 1) The overall capacity of the facilities to provide quality family planning services, including counseling, availability of free contraceptives, availability of counseling for both men and women, information support to the population, family planning M&E, and adequate staffing and facility provisions; and 2) The quality of contraceptive counseling provided. Key results are presented on page 46 and in Annex 2.c.

Lessons Learned and Solutions for Resolving Constraints

Most of the lessons learned come from the areas of work that were new in this project, compared to prior projects. The bulk of the lessons come from working with the Federal Centers, which was a major new priority area for project staff, while there are fewer lessons from working with the regions, where project approaches had been fine-tuned over a decade. There are also some initial conclusions from the project's work on regionalization and on medical-social care, but more time and experience would be needed to draw firm conclusions on these two topics.

- *Enormous progress was made in adoption of evidence-based federal policies, but more work is needed to build capacity on EBM.*

The project's work with the Kulakov Center was highly successful and productive, demonstrating the importance of working at the top of the Russian health system, which, despite liberalization, remains very "top down." It was most productive in the policy arena, with the development and adoption of eight new federal policies on MCH/RH that, collectively, create a modern policy framework for effective clinical practice in the field. The project's approach of open discussion in working groups about the international evidence and the involvement in the process of partners from the regions, who could bring Russian evidence of the benefits of the new evidence-based practices, proved effective. In a highly significant shift, the leadership of the Kulakov Center is now committed to EBM and senior staff gained a good general understanding of the topic. It will still take time, however, to build expertise at the Center to research and evaluate international evidence and use it to formulate policy and practice for the Russian Federation. Only then will the capacity to develop effective policies in Russia be effectively institutionalized.



Dr. Galina Gerasimova, Deputy Director of the Kulakov Center, and Dr. Genadiy Sakhin, Director of the Kulakov Center, presenting the Guide on the Essentials of Evidence-Based Care at the Mother and Child Forum 2011

- *The Kulakov Center has the potential to provide leadership for the MCH field, given considerable continued technical assistance. Developing that leadership role in other Federal Centers will be more difficult.*

Although the Federal Centers are charged with providing leadership for the MCH field in their Federal Districts—and in the case of the Kulakov Center, nationwide—this is not yet a role they are comfortable performing. The vision of the Federal Centers as leaders in the MCH field, promoting new evidence-based practices to providers in their territories, training service providers, providing technical assistance and/or monitoring the quality of care, is far on the horizon. Many regions are not ready to follow the Federal Centers' lead, with the more progressive regions providing better MCH/RH care than the Federal Centers and having little respect for them. In addition, in a health system still built on fear of punishment, health workers and health facility managers are afraid that the Federal Centers will abuse the information they obtain during site visits, with negative repercussions for individual staff or for the facility as a whole. Indeed, some project partners would not permit the staff of their Federal Center to

visit in a supportive or monitoring role, even though the project assured them that all information would remain confidential.

Project staff believe it is important to continue working with the Kulakov Center, in particular, to strengthen all aspects of its leadership role—particularly on policy development—as well as the quality of the clinical care it provides at its own health facility. With other Federal Centers, their leadership efforts should focus initially on building a positive relationship with the regions for which they are responsible and being seen as serving a useful function. Many aspects of the resource center role envisioned in the IBP-MCH contract could help them position themselves in constructive ways. Disseminating modern policies and best practices in a variety of ways and facilitating exchanges and cooperation between model sites in their territories could enhance their reputation, while avoiding training/supervisory/monitoring relationships that threaten providers and managers in the regions.

The staff of the Federal Centers also badly need some exposure to public health and modern health management, particularly using systematic approaches to analyzing priority problems in MCH/RH outcomes, developing and testing solutions and scaling up successful strategies. Currently, they have no background in modern approaches to health management or public health and a very limited understanding of the importance of these functions.

It should be noted, however, that there is a disincentive for staff in the Centers to perform training, technical assistance and leadership functions for the field, since they then forego the income generated by serving patients.

- *Changing clinical practices at the Federal Centers will take time.*

Changing clinical practices at the Federal Centers proved to be a slow undertaking, despite the progressive leadership of Dr. Sukhikh. These are conservative institutions staffed largely by the MCH leadership that set the old Soviet standards and defended them for many decades. It was challenging for the project to conduct training for Kulakov Center staff, in particular, because they considered it unnecessary, time-consuming and taking them away from their ongoing responsibilities. While the project sought to provide technical assistance to improve service provision in other ways, the audits showed that short lectures were not enough to bring about meaningful changes in practice. In addition, the high-tech, over-medicalized services they provide produce more income for providers than lower-tech, client-friendly services. Moreover, the Centers are large institutions—the Kulakov Center has about 1,000 staff—with many leadership positions, so building relationships with the most important leaders is time-consuming. And even when these leaders are convinced, substantial effort is still needed to reach the entire workforce and actually change practices for all clients.

Project staff found that the weight of the evidence presented by the project in support of modern practices caused many of the leaders at the Federal Centers to pause for thought. However, persuading them to actually adopt the new practices in the care they themselves provide and instruct their staff to provide, will probably take orders from the top of the MOHSD or involve several years of continued dialogue about the evidence on a variety of topics—and probably a larger body of Russian evidence.

- *There are other leaders in MCH around the country who are interested in bringing about change and who could potentially play leadership roles.*

The credibility conferred on the project, and on IFH as an organization, as a result of its open collaboration with the MOHSD, and particularly the Kulakov Center, coupled with wide dissemination of high quality, evidence-based protocols, guidelines and materials generated growing interest in the new approaches promoted by the project—and in actually participating in the project—from many quarters. The project received requests from MCH research institutes, regional policy makers, medical schools and other opinion-leaders.

Involving medical professionals from other academic groups beyond the two Federal Centers, as well as presentations at regional professional events demonstrated a clear shift across the country toward adoption of evidence-based care. For further activities, it would be beneficial to work on building professional networks across the regions, while continuing the capacity-building of the Federal Centers.

- *The collaboration with ACOG was highly productive and merits continuation.*

The collaboration with ACOG was another highly successful area that led leaders in the Russian MCH/RH community to recognize the value of professional exchanges with other countries. They were enormously impressed by the ACOG Annual Clinical Meetings and the level of the presentations and discussion at those meetings. It brought home to them that the US ob-gyn community practices based on the best evidence from research and clinical trials. And it allowed them to see the broad scope of services that ACOG provides to its members and to the field of obstetrics and gynecology.

The visits of ACOG representatives to Russia enabled many in the broader MCH/RH community to share that experience on a more modest scale and closer to home. The contacts with ACOG also gave Russian counterparts first-hand exposure to US practices on “hot topics” in MCH/RH (like premature birth and reporting of maternal deaths), quality and safety in medical care, development of clinical protocols/guidelines, medical education and other matters.

The visit of a group of providers from Moscow to Syracuse, New York, to spend a week learning about and observing the provision of obstetrical and newborn care at an American health facility proved a particularly effective—if costly—method of helping Russian providers envision how to provide care in line with the practices promoted by the project. However, the study tour did not take the place of the project interventions, which were still needed to provide support and encouragement to the staff as they began to implement what they had seen in the US at their own facility in Moscow.

A program of exchange visits could be maintained at modest cost and would bring continued benefits. However, the Kulakov Center is ready to expand beyond simple exchange visits between Russia and the US to more in-depth collaboration. It would appreciate assistance from ACOG on a long list of topics, including exchange visits, video conferences, EBM, Board exams, postgraduate medical education, and publication in US journals. While the Center isn’t yet requesting such assistance, it would also be beneficial to give both Centers greater exposure to client education, building demand, empowering women, working with women’s groups and developing Internet resources.

- *Family planning needs to be better mainstreamed into the broader health system to improve access to services.*

Integration of family planning into a variety of services needs more attention. Specifically, it would be desirable to position family planning as a public health issue, include it in healthy lifestyle activities and integrating it into therapeutic/general practitioners/primary health care, building on the successful experience in Tyumen Region. The recent RLMS also suggests that more attention should be given to postpartum and postabortion counseling on family planning.

- *Work on introducing evidence-based care for infants in the first year of life got off to a good start, but needs more time to build momentum.*

The project’s work to develop a training course on care for infants in the first year of life served as a reminder of the obstacles to be overcome in introducing modern practices to a specialty with little or no exposure to international practices or EBM. Working with pediatricians—who had not been much involved with prior projects—was reminiscent of the difficulties of convincing the ob-gyn and neonatology communities of the new perinatal care practices a decade ago. Progress was made, but it was challenging to convince leaders in the pediatric community that most children are healthy, that doctors should help parents take responsibility for the health of their children, and to combat ingrained

clinical practices based on antiquated understanding of the neurological development of children—to name just a few topics. Project staff followed their model for introducing best practices (see page 23) and the expectation is that, in time, and with continued support, as providers try the new practices, some visionaries will emerge who will implement them fully and go on to convince others.

