THE WOMEN and INFANTS' Health Project

A Guide to Implementing Effective Health Care for Women and Infants

Editor:
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The WIN Project is implemented
by John Snow, Inc (JSI) in collaboration
with the Russian Federation Ministry
of Health and with participation
of EngenderHealth, Johns Hopkins
University Center for Communication
Programs and the University Research
Corporation (USA).

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Introduction

This Guide is based on the experience of the Women and Infants’ Health Project (WIN) in Russia. The WIN Project was designed to help incorporate modern, evidence-based international recommendations and technologies for maternal and infant health into Russian health care practice.

The recommendations of this Guide are based on the three-year experience of the WIN Project in 20 medical facilities, providing services to women and newborns. During the Project, facility specialists assisted in the birth of 34,411 children. Many methods and procedures of work, as well as corresponding materials, were developed and improved during the Project implementation. This Guide was written for medical providers who want to improve the quality of services in their facilities.

This Guide presents the WIN Project’s methodology for developing a quality improvement process as well as detailed overviews of WIN training courses and communications approaches.

This Guide also will be useful at the regional level as well as for individual health care institutions — wherever health professionals are introducing state-of-the-art recommendations into their own systems and procedures. Readers may include any personnel who are involved in caring for women and children, such as state authorities and health care administrators; individuals serving on regional, district, and municipal authorities and self-governance bodies; insurance providers; and maternal and child health care providers.
I. About the WIN Project

The Women and Infants’ Health Project is a comprehensive health initiative launched in 1999. It was designed and implemented as an intergovernmental, bilateral health care collaboration funded by the United States Agency for International Development (USAID).

The WIN Project was piloted in 20 facilities in two regions, Perm Oblast and Novgorod the Great (Velikiy Novgorod). The Project is implemented by John Snow, Inc. (JSI) and partners EngenderHealth, Johns Hopkins University Center for Communication Programs (JHU/CCP), and the University Research Corporation (URC), in cooperation with the Ministry of Health of the Russian Federation, the Perm Oblast Health Care Department, and the Health Care Committee of Veliky Novgorod Oblast.

The WIN Project aims to improve the health of women and children. WIN interventions include the following evidence-based approaches: family-centered maternity care (FCMC), essential newborn care, exclusive breastfeeding, and client-centered family planning counseling and services, especially for postpartum and postabortion clients. WIN activities also focus on promoting appropriate antenatal care, promoting healthy lifestyles including healthy nutrition, and prevention of domestic violence.

The WIN Project trained health care providers at all levels in client-oriented clinical and counseling practices. Training programs emphasize that the practice of evidence-based medicine and use of quality assurance methods will both enhance clinical practice and reduce unnecessary medical interventions. The training programs use practices based on the World Health Organization (WHO) international recommendations and other international experience, while taking local resources and conditions into account. Most of the methods suggested in WIN training courses can be incorporated quickly and inexpensively into the routine of a health care facility as personnel acquire the appropriate skills.

Educational materials, developed for clients and health care providers, are distributed at the 20 pilot sites. Media campaigns on breastfeeding and family planning and community-based promotional activities have reinforced the WIN Program’s messages. These activities have helped create a supportive environment for the new services among families and providers.

The WIN Project’s successful implementation of health service changes has depended upon crucial factors: the support of health authorities at national, oblast, city, and facility levels; local team-building; and positive, multidisciplinary dialogue.

The Project instituted a facility-based data collection system to monitor changes in provider practices, and conducted rounds of facility surveys to measure changes in provider knowledge, provider practice, client experiences, and client satisfaction. The survey results demonstrate that the WIN Project’s several years of intensive interventions have improved the quality of maternal and child care in the pilot sites. Today, the Project’s pilot facilities have incorporated most of the newly introduced, effective modern approaches into routine practice.

The data show both positive social changes and cost savings as a result of WIN interventions. For example, client satisfaction with medical services in the pilot facilities has increased from 60% before WIN intervention were introduced to 83% in 2003. And, in Perm Oblast, in six pilot facilities the Health Administration calculated direct savings of 4.6 million rubles ($153,000) due to WIN interventions.
News of the WIN Project's activities and outcomes spread by way of peer journal publications, presentations to professional organizations, and word of mouth. Health authorities and providers in other regions of Russia have shown great interest in the Project's approaches. In order to respond to the numerous requests for expansion of the WIN Project to other sites, and in accordance with recommendations from the Ministry of Health and USAID, we have created this guide. Further, WIN has helped the Project pilot facilities and the Russian health authorities to establish a WIN Training and Resource Center in Perm. This Center offers consultant expertise, access to demonstration sites for observation, and the curricula and teaching tools to help expand WIN interventions to more maternal and child health care facilities.
II. WIN Project: Key Approaches

The WIN Project used several key approaches in pilot facilities to successfully implement new clinical and organizational methods:

✔ Instilling team spirit and securing administrative and political support
✔ Training medical staff to provide international-standard, evidence-based clinical and counseling services
✔ Collecting and analyzing data to track the implementation of new practices
✔ Providing the support of experienced specialist/consultants to facilities implementing the interventions
✔ Disseminating new information using an active information campaign targeting women, their families, and the general public

Team spirit / Administrative and political support

Before the quality of health care could be raised, the WIN Project had to prepare the providers and institutions involved for often a complicated process of introducing new practices and eliminating the old ones. A coordinated plan reflecting collaboration between government, health care, and public participation was needed to introduce new, high-quality health care approaches to protect the health of women and newborn infants. The WIN Project involved participants at all levels—clients, providers, administrators, and policymakers—as team players with a common goal.

To create team spirit and invite policy support from the beginning, there must be a plan to involve regional department executives/health care ministries, maternal and infant health departments; and chief specialists and heads of the facilities that plan to introduce the new services. The State Sanitary and Epidemiological Inspection centers involved in the operation of maternity hospitals, and medical educational institutions also may be included. Each community, region, or state must decide what offices, institutions, and individuals will be involved, based on local infrastructure and circumstances. As the Project proceeds, keeping the authorities, politicians, and mass media informed about planned and implemented changes in health care services will help to keep the public, as well as specific target groups (women, families, and medical providers), informed.

Fig. 1 The Structure of WIN Project in pilot regions
Formally, key partners are included in a work team or coordination committee that provides oversight and steers the entire scope of health care improvement activities. The WIN Project has found such committees crucial for finding paths to implementation, working through issues, and promoting teamwork (see Figure 1, next page).

An activity that can broaden support for the planned health care changes is a conference or workshop hosted by a participating health care facility, before the Project officially begins. This event can focus on educating facility management and medical specialists on the coming changes, evidence-based medicine, and/or quality improvement theory. A conference can be a venue for presenting information about specific interventions to begin the transfer of practical knowledge.

The next step is choosing priority areas for intervention. You may plan from the start to cover all areas comprehensively or, you may use a step-by-step approach, starting with interventions that are more familiar to providers (e.g., quality improvement in services for postabortion clients or implementation of FCMC) and plan to gradually widen the project’s scope. If some new procedures are already in place, you may only have to introduce new interventions in a single area. Another situation where limited interventions could be more appropriate would be if a program is beginning at a single facility, such as a children’s policlinic or a women’s consultation, where some services may not be appropriate.

To ensure government support and legal permission for the introduction of health care changes and innovations, the intervention strategies that are chosen must be supported—and signed into action—by the appropriate health care departments or ministries.

Where to begin at a specific health care facility?
Any facility, whether regional or municipal, that will participate in a project should establish a working group to coordinate and promote the process of change. Representatives from each affected department should be included in the working group, including midwives and nurses as well as doctors and heads of departments. The chief physician and chief nurse or midwife should also be included. The facility head must be informed of everything the working group does and be ready to support the group’s activities.

The facility’s medical providers must attend data presentations, workshops, and conferences to learn about the recommended changes, understand the scientific evidence behind the changes, and recognize the ways to improve services. They must understand clearly why and how they should change their professional approaches. They should be encouraged to provide feedback and suggestions for how to improve services and streamline the new approaches. The project’s success depends primarily on the medical providers’ commitment and level of engagement.

International standards for clinic and counseling services
The WIN Project was developed to introduce and optimize a comprehensive, integrated system of quality health care services to meet the needs of women of fertile age and newborn infants. WIN also promotes public awareness in the areas of reproductive health and family planning, with the aim to improve reproductive and sexual health in particular and quality of life in general. The Project focuses on creating an efficient system for providing maternal and child health services to women, infants, and families. Moreover, this focus encompasses the rights of patients and the needs of medical workers, and is based on worldwide experience, particularly the latest scientific and technological achievements and the results associated with evidence-based medicine.
The system promotes a comprehensive, integrated approach that is standardized and consistent between and among different providers across multiple types of health care facilities. The WIN Project has achieved this consistency by tailoring high-quality services and methods to fit local needs and capacities.
III. Areas of Intervention

Family Planning

Notwithstanding the fact that Russian women of reproductive age currently use more contraceptive pills than ever, abortions still remain a birth control method for many. According to the Russian Ministry of Health, in 2001, there were 47.7 cases of abortion per 1,000 women of reproductive age, or 142.2 abortions per 100 births. High frequency of abortion—including 11% of women with a first pregnancy when women under age 15 are counted—correlates with a high occurrence of complications and consequences for women’s later reproductive functions. Complications from abortions are the primary cause of maternal mortalities; in 2001, abortions were responsible for 27.7% of mortalities among women. Thus, reducing the frequency of abortion procedures and providing wider access to modern contraceptive methods are still high on the Russian agenda. Family planning programs are a key factor in improving the reproductive health of women, preventing unplanned pregnancies, and reducing the numbers of legal and illegal abortions.

A comprehensive, integrated approach to providing family planning services has proven essential to expanding the use of modern contraceptive methods and reducing the number of abortions, including repeat abortions or those following births. Further, a comprehensive approach tends to reduce related mortalities and improve the health status of the Russian women in general.

