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# RUSSIA: INTEGRATING FAMILY PLANNING INTO THE HEALTH SYSTEM

## A CASE STUDY OF THE MATERNAL AND CHILD HEALTH INITIATIVE

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## DELIVER

DELIVER, a six-year worldwide technical assistance support contract, is funded by the United States Agency for International Development (USAID).

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## Abstract

The pilot phase 1999–2003 Women and Infants' Health (WIN) project and the scale-up phase 2003–2006 Maternal and Child Health Initiative (MCHI) integrated family planning into the spectrum of maternal and infant health care in 16 regions of the Russian Federation. WIN/MCHI's innovative design helped regional and municipal government-supported health facilities adopt internationally recognized, client-centered, evidence-based maternal and child health standards and practices in multiple areas: antenatal care; family-centered maternity care; essential newborn care; exclusive breastfeeding; and family planning counseling and services, especially for postpartum and post-abortion clients. Attention was also given to family planning for HIV-positive women and the prevention of mother-to-child transmission of HIV.

The objectives were to provide a new evidence-based model for reproductive health care services and to increase access to, demand for, and quality of these services, as well as to increase the practice of preventive health behaviors among women in the community. WIN/MCHI chose strategies that not only stressed evidence-based medicine but that also offered a total paradigm shift from focus on the provider to focus on the client, a shift that transformed the way maternal and infant services were delivered. Implementation involved health care providers, administrators, and authorities in the planning, policymaking, hands-on training, and public education needed to achieve change.

This case study looks specifically at the integration (*horizontalization)* of the family planning component into the other WIN/MCHI components. As a result, access to client-centered counseling has increased, unplanned pregnancies have decreased, and the abortion rate has declined.

A companion case study from the Romanian Family Health Initiative (RFHI) is also available (Gasco, Merce, Christopher Wright, Magdalena Pătruleasa, and Diane Hedgecock. 2006. *Romania: Scaling Up Integrated Family Planning Services: A Case Study.* Arlington, Va.: DELIVER, for U.S. Agency for International Development).

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# ACRONYMS

| | |
|---|---|
| AIDS | acquired immunodeficiency syndrome |
| CAR | crude abortion rate |
| CPR | contraceptive prevalence rate |
| EE/EA | Eastern Europe and Eurasia |
| FCMC | family-centered maternity care |
| HIV | human immunodeficiency virus |
| IEC | information, education, and communication |
| JSI | John Snow, Inc. |
| MCHI | Maternal and Child Health Initiative |
| M&E | monitoring and evaluation |
| MOH | Ministry of Health |
| MOHSD | Ministry of Health and Social Development |
| MTCT | mother-to-child transmission (of HIV) |
| NGO | nongovernmental organization |
| PMTCT | prevention of mother-to-child transmission (of HIV) |
| RSOG | Russian Society of Obstetricians/Gynecologists |
| STI | sexually transmitted infection |
| TAR | total abortion rate |
| TFR | total fertility rate |
| TOT | training-of-trainers |
| USAID | United States Agency for International Development |
| WHO | World Health Organization |
| WIN | Women and Infants' Health project |
| WRHP | Women's Reproductive Health Program |

# ACKNOWLEDGEMENTS

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Overall, the Ministry of Health and Social Development of the Russian Federation deserves recognition for its support and close collaboration during the implementation of the Women and Infants' Health (WIN) project and MCHI projects, as do the multiple regions and municipalities who were such active participants.

Special thanks are due the many health professionals in Krasnoyarsk and Vologda Oblasts who shared their knowledge, insights, expertise, and experiences during site visits as this document was developed. Special thanks are also due to every speaker, panelist, trainer, and participant at the May 2006 Final Dissemination Conference *"*Improving Quality of Medical Care of Women and Infants: The MCHI Experience,*"* held in Moscow. The presentations, discussions, and obvious enthusiasm from all who attended made the achievements of the WIN/MCHI interventions come alive.