- *Work is needed to combat the climate of secrecy that surrounds health statistics.*

The climate of secrecy that continues to surround health statistics and the tendency to present data that are politically correct presented an ongoing challenge for the project to get regional and facility-level statistics from partners to use for program development and evaluation. More importantly, the unwillingness of top authorities to use data to identify, analyze and address health problems remains a significant constraint on improving health care and, ultimately, improving public health in Russia. The project's efforts to introduce data-based decision-making were a valuable contribution and ACOG's presentations on how US health authorities and advocates emphasize accurate data in order to improve health services gave the ob-gyn leadership in Russia cause for reflection.

- *The regionalization of perinatal care is moving forward rapidly. However, some fundamental problems need to be tackled before effective systems of regionalization can be put into place.*

Work on the regionalization of perinatal care led to many lessons learned—and the recognition that there are many more still to be learned. The process of developing guidelines on regionalization helped counterparts appreciate what was involved and the complexity of the exercise. As regions began implementing regionalization, those that were more sophisticated began to recognize that it is important to have a clear definition of high-risk patients; to have clear referral pathways and procedures; to define which women should be delivering at which levels of the system; to have coherent standards, protocols and guidelines across the region describing which types of care should be provided at different levels; and to have distance consultation technology in place. They also learned that regionalization calls for good infrastructure—an ambulance can only go to places served by roads! And it involves difficult political decisions to close some hospitals and to rationalize the procurement of expensive medical equipment.

All the regions struggled with the contradiction inherent in current policy that, on the one hand, mandates the development of a regionalized system of care, and on the other, guarantees patients the freedom to choose a health facility. That means that most women would like to deliver at the most modern, well-equipped hospitals—which is usually the Level III facility—threatening to leave these facilities fully occupied, with no beds available for high-risk patients who genuinely need their facilities and expertise.

Many counterparts also saw that there were very few facilities—even perinatal centers or Federal District facilities—that are ready to function at the tertiary level. While most regions could identify the funding and equipment needed to meet Level III standards, the fundamental problem was the dearth of adequately trained physicians and other health professionals. This reflects the weakness of the medical education system—both pre-service and postgraduate—in the area of MCH/RH. While this needs to be addressed, it will be difficult to do so in the current medical education system that does not recognize some of the essential principles needed to produce highly qualified specialists, for example, evidence-based practice, the development of practical skills, development of quality improvement approaches to build effective systems of care, and teamwork between different specialties, including mid-level staff and para-professionals. Moreover, from a public health perspective, the need to strengthen tertiary care must be balanced against the benefits of upgrading basic maternal and infant care and family planning/reproductive health services for the vast majority of women and children who are not facing special risks and can be effectively served in Levels I and II facilities when their staff use modern, effective approaches to MCH/RH care.

- *Strengthening the linkages between medical and social care is a promising avenue to improve services for high-risk women during pregnancy and after delivery.*

The project's work to strengthen medical-social care on MCH/RH for socially vulnerable groups was warmly welcomed by partners in the regions and looks very promising. However, the *Algorithms on Medical and Social Care for High-Risk Women* were only introduced toward the end of the project and they need time to prove their effectiveness. It is likely, too, that additional training will be needed to ensure that health workers are aware of the social services available to their clients, how to help women access those services and to better combat negative attitudes toward high-risk women. It is clear, however, that the social care system is a new and potentially valuable partner in improving the health and the lives of the most vulnerable, at-risk and needy women and children.

Annex 1: Project Deliverables

Key: X = done;
* = not done because activities were suspended

	Submitted	Approved
Deliverables under the initial contract/scope of work (October 2008 to March 2010)		
Life-of-project implementation plan	X	
Performance monitoring and evaluation plan	X	
Quarterly performance reports	X	
Annual implementation plans	*	
Monitoring and evaluation plans (part of implementation plans)	*	
Task 1:		
Selection criteria and rationale for selecting a Federal District level institute in each of two Federal Districts.	X	
Proposed institute(s), research center(s) or organization(s) at the Federal District level in two Federal Districts selected.	X	
Partnership with at least one federal institute, research center or organization(s) at the Federal District level established in two Federal Districts.	*	
Plan to develop the capacity of the selected federal entity in each of the two Federal Districts to disseminate best practices in MCH and use data on the quality of MCH care for decision making, including proposed indicators.	X	
Task 2:		
Selection criteria and rationale for the 4-5 regions proposed within each of two Federal Districts.	X	
List of proposed regions in each of the two Federal Districts.	X	
Dissemination Plan	X	

Region-to-region exchange program designed, including selection criteria for proposed participants.	X	
Task 3:		
No deliverables	N/A	
Task 4:		
Proposal identifying up to three regions within the selected Federal Districts where an integrated model of FP and social services could be piloted, including rationale and selection criteria	*	
Assessment of FP/social service integration completed in selected regions	*	
Task 5:		
Sustainability Plan	*	
Deliverables under the modified contract/revised scope of work (since March 2010)		
Annual implementation plans	X	X
Monitoring and evaluation plans (part of implementation plans)	X	X
Quarterly performance reports	X	
Mid-Term Report	X	X
Demobilization Plan	X	X
Final Report	X	#
Task 1:		
Memorandum of Cooperation or other agreement establishing partnership with two federal institutes	X	X
Selection criteria and rationale for the additional regions proposed (beyond the Urals Federal District and Moscow Oblast)	X	X
A plan of collaboration to support the leadership role of the selected institutes to promote best practices in MCH, including proposed tools which can be used by the federal centers to monitor and improve the quality of MCH services	X	X

Study tour for a delegation of Russian experts from the selected federal centers to participate in the ACOG annual congress in May 2010 organized	X	X
Plan for additional study tours (including participation of U.S. experts in relevant events in Russia and the participation of Russian experts in relevant visits to the U.S.) during the life of the project	X	X
Task 2:		
Plan to disseminate and operationalize approved MCH guidelines in target regions in collaboration with the federal centers	X	X
Approved MCH guidelines rolled out to selected regions by the completion of the Task Order; an estimated 2-3 tiers of health care facilities trained on evidence-based guidelines and practices integrated; at least 2-3 urban centers and their rural areas trained in evidence-based guidelines and practices integrated.	X	#
List of proposed regions to serve as training sites	X	X
Region-to-region exchange program designed, including selection criteria for proposed regions	X	X
Task 3:		
Regions where the contractor will provide technical assistance to develop regional frameworks on the system of MCH care, and the rationale for their selection	X	X
Model delivery systems of MCH/RH care functioning effectively at the regional (<i>sic</i>) in selected regions by the completion of the Task Order.	X	#
Task 4:		
Proposal identifying up to two regions within the Urals Federal Districts where the access to MCH care, including appropriate FP, prenatal and postnatal care, will be improved among high-risk women, including rationale and selection criteria	X	X
Assessment of current practice to reach high-risk women with appropriate FP, prenatal and postnatal care and plan of action completed in selected regions	X	X
Task 5:		
Sustainability Plan	X	X
Dissemination conference including participating and non-participating federal districts and the federal level held by the completion of the Task Order	X	

Deliverables submitted for approval as part of this Final Report

Annex 2: Audit/Assessment Results

Annex 2.a: Summary Results of Audits on Perinatal Care in Maternity Settings (Preparedness for Emergency Care Provision and Professionals' Practical Skills)

Labor and Delivery Indicators	Kurgan Region			Moscow City		Moscow Region	Yekaterinburg City
	Kurgan Regional Hospital	Kurgan Maternity Hospital №1	Obstetric Dept., Kurgan City Hospital №2	Kulakov Center		Perinatal Center	Urals Institute
	2011	2011	2011	2008	2011	2011	2011
Delivery Management							
Facility, equipment, protocols	12	8	13	9	11	9	5
%	43%	29%	46%	32%	39%	32%	18%
Practices	20	8	20	7.5	13.5	8	7
%	49%	20%	49%	18%	33%	20%	17%
Ineffective / Harmful practices	3	9	10	15	12	13	14
%	13%	47%	53%	79%	61%	68%	74%
Postpartum Period							
Facility, equipment, protocols	11	1	12	0	7	3	4
%	58%	5%	63%	0%	34%	16%	21%
Ineffective / Harmful practices	5	3	4	9	8	6	11
%	38%	19%	31%	69%	62%	46%	85%
Obstetric Bleeding							
Emergency care kit & protocols	0	4	4	0	0	0	0
%	0%	67%	67%	0%	0%	0%	0%