Optimizing family planning services by providing quality family planning counseling at all stages of health care service is instrumental in cutting the number of unwanted or untimely pregnancies among women of reproductive age.

The WIN Project widened the traditional understanding of family planning services that has existed in Russia. Indeed, in addition to discrete family planning centers, women now receive family planning counseling and services when accessing antenatal care, when confined before delivery, and pre- and postabortion. Other service delivery points that now provide family planning services include children’s policlinics; and the home postpartum care provided by neonatologists, health nurses, and pediatricians (see Figure 3).

As a result of activities conducted by the WIN Project, the number of women reporting that they had been counseled on family planning during antenatal and postpartum periods, and also in the postabortion period, doubled in all Project facilities (see Attachment 1, Figure 2).

Providing family planning counseling for postabortion and postpartum women and ensuring that facilities are stocked with educational materials helped improve women’s knowledge of fertility recovery and appropriate contraception methods for the postabortion period. These interventions led to broader use of family planning methods among postabortion women. In Perm, the
Postabortion Care Operations Research Project analyzed the effectiveness of WIN Project family planning interventions in the postabortion period. The results showed that use of modern methods of contraception among postabortion women in the pilot facilities rose to 20%, and the level of repeated abortions fell to 10% during 2001-02. (“Operations and Research Project ‘Family Planning in Post-Abortion Period,’ Perm, Russian Federation,” EngenderHealth and Research Center of Obstetrics, Gynecology and Perinatology, 2003).
Maternal and Infant Health Care

Family Centered Maternity Care and Neonatal Care

Maternal and infant health care aims to ensure the physical, psychological, and social well-being of women before, during, and after delivery, to secure the birth of healthy children and their experience of healthy childhood. An integrated family-centered maternity care (FCMC) health care system is key to reaching that goal. FCMC is care designed to meet the informational, social, emotional, comfort, and support needs of normal pregnant women (without complications or co-existing disease) and their families during pregnancy and childbirth.

The FCMC system relies upon the following approaches:
✔ encouraging each woman to take a knowledgeable, active role in promoting her own health and that of her fetus and baby;
✔ encouraging each pregnant woman to include family members or others of her choice in her preparation for childbirth and motherhood and to invite their supportive presence during labor and birth;
✔ avoiding unnecessary use of invasive, uncomfortable, and/or restrictive procedures;
✔ encouraging women to be active during labor—to sit up, walk, assume whatever position is comfortable, change positions frequently (avoiding the supine and lithotomy positions)—and support women to assume squatting or semi-upright positions during second stage contractions;
✔ manage birth as a process requiring cleanliness but not sterility;
✔ recommend the use of WHO partograph during labor, which displays progress in cervical dilatation as a continuous graph while at the same time displaying—in graphic form—many other aspects of the status of mother, fetus, and labor;
✔ provide skin-to-skin contact between the mother and newborn immediately after the birth; and
✔ support breastfeeding and rooming-in.

Essential Newborn Care
Essential newborn care involves the following principles and technologies:
✔ identifying at high risk for obstetric complications and provision of the appropriate care;
✔ actively observation and management of labor, with early identification of complications of labor and fetal distress (using WHO partograph);
✔ creating a friendly environment for childbirth and promotion of mother-infant bonding;
✔ maintaining temperature;
✔ initiating spontaneous breathing;
✔ preventing and managing infections; and
✔ beginning breastfeeding shortly after birth.

These approaches have been highly effective in reducing neonatal morbidity and mortality and have been shown to substantially reduce post-neonatal morbidity and mortality. These interventions can be fully implemented without major capital or operational costs.
Essential Antenatal Care

antenatal care helps women remain healthy and protects the health of the developing fetus. Antenatal care should also support and guide the pregnant woman and her partner or family, to help them transition to parenthood. Thus, health care providers should not only deliver medical services, but also provide pregnant women or couples with advice on healthy lifestyles, family planning, and childbirth and parenthood education. WIN Project providers also learned to support women by listening to and helping with any issue related to pregnancy, delivery, and the postpartum period.

important issues related to antenatal care, including determining the types of services that should be offered to all women and identifying additional services that might be needed by women with complications that arise during pregnancy or birth. this comprehensive, integrated approach should be based on client-specific data (e.g., number of infections). applying modern techniques for early detection of complications is more effective than approaches based solely on risk groups, for example. such a traditional approach has too low a prognostic value to render it cost-efficient.

As the content of services changes, so too must the information that is given to women and families. Childbirth and parenthood education gives parents information on what to expect during pregnancy and labor, and also on the changes that come with becoming parents. New aspects of childbirth education introduced by the WIN Project include classes on breastfeeding and healthy lifestyles. The objectives for educating mothers and fathers for parenthood are to:

✔ provide new parents with appropriate knowledge and information about pregnancy, childbirth, and parenthood;
✔ give a couple more confidence;
✔ help a woman have a happy, healthy pregnancy, birth, and parenthood experience;
✔ prepare a couple for the reality of labor and to provide the woman with coping tips;
✔ persuade parents to adopt a healthy lifestyle to ensure a speedy recovery after birth;
✔ help and support the woman to breastfeed by teaching her about successful breastfeeding techniques and management;
✔ assist the woman to care for her baby regardless of the feeding method she uses; and
✔ help the couple adjust to parenthood.

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<td>• Skin-to-skin contact</td>
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Preventing Hypothermia in Newborns

- Skin-to-skin contact
- Dry the infant and postpone bathing
- Use caps and socks
- Maintain body temperature in the delivery room
IV. Clinical Guidelines for Quality Improvement

Clinical guidelines and protocols are important tools for coordinating, optimizing, and assessing the introduction of new practices that comply with international standards. They also help standardize services across a district or country. You may use existing protocols that are built upon principles of evidence-based medicine and have proven helpful, or you can adapt such standards to suit your local project needs (see Attachment 1, Table 3).

A Model for Quality Improvement of Clinical Services:

The WIN Project based its clinical guideline development methodology on a Framework for Clinical Quality Improvement, below. The Framework illustrates that in order to improve health care it is important to address two key components of care: the content of care, and the process of care. “Content of care” refers to the technical subject matter of the medical intervention being addressed, for example, pregnancy-induced hypertension. The content of care must be based on the best scientific evidence available on the subject. “Process of care” are the systems by which health care is delivered. Often, the systems of health care delivery must be reorganized to enable implementation of new evidence-based practices at the highest possible levels of quality.

![Framework for Clinical Quality Improvement](image)

The WIN Project developed three sets of guidelines:

- breastfeeding
- postabortion care
- infection control

that are evidence-based and compatible for use with modern quality improvement methods.
Clinical Guidelines Development Methodology
Developing or adapting clinical guidelines is a first step in upgrading and standardizing services. The clinical guideline development methodology consists of the following steps:

**STEP 1.** As described above, form a working group to assess the existing system of health care delivery.

**STEP 2.** The team should review the organization of the existing system and process of care. The team discusses their understanding of the current process of care and illustrates those processes in a detailed flow chart.

**STEP 3.** Team identifies the clinical content (if any) rendered at each point in the service delivery process. The result is a list of the clinical and diagnostic criteria, treatments, procedures, referrals, etc. currently being practiced.

**STEP 4.** Review current literature on each clinical topic. The team performs a literature review of evidence-based materials on clinical diagnosis, treatment, and related issues. (The WIN Project provided these materials to teams for review and discussion.)

It is important to keep in mind that levels of evidence in different studies may vary from highly rigorous randomized controlled studies down to descriptive trials and reports of expert committees. Teams are encouraged to review the type and level of evidence to ensure the highest quality possible (see Attachment 3, Levels of Clinical Evidence).

**STEP 5.** Compare existing system and process of care with evidence-based literature to determine the gaps and identify the areas of improvement.

**STEP 6.** Update existing clinical content to comply with evidence-based knowledge. The objective of this step is to determine the clinical content that must be changed or updated in order to comply with the best available evidence. Develop new clinical guidelines and have team review. Produce/print guidelines.

**STEP 7.** Introduce new policies in order to support the changes identified. The team must then review the normative and legal documents related to each content topic, noting any ways in which normative or regulatory policies must be changed to foster implementation of the evidence-based guidelines. In most cases, this step requires that new directives and methodological recommendations be issued.

**STEP 8.** Introduce changes to the system of care that that reflect updated content knowledge. While considering clinical changes, the team also reviews the organization of care for potential changes. The objective of this step is to change the existing system in a manner that will realistically enable implementation of the updated clinical content.
Practical Application of the Clinical Guidelines Development Methodology

1. Once the topic area for a guideline review is decided, the first step is to select participating organizations. In most cases, more than one type or level of facility will be involved in delivering care in the chosen care content area. Include at least one organization to represent each level of care.

2. Selecting multidisciplinary team members. In each pilot facility, WIN formed one team to participate in the guideline development process. The team members are selected to represent each of the different professional functions involved in the relevant processes of care delivery. Multidisciplinary teams may include physicians, nurses, midwives, administrative staff, laboratory personnel, and other ancillary staff, depending on the care area.

3. Preparatory work. Team members review evidence-based literature. It may be necessary to conduct training, skills development, and other capacity-building activities for team members in order to accomplish this step.

4. After comes organization of the guideline development activity. The team members from all the facilities identified are invited to take part in a three day workshop to develop the clinical guideline. The setting used at the workshop is such that each team from one facility is seated at a separate worktable throughout the workshop and each team works to produce one joint product. More than one team can later be linked up, or leaders from the authorities come together to work on referrals between facilities and other processes involving more than one facility. Workshop facilitators include both experts in the care topic area and in improvement. Access to photocopy facilities is important in running the workshop.