# EXECUTIVE SUMMARY

In the mid-1990s, the Government of the Russian Federation launched a nationwide family planning initiative aimed at promoting modern methods of contraception as culturally acceptable and as an accessible way to manage fertility, thereby reducing the historical reliance on abortion. However, over time, various groups opposed family planning on political, demographic, moral, and religious grounds, with the well-documented population decline in Russia being a frequently misunderstood and complicating factor.

> "We pay attention to quality and to public opinion. The client focus is the most important part of this project."
>
> *Head of Maternity House, Tyumen Oblast at MCHI's Final Dissemination Conference*

As a consequence, in 1998, the Duma—the lower house of Russia's parliament— ultimately withdrew financial support for the federal family planning program, leaving family planning services to the regional and municipal levels.

In this context, USAID funded two sequential programs in the Russian Federation—the Women and Infants' Health (WIN) pilot project from 1999 to 2003; and the Maternal and Child Health Initiative (MCHI) from 2003 to 2006, which was tasked with scaling up the WIN interventions. With the goal of integrating family planning into the broader reproductive health care continuum, WIN was launched with an innovative design that covered a broad array of reproductive health services, not just family planning. Key program components promoted evidence-based, family-centered, client-friendly antenatal care; maternity care; essential care of the newborn; exclusive breastfeeding support; and family planning counseling and services, especially for postpartum and post-abortion clients. WIN's objectives were to provide a new evidence-based model for reproductive health care services and to increase access to, demand for, and the quality of these services, as well as to increase the practice of preventive health behaviors among women in the community. To do this, WIN would work with existing health care facilities and involve health care providers, administrators, and authorities in the planning, policy making, hands-on training, and public education needed to achieve change.

To introduce new evidence-based clinical practices into an historically inflexible health care system that was locked into largely outmoded practices and to meet their strategic objectives and achieve demonstrable results, WIN/MCHI used approaches that respected existing Russian systems, structures, and professionals while, simultaneously, provided training and education to ensure policymakers' and providers' ability to improve Russia's maternal and child health.

To thoroughly test this new programmatic approach, WIN focused on two pilot regions (Perm Oblast and Velikiy Novgorod City in Novgorod Oblast), working closely with the Ministry of Health of the Russian Federation, the Health Care Department of Perm Oblast, and the Health Care Committee of Velikiy Novgorod City in Novgorod Oblast. Building on WIN's accomplishments and benefiting from its lessons learned, WIN/MCHI then scaled up to ultimately include 16 of Russia's 89 regions, encompassing 26 million people or 18 percent of Russia's total population of 143 million.

In each region, WIN/MCHI worked with an urban-based set of related health care facilities that had the potential to reach a large number of women. In 10 of the regions, these facilities were a mix of region-level facilities and municipal-level facilities; in the other six, the facilities were municipal-level only. Initially, the cluster of facilities included maternity hospitals, gynecological units, women's consultation clinics, family planning centers and children's polyclinics. Over time, in response to Russia's growing

HIV/AIDS epidemic, HIV/AIDS centers were also included. Ultimately, 198 facilities were involved directly in WIN/MCHI program activities.

## STRATEGIC APPROACHES

WIN/MCHI's goal was to introduce new evidence-based clinical practices into a historically inflexible health care system that was locked into largely outmoded practices, while meeting their strategic objectives and achieving demonstrable results. To do this, they used an approach that respected the existing Russian systems, structures, and professionals while, at the same time, provided training and education to ensure that the policymakers and providers could improve Russia's maternal and child health care. WIN/MCHI's implementation strategies focused on process as well as content; they included strategies that not only stressed evidence-based medicine but that also offered a total shift from focus on the provider to focus on the client. This paradigm shift transformed the way maternal and infant services were delivered.