Warm Chain							
Practices & protocols	17	2	15	0	3	0	1
%	77%	9%	68%	0%	11%	0%	5%
Infection Control/Prevention of Hospital-Acquired Infections							
Practices & protocols	29	11	19	18	25	20	21
%	59%	22%	39%	37%	51%	41%	43%
Basic Neonatal Resuscitation (Delivery Room only)							
Practices & protocols	10	7	0	0	0	9	10
%	59%	41%	0%	0%	0%	53%	59%
TOTAL	107	53	97	59	78	68	73
	50%	25%	45%	27%	36%	32%	34%

Annex 2.b: Summary Results of Audits on Essential Neonatal Care

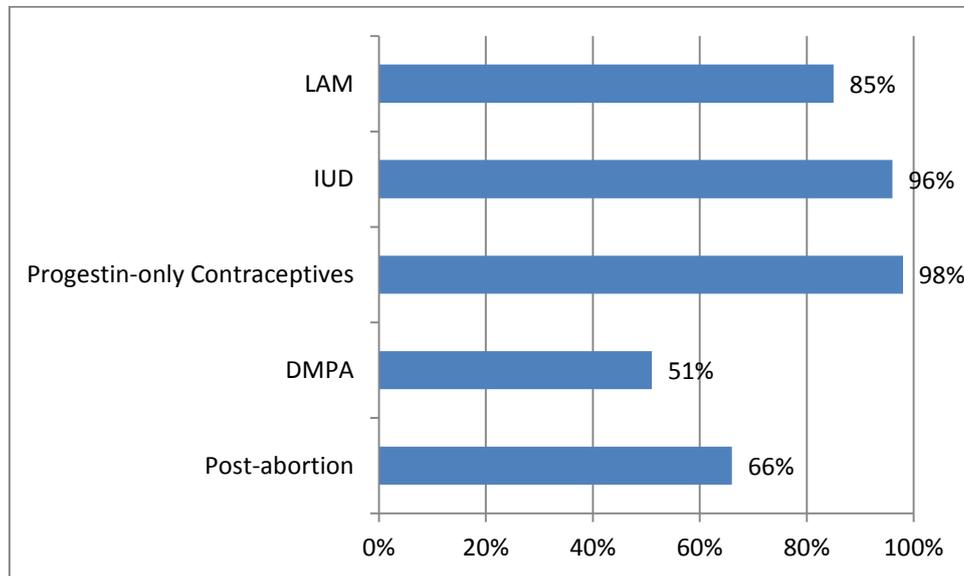
ENC Indicator	Old Regions										New Regions								
	Tyumen' Region		Vologda Region				Kurgan Region		Khanty-Mansiysk AD		Yamalo-Nenetskiy AD	Moscow Region		Sverdlovsk Region		Chelyabinsk Region			
	Maternity Hospital №3	Tyumen' Regional Center	Vologda Regional Maternity Hospital	Vologda Maternity Hospital №1	Cherepovets Maternity Hospital	Cherepovets Regional Maternity ("Severstal")	Maternity Hospital №2	Kurgan Regional Maternity Hospital	Khanty-Mansiysk Perinatal Center	Nijnevartovsk Perinatal Center	Noyabr'sk	Moscow Maternity Hospital №4	Moscow Regional Center (Balashkha)	Sverdlovsk regional Center	Ekaterinburg City Center	Chelyabinsk Medical Academy Maternity	Maternity Hospital №2	Maternity of the City Clinical Hospital №3	Maternity of the City Clinical Hospital №9
Rooming-in:	1	1	1	1	1	1	1	1	1	1	0.5	1	0.5	1	1	1	1	1	1
Breastfeeding:	1	1	1	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1
Warm Chain:	1	1	0.75	1	0.75	0.75	0.5	0.5	0.5	0.5	0	0.75	0.5	0.5	0.75	0.5	0.5	0.25	0.5
Inefficient practices	0.8	0.7	0.9	0.4	0.9	0.8	0.8	0.5	0.6	0.7	0.2	0.5	0.4	0.7	0.6	0.6	0.6	0.2	0.4
Hands hygiene	1	1	0.5	0.5	0.5	1	0.5	0.5	1	1	0.5	0	0	1	1	0	0	0.5	0.5
Complete neonatal resuscitation kit in every delivery room	1	1	1	1	1	1	0	0	1	1	0	1	1	1	0	0	0	0	0
Training on neonatal resuscitation for facility health care providers	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Number of ENC points	6.8	6.7	6.15	5.9	6.15	6.55	4.8	4.5	6.1	6.2	2.2	5.25	4.4	6.2	5.35	4.1	4.1	3.95	4.4
Percent ENC score	97%	96%	88%	84%	88%	94%	69%	64%	87%	89%	31%	75%	63%	89%	76%	59%	59%	56%	63%
Average regional percent	96%		88%				66%		88%		31%	69%		83%		59%			
Average facility improvement from baseline	66%	64%	56%	53%	56%	62%	37%	33%	56%	57%	0%	44%	31%	57%	45%	27%	27%	25%	31%
Average regional improvement from baseline	65%		57%				35%		56%		0%	38%		51%		28%			

Annex 2: Results of Family Planning Audits

Annex 2.c.i: Summary Results of Audits of the Quality of Family Planning Service Delivery (Health Facilities)

Chelyabinsk			Tyumen	Kurgan
Women Consultation, Chelyabinsk State Medical Academy	Women's Consultation, City Clinical Hospital #3	Women's Consultation, City Clinical Hospital #9	City Women's Consultation #2	Women's Consultation, City Maternity Hospital #1
Organization of FP Activities				
100%	100%	100%	67%	67%
Staffing				
82%	96%	93%	92%	45%
Equipment Availability				
100%	100%	100%	100%	100%
Quality of FP/RH Service Provision (e.g., FP counseling quality, availability of free contraceptives, availability of counseling to both men and women)				
70%	60%	77%	30%	60%
Integration and Cooperation with other Services (e.g. Education & Social Protection)				
83%	83%	83%	33%	33%
Information Support for the Population				
100%	100%	75%	50%	50%
FP M&E System				
67%	67%	83%	33%	17%
Average percent score of facility FP operating capacity				
86%	87%	87%	58%	53%

Annex 2.c.ii: Percent of Providers Surveyed who Described Appropriate Content of FP Counseling, by Contraceptive Method



Annex 3: Trainings Conducted

Annex 3.a: Trainings on Evidence-Based MCH/RH Practices

Federal District / Region	Training Topic	Date	Number of Participants F/M	Participant Type	Average Pre-test Score	Average Post-test Score
Federal Centers						
Kulakov Center	Family-Centered Maternity Care	Sept 8-10, 2010	31 27/4	Ob-gyns, neonatologists, midwives	32%	82%
Urals Institute***	Breastfeeding	Feb 14-18, 2011	5 5/0	Ob-gyns, neonatologists, midwives		
	Antenatal Care	April 18-22, 2011	4 4/0	Ob-gyns, midwives		
	Family Planning	May 23-27, 2011	1 1/0	Ob-gyns		
	Family-Centered Maternity Care	October 24-29, 2011	2 2/0	Ob-gyn, neonatologists		
	Neonatal Care & Resuscitation	January 23-27, 2012	2 2/0	Neonatologists		
	Family Planning TOT	January 30 – February 3, 2012	1 1/0	Ob-gyns		
	Emergency Obstetric Care	March 26-30, 2012	2 1/0	Ob-gyns, resuscitation specialists		
Urals Federal District						
Chelyabinsk	Breastfeeding	Apr 11-15, 2011	31 31/0	Ob-gyns, pediatricians, neonatologists	11%	88%
	Antenatal Care	May 23-27, 2011	34 33/1	Ob-gyns, midwives	48%	89%
	Family Planning	June 14-17, 2011	35 33/2	Ob-gyns, midwives	55%	83%
	Family-Centered Maternity Care	September 12-17, 2011	39 38/1	Ob-gyns, neonatologists, midwives	55%	87%
	Emergency Obstetric Care	February 6-10, 2012	31 24/7	Ob-gyns, neonatologists, resuscitation specialists	69%	94%