5. The next step is the guidelines development workshop. The workshop starts with a quality improvement overview emphasizing clinical guideline development methodology. Teams go through the process of describing their current care systems by flowcharting them and noting the clinical care provided at each step in the process. An evidence-based review follows. The review emphasizes areas needing special attention based on the descriptions of the current systems. The teams then proceed to listing changes. Each team fills in sheets of paper with three columns: Clinical Changes, Organizational Changes, and Normative Changes. Based on these changes, the teams proceed to drawing new flowcharts and noting clinical practices associated with each step in the process. This is the first draft of the guideline. Indicators are reviewed and updated. Photocopies are made at the end of each day and are distributed to all participants.

6. Leadership commitment. On the final day of the workshop, the leadership is invited to hear presentations of the new systems of care developed by the teams. Particular emphasis is placed on the normative and regulatory changes required. The usual practice has been the agreement of authorities to sign a new directive that supports the changes. A draft directive is prepared. Next steps are agreed upon.

7. Follow-up work. Identify a lead facilitator for follow-up. This lead facilitator organizes the draft products of all the teams, following the outline presented to the left. The draft, using the basic format, left, is sent to the content of care experts, who add detail as needed. Meanwhile, team members produce notes on the clinical content of the guidelines, adding the more detailed descriptions and definitions needed to convert the draft into a guideline format. (This is a substantial level of effort requiring input from one or more content experts from the teams.) The detailed version is returned to all members of the team, who each conduct a final review it and make any further notes.

They then meet again with the workshop facilitators and discuss all of the comments. Team consensus must be reached on each comment. The facilitators incorporate the final comments into the clinical guidelines document.
8. Technical review. The draft guidelines document is then submitted for technical review and sign-off to the Ministry of Health experts in the care topic area. The teams must discuss any substantive changes these experts recommend, again reaching consensus before incorporating further changes into the guidelines.

**Advantages of this approach to clinical guidelines development**

1. The guidelines are evidence-based.
2. The guidelines are locally adapted while also being standardized across facilities.
3. The guidelines are developed in accordance with the Ministry of Health instructions and formats.
4. The guidelines are supported by local teams who have ownership of them and will implement them.
5. The guidelines are approved by Ministry of Health experts in the care topic area.
6. Disseminating the new systems of care and evidence-based guidelines is enhanced by the fact that they were locally developed.
7. Updating the guidelines is streamlined since local health care personnel comprise the team that developed them.
V. Training at Health Care Facilities

The WIN Project integrated training of physicians (obstetrician-gynecologists, neonatologists and pediatricians) and nurses in modern clinical and counseling services in compliance with international recommendations (WHO) and international best practices and experiences, adapting them for specific local resources and conditions.

The WIN Project both developed and implemented new training courses and also used some existing training programs designed by WHO, UNICEF, and other groups that previously had been tested in Russia. Each topic is discussed in detail below. Methodologically, these courses were based on modern approaches of participatory, interactive adult teaching.

In all WIN trainings, participants learn to use an integrated approach when treating clients; develop their interpersonal communication abilities; provide clients with up-to-date and accurate research information; and involve women in making decisions about their own health care. Most of the courses also include training in counseling skills as well as a pre- and post-test to track the knowledge gained by participants.

Providing Quality Family Planning and Reproductive Health Services

Training medical workers in modern family planning methods includes the following topics:
- contraceptive techniques;
- postpartum and postabortion counseling;
- extensive use of “no-touch” technique for IUD insertion to reduce the risk of infection and increasing the efficiency of this the most widespread method in Russia; and
- youth friendly reproductive health services.

For a training developed on the basis of evidence-based medicine, training manuals on conducting of reproductive health and family planning training seminars are used. Family planning counseling is an important component in the improvement of Russia’s reproductive health services. Therefore, it must become a routine aspect of care for women at all stages of family and reproductive health care services.

With this aim in view the WIN Project employs a standardized, ready-to-use workshop agenda for training doctors-cum-teachers in the field of family planning and reproductive health (see Attachment 3). Special attention at this stage is to be given to training mid-level personnel to deal with women in the postabortion and postpartum periods.
Training: Providing Quality Family Planning and Reproductive Health Services (including Postpartum and Postabortion Counseling)

**OBJECTIVE:** To boost the knowledge and capabilities of doctors and nurses in family planning and reproductive health care, including the ability to provide (1) early detection of postabortion complications and appropriate care or referral, and (2) counseling skills at all stages of health care.

**INCLUDES:** The course teaches health care workers to provide women with recommendations about contraception and healthy self-care following delivery or abortion. Health care workers also learn to provide information on where to receive family planning services and counseling, on the basis that every woman is entitled to a customized pregnancy prevention method corresponding to her reproductive plans and state of health. Training sessions are based on family planning and reproductive health practices developed in compliance with evidence-based results.

Family-Centered Maternity Care (FCMC)

This course is based on modern recommendations of effective maternity care. It presents latest evidence-based data (source: the Cochrane Library) and relevant WHO materials. It also contains exercises on clinical practice.

Training: Family-Centered Maternity Care (FCMC)

**OBJECTIVE:** To improve the health and well-being of mothers and babies by preparing health providers to implement family-centered maternity care (FCMC) practices in their hospitals.

**INCLUDES:** Introduction to FCMC, alternative positions for labor and birth, support during labor, non-pharmacologic pain relief, active management of the third stage of labor. Specific attention is paid to evidence-based labor and birth practices. Special sessions are focused on such topics as partographs, newborn care, postpartum care of the mother, childbirth education, and family counseling. Infection control issues and case studies that apply FCMC are of great importance in the course. Other sessions cover evaluation of FCMC implementation, strategies for change, situation analysis, and action plan. Much attention in the course is paid to clinical work.

Breastfeeding Counseling / Essential Newborn Care and Breastfeeding

These courses were developed by WHO and UNICEF. The WIN Project added material, including sessions to teach the “Baby-Friendly Hospital” initiative.

Training: Breastfeeding Counseling

**OBJECTIVE:** To train doctors and mid-level personnel at maternities, women's consultations, children's polyclinics, and hospitals on protecting and supporting breastfeeding.

**INCLUDES:** Sessions include the importance of breastfeeding and local breastfeeding data. The course emphasizes both theoretical and practical aspects of breastfeeding, including the assessment and observation of breastfeeding. Sessions on creating self-confidence and support are key. Participants are trained in recording breastfeeding, examining breasts, expressed breast milk techniques, and counseling. Also covered are problems such as “not enough milk,” crying, breast rejection, feeding low-weight and sick infants, and increasing lactation and relactation, as well as the ten steps of effective breastfeeding and how to implement the “Baby Friendly Hospital Initiative.”

Newborn Resuscitation

The American Heart Association and the American Academy of Pediatrics co-developed this course as part of a training program for medical professionals. The course was tested in the Russian Federation and has
been proved to be highly useful for American International Health Alliance (AIHA) partnerships in Russia. This basic course provides participants with key concepts and practical skills essential for newborn resuscitation as commonly practiced in the U.S., Western Europe, and other regions. The course instructs on fundamental skills of caring for newborns that can be done with little equipment.

Training: Newborn Resuscitation

**OBJECTIVE:** To train medical providers in neonatal resuscitation in delivery rooms and maternities.

**INCLUDES:** both theoretical and practical aspects of neonatal care, covering fundamental skills including monitoring of body temperature, correct body position, clearing of respiratory tracts, and tactile stimulation. Special training sessions prepare participants to use reanimation bags and masks, external heart massage techniques and endotracheal intubation. Also covered are drug therapy and neonatal resuscitation practice. Sessions include demonstration of clinical skills. The course provides for assessment of both the theoretical and practical skills of the students.

Training: Antenatal Care (Antenatal Care, Childbirth Education, and Healthy Lifestyle)

**OBJECTIVE:** Enhance health professionals’ knowledge and skills in maternity care and introduce modern principles and practices of sound pregnancy care, childbirth education, and healthy lifestyle counseling.

**INCLUDES:** issues regarding the role and responsibilities of the health care provider during pregnancy, and the psychological, biological, cultural and social issues that affect the antenatal period. Issues emphasized include how to avoid care that is not beneficial, how to recognize the necessity of being familiar with research and to develop critical thinking toward routine methods of care. Also emphasized is a teamwork approach to improving managerial standards regarding care during pregnancy, e.g., documentation of complicated cases. The course aims to improve clinical skills in caring for high-risk women during labor.

The course includes a section on **childbirth education** that describes types and purposes of antenatal training, such as lessons to instruct parents on hygiene and general care of infants and on use of pain medication.

A section on **healthy lifestyles** looks at nutrition and food consumption during pregnancy, including factors in designing a diet for pregnancy, food requirements during pregnancy, and proper nutrition guidelines for mothers and their families. The section covers key aspects of healthy lifestyle for a pregnant woman and the fetus, including prescription of folic acid, giving up smoking and alcohol use, and physical exercise.
Antenatal Care (Antenatal Care, Childbirth Education, Healthy Lifestyle)

This course has been constructed by the WIN Project, based on WHO/UNICEF materials on “essential antenatal, perinatal, postpartum care” and “healthy diet and nutrition of women and their families.” The course presents a client-centered approach and is designed to encourage health professionals and policymakers to apply a new, deeper understanding to improve standards and quality of care.

Community Mobilization

This seminar is an advanced training workshop for medical providers. The training is devoted to the principles of communication and how to apply new and traditional information technologies to create demand for the new health services at the community level.

Training: Community Mobilization

**OBJECTIVE:** For medical providers to learn and practice basic communication skills; to recognize communication as an integral part of work in health improvement; and to acquire the skills to plan and conduct informational campaigns.

**INCLUDES:** Basic principles of interpersonal communication; importance of defining a target audience; the steps in changing behavior; motivation and persuasion; roles of qualitative and quantitative research; how to organize and conduct information campaigns; description of campaign components; how to work with mass media; and creating campaign plans and budgets.