### 1. ESTABLISH A SOUND POLICY CONTEXT AND A SHARED VISION

Initially, the Ministry of Health (MOH) provided a Letter of Support to WIN that was a vital endorsement: the letter stated that the MOH considered the participating facilities to be demonstration sites for future dissemination of a national strategy to improve maternal and child health. This official recognition was crucial because many of the new clinical practices and administrative procedures that WIN/MCHI would introduce contradicted existing *prikazes* (ministerial orders). From the outset, it was crucial to secure political, organizational, and financial support from regional and municipal health authorities. A set of working groups was introduced using teamwork and coalition building as the guiding principles. For many Russian health care professionals at all levels, these were novel concepts.

### 2. BUILD IN A STRONG MONITORING AND EVALUATION PROCESS

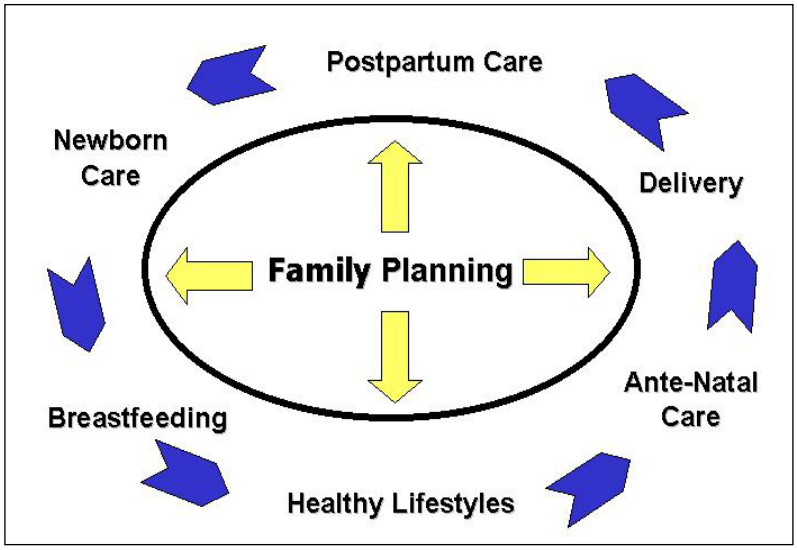
From the beginning, planning for results was a key approach, with evaluation activities built into the program design, especially at the facility level. A key lesson learned during the WIN project was that provider-derived data often differed from client-derived data, and that the client-derived data was the most useful and accurate in terms of assessing progress (or lack thereof). In response, MCHI decided to forgo the effort and expense of also surveying providers and—in what was a crucial move—shifted from internal measurement systems that focused on feedback from providers to systems that focused on feedback from clients. Also, whereas the population-based household surveys had been useful at the pilot stage, such surveys in the scale-up regions were not considered necessary.

### 3. PROVIDE INTERNATIONAL STANDARD, EVIDENCE-BASED TRAINING

The effective introduction of evidence-based practices required the development of training curricula (including new clinical guidelines) that used innovative training methodologies and the identification and development of a cadre of competent trainers. Using basic principles of adult learning, the format of the training sessions was new to most health care providers. Theory was combined with opportunities for hands-on practice in clinical skills.

The training provided using the core family planning curriculum was strengthened and complimented by also integrating family planning into other maternal and child health training courses. Training in healthy lifestyles, antenatal care, family-centered maternity care (FCMC), postpartum care, newborn care, and breastfeeding all included relevant family planning components (see figure 1). This integration into the whole spectrum of training reemphasized the *horizontal* role of family planning in comprehensive reproductive health care, while enhancing provider knowledge and skills.

**Figure 1. Family Planning as an Integral Component of the Whole Maternal and Child Health Care Spectrum**




**4. DESIGN SUPPORTIVE/COMPLEMENTARY IEC/BCC MATERIALS AND ACTIVITIES**

A major WIN/MCHI objective was to increase demand for the new services as well as to encourage good preventive health behaviors in the community. Qualitative research on the knowledge, attitudes, and practices of clients about their reproductive health needs and how they prepared for childbirth, spaced children, and prevented unwanted pregnancies was used in the design and implementation of a creative and effective information, education, and communication/behavior change communication (IEC/BCC) strategy. WIN/MCHI produced and disseminated appropriate health messages to inform and educate the population and also developed and produced materials and media for use within participating facilities. This multi-channeled approach incorporated posters, flipcharts, booklets, brochures, television and radio spots, the Internet, and advocacy events.