Sverdlovsk (Yekaterinburg)	Breastfeeding	February 14-18, 2011	30 30/0	Ob-gyns, neonatologists, midwives, nurses	26%	85%
	Antenatal Care	April 18-22, 2011	28 27/1	Ob-gyns, midwives	52%	84%
	Family Planning	May 23-27, 2011	30 26/4	Ob-gyns, midwives	59%	81%
	Family-Centered Maternity Care	October 24-29, 2011	35 34/1	Ob-gyns, neonatologists, midwives	50%	82%
	Neonatal Care & Resuscitation	January 23-27, 2012	37 37/0	Ob-gyns, neonatologists, resuscitation specialists, midwives, nurses	53%	90%
	Emergency Obstetric Care	March 26- 30, 2012	34 34/0	Ob-gyns, anesthesiology and resuscitation specialists, midwives	32%	73%
Sverdlovsk (Yekaterinburg), Tyumen, KHMAO, Chelyabinsk, Kurgan – joint training	Family Planning TOT	January 30 – February 3, 2012	24 24/0	Ob-gyns, midwives	71%	91%
KHMAO (Nizhnevartovsk)	Family Planning	September 12-16, 2011	26 26/0	Ob-gyns, midwives	52%	82%
Kurgan	Breastfeeding	May 24-28, 2010	30 30/0	Ob-gyns, neonatologists, pediatricians, college professors	33%	92%
	Family-Centered Maternity Care	October 18- 22, 2010	40 39/1	Ob-gyns, neonatologists, midwives	31%	82%
	Pediatric Care	November 22-26, 2010	32 29/3	Neonatologists, pediatricians	49%	93%
	Emergency Obstetric Care	April 11-13, 2011	41 35/6	Ob-gyns, neonatologists, anesthesiology and resuscitation specialists, pediatricians, midwives	31%	81%
	Family Planning Refresher Course	September 20-21, 2011	36 35/1	Ob-gyns, midwives	54%	86%

Tyumen	Prevention of Antenatal Mortality	February 20-21, 2012	73 70/3	Ob-gyns, residents, faculty members		
	Pediatric Care	March 11-16, 2012	32 31/1	Neonatologists, pediatricians, nurses	49%	94%
YANAO	Antenatal Care	March 12-16, 2012	24 23/1	Ob-gyns, psychologists, midwives	25%	75%
Northwestern Federal District						
Leningrad (Vyborg)	Neonatal Resuscitation	February 28 – March 4, 2010	25 24/1	Ob-gyns, neonatologists, pediatricians, midwives, nurses	57%	84%
Central Federal District						
Moscow City	Breastfeeding	Maternity # 4 June 6-10, 2011	36 33/3	Ob-gyns, neonatologists, midwives, nurses	19%	78%
Moscow Region	Neonatal Resuscitation	Dubna, June 15-19, 2010	17 15/2	Ob-gyns, neonatologists, pediatricians, resuscitation specialists	58%	88%
Moscow Region	Family-Centered Maternity Care	Balashikha, October 3-7, 2011	38 35/3	Ob-gyns, neonatologists, epidemiologists, resuscitation specialists, midwives, nurses	39%	89%
TOTAL	--		869 823/46	--	43%	82%

*** The Urals Institute participated in training for Sverdlovsk Region health facilities. Participants and scores are included in the Sverdlovsk totals.

Annex 3.b: Social-Medical Trainings Conducted

Federal District / Region	Training Topic	Date	Number of Participants F/M	Participant Type	Average Pre-test Score	Average Post-Test Score
Urals Federal District						
KHMAO	Medical-Social Care for High-Risk Women	February 27-29, 2012	35 *	Ob-gyns, social care specialists, psychologists, midwives	74%	99%
Tyumen	Medical-Social Care for High-Risk Women	March 27-29, 2012	31 *	Ob-gyns, social care specialists, psychologists, midwives		
Kurgan	Training on Medical-Social Care for HIV-Positive Women	February 7-9, 2012	32 29/3	Ob-gyns, neonatologists, pediatricians, psychologists	87%	96%
TOTAL	--		98 92/6	--	81%	97%

**The female/male breakdown for the KHMAO and Tyumen courses together was 63/3*

Annex 3.c: Total Trainings Conducted

(Total from Annexes 10.a and 10.b)

	Number of Trainings	Number of Participants F/M	Average Pre-test Score	Average Post-Test Score
Total	29	967 915/52	46	83

Annex 4: Workshops and Seminars Conducted

Title of Workshop	City/Region	Date	Number and Types of Participants	Regions Represented
Meeting on Implementation of Evidence-Based Medicine	Moscow Region	February 16-17, 2010	25 participants MCH specialists of Kulakov Center, Health Departments, chief doctors, heads of departments of maternal facilities, chief regional ob-gyns	Moscow City, Moscow Region, Vologda Region, Sverdlovsk Region, Leningrad Region, Tyumen Region, Irkutsk Region, Kemerovo Region, Republic of Komi, Perm Krai, Samara Region
Implementation of Best Practices in Mother and Child Health in Russia	Moscow	April 12-13, 2010	26 participants Regional project coordinators, MCH specialists and heads of MCH departments	Moscow City, Moscow Region, Vologda Region, Leningrad Region, Tyumen Region, Irkutsk Region, Kemerovo Region, Altaysky Krai, Kurgan Region, Orenburg Region, Primorskiy Krai, Republic of Karelia, Republic of Sakha (Yakutia), Sakhalin Region, KHMAO
Follow-up Meeting on Implementation of Evidence-Based Medicine	Yekaterinburg	June 28-30, 2010	21 participant MCH specialists of Kulakov Center, Ural Research Institute of Maternity and Infancy, Health Departments, chief doctors, heads of departments of maternal facilities, chief regional ob-gyns	Moscow City, Moscow Region, Sverdlovsk Region, Leningrad Region, Tyumen Region, Irkutsk Region, Kemerovo Region, Republic of Komi, Samara Region, Orenburg Region
Workshop on Developing Premature Delivery Protocols	Moscow	September 6, 2010	19 participants MCH specialists of Kulakov Center, Health Departments, chief doctors, heads of departments of maternal faculties, chief regional ob-gyns	Moscow City, Moscow Region, Republic of Komi, Orenburg Region, Sverdlovsk Region, Leningrad Region, Tyumen Region, Irkutsk Region

Evidence-Based Medicine (EBM) an Introduction of Best Practices	Moscow	September 7, 2010	23 participants MCH specialists of Kulakov Center, Health Departments, chief doctors, heads of departments of maternal faculties, chief regional ob-gyns	Moscow City, Moscow Region, Republic of Komi, Orenburg Region, Sverdlovsk Region, Leningrad Region, Tyumen Region, Irkutsk Region, Kemerovo Region, KHMAO
Workshop for Urals Federal District Mother and Child Health Officials "IBP-MCH in the Urals Federal District"	Tyumen	October 27-28, 2010	30 participants MCH specialists of Kulakov Center, Health Departments, chief doctors, heads of departments of maternal facilities, chief regional ob-gyns	Moscow City, Moscow Region, Tyumen Region, Sverdlovsk Region, YANAO, Chelyabinsk Region, Kurgan Region
IBP-MCH Workshop in the Urals Federal District "Modern Approaches to Quality Management in Medical Services: Risk Management"	Yekaterinburg	December 6-7, 2010	23 participants MCH specialists of Kulakov Center, Ural Scientific and Research Institute of Motherhood and Childhood Defense, Health Departments, chief doctors, heads of departments of maternal facilities, chief regional ob-gyns	Moscow City, Moscow Region, Sverdlovsk Region, Tyumen Region, YANAO, Chelyabinsk Region, Kurgan Region
Workshop on Improving Children's and Teenagers' Reproductive Health Services	Moscow	December 14-15, 2010	28 participants MCH specialists of Kulakov Center, Chief children's' obstetrician-gynecologists of Russian Federal Districts, leading ob-gyns and andrologists	Moscow City, Leningrad Region, Altaiysky Krai, Irkutsk Region, Smolensk Region, Krasnodar Krai, Orenburg Region, Ivanovo Region, Tambov Region, Omsk Region, Chelyabinsk Region, Rostov Region, Novosibirsk Region, Republic of Chuvashia
IBP-MCH Annual Follow-Up Meeting: Year 2010 Results and Year 2011 Prospects	Moscow Region	December 21-22, 2010	26 participants MCH specialists of Kulakov Center, head of departments of MCH faculties, international organizations	Moscow City and Moscow Region

Meeting on Medical Services for High-Risk Women	Tyumen	February 21-22, 2011	21 participant Chief doctors, chief neonatologists and pediatricians, heads of social care facilities, heads of MCH departments	Moscow City, Tyumen and Tyumen Region
Workshop on Development of a Newborn Resuscitation Training Course	Moscow	March 28-29, 2011	21 participants Heads of neonatal care departments, chief neonatologists, heads of pediatric and neonatal care departments	Moscow City, Moscow Region, Sverdlovsk Region, Leningrad Region, Tyumen Region, Chelyabinsk Region, Orenburg Region, Vologda Region
Workshop on Medical Audit in Obstetric Facilities	Kurgan	April 14-16, 2011	16 participants Ob-gyns, heads of obstetric departments, medical faculties	Moscow City, Irkutsk Region, Tyumen Region, Kurgan Region, Republic of Komi
Medical-Social Care for High-Risk Women	Khanty-Mansiysk/ KHMAO	April 21, 2011	10 participants Representatives of KHMAO Department of Health, KHMAO Department of Social Development, KHMAO social care organizations	Moscow City, KHMAO
Newborn Resuscitation Training Development	Gelendzhik/ Krasnodar Krai	June 29, 2011	8 participants Neonatologists and resuscitation specialists	Moscow City, Moscow Region, Sverdlovsk Region, Leningrad Region, Tyumen Region, Chelyabinsk Region, Orenburg Region, Vologda Region
Development of Guidelines on Perinatal Care Regionalization	Saint Petersburg/ Leningrad Region	July 27-30, 2011	19 participants MCH specialists of Health Departments, head doctors, heads of departments of maternal facilities, chief regional ob-gyns	Moscow City, Moscow Region, Vologda Region, Leningrad Region, Republic of Komi, Sverdlovsk Region, Kiev (Ukraine), Chelyabinsk Region, KHMAO