How to organize the training process

In order to conduct a successful training it must be well organized. The training program should:

- be based on participants’ needs;
- have targets;
- be led by a competent trainer;
- involve adequate training methods; and
- be reviewed from time to time.

With these organizational points in mind, the following steps should be followed to prepare thoroughly for a successful set of training courses.

1. Assessing need for training is the first step in developing the course curricula. These needs should have been identified in Step 5 of Developing a Clinical Guidelines, when gaps in services and skill level were found.

2. Next, it is important to identify the conceptual content and practical tasks that the training courses will include.

3. Determine, by job categories, who the participants will be. It is important to invite not only obstetrician-gynecologists but also pediatricians, neonatologists, and nurses to participate in family planning training sessions.

4. The selection of teaching methods (lectures, group work, demonstrations and practical sessions, role-plays) is of great importance. Use adult learning technologies that are participatory. Participants should have active roles to play during the training course, and they should be provided with opportunities to practice practical tasks.

5. Training course format and curricula. Courses are to be structured according to a standardized format: each training session should include the topic for the session, a plan of instruction for the session, comments to guide the instructor, and key issues that will be written on a board, an overhead, a large pad or elsewhere.
In the detailed plan of each training course, each session should contain:

- the learning objectives,
- length of session,
- materials and preparation needed, and
- teaching methods used.

The steps to carry out in the session should be described in detail.

The role of the Course Supervisor is extremely important for successfully conducting training. The Course Supervisor could be a facility director who has a combination of technical and management skills. It could be someone who is a Master Trainer. The Course Supervisor is responsible for the quality of the training process, including ensuring that equipment is available, the methods participatory, the environment is comfortable, and breaks are scheduled.

During the planning process, it is important to pay attention to the preparation of audio-visual aids and equipment and to make complete arrangements for the training location and room.

6. Courses must be supported by training manuals (for use by students and instructors) and audio and visual aids.

Manuals for students should cover the tasks and aims of the courses, requirements of the students (target groups), benefits that successful graduates will receive from the training, the curriculum, time schedules, training topics, recommended supplemental literature, the duration of courses and training sessions, and suggested ways that participants can pursue further theoretical and practical training. An instructors manual, in addition to the above, should provide guidance about means and methods of teaching and assessment. Instructors will also need a list of essential facilities (e.g., information on access to presentation equipment, overheads, slide projectors, etc.) and the materials and forms to be photocopied as hand-outs to the participants (e.g., questionnaires or test forms). For courses that are designed to educate trainers, the manual must provide the requirements that the student must meet. Any instructors manual should explain how the students' acquired knowledge will be tested and how the courses themselves will be evaluated.

7. It is very important to evaluate each training course. Evaluation results should be used when planning the next course, to improve the quality of instruction by (1) identifying any weak points in the curriculum, materials, or teachers, and (2) deciding whether it is appropriate to add requirements for the participants or for the course as a whole.

Evaluation may be done using direct observation; questionnaires and ratings (before, during, and after a course); interviews of both participants and trainers; and tests to assess participants' knowledge and skills before and after the courses. To assess instruction efficiency it is essential to analyze the job performance of newly trained alumni or alumnae; experts should visit facilities to observe how personnel apply in practice their new knowledge and techniques. Such an analysis may involve the monitoring of the work process, soliciting reports from relevant institutions, distributing questionnaires, interviewing health care clients, and direct appraisal of job performance.

8. Under the WIN Project, the training agenda for medical staff curriculum was planned with regard for participants' positions. For the breastfeeding trainings, doctors and nurses attended 40-hour courses plus three hours of clinical practice and an 18-hour course plus three hours of clinical practice respectively, while junior staff attended six-hour courses. The courses were held twice a year. Between the scheduled trainings each new employee was briefed on breastfeeding. In the case of family planning training the sessions lasted from 14 hours (two working days) to 35 hours (five working days), depending on the results of the assessment of the quality and the state of family planning services at the facility.
VI. Physical Changes at Health Care Facilities

This section describes physical changes that the WIN Project implemented in pilot facilities. These changes were designed to (1) provide a friendly, welcoming environment and (2) better utilize the facility to deliver important health care information to clients.

Arguably, creating the right environment in a health care facility is as important as administrative and instruction innovations. While staff participate in training, administrators can prepare to improve client satisfaction by enhancing their facilities.

Nobody feels completely at ease in a medical facility. Hence the environment is an important factor in client satisfaction with the visit in particular, and in their perception of the quality of services in general. Many Russians are accustomed to dull walls, lack of intelligible information (e.g., the common use of large displays that are confusing to read) and personnel, such as reception staff, who are unfriendly and unprepared to provide helpful information. The environment in such facilities is not welcoming or cheerful. The facility environment is most important with young children or pregnant women.

Maternity

A relaxed, homey environment, enlivened with bright curtains, full-color bed linen or children's underclothes, and nicely colored walls makes people feel at ease. Such seemingly unimportant details can significantly influence the emotional and psychological condition of visiting women, their health, and even the outcomes of their pregnancies and deliveries.

In Russia, research findings have shown that maintaining a pleasant environment at the maternity hospital and perfect cleanliness (not sterility) boost the psychological and physiological state of pregnant women, mothers, and newborn babies. In this environment, it is also important to have easily accessible information and visual aids on the course of pregnancy, the postpartum period, and breastfeeding. Information about family planning, as well as hotlines, and other forms of support available to new parents should be highlighted.

Women's Consultation

Women visiting women's consultations may be subdivided into two major groups: those who are pregnant, and all the others—for example, women coming for a check-up, prevention, or diagnosis and treatment of a gynecological disease. More often than not, women must wait before they see a provider. Thus, an attractive, comfortable, and relaxing waiting room with sufficient seating enhances their wait. This provides an ideal opportunity to offer women information.

Information leaflets should be available that include detailed information about that particular maternity welfare clinic (the working hours, rooms, and names of specialists and obstetricians). Wall posters and leaflets should provide comprehensive information about reproductive health, pregnancy, delivery, breastfeeding, prevention of unwanted pregnancy, sexually transmitted infections including HIV/AIDS, and a healthy way of life.

Similar information should be provided in the form of give-away booklets and leaflets that women can take home. Some women's consultations also feature displays that list public organizations that provide family violence victims with psychological support and legal advice.

Family Planning Center

Family planning centers (FPCs) provide information and services to women and couples in family planning, reproductive health (e.g., issues of gynecological diseases, infertility), and unwanted pregnancy and abortion. Consequently, all recommendations for the environment of maternity welfare clinics also apply to FPC.
In addition, each FPC needs to have more detailed information (posters, booklets, leaflets, etc.) on prevention of unwanted pregnancy and contraception methods. Because many FPCs also serve adolescents, it is strongly recommended that information targeted for teenagers on maturity, sex education, a healthy way of life, prevention of HIV/AIDS, drug addiction, and other issues, be made available.

**Children’s Policlinic**

Children’s policlinics serve children whether accompanied by adults or not (depending on the age). Detailed information about working hours, doctors, rooms, etc. should be made available at the entrance to any such policlinic. The interior should satisfy both children and parents. The same is true of the furniture—children's policlinics should have enough furniture intended for children of different ages (from swaddle tables for infants to chairs of different sizes for older children) as well as for adults.

Curtains with colorful patterns, drawings on the walls depicting characters from children's stories, and toys can comfort visiting children. Display stands or posters should have information for the accompanying adults about children’s health issues, such as the most widespread and dangerous diseases and their prevention, infections, health-boosting practices, vaccinations, and breastfeeding. Booklets and leaflets that can be taken home on the same subjects are equally important.

The Russian experience of an “informal approach” to the interior decoration of a health facility proves that you can do a lot on your own without spending much money!
VII: Implementation Challenges: Problems and Solutions

Implementing the WIN Project’s practices into the activity of pilot facilities took place against a backdrop of circumstances common to all the pilot regions. At the same time, the implementation had to address the specifics of each individual health care facility.

Even before the Project started, some facilities had partially implemented some of the new, recommended practices (e.g., rooming-in or support for breastfeeding). These facilities had proceeded without a formal training process. Indeed, many specialists boasted success stories about the new approaches, while some facilities had received the support of authorities. Moreover, some individual facilities had rewarded doctors and nurses who already used innovative programs and practices in serving women and their families.

Despite a largely favorable atmosphere toward the WIN Project at most facilities, the implementation of significant changes in established practices and attitudes met with some roadblocks. Common problems included:

- Lack of formal training;
- Use of the new practices only as individual medical providers deemed them suitable;
- Preference given to costly, often unnecessary, technologies and treatment methods (i.e., Doppler supersonic research; electronic monitoring of fetuses; and use of prostaglandins and surfactants);
- Inadequate understanding of evidence-based medical approaches to care for women and newborn babies in different risk categories; and
- Mistaken beliefs on the part of many specialists that the existing practices of their respective facilities complied with modern standards.

For example, before the WIN interventions, some maternity hospitals allowed a relative to be present during delivery (grannies were present more often than fathers); some of these facilities charged extra money for the privilege of including a relative. Even in these facilities, the personnel stopped short of actively involving relatives or rendering support to laboring women. Maternities segregated women with physiological and pathological deliveries and also segregated women in the postpartum period on the basis of risk criteria. Each newly admitted woman was given an enema and had her pubis shaved. The women were given many medications, and ice was applied to their abdomen (lower uterus area). Personal “skin-to-skin” contact between mother and child was used only sporadically or for just a few minutes—for example, during a medical procedure. Training in evidence-based care during delivery and the postpartum period updated these practices.

In the field of family planning, the introduction of family planning centers led to a situation where obstetricians-gynecologists at women’s consultations failed to provide enough information on family planning, sending women to specialists instead. As a result, most patients could not get access to reasonable family planning information. To address this problem, the WIN Project invited doctors from local women’s consultations to take part in training sessions.