**5. DEVELOP A SOUND PLAN FOR SCALING UP**

As the pilot phase of WIN progressed, the importance of local team building, multidisciplinary discussions, and securing the support of the health authorities at the national, oblast, city, and facility levels became increasingly evident. One lesson learned during the WIN project was that the various pilot sites/regions showed uneven commitment and insufficient support from key decision makers at the regional level; this was thought to be due to the way the pilot sites had been selected.

In response, a working group was formed that concluded that a competitive selection process could help ensure that participating regions would demonstrate the commitment and determination needed to make the expansion succeed. Next, the working group developed site selection criteria and a scoring system for evaluating regions. The criteria were structured and weighted by priority and reflected a comprehensive set of requirements that the working group felt would be likely determinants of program success.

**6. PLAN FOR DISSEMINATION AND REPLICATION FROM THE BEGINNING**

Part of the original WIN strategy was to create a model and resources that could be replicated. Many of WIN/MCHI's successes can be attributed to their concerted efforts to document and disseminate results and best practices in multiple ways. Although not in MCHI's original scope of work, MCHI realized that the Internet could provide additional opportunities for replication and dissemination; in response, MCHI added a website to its objectives. The MCHI website was launched in January 2006 in Russian and English as www.jsi.ru. Anyone—from Russia, the Eastern European/Eurasia region, and anywhere else in

the world—can download a complete set of replication packages, training materials, communications materials, plans, and success stories.

#### 7. CONTINUE TO INNOVATE AND ANTICIPATE NEXT STEPS

To adapt to changing needs and respond proactively, WIN/MCHI regularly monitored the implementation progress but stayed sensitive to changing outside events. Responding to the increasing prevalence of HIV/AIDS in Russia, MCHI added prevention of mother-to-child transmission (PMTCT) of HIV into its scope of work and did some preliminary work on the family planning needs of HIV-positive women. In MCHI's final year, it began working with two regions—Tyumen Oblast and Vologda Oblast—on a pilot program to provide family planning services to rural areas by integrating family planning into the primary health care system.

## CONCLUSIONS

The impact of the pilot phase 1999–2003 WIN project and the scale-up phase 2003–2006 MCHI has been significant. WIN/MCHI's innovative design helped regional and municipal government-supported health facilities adopt internationally recognized, client-centered, evidence-based maternal and child health standards and practices in multiple areas: antenatal care, family-centered maternity care, essential newborn care, exclusive breastfeeding, and family planning counseling and services, especially for postpartum and post-abortion clients. Attention was also given to family planning for HIV-positive women and the PMTCT of HIV.

> "Now when someone asks why do you do this, it's no longer because we've always done that. It's because it's evidence-based."
>
> *Chief Physician, Municipal Perinatal Center, Orenburg at MCHI's Final Dissemination Conference*

Both sustainability and replicability are key WIN/MCHI success stories. The capacity building that occurred at the regional level is impressive, and there is an enormous potential for further expansion within the target regions. By identifying and supporting *catalyst* institutions and individuals, WIN/MCHI has helped multi-level leadership implement bold, rapid, substantive changes, and has created a community of change agents.

The WIN/MCHI design, content, and implementation process could be a very useful model (and has been in Ukraine and Georgia) for similar work in other countries, especially in former Communist-block countries, Their strategies offer innovative ideas and practical approaches that program managers and policymakers can adapt. Additionally, it could be a very useful model for incorporating other evidence-based, internationally recognized standards of care into the Russian and other health care systems (e.g., additional reproductive health, family planning, and HIV/AIDS interventions; tobacco; and tuberculosis). Because of its client-centered, client-friendly approach, the WIN/MCHI model could also be a model for reaching traditionally hard-to-reach and/or stigmatized populations (e.g., groups in prisons or drug rehabilitation centers, and institutionalized youth).

The transformation of