Test of Questionnaire for High-Risk Women	Moscow	October 20-21, 2011	7 participants Representatives of maternal, HIV and social care facilities	Moscow City, Tyumen Region, KHMAO
Development of National Medical Eligibility Criteria for Contraceptive Use	Moscow	October 31 – November 01, 2011	20 participants Heads of ob-gyn departments and professors of medical educational facilities, head doctors of maternity facilities, representatives of Kulakov Scientific Center of Obstetrics, Gynecology and Perinatology	Moscow City, Moscow Region, Leningrad Region, Republic of Tatarstan, Irkutsk Region, Kemerovo Region, Altayskiy Krai, Krasnodar Krai
Development of Guideline on Perinatal Care Regionalization	Yekaterinburg	December 20-21, 2011	20 participants MCH specialists of Health Departments, head doctors, heads of departments of maternal facilities, chief regional ob-gyns	Moscow City, Moscow Region, Sverdlovsk Region, Chelyabinsk Region, Leningrad Region, Republic of Komi, Tyumen Region, Kurgan Region, Republic of Tatarstan
International Cooperation under IBP MCH	Moscow	December 23, 2011	26 participants Representatives of Kulakov Scientific Center of Obstetrics, Gynecology and Perinatology, Moscow Maternity # 4, Moscow Regional Perinatal Center, scientific and educational facilities of Moscow	Moscow City, Moscow Region
Medical and Social Care to High-Risk Women	Tyumen	January 26-27, 2012	34 participants MCH specialists of Health Departments, head doctors, deputy head doctors and ob-gyns of maternity facilities, social care specialists	Tyumen Region, KHMAO
Training on Medical-Social Care for Women Living with HIV	Kurgan	February 7-9, 2012	32 participants Ob-gyns, neonatologists, pediatricians, psychologists	Kurgan

Development of National Medical Eligibility Criteria for Contraceptive Use	Moscow	February 16-17, 2012	26 participants Hheads of ob-gyn departments and professors of medical educational facilities, head doctors of maternity facilities, representatives of Kulakov Scientific Center of Obstetrics, Gynecology and Perinatology	Moscow City, Moscow Region, Leningrad Region, Republic of Tatarstan, Kemerovo Region, Altayskiy Krai, Krasnodar Krai, Nizhniy Novgorod Region, Volgograd Region
Prevention of Antenatal Mortality	Tyumen	February 20-21, 2012	73 participants Ob-gyns, residents, academic faculty members	Tyumen
Evidence-Based Medicine	Moscow	April 9-10, 2012	25 participants Interns, residents from Kulakov Center	Moscow
Total: 24 workshops, 579 participants				

Annex 5: Number of Service Delivery Points in Project Regions Providing MCH/RH Care and Number of Networks of Care Established

Regions/Sites	Maternities	Women's Consultations	Family Planning Centers	Children's Polyclinics	Total
Chelyabinsk					
Chelyabinsk City	5	5	1	2	13
Other urban/rural areas	2	2		2	6
Chelyabinsk Region Total	7	7	1	4	19
KHMAO					
Khanty-Mansiysk City	1	1		1	3
Surgut City	1	1		1	3
Nijnevartovsk City	1	1	1	1	4
Other urban/rural areas	1			1	2
KHMAO Total	4	3	1	4	12
Kurgan					
Kurgan City	3	3	1	3	10
Other urban/rural areas	3	3		3	9
Kurgan Region Total	6	6	1	6	19
Leningrad					
Leningrad Region	5	6	3	4	18
Leningrad Region Total	5	6	3	4	18
Moscow					
Moscow City	2				2
Other urban/rural areas	5	3		3	11
Moscow Region Total	7	3		3	13
Sverdlovsk					
Yekaterinburg City	1	1		1	3
Other urban/rural areas	1	1	1		3
Sverdlovsk Region Total	2	2	1	1	6

Tyumen					
Tyumen City	3	3	1	3	10
Tobolsk City	1	1		1	3
Other urban/rural areas	19	18			37
Tyumen Region Total	23	22	1	4	50
Vologda					
Vologda City	2	5	1	3	11
Cherepovets City	1	2		2	5
Other urban/rural areas	8	26		9	43
Vologda Region Total	11	33	1	14	59
YANAO					
YANAO urban/rural areas	2	2		2	6
YANAO Total	2	2		2	6
TOTAL	67	84	9	42	202
<i>These facilities made up 67 “networks” of care across rural and urban areas, encompassing a maternity hospital, women’s consultation, family planning center (where it exists) and children’s polyclinic.</i>					

Annex 6: Conferences Conducted by the Project

Title of Conference	City/Region	Date	Number and Types of Participants	Regions Represented
Perinatal Care in USA. Role of Professional Medical Associations	Moscow	March 18, 2011	145 participants Members of Board of Russian Society of Obstetrician-Gynecologists, chief obstetrician-gynecologist of Moscow, heads of departments of Moscow medical institutes, representatives Kulakov Center	Moscow City and Moscow Region
Perinatal Care in USA. Role of Professional Medical Associations	Tyumen/ Tyumen Region	March 23, 2011	214 participants Head doctors, heads of obstetrics departments, ob-gyns, interns, chief MCH specialists, chief obstetricians-gynecologists	Moscow City, Kirov Region, Krasnoyarsk Krai, Kurgan Region, Moscow Region, Perm Region, Republic of Ingushetia, Republic of Karelia, Republic of Sakha (Yakutia), Sakhalin Region, Sverdlovsk Region, Tomsk Region, Tyumen Region, Chelyabinsk Region, KHMAO, YANAO
Perinatal Care in USA. Role of Professional Medical Associations	Saint Petersburg/ Leningrad Region	March 25, 2011	106 participants Head doctors, heads of obstetrics departments, ob-gyns, interns, chief MCH specialists, chief obstetricians-gynecologists, students	Moscow City, Saint Petersburg and Leningrad Region
Modern Strategies to Improve Quality of Care for Women and Children	Surgut/ KHMAO	May 19-20, 2011	336 participants Deputy Governor of KHMAO, MCH specialists of Departments of Health, head regional ob-gyns, head doctors, heads of departments of maternal facilities, ob-gyns, pediatricians, social care specialists, interns	Moscow City, KHMAO, Vologda Region, Irkutsk Region, Kurgan Region, Moscow Region, Leningrad Region, Sverdlovsk Region, Tyumen Region, Chelyabinsk Region, YANAO, Republic of Komi

<p>US-Russia Forum: Bilateral Collaboration to Improve Maternal and Infants' Health</p>	<p>Moscow</p>	<p>May 21-23, 2012</p>	<p>256 participants</p> <p>Representatives of MOSHD, Kulakov Center, MCH specialists of Departments of Health, chief regional ob-gyns, head doctors, heads of departments of maternal facilities, ob-gyns, pediatricians, social care specialists, interns. pharmaceutical companies, journalists</p>	<p>Moscow City, Moscow Region, Volodga Region, Kurgan Region, Leningrad Region, Sverdlovsk Region, Tyumen Region, KHMAO, Chelyabinsk Region, YANAO, Irkutsk Region, Ivanovo Region, Kemerovo Region, Kirov Region, Krasnoyarsk Krai, Krasnodar Krai, Kaluga Region, Nizhny Novgorod Region, Orenburg Region, Penza Region, Perm Region, Primorskiy Krai, Republic of Sakha (Yakutia), Republic of Karelia, Republic of Komi, Samara Region, Sakhalin Region, Stavropol Krai, Tomsk Region, Republic of Tatarstan, USA, CIS countries: Kazakhstan, Kyrgyzstan, Ukraine</p>
<p>Total: 5 conferences, 1,057 participants</p>				

Annex 7: Presentations by Project Staff and Experts at National and Subnational Conferences