The Project results show that to ease the introduction of new contraceptive methods, and also to assist in sorting out problems, it is essential to provide for the involvement and input of experts and consultants.

Consultant visits are a way to collect first-hand information about the introduction of new practices. External experts can help identify any issues faced by the facility workers and to develop suggestions for how facilities can solve their problems. Such visits involve:

- clinical observation of the practices;
- interviews with the clients; and
- reviews of medical documents.

Expert visits should not be made for the purpose of inspection,
The expert's role is to support collaboration and knowledge transfer among medical providers, clients, and visiting inspectors. Results of such visits in the WIN Project can be seen in Attachment 1, Figure 4.

Under the WIN Project, expert/consultant visits to health care facilities aimed to:
• Assess the need for and assist in creating a staff training system;
• Consolidate and ensure skills in newly introduced practices;
• Identify problems preventing the application of new skills in clinic routine;
• Assist medical providers in seeking adequate solutions to problems; and
• Strengthen the existing system of sponsoring of clinic practice on the local level through the use of standard mechanisms of sponsoring and monitoring.

Visiting experts are given standardized record forms by which to methodically check the state of affairs at the facilities they visit. The forms also enable the experts to develop clear-cut and specific recommendations for the facility staff regarding any identified areas of improvement.

The record forms cover all areas of possible problems. Obstacles to project implementation may arise from anywhere, including:
• medical providers;
• facilities;
• clients; and
• external conditions, such as laws, regulations, rules and directions in the field of district healthcare, etc., and public opinion.

These forms also enable the project to track whether an area of concern arises in multiple facilities, enabling the project to target planning and adapt training as required.

Most issues can be rectified by applying a combination of the following approaches:
• Providing continuous, ongoing staff training, with a special emphasis on clients counseling skills;
• ensuring an in-depth knowledge of the principles of evidence-based medicine and continuous quality improvement across the health care facility;
• improving care for women and newborn infants;
• timely provision of information;
• administrative support; and
• Fostering a team spirit throughout the health care facility.

Team spirit will be greatly strengthened by activities that help the staff to reach agreement on common goals.

The boxes below present solutions to some common problems that emerged during implementation of the WIN Project.

**Problem:** Pediatricians, neonatologists, and pediatric nurses do not believe that providing services and/or information regarding family planning is their responsibility. Moreover, at times they provide information that contradicts the information provided by obstetricians-gynecologists.

**Solution:** Involve all pediatricians, neonatologists, and pediatric nurses at maternity hospitals or children's polyclinics in education and information about family planning and reproductive health. Provide manuals on family planning and postpartum contraceptive methods which they can offer to mothers at a maternity, a children's policlinic, or at home.

**Problem:** Absence of new orders from the Russian Federation Ministry of Health on newest evidence-based practices, while some provisions of the old orders slow the introduction of modern recommendations.

**Solution:** A regional health care department, committee and/or ministry, jointly with the state and epidemiological inspection services, may issue their own standard-setting documents to accompany the introduction of new practices.
VIII. Creating Demand and Community Mobilization

While pursuing improved quality and access to health care, a Project should work to create demand among the community for new medical services. For instance, prior to the WIN Project, only 44% of women in Perm and 29% in Berezniki wanted a partner attending during childbirth. In this context, the Project aimed to both create the capacity for this support at maternity hospitals and to inform the community of the advantages of this approach (see Attachment 1, Table 5).

Creating a demand for health care services, or priming a community for action, is a crucial component of health promotion campaigns. To create or increase demand, it is important to motivate consumers to take care of their own health, and once counseled, to make informed decisions for healthy lifestyles. Community-based work, and information and communication facilitates the delivery of information to the community and motivates community action.

Creating community awareness of the basics of reproductive health and health promotion involves distributing information such as practical guidelines, educational brochures and booklets; creating video libraries, public lectures, and hotlines; and ad hoc promotional activities.

The resources and expertise of mass media organizations, as well as electronic communication (Internet, television), offer excellent opportunities to inform and educate the entire community on the individual and collective value of health.

For a communication campaign to be effective in motivating the community, it should be based on the following:

- results of qualitative and quantitative research on people’s knowledge, attitudes and behaviors about services;
- a strategy targeted to a particular community; and
- an approach that integrates communication into the wide scope of implementation activities.

Using qualitative and quantitative data, including pre-tests

While developing public health programs it is necessary to deeply understand the audience—the part of the population to which a health program is targeted. The analysis of quantitative data helps to answer the question “how many?” and to define the interrelationship of variable data while using a larger sample size; quantitative data gives the rationale for making useful generalizations, comparing performance on indicators, and summing up these numbers to assess a Project. Qualitative data, on the other hand, answer the question “why?”. When using qualitative data, concentrate on the process and aim to understand the survey participants’ emotions, feelings, and motivations. Qualitative data can be gathered by conducting surveys, focus groups, interviews, and observations.

A major step in creating a informational material is to

**Community-based work**
- Information and education at health facilities
- Volunteers
- Hotlines
- Targeted promotional activities

The WIN campaign resources for family planning include:
- 8 videotapes
- 2 posters
- 3 booklets
- 2 flyers
- 11 cue-cards
- Badges

While working to support the implementation of exclusive breastfeeding, a qualitative inquiry showed that future mothers misunderstood the term “exclusive.” The women feared that they would not produce “enough milk” and that the recommended method of feeding would be burdensome. Answers were provided to questions that had arisen in printed materials, social spots (public service announcements), and in the mass media. The study also showed that relatives played an important role in answering new mothers’ questions about newborn feeding and care. As a result, special activities were organized for grandmothers at a health care facility.

Discussions about family planning in focus groups disproved the notion that the price of contraceptive methods is a main obstacle to their constant use. In fact, women continue to worry about the safety and reliability of methods.

That’s why the radio and TV social advertisements in support of reproductive health focused on dispelling these doubts and recommended that women seek counseling with a specialist.
pre-test its style, text, design, and even color with members of the target audience. Only after a thorough pre-testing should one proceed to produce a printed material, video, or radio spot.

The WIN Project created many communication resources, which may be used in future information campaigns to create demand for services and mobilize communities for action.

Information and Education Materials in Health Care Facilities

Information and education support for changes at health care facilities may include the distribution of educational print materials, videotapes and audio tapes, and the introduction of group discussions and exercises as well as telephone hotlines.

The WIN Project used all of these strategies. Thus, information materials reached significant numbers in the pilot communities and had a powerful effect among the women and their families (see Attachment 1, Figure 6).

For a communications campaign at a health care facility it is effective to use posters, display stands, and leaflets. Two types of materials effective in medical facilities are motivational and informational materials. Motivational materials are posters that speak directly to the reader with messages such as “Mother, for the first half of a year, only you and your milk,” or posters with photos of healthy children who were exclusively breastfed for the first six months. Motivating materials often use emotion to change behavior. Informational materials include facts and other relevant data, for example, posters on a healthy diet during pregnancy, a list of family planning methods, or display stands with information on breastfeeding. Materials handmade by children, parents, or providers are also an effective tool to engage visitors.

When there is insufficient funding to publish colorful brochures, information and brochures may be printed on any copying paper—better if a bright color—to hand out to women who visit the facility.

Health care facilities provide the best location for counseling and client education. Priority topics for education include antenatal care to the pregnant woman and women in general; support for breastfeeding, neonatal care, and family planning to postpartum women; and family planning for abortion clients. Educators at health care facilities can make good use of videotapes and visual aids. Cue cards and manuals such as those developed by the WIN Project can be helpful as a quick reminder of points to be covered by a provider when counseling. Such aids are especially useful to nurses at hospitals for teaching women about family planning, before and after an abortion or birth.

Remember not to promote a service if it is not yet available or providers have not yet been trained. Such “false advertising” leads to unmet expectations and can incite clients against the health care system or these services.

Work with mass media

Mass media—newspapers, magazines, television, radio, and the Internet—are integral to our lives and have enormous impact on society. Relevant advertisements in mass media help to create social action. With health promotion in mass media, as the number of positive public messages increases, so does the potential for changing behavior and attitudes.

To deliver relevant information to a community—including professionals and the public at large—television, publications in magazines and local periodicals, including medical journals distributed to health institutions, and the education of local broadcasting, radio and print journalists can have a significant impact.
Health workers should meet with journalists on a regular basis to highlight relevant changes at health care institutions and to announce new medical training programs and services. Getting talk show hosts or journalists to feature the issue of health services is a very cost-effective way to change behavior. Journalists are seen as objective and trustworthy.

Advertising is a significant part of the content of mass media campaigns. Advertising makes an impression on the minds of all age groups of various social norms, and helps shape people’s values.

Television
Television reaches a larger audience than printed publications. That’s why to air either paid or free-of-charge materials on TV are an effective way to reach an audience. In the WIN Project, talk shows, interviews with specialists, regular topical programs, and also mini-spots about new services were organized on the local TV channels.

Social Advertisements
Social advertisements, or public service announcements, serve the public good and are provided free in Russia. The public need is met by social advertisements that convey to the society a general understanding of topics including healthy lifestyles, family planning, abortion implications, and the threats of HIV/AIDS and STIs.

Social spots for TV and radio are supposed to be “a business card” of the educational work of a campaign. The advertisements should identify main ideas, demonstrate the desirable behavior, and provide general information about health services.

The TV spots produced under the WIN Project and supported by the Russian Federation Ministry of Health to the Ministry of the Press, TV and Broadcasting and Mass Communication Media were placed as social ads with local and central TV channels.

The time provided by the local and central TV channels free-of-charge for WIN social spots on breastfeeding is the equivalent of $1,000,000. During the family planning campaign, WIN aired two 30 second spots and six 15 second spots, saving an estimated $600,000 with free-of-charge air time.

Volunteer Capacity Building
Volunteer training is a prospective way to promote new ideas and procedures in maternal and child health. The WIN Project has shown that the involvement of volunteers can be most successful.

Internet
Establishing an informational and educational Website is a crucial step to mobilize individuals and the community to obtain current health information. A Website can include educational materials (training
course, manuals, guides); regulations; notices about training seminars and workshops; information materials (brochures, booklets, flyers); health research data; scientific literature (manuals, articles from medical periodicals, etc); a resource library; and more.

When developing a Website—as with any communications vehicle—it is critical to identify target audiences and purpose of the site before implementing it.

Assisted by the WIN Project, Maternity Hospital # 21 in Perm established its Website, which is being expanded as a resource-center Website.

Hotlines
Establishing a telephone hotline is an efficient method of providing clients with additional, relevant health information. A hotline ensures interaction between health care workers and consumers.

Hotline efficiency requires that those who operate the hotline receive training in the respective medical or health procedures to be introduced (e.g., breastfeeding, neonatal care), and that relevant literature be available for hotline operators. The next step should be a promotional campaign in local mass media—video and audio tapes—to announce that the hotline has been launched. In addition, it will be effective to place ads in print media and put up notices at maternity hospitals, children’s polyclinics and hospitals, women’s counseling offices, family planning centers, various sector/agency-related health facilities and the Health Department. An announcement about the hotline can also be offered as a flyer or memo to mothers on discharge.

After a hotline has been in use for a few months, the documentation of calls received should be reviewed to track successes and make decisions on further dissemination of relevant information.

Ad hoc Promotional Activities
Special promotion activities can play an important role in community behavior change efforts, and also in people’s attitudes toward medical providers and the health care system in general.

Ad hoc promotional activities can include the following:

- **Competitions** involving the community and public at large, e.g., the best display, poster, or drawing on breastfeeding or family planning. The competition may be organized for health institutions, medical high schools, or colleges. A contest such as “Best Breastfeeding Support Facility” also may be organized.
- **Prize-award ceremonies** at health care facilities for breastfeeding mothers to encourage breastfeeding and make it a focus for a group of mothers.
- **Meetings or lectures** on reproductive health at schools and summer camps for adolescents who may lack current information.
- **Roundtables** which target large families, for instance, to present health education, social services, or highlight family planning. This is a helpful service to both the community and the public at large.
- **Family and Mother’s Day events** attract young families, future parents, grandmothers and grandfathers, and many others to participate.
The telephone hotline in Berezniki was operated by four health workers (one neonatologist and three nurses) who reported that more than 50% of all questions related to baby-feeding, with the balance related to maternal and neonatal pathologies and care. Some calls concerned contraception. Eighty-nine percent of the calls came from mothers, 7% from grandmothers and 4% from fathers.

- **Afternoon Tea Hour for girls, young women, and grandmothers** provides an informal environment for discussions on reproductive health (family planning, STIs, breastfeeding, neonatal care, and other topics).
- **Open Door Day for newly-weds** promotes discussion on reproductive health and family planning, at registration offices. The Project has shown such activities as most effective, with many couples participating.

- **Materials distribution at public events.** Educational or informational materials on reproductive health can reach crowds attending city festivals, sports, conferences, exhibitions and open-door days, presentations, and other events.

The aim of *ad hoc* activities conducted under the WIN Project was to provide reliable information in an atmosphere of friendliness and festivity. As a result, visitors changed their attitudes toward health care. Activities where journalists were present were aired in the local press, which also helped to reach a larger audience with the information campaigns.

**Local Collaboration**

Community education may be facilitated by working with an NGO that is also addressing non-routine health issues. The WIN Project collaboration with the Center Against Violence and Human Trafficking, a Perm NGO, contributed enormously to increased health worker awareness of domestic violence as well as improved skills in victim counseling. This NGO also engaged the local Project to create an Emergency Support Center for women victims of domestic violence. One of the clinics in Perm has set up such a center with 28 beds.
IX. Monitoring and Evaluation of Changes in Health Facilities

This chapter provides an overview of a monitoring and evaluation system and examples of how the data it produces can be used. The monitoring system described in this chapter is designed to:

- track whether services are being delivered as planned,
- compare quality of care and service outcomes over time,
- document program successes in order to obtain further support or funding for program expansion, and
- transfer knowledge between facilities and build on lessons learned, ultimately leading to greater program effectiveness.

Implementing a monitoring system consists of two steps. The first step is to collect reliable data using standardized methods and consistent definitions of terms. The second step is to analyze the data and use the findings as a basis for discussion and improvement.

Before designing a system to monitor progress, it is important to know how you want to use the information it will produce. You need to determine the questions that you want the data to answer and to assess the resources needed to implement data collection. The answers to these questions will define the indicators you choose to monitor, as well as how frequently they are measured.

The WIN Project used a monitoring system based on data that the pilot facilities were already collecting and reporting to the Ministry of Health. Information from the facilities and providers was supplemented with information collected in interviews with clients about their experience of care before the Project started, and again after the interventions had been in place for two or more years.

The WIN monitoring system had two essential elements:

1. Monitoring the practices and outcomes in facilities, and
2. Monitoring how women perceive the care they receive.

Using Routine Data: A facility monitoring system (FMS)

Routine data collected by health facilities are useful for monitoring changes in both the services being delivered and in health outcomes, which should improve over time. The WIN Project consulted its Technical Advisory Group to develop a concise set of indicators chosen from data already collected and reported by facilities.

For example, the WIN Project asked facilities to report the number of maternity clients who had family support during labor or delivery. Then, the Project calculated this number as a percentage of all women who delivered in the maternities (see Figure 3, below). Changes in this indicator reflect changes in the emotional and psychological support provided to the mother during labor and birth, which fosters better health outcomes for mothers and babies.

When collecting data, it is important that standard definitions of all of the terms are used to measure indicators, so that the same information is collected about each client no matter who reports it. Only with standard definitions can one be sure that when looking at changes in indicators over time, the changes are real. This also makes it possible to compare data from different facilities.

![Fig. 3. Percent of women with family support during labor](image-url)
Obtaining data from clients: A self-administered client questionnaire (SAQ)

One gap in routine health information systems is that they lack the client's point of view about service delivery. Therefore, in addition to the data reported by providers, it is useful to monitor the experiences of clients when they attend facilities. This information is important because WIN interventions aim to achieve higher client satisfaction and to ensure that the services provided to them address their psychosocial needs as well as their medical needs.

An additional benefit of obtaining data directly from clients is that this allows you to track information that is not usually included in medical records, such as which kinds of information a client received at a facility. These data can be collected using self-administered client questionnaires, filled in by women after receiving services and before leaving the facility.

Informed consent and confidentiality

It is important to obtain informed consent before gathering any information from clients. They need to know that their participation is voluntary, and that the information they provide will be kept confidential.

Indicators

A variety of indicators may be calculated based on information gathered from both providers in facilities (Facility Monitoring Sheets) and clients (SAQs). The indicators suggested in Attachment 4 cover each service area of the WIN Program—antenatal care; delivery and postpartum care; and postabortion, postpartum, and other client family planning counseling.

Indicator Selection

You may choose to gather information for all of the suggested indicators, or to be selective in the ones you monitor. You may also develop your own indicators to address special local concerns or interests. At the same time, it is important not to overburden the data collection system. Before adding items to the Facility Monitoring Sheets or client questionnaires, evaluate how each new indicator will aid in program management, and how the information it provides will help in making program decisions.

There are some general guidelines for choosing indicators. More complex information is usually more expensive to gather, so choose less complicated measures where possible. If you add indicators to your monitoring system, try to choose indicators that are specific, so that each indicator reflects changes in only one issue or factor that you want to monitor. Where possible, select indicators (and the questions to measure them) that already have been field-tested. Make sure you know how you will use each indicator. The indicators you choose to measure should be understandable—you should be able to define and describe it easily.

Adding New Questions

All of the questions included in the SAQs and FMS are standardized and are used by the WIN Project to provide information for each of the suggested indicators. They have all been pre-tested. This means that women have answered these questions before, so that the Project could ensure that the questions were clear enough, and that women would answer them. Because these questions have been pre-tested, we can be fairly certain that these data collection tools will gather the information needed.

If you add new questions to measure other indicators, it is important to use a similar process of pre-testing the revised questionnaire with a small group of women. Then, make changes if the women find the questions difficult to understand.

Steps in the monitoring process

There are several steps in the monitoring process. Data must be:

1. collected at the facilities,
2. entered into a database,
3. analyzed, and
4. discussed and acted upon.
You will need to assign responsibility for each step in the process. One person at each facility should be assigned the task of collecting data and entering it on the facility forms (FMS forms). It may be best to assign responsibility for distributing and collecting the client questionnaires (SAQs) to another person. Your system for data collection must ensure that information is collected anonymously, in order to protect the privacy of clients and to maintain their trust in the facility staff. Data entry and analysis is likely be done most efficiently by someone in the oblast administration who is familiar with statistical computing programs, such as EPI-INFO, and has access to a computer.

Establishing a baseline
In order to measure how much impact a program has, it is essential to document conditions in the facility before the interventions are implemented—that is, conduct a baseline assessment. This assessment draws on both the official health data and the client questionnaires. The first three months’ data from the FMS and the first 300 to 500 client questionnaires (or all of the questionnaires collected within the first quarter of data gathering) will form your baseline.

The baseline will provide quantitative information on current practices that may help to fine-tune the training program. It will also provide a point of comparison after the program has been operating for some time, so that you can monitor improvements, assess success, and identify areas that need more effort.

Because some of the new interventions may be controversial, it can be helpful to present the baseline information to everyone involved in the Program at the start of Program activities. The information baseline data supplies about current practices can be used to stimulate discussion among providers and inform decision-making. For example, at one facility, the first round of a facility-based survey revealed a great difference between the clients and the health care providers’ perceptions about existing family planning counseling practices. As a result, training activities were developed that targeted providers and led to considerable changes in practice. For example, one baseline indicator showed that while providers thought they discussed family planning with clients, most women reported not having received such information. Dramatic improvements are shown 2 years later (Figures 4 and 5, below).