Conference Organizer(s)	Title of Conference	City/Region	Topic of Presentation	Date
Russian Ministry of Health and Social Development Kulakov Scientific Center of Obstetrics, Gynecology and Perinatology Reproductive Medicine & Surgery Society Russian Endometriosis Association	IV International Reproductive Health Congress	Moscow	“STI Prevention is One of the Highest Priorities of Modern Healthcare” by Dr. Vartapetova “Negative Consequences of High STI Sickness Rate” by Dr. Karpushkina “Global and Regional Prospects of Family Planning” by Dr. Sheshko	January 18-21, 2010
Russian Ministry of Health and Social Development Russian Obstetrics & Gynecology Society Neck of Uterus Pathology and Colposcopy Association Russian Society for Contraception	All-Russian Congress “Ambulatory & Outpatient Practice: Modern Prospects”	Moscow	“Ambulatory & Outpatient Practice: Adapting to New Challenges of Health and Healthcare” by Dr. Vartapetova “Women’s Consultation. Changing Values and Rising Expectation” by Dr. Sheshko “Primary Medical Care. Focusing on the Family’s Interests” by Dr. Bugaeva “Counseling: From VIP Assistance to Basic Medical Service” by Dr. Khayrova	March 29 – April 02, 2010
Kulakov Scientific Center of Obstetrics, Gynecology and Perinatology Russian Society of Obstetrician-Gynecologists	I All-Russian Theoretical and Practical Conference “Woman’s Health”	Moscow	“Way of Life and Fertility” by Dr. Vartapetova “Young Woman: Attention Priorities – Contraception, STI/HIV, Screening Programs” by Dr. Karpushkina “Preparation for Pregnancy: What Is Evidenced (What Should Be Done to Improve Result)” by Dr. Shvabskiy	April 26-28, 2010

<p>Russian Association of Perinatal Care Specialists</p> <p>Saint-Petersburg Perinatal Care School</p> <p>Health Committee of Saint-Petersburg</p>	<p>International Interdisciplinary Conference “Premature Birth”</p>	<p>Saint Petersburg/ Leningrad Region</p>	<p>“Actual Protocol “Premature Birth” Implementation Results – MCHI Project Experience” by Dr. Shvabskiy</p>	<p>May 31 – June 02, 2010</p>
<p>Russian Ministry of Health and Social Development</p> <p>Ministry of Health of Sverdlovsk region</p> <p>Kulakov Scientific Center of Obstetrics, Gynecology and Perinatology</p> <p>Russian Society of Obstetrician-Gynecologists</p> <p>Urals Scientific and Research Institute of Maternity and Infancy</p> <p>Ural State Medical Academy</p>	<p>IV Regional Scientific Forum “Mother and Child”</p>	<p>Yekaterinburg/ Sverdlovsk Region</p>	<p>“Risk Management Evaluation in Healthcare: from Theory to Practice” by Dr. Vartapetova</p>	<p>June 28-30, 2010</p>
<p>University Research Corporation</p> <p>Kulakov Scientific Center of Obstetrics, Gynecology and Perinatology</p> <p>Tver City Administration</p> <p>Tver State Medical Academy</p> <p>Central Science and Research Institute of Health Organization and Information</p>	<p>International Conference “Perinatal Care Regionalization”</p>	<p>Tver/Tver Region</p>	<p>“Basic Steps in Building Up a Perinatal Care Regionalization System in IBP Project Pilot Regions” by Dr. Safronova</p> <p>“Perinatal Care Regionalization Experience in Perm Krai” by Dr. Trushkov</p>	<p>May 20-21, 2010</p>

<p>Russian Ministry of Health and Social Development</p> <p>Kulakov Scientific Center of Obstetrics, Gynecology and Perinatology</p> <p>Russian Society of Obstetrician-Gynecologists</p>	<p>XI All-Russian Scientific Forum "Mother and Child 2010"</p>	<p>Moscow</p>	<p>"Diagnosis and Prevention of Premature Delivery" by Dr. Shvabskiy</p> <p>"Treatment of Low-Weight Newborns" by Dr. Safronova</p> <p>"Professional Growth Opportunities for Modern Doctor" by Dr. Shvabskiy</p>	<p>September 28 – October 01, 2010</p>
<p>Russian Ministry of Health and Social Development</p> <p>Russian Federal Service on Surveillance in Healthcare and Social Development (Roszdravnazor)</p> <p>Russian Society of Obstetrician-Gynecologists</p> <p>Health Department of Administration of Sochi</p>	<p>Seminar "Reproductive Prospects in Russia: Versions and Contraversions"</p>	<p>Sochi/ Krasnodar Krai</p>	<p>"Efficient and Economically Feasible Population Reproductive Health Defense Projects" by Dr. Karpushkina</p> <p>"Reasonability of Reconsidering Restrictions for Contraceptive Use" by Dr. Sheshko</p>	<p>September 09-11, 2010</p>
<p>Russian Ministry of Health and Social Development</p> <p>Russian Academy of Medical Sciences</p>	<p>Regional Scientific Congress "Humans and Medicine, Urals – 2010"</p>	<p>Tyumen/ Tyumen Region</p>	<p>"Life-Style and Reproductive Health" by Dr. Vartapetova</p> <p>"Healthy Life-Style: History and Nowadays" by Dr. Karpushkina</p>	<p>October 26-28, 2010</p>
<p>Russian Ministry of Health and Social Development</p> <p>Kulakov Scientific Center of Obstetrics, Gynecology and Perinatology</p> <p>Russian Association of Perinatal Medicine</p> <p>Russian Federation of Anesthesiology and Resuscitation Specialists</p>	<p>III National Congress "Anesthesia and Resuscitation in Obstetrics and Neonatology"</p>	<p>Moscow</p>	<p>"Evidence-Based Patient Safety" by Dr. Shvabskiy</p>	<p>November 23-26, 2010</p>

<p>Scientific and Research Institute of Obstetrics, Gynecology and Perinatology of the Siberian Branch of Russian Academy of Medical Sciences</p> <p>Health Department of Tomsk Region</p>	<p>National Conference, "The Health of Women, Teenagers and Girls."</p>	<p>Tomsk/Tomsk Region</p>	<p>"Pelvic Presentation, Premature Delivery and Labor Complications according to Evidence Based Medicine" by Dr. Shvabskiy</p>	<p>November 23-24, 2010</p>
<p>Kulakov Scientific Center of Obstetrics, Gynecology and Perinatology</p> <p>Obstetrics, Gynecology and Perinatology Department of People's Friendship University of Russia</p>	<p>Conference "Infections and Infection Control in Obstetrics and Gynecology"</p>	<p>Moscow</p>	<p>"Treatment of Urogenital Chlamydia Infection in the Course of Pregnancy" by Dr. Kisina</p>	<p>February 24-26, 2011</p>
<p>Russian Federal Service on Surveillance in Healthcare and Social Development (Roszdravnazor)</p>	<p>Workshop for Central Federal District Specialists, "Enhancing the Effectiveness of Prevention, Diagnosis and Treatment of HIV/AIDS under the National Priority Project"</p>	<p>Moscow Region</p>	<p>"Possibilities of Prevention of Mother-to-Child HIV Transmission: Results of Research under the National Priority Project" by Dr. Karpushkina</p>	<p>March 15-17, 2011</p>
<p>National Research University – Higher School of Economics</p> <p>World Bank</p> <p>International Monetary Fund</p>	<p>XII April International Academic Conference on Economic and Social Development</p>	<p>Moscow</p>	<p>"Ways of Improving the Quality of Medical Care for Women and Children – Ten Years of Experience of the MCHI Project in Russia" by Dr. Vartapetova</p> <p>"Modern Tools to Assess the Effectiveness of Healthcare for Women and Children" by Dr. Vartapetova, Dr. Shvabskiy</p> <p>"Priority Objectives for Healthcare System to Prevent Mother-to-Child HIV Transmission" by Dr. Karpushkina, Dr. Brynza, Dr. Gorbunova</p>	<p>April 05-07, 2011</p>

<p>Ministry of Health and Social Development of the Russian Federation</p> <p>Russian Federal Consumer Rights Protection and Human Health Control Service (Rospotrebnadzor)</p> <p>Republic Clinical Infection Hospital</p>	<p>International Scientific and Practical Conference “Children and HIV”</p>	<p>Saint-Petersburg/ Leningrad Region</p>	<p>“Healthcare Priorities in Preventing Mother-to-Child HIV Transmission” by Dr. Karpushkina</p> <p>“Integration of Medical Care to Prevent HIV and STI’s” by Dr. Karpushkina</p>	<p>June 29 – July 01, 2011</p>
<p>World Vision</p>	<p>International Conference “The Achievements of Medical Science and Education in the Healthcare System in an Era of Rebirth”</p>	<p>Ashkhabad/ Turkmenistan</p>	<p>“Programs to Prevent Drug Addiction among Teenagers” by Dr. Shvabskiy</p>	<p>September 20, 2011</p>
<p>Ministry of Health and Social Development of the Russian Federation</p> <p>Kulakov Scientific and Research Center of Obstetrics, Gynecology and Perinatology</p> <p>Russian Society of Obstetricians and Gynecologists</p>	<p>XII All-Russian Scientific Forum “Mother and Child”</p>	<p>Moscow</p>	<p>“Presentation of Essentials of Evidence Based Care Guide” by Dr. Vartapetova, Dr. Sukhikh</p> <p>(under respective session)</p>	<p>September 27-30, 2011</p>
<p>Medical and Sanitary Facility № 59 of the Russian Federal Medical and Biological Agency</p>	<p>II Interregional Scientific Conference “Obstetrics, Gynecology, Perinatology in Modern Russian Healthcare”</p>	<p>Penza/Penza Region</p>	<p>“New Aspects of the Protocol on Management of Hypertension durin Pregnancy, Delivery and the Postpartum Period” by Dr. Shvabskiy</p> <p>“Post-term Pregnancy and Induction of Labor” by Dr. Shvabskiy</p> <p>“New Aspects of the Protocol on Premature Delivery” by Dr. Shvabskiy</p>	<p>October 07-08, 2011</p>