Using the monitoring results
After data has been collected on the indicators for a specified period of time, reports should be prepared for each facility. Service providers will use these reports to identify whether improvements are taking place as expected, and if not, where more effort is needed. It is not necessary to report on each indicator at each reporting cycle. Choosing a few key indicators to report on a quarterly basis may help the facility staff focus attention on critical areas.

The following questions may help to guide health care providers’ discussion of data:
• What are the primary areas of success?
• What are the primary issues of concern?
• What are the steps that might be taken to meet these issues of concern?
• Who has authority to take these steps, and does he or she have the resources to do so?
• What are priority actions will be taken?
• How will these actions be followed up?

For example, the WIN Project found that introducing the practice of exclusive breastfeeding and advising against newborns drinking water raised many questions and much apprehension among medical providers, about the control of hyperbilirubinemia (jaundice). Monitoring of corresponding indicators provided data that helped to dispel the specialists’ doubts (see Figure 6).

![Graph showing level of exclusive breastfeeding and jaundice prevalence among newborns.](image)

**Fig. 6. Level of exclusive breastfeeding and jaundice prevalence among newborns, based on Berezniki Maternity data**

Evidence of progress as in this example can help to sustain the efforts of those who have worked hard to implement the new interventions and quell doubts of those who might not support the new approaches.
X. Conclusion

The health of women and children is the foundation for healthy families and the well-being of society in general. The role of adequate and high quality medical care in reaching this goal cannot be overestimated. Knowledge about the interventions that today are considered effective in mother and child health care, cannot do the job alone. We also must clearly see the ways and also possess the methods of implementing of these effective interventions.

We hope this Guide will support medical providers by generalizing the Project experience and thus helping you to formulate your own original “recipe for success.” General approaches have been described in the Guide. In the Attachment you can find a list of resources recommended by the WIN Project that you may use in this work. More detailed and specific resources including contact information for consultants and trainers, training materials, and more can be obtained from the Project Representative Office in Moscow or the Perm Oblast Training and Resource Center in Perm.

For more information:

**WIN Project Representative Office**
107031, Moscow, Maliy Kisselniy Per., 1/9, room 301
Tel. +7 (095) 921 75 04
Fax +7 (095) 792 50 04
Resident Advisor: Vartapetova Natalia

**Perm Oblast Training and Resource Center**
614023, Perm, Ung Prikamia str., 3
Tel. +7 (3422) 55 81 70
Head of the Center: Fokeeva Tatiana
Results of the WIN Project’s comprehensive approach can be seen in Figure 1, which shows that women are now counseled about breastfeeding at every service point during and after their pregnancy.

When WIN conducted its baseline, most providers thought they practiced medicine consistently with their colleagues. As the data in Figure 3 illustrates, however, there were vast differences. After WIN training on evidence-based use of medicines during birth, two maternities in Perm had similar and consistent results.
Figure 4 illustrates the improved breastfeeding results after follow-up visits to the hospitals by experts.
Attachment 2:
WIN Project List of Resources

Representative Office:
117049, Moscow, Koroviy Val Street, 7, office 175
Tel. +7 (95) 937 36 23
Fax +7 (95) 937 36 80
Resident Advisor: Vartapetova Natalia

Perm Oblast Training and Resource Center:
614023, Perm, Ung Prikamia str., 3
Tel. + 7 (3422) 55 81 70
Head of the Center: Fokeeva Tatiana

WIN Project Facilities

City Hospital # 21, Perm
614113, Perm, Avtozavodskaya str., 82
Chief Physician – Nikolaev V.I.
- Maternity
- Women’s Consultation
- Gynecological Department

MSU # 9, Perm
614600, Perm, Bratiev Ignatovich str., 2
Chief Physician – Padrul M.M.
- Maternity
- Women’s Consultation
- Gynecological Department

City Children's Hospital # 24, Perm
614113, Perm, Ushakova str, 55/2
Chief Physician – Krivenko E.I.
- City Children’s Policlinic # 3
- City Children’s Policlinic # 4

City Children's Clinical Hospital # 15, Perm
614066, Perm, Sovetskoy Army str., 10
Chief Physician – Kabanova N.K.
- City Children’s Policlinic # 1

Perm Oblast Family Planning Center
614023, Perm, Ung Prikamia str., 3
Head of the Center: Fokeeva Tatiana

Berezniki Maternity
618419, Berezniki, Cherepanova str, 14
Chief Physician – Manzhai V.N.

Children’s Hospital, Berezniki
Berezniki, Sovetskiy pr., 67
Chief Physician – Kostenkova V.V.
- Children's Policlinic # 1
Maternity # 1, Velikiy Novgorod
173001, Velikiy Novgorod, Yakovleva str., 1/11
Chief Physician – Khomusiko V.N.
• Women’s Consultation # 1
• Women’s Consultation # 2
• Gynecological Department

Maternity # 2, Velikiy Novgorod
173020, Velikiy Novgorod, Derzhavina str., 1
Chief Physician – Solianov I.V.
• Women’s Consultation # 3
• Gynecological Department

Children’s Policlinic # 1, Velikiy Novgorod
173004, Velikiy Novgorod, Olovianka str., 17/3
Chief Physician – Soloviova T.M.

Children’s Policlinic # 2, Velikiy Novgorod
173023, Velikiy Novgorod, Kochetova str., 31
Chief Physician – Beliy G.I.

Children’s Policlinic # 3, Velikiy Novgorod
173007, Velikiy Novgorod, Bolshaya Vlasievskaya str., 6
Chief Physician – Ivanova A.I.
Russian Trainers and Experts

1. Alabugina, I.G.  Project Expert on Reproductive Health Head of Women's Consultation # 1, Maternity # 4, City of Novosibirsk, Russia
2. Dinekina, T.Ya.  Project Expert on Breastfeeding, Family Centered Maternity Care (FCMC), Antenatal care Head of Physiological Department, Maternity # 3, City of Murmansk, Russia
3. Grigorieva, V.A.  Project Expert on Reproductive Health Family Planning Center, D. Ott Institute of Obstetrics & Gynecology, St. Petersburg, Russia
4. Kabakov, V.L.  Project Expert on Family Centered Maternity Care (FCMC) Deputy Head of the Health Department, Administration of Arkhaengelsk Oblast, Russia
5. Kolossovskaya, E.N.  Project Expert on Infection Control Professor of the Epidemiological Department, St. Petersburg State Medical Academy
6. Korotkova, A.V.  Project Expert on Medical Service Quality Improvement Head of Methodological Center for Quality, CPHRI, Moscow, Russia
7. Mamoshina, M.V.  Project Expert on Breastfeeding Head of the Pediatric Department City Children's Hospital, Elektrostal, Russia
8. Potemkina, R.A.  Project Expert on Data Collection, Monitoring and Evaluation National Research Center for Preventive Medicine, Moscow, Russia
9. Riumina, I.I.  Project Expert on Neonatal Care, Breastfeeding Coordinator of WHO Regional Representative Bureau on Maternal and Infant Health, Moscow, Russia
10. Romanenko, V.A.  Project Expert on Newborns Resuscitation Chief of the Emergency Pediatrics Department with the Course on Neonatology, the Ural State Medical Academy, Cheliabinsk, Russia
11. Safronova, E.I.  Project Expert on Breastfeeding, Neonatal Care Head of the Newborns and Pre-term Department, Maternity # 3, Murmansk, Russia
12. Samarina, A.V.  Project Expert on Reproductive Health Doctor of the Family Planning Center, Dr. Ott Institute of Obstetrics and Gynecology, St. Petersburg, Russia
13. Savelieva, I.S.  Project Expert on Reproductive Health Head of the International Programs Department, Research Center of Obstetrics, Gynecology and Perinatology, Moscow, Russia
14. Shapovalova, K.A.  Project Expert on Reproductive Health Assistant of Gynecology and Neonatology Department, First Medical Institute named after Academician Ivan Pavlov, St. Petersburg, Russia
15. Sharapova, E.I.  Project Expert on Medical Service Quality Improvement Chief Specialist of Methodological Center for Quality, CPHRI, Moscow, Russia
16. Shmarova, L.M.  Project Expert on Breastfeeding Head of the Children's Policlinic # 1, Elektrostal, Russia
17. Tarasova, M.A.  Project Expert on Reproductive Health, Deputy Director on Science, Dr. Ott Institute of Obstetrics and Gynecology, St.Petersburg, Russia
18. Vartapetova, N.V.  Project Expert on Breastfeeding, Healthy Lifestyle, Nutrition WIN Project Resident Advisor, Moscow, Russia
19. Zueva, L.P.  Project Expert on Infection Control Head of the Epidemiological Department, St.Petersburg State Medical Academy
International Consultants

1. Anna Kaniauskene  Project Consultant on Reproductive Health Senior Program Officer, EngenderHealth, USA

2. Alberta Bacci  Project Consultant on Family Centered Maternity Care (FCMC), Antenatal, Perinatal Care, WHO Europe Bureau

3. Gelmius Siupsinskas  Project Consultant on Family Centered Maternity Care (FCMC), Antenatal, Perinatal Care, Evidence-based Medicine, Lithuania

4. Inna Sacci  Project Consultant on Reproductive Health, Head of the Representative Office, EngenderHealth, Russian Federation, USA

5. Lawrence Impey  Project Consultant on Family Centered Maternity Care (FCMC), Antenatal, Perinatal Care, Great Britain

6. Michele Berdy  Project Consultant on Community Mobilization Head of the Representative Office of Johns Hopkins University in Russia, USA