Health Department of Tyumen oblast Tyumen State Medical Academy	IV Therapeutic Forum	Tyumen/ Tyumen Region	“Client-Friendly Medical Care” by Dr. Karpushkina “Importance of an Interdisciplinary Approach to Reproductive Health” by Dr. Shvabsky	November 09-10, 2011
Ministry of Education of the Russian Federation Ministry of Health of Republic of Tatarstan	II Russian Scientific and Practical Seminar “Reproductive Potential in Russia: Kazan Readings”	Kazan/ Republic of Tatarstan	“Medical Eligibility Criteria for Contraceptive Use: From International Experience to Russian Practice” by Dr. Sheshko “Post-term Pregnancy and Induction of Labor” by Dr. Shvabskiy	November 24-26, 2011
Urals Scientific and Research Institute for Maternity and Infancy Urals Medical Academy	II Urals Obstetrics and Gynecology Congress “Modernization of Maternal and Child Health Services”	Yekaterinburg/ Sverdlovsk Region	“Modern Trends in Perinatology” by Dr. Shvabskiy	December 06-07, 2011
Rospotrebnadzor	All-Russian Workshop “Improving the Surveillance of Anti-Epidemic Measures, Implemented as Part of HIV Prevention”	Suzdal/ Vladimir Region	“Algorithms on medical and social care to high-risk women” by Dr. Karpushkina	December 06-08, 2011
Kulakov Scientific and Research Center of Obstetrics, Gynecology and Perinatology Russian Society of Obstetricians and Gynecologists Russian Society of Contraception	“Ambulatory and Outpatient Practice - in the Epicenter of Women Health”	Moscow	“Medical Eligibility Criteria for Contraceptive Use: from International Experience to Russian Practice” by Dr. Vartapetova, Dr. Sheshko, Dr. Prilepskaya “COC: What’s New?” by Dr. Podzolkova “Progestin-Only Contraceptives: Is It in Demand?” by Dr. Mezhevitinova “IUD: New about Old” by Dr. Yevtushenko “Sterilization: Is It Eligible for Russia?” by Dr. Artymuk	March 20-23, 2012

<p>Snegiryov Ob-Gyn Clinic Sechenov Moscow State University Moscow Society of Obstetricians and Gynecologists</p>	<p>International Congress “Hypertensive Disorders during Pregnancy”</p>	<p>Moscow</p>	<p>“International Experience in Managing Preeclampsia” by Dr. Shvabskiy</p>	<p>April 03-04, 2012</p>
<p>Kemerovo Region Health Care Department Kemerovo State Medical Academy KRNGO “Obstetricians and Gynecologists Association”</p>	<p>16th International Conference “From Hypothesis – to the Truth”</p>	<p>Kemerovo/ Kemerovo Region</p>	<p>“Modern Possibilities of Reducing Maternal Mortality” by Dr. Shvabskiy “Informed Consent as a Defense of a Patient and Physician” by Dr. Shvabskiy “Family-Oriented Technologies in Neonatal Practice in the Perinatal Center” by Dr. Martirosyan “Family-Oriented Technologies in Obstetrical Practice in the Perinatal Center” by Dr. Belomestnov</p>	<p>April 18-21, 2012</p>
<p>Ethiopian Public Health Association World Federation of Public Health Associations</p>	<p>13th World Congress on Public Health “Towards Global Health Equity: Opportunities and Threats”</p>	<p>Addis-Ababa/ Ethiopia</p>	<p>“Best Perinatal Practices: Regionalization of Maternal and Neonatal Health Services in Russia” by Dr. Vartapetova</p>	<p>April 23-27, 2012</p>
<p>USAID</p>	<p>Europe and Eurasia Regional Family Planning Conference “Capturing Legacy, Maximizing Sustainability”</p>	<p>Tbilisi/ Georgia</p>	<p>“Family Planning in Russia: Challenges and Accomplishments” by Dr. Vartapetova, Dr. Sheshko</p>	<p>May 16-18, 2012</p>

Obstetrics, Gynecology and Perinatology Department of People's Friendship University of Russia	II International Conference "Infections and Infection Control in Obstetrics and Gynecology"	Moscow	"Infection Control in Obstetrics from the Point of View of World Medicine" by Dr. Karpushkina	May 23-26, 2012
Total: 28 conferences, 54 presentations				

Annex 8: List of Professional Publications by Project Staff

<i>No</i>	<i>Title of Article</i>	<i>Authors</i>	<i>Name of Publication</i>	<i>Year</i>
1.	Results of Surveying Specialists on Enhancing Professional Competence	Dr. Vartapetova	The Doctor and Informational Technologies	2010
2.	Prevention of Sexually Transmitted Infections as a Public Health Priority	Dr. Vartapetova	Andrology and Genital Surgery	2010
3.	Reproductive Health Counseling	Dr. Vartapetova	The Doctor	2010
4.	Term Infant Mortality and Stillbirths as Factors in Healthcare Quality Assessment in Maternity Care Settings	Dr. Vartapetova	Social Aspects of Public Health	2010
5.	Current Situation in Obstetrics (Perm Krai Experience)	Dr. Vartapetova Dr. Trushkov	Social Aspects of Public Health	2010
6.	Institutionalizing Best Perinatal Technologies in Maternity Facilities' Everyday Practice	Dr. Vartapetova Dr. Shvabsky	Medical Science and Education in the Urals Federal District	2011
7.	Frequency of Pathological Cases and Outcomes of Pregnancy in Perm	Dr. Vartapetova Dr. Trushkov Dr. Alexeev	Social Aspects of Public Health	2011
8.	Prevention of Maternal Mortality: Monitoring during Pregnancy and Delivery	Dr. Bashmakova Dr. Kovalev Dr. Tatareva Dr. Zilber Dr. Kayumova Dr. Davydenko Dr. Vartapetova	Obstetrics and Gynecology	2011
9.	Evidence-Based Medicine and Medical Education	Dr. Vartapetova Dr. Sheshko	Modern Medical Technologies	2011

10.	Improving Healthcare for HIV-Positive	Dr. Vartapetova Dr. Karpushkina Dr. Dementyeva Dr. Brynza Dr. Gorbunova	Public Health	2011
11.	Implementation of Evidence-Based, Safe Practices is our Principle	Dr. Vartapetova	Effective Pharmacotherapy. Obstetrics and Gynecology	2011
12.	Medical Eligibility Criteria for Contraceptive Use	Dr. Vartapetova Dr. Sheshko	Effective Pharmacotherapy. Obstetrics and Gynecology	2011
13.	Tobacco Children – Smoking during Pregnancy	Dr. Vartapetova	Your Gynecologist	2011
14.	Organization of Perinatal Care – Modern Trends	Dr. Vartapetova Dr. Shvabskiy	Public Health	2012
15.	Indications of Social Risk Factors for Women During Pregnancy	Dr. Vartapetova Dr. Karpushkina Dr. Goliusov Dr. Gorbunova Dr. Baryshnikova Dr. Dulgerova	Public Health	2012

Annex 9: Mass Media Coverage

Oblast	TV	Radio	Print	Internet
Moscow		1	6	16
Tyumen Region	7		2	45
Chelyabinsk Region	1		1	21
Khanty-Mansiysky Autonomous Region	3		1	29
Sverdlovsk Region	1		1	4
Perm Region			1	3
Samara Region			1	
Tomsk Region			1	
Total	12	1	14	118

Annex 10: Maternal Mortality Ratio
(Number of maternal deaths per 100,000 live births)

Region	2007	2008	2009	2010
Russian Federation	24.2**	22.6*	26.1*	18.6*
Old Project Regions				
Vologda Region (since 2004)	21.2**	6.8* (**)	13.2* (**)	46.5** 46.4*
Tyumen Region (since 2004)	10.8**	15.0* (**)	9.6* (**)	4.7* (**)
KHMAO (since 2007)	22.8**	21.6** 21.5*	16.7** 16.8*	8.0* (**)
Kurgan Region (since 2007)	35.8**	33.8* 33.5**	16.8** 16.7*	25.2** 25.4*
Leningrad Region (since 2008)	7.3**	28.0** 35.0*	33.2** 33.3*	6.6** 6.7*
New Project Regions				
Moscow Region		19.9*	24.3*	15.7** 15.6*
Moscow City		21.3*	22.4*	20.3*
Sverdlovsk Region		33** 33.1*	21.2** 21.3*	17.5** 17.4*
Chelyabinsk Region		11.2** 11.1*	37.1** 37.3*	15.5** 15.0*
YANAO		25.3*	12.2*	0*

* Ministry of Health and Social Development, *Basic Indicators of Obstetrics and Gynecology Service Activities in the Russian Federation, 2010*

** Data provided by the region

Annex 11: Infant Mortality Rate

(Number of deaths of infants (0-1 years) per 1,000 live births)

Region	2007	2008	2009	2010
Russian Federation	9.4*	8.5* (**)	8.1* (**)	7.5*
Old Project Regions				
Vologda Region (since 2004)	9.0***	7.7** (***)	7.8** (***)	7.3***
Tyumen Region (since 2004)	7.4***	7.1** 7.7***	6.1** 6.8***	6.1***
KHMAO (since 2007)	5.6***	5.2** (***)	4.0** (***)	4.2***
Kurgan Region (since 2007)	12.0***	10.1** (***)	10.5** (***)	8.8***
Leningrad Region (since 2008)	7.6***	7.9**	5.5**	6.0***
New Project Regions				
Moscow Region		7.5**	7.4**	6.7***
Moscow City		6.3**	6.7**	NA
Sverdlovsk Region		7.6** 7.4***	6.4** (***)	6.1***
Chelyabinsk Region		8.7** 8.6***	8.4** 8.2***	7.8***
YANAO		11.4**	10.7**	NA

* Ministry of Health and Social Development, *Basic Indicators of Obstetrics and Gynecology Service Activities in the Russian Federation, 2010*

** The Demographic Yearbook of Russia (Federal State Statistics Service "Rosstat" 2010)

*** Data provided by the region

Annex 12: Abortion Rates and Ratios

Annex 12.a: Total Abortion Rate

(Number of abortions per 1,000 women of reproductive age (15-49 y.o.) in participating regions)

Region	2007	2008	2009	2010
Russian Federation	33.3	32	34.2	N/A
Old Project Regions				
Vologda Region (since 2004)	59.0	49.0	45.0	42.0
Tyumen Region (since 2004)	38.4	38.1	37.0	33.7
KHMAO (since 2007)	41.0	38.0	36.0	31.3
Kurgan Region (since 2007)	51.0	53.0	51.0	41.1
Leningrad Region (since 2008)	35.0	32.0	31.0	27.1
New Project Regions				
Moscow Region		27.0	27.0	24.3
Moscow City		14	13.0	N/A
Sverdlovsk Region		50	48.0	40.6
Chelyabinsk Region		45	42.0	34.0
YANAO		46	46.0	N/A

* Ministry of Health and Social Development, *Basic Indicators of Obstetrics and Gynecology Service Activities in the Russian Federation, 2010*

** Data provided by the region

Annex 12.b: Abortion Ratio
(Number of abortions per 100 live births in participating regions)

Region	2007	2008	2009	2010
Russian Federation	81.9*	73.1*	66.7*	59.7*
Old Project Regions				
Vologda Region (since 2004)	128.0*	112.9*	100.2*	89.8*
Tyumen Region (since 2004)	84.2*	75.4*	68.8*	61.4*
KHMAO (since 2007)	85.5*	75.8*	68.6*	60.5*
Kurgan Region (since 2007)	109.8**	98.2**	90.7**	86.2**
Leningrad Region (since 2008)	143.3*	115.4*	99.1*	84.2*
New Project Regions				
Moscow Region		71.4*	68.6*	61.5*
Moscow City		25.5*	21.9*	20.1*
Sverdlovsk Region		96.7*	90.0*	85.0*
Chelyabinsk Region		88.2*	80.0*	70.5*
YANAO		84.7*	81.4*	71.4*

* Ministry of Health and Social Development, *Basic Indicators of Obstetrics and Gynecology Service Activities in the Russian Federation, 2010*

** Data provided by the region

Annex 13: FP/RH Counseling Visits in Project Regions
(Number of counseling visits for FP/RH as a result of USG assistance)

Region	2007	2008	2009	2010
Old Project Regions*				
Vologda Region (since 2004)	19,470	25,341	37,609	41,280
Tyumen Region (since 2004)	29,240	38,786	45,032	52,361
KHMAO (since 2007)	45,231	47,892	51,045	56,449
Kurgan Region (since 2007)	15,672	19,344	28,689	31,145
Leningrad Region (since 2008)	N/A	37,890	51,046	54,120
Total	109,613	170,253	213,421	235,355

* FP interventions in the new regions were not rolled out in time to be measured adequately by the project's monitoring tools used in "old" project regions

Annex 14: Perinatal Mortality Rate

(Number of stillbirths (22 weeks to birth) and deaths in first week of life per 1,000 live births)

Region	2007	2008	2009	2010
Russian Federation	9.07**	8.3**	7.81**	7.37**
Old Project Regions				
Vologda Region (since 2004)	10*	9.1*	9.2*	8.2*
Tyumen Region (since 2004)	8.1*	7.3*	6.2*	6.4*
KHMAO (since 2007)	5.5*	5.0*	4.7*	4.9*
Kurgan Region (since 2007)	9.3*	10.2*	9.7*	8.4*
Leningrad Region (since 2008)	8.55*	8.42*	7.33*	6.49*
New Project Regions				
Moscow Region	N/A	N/A	N/A	N/A
Moscow City	N/A	N/A	N/A	N/A
Sverdlovsk Region	7.5*	7.5*	5.9*	6.0*
Chelyabinsk Region	8.0*	7.8*	6.8*	7.0*
YANAO	N/A	N/A	N/A	N/A

* Data provided by the region

** Ministry of Health and Social Development, *Basic Indicators of Obstetrics and Gynecology Service Activities in the Russian Federation, 2010*

Annex 15: Early Neonatal Mortality Rate

(Number of deaths in first 28 days of life per 1,000 live births)

Region	2007	2008	2009	2010
Russian Federation	3.75**	3.3**	3.08**	2.75**
Old Project Regions				
Vologda Region (since 2004)	3.3*	2.1*	2.5*	2*
Tyumen Region (since 2004)	2.1*	1.4*	1.3*	1.6*
KHMAO (since 2007)	1.8*	1.5*	1.0*	1.2*
Kurgan Region (since 2007)	4.4*	4.4*	3.4*	2.9*
Leningrad Region (since 2008)	2.37*	2.87*	2.26*	2.06*
New Project Regions				
Moscow Region	N/A	N/A	N/A	N/A
Moscow City	N/A	N/A	N/A	N/A
Sverdlovsk Region	2.3*	2.2*	1.7*	1.7*
Chelyabinsk Region	2.6*	2.5*	2.7*	2.2*
YANAO	N/A	N/A	N/A	N/A

* Data provided by the region

** Ministry of Health and Social Development, *Basic Indicators of Obstetrics and Gynecology Service Activities in the Russian Federation, 2010*

Annex 16: Essential Newborn Care (ENC)

(Number and percent of newborns receiving essential newborn care, by region)

Region	2009			2010			% Change 2009 - 2010
	# newborns receiving ENC in facilities	Total # of newborns in project facilities	% of newborns receiving ENC in project facilities	# newborns receiving ENC in facilities	Total # of newborns in project facilities	% of newborns receiving ENC in project facilities	
Old Project Regions							
Vologda Region (since 2004)	5,540	9,814	56%	7,470	9,628	78%	21%
Tyumen Region (since 2004)	8,436	17,629	48%	11,878	18,244	65%	17%
KHMAO (since 2007)	10,987	13,066	84%	14,321	13,950	N/A	19%
Kurgan Region (since 2007)	4,714	8,229	57%	6,245	8,347	75%	18%
Leningrad Region (since 2008)	7,711	6,805	N/A	8,129	7,085	N/A	N/A

Annex 17: Antenatal Care

(Number of antenatal care visits by skilled providers from USG assisted facilities, by location)

Region	2009	2010
Vologda Region (since 2004)	11,926	12,204
Tyumen Region (since 2004)	21,323	25,622
KHMAO (since 2007)	22,735	24,249
Kurgan Region (since 2007)	10,554	11,191
Leningrad Region (since 2008)	15,567	17,924