7. Pauline Glatleider  Project Consultant on Family Centered Maternity Care (FCMC), Antenatal Care, USA

8. Patricia David  Project Consultant on Monitoring and Evaluation, USA

9. Rashad Massoud  Project Consultant on Medical Service Quality Improvement, USA

10. Roberta Prepas  Project Consultant on Family-Centered Maternity Care (FCMC), Antenatal Care, USA

11. Fabio Uxa  Project Consultant on Neonatal Care, Italy

12. Ann Trudell  Project Consultant on Antenatal Care, USA
WIN Project Training Materials

**In Russian:**

**Family Centered Maternity Care (FCMC)**
   WIN Project 2002
2. A Variant of the Training Course on Childbirth Education
   WIN Project 2001

**Background materials**
3. Obstetrics
   CA Reference Book of California University, 1996
4. A Guide to Effective Care and in Pregnancy and Childbirth,
   Second Edition

**Breastfeeding**
5. Breastfeeding Counseling (manuals for trainers and participants)
   WIN Project 2003
6. Clinical Guideline on Breastfeeding
   WIN Project 2002

**Background materials**
7. Breastfeeding Counseling: Training Course
   (manual for facilitators and participants; transparencies)
   WHO 1998

**Essential Newborn Care**
8. Essential Newborn Care and Breastfeeding (methodical recommendations for trainers conducting the seminar)
   Part 1 – training course; Part 2 – annexes.
   WHO 2002

**Newborn Resuscitation**
9. Newborn Resuscitation
   4th edition, American Academy of Pediatrics, American Cardiological Association

**Antenatal Care/Healthy Lifestyle/Healthy Diet**
10. A Training Course on the Seminar: Antenatal Care,
    Childbirth Education, Perinatal Care, Healthy Lifestyle.
    Materials for Health Care Providers.
   WIN Project 2001
11. Materials for the Seminar on Antenatal Care,
    Healthy Lifestyle, Childbirth Education
   WIN Project 2001

**Background materials**
    A Training Course and Workshop for Health Care Providers.
    WHO, UNICEF, 2000

**Family Planning/Reproductive Health**
13. IUD Insertion: Integration of Clinical and Counseling Skills. A Book for Participants
    WIN Project (EngenderHealth, 2001)
    AVSC Int.NY, 1998
15. Counseling and Information on Family Planning. A Book for Participants.
    WIN Project (EngenderHealth)
16. Post-partum and Post-abortion Family Planning Counseling (book for participants)
    WIN Project (EngenderHealth, 2002)
17. Post-abortion Care
    WIN Project (EngenderHealth, 2002)
18. Youth-Friendly Reproductive Health Services Seminar (book for participants)
    WIN Project (EngenderHealth, 2003)
19. Seminar on Reproductive Health (set of slides for facilitator)
    AVCS Int. 2000
21. Reproductive Health Seminar: (book and set of slides for facilitators)
   WIN Project (EngenderHealth, 2001)

**Background materials**
22. A Set of Educational Flyers Johns Hopkins University, 2001
   • Breastfeeding
   • Health Care during Pregnancy
   • Sexually-Transmitted Diseases
   • Combined Oral Contraceptives
   • Injectables
   • Natural Family Planning Method
   • Condom
   • Free sterilization of women
   • IUD
   • Postpartum Counseling on Family Planning Issues
   • Postpartum and Post-abortion Counseling
   • LAM
   • Domestic Violence

**Videos in Russian:**
Mother is Better (video about breast milk, breastfeeding, and early contact with a newborn)
Mother and Child (program for regional television on breastfeeding)
Health Care (series of seven social videos on family planning topics)
Every day joy: the value of a healthy future (video on family planning for regional television)
Effective Counseling (video on family planning for providers)
Infection Prevention (video for clients in family planning programs)

**Materials in English:**
**Family Centered maternity Care (FCMC)**
FCMC Curriculum: Trainer's Guide / Participants' Guide Russia 2002
Childbirth Education Connie O'Neil, 2001
A guide to effective care and in pregnancy and Childbirth, Murray Enkin & others. 1996 Oxford University Press

**Breastfeeding**
Breastfeeding Counseling - Training Course WHO, 1998
Evidence for the 10 steps to successful breastfeeding WHO/CHD –98.9

**Essential Newborn Care**
ANC/CBE (seminar) WIN Project, 2001
Essential Newborn Care & Breastfeeding (guidelines for facilitators conducting the course; annexes) WHO, 2002

**Essential Antenatal Care**
Essential Antenatal, Perinatal and Postpartum Care WHO, 2002
## Levels of Clinical Evidence

<table>
<thead>
<tr>
<th>Level of Evidence</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Randomized controlled trial</td>
</tr>
<tr>
<td>II – 1a</td>
<td>Pseudo-randomized controlled trials</td>
</tr>
<tr>
<td>II – 1b</td>
<td>Non-randomized controlled trials</td>
</tr>
<tr>
<td>II – 2a</td>
<td>Cohort (prospective) trials with parallel control groups</td>
</tr>
<tr>
<td>II – 2b</td>
<td>Cohort (prospective) trials with historical control groups</td>
</tr>
<tr>
<td>II – 2c</td>
<td>Cohort (retrospective) trials with parallel control groups</td>
</tr>
<tr>
<td>II - 3</td>
<td>Collective (retrospective) trials</td>
</tr>
<tr>
<td>III</td>
<td>Great differences from comparisons in time and/or place with or without intervention (in some cases it is equivalent to level II or I)</td>
</tr>
<tr>
<td>IV</td>
<td>Opinions of outstanding specialists, based on clinical experience, descriptive trials and reports of expert's committees</td>
</tr>
</tbody>
</table>
Suggested workshops to train doctors to be instructors in family planning (FP) and reproductive health (RH) are listed by the training event, how many people can participate (maximum), and which specialists should attend the event.

<table>
<thead>
<tr>
<th>Training event</th>
<th>Maximum number of participants</th>
<th>Specialists</th>
</tr>
</thead>
</table>
| A workshop on FP /RH for obstetricians / gynecologists                          | 50                             | • District obstetricians/gynecologists at women’s consultations  
• Obstetricians/gynecologists at women’s consultations (minor operating rooms)  
• Obstetricians/gynecologists at maternity consultations  
• Doctors at family planning centers |
| A workshop on FP /RH for pediatricians                                          | 50                             | • Neonatologists and pediatricians at maternity consultations  
• Neonatologists and pediatricians at children's policlinics                           |
| A workshop on FP /RH for mid-level personnel                                    | 50                             | • Mid-level personnel at women's consultations  
• Mid-level personnel at maternity consultations  
• Home nurses at children’s policlinics  
• Mid-level personnel at FP centers                                               |
| A workshop on postpartum and post-abortion counseling                           | 20                             | • District obstetricians/gynecologists at women’s consultations  
• Obstetricians/gynecologists at women’s consultations (minor operating rooms)  
• Obstetricians/gynecologists at maternity consultations  
• Nurses at women’s consultations  
• Doctors at FP centers  
• Nurses at FP centers                                                          |
| A workshop on integration of clinical and counseling skills for insertion and removal of IUD | 20                             | • Obstetricians/gynecologists at women’s consultations (minor operating rooms)  
• Obstetricians/gynecologists at maternity consultations  
• Doctors at FP centers  
• Nurses at FP centers                                                          |
| A workshop on training instructors in FP/RH counseling                           | 15                             | • Doctors at FP centers  
• Mid-level personnel at FP centers                                                |
| A workshop on youth-friendly services                                            | 20                             | • Doctors at FP centers  
• Mid-level personnel at FP centers  
• Teenager obstetricians/gynecologists who work at women's consultations  
• Providers from the staff of youth centers                                       |
Facility Monitoring System: Suggested Indicators

Indicators for City and Oblast
• Infant and perinatal mortality
• Abortion-to-live-birth ratio

Indicators for Maternity Hospitals
• % of newborns exclusively breastfed throughout hospital stay
• Facility practices (examples)
  - % of women receiving periotomy (including episiotomy)
  - % of women given pain medication during labor/delivery
  - % of women rooming-in

Indicators for Women's Consultations
• % of women who return for a post-natal check-up (within two months after delivery)
• % of women who receive family planning counseling or information

Indicators for gynecology units (abortion and contraception)
• % of post-abortion women who receive family planning counseling before discharge
• % of post-abortion women who receive family planning information before discharge
• % of women, who return for a follow-up visit after abortion
• Number of new family planning clients (total and by the kind of method)
• Number of continuing family planning clients (by client, and by number of visits)

Indicators for Children's Polyclinics
• % of infants from zero to five months old who are exclusively breastfed

General facility monitoring indicators (for use at various facilities):

Women who come for abortion
• % of women who come for repeat abortion during a year period
• % of women who become pregnant, despite use of a method of contraception (by the kind of method)
• % of women who receive family planning information on follow-up visit after abortion

Women who come for antenatal care
• % of women who can correctly define “exclusive breastfeeding”
• % of women who discuss methods of postpartum pregnancy prevention
• % of women who receive counseling on lactational ammenorhea method of contraception (LAM)
• % of women, who become pregnant, despite use of a method of contraception (by kind of method)

Women who are postpartum
• % of women who received the following during labor:
  - perineal shave
  - enema
  - episiotomy
• % of women who were allowed to:
  - walk
  - sit
• % of women who had support during labor
• % of women who had “skin-to-skin” contact with their newborns immediately after delivery
• % of women who attached the newborn to breast within an hour period after birth
• % of women whose babies were on exclusive breastfeeding throughout whole hospital stay
• % of women choosing rooming-in with the baby

Women who come for family planning services
• % of women who participated in family planning counseling with a partner
• % of women wishing to have partner's participation during family planning counseling
• % of women choosing pharmacological methods of contraception
• % of women who receive adequate information on the chosen method of contraception

Women in all categories
• % of women expressing satisfaction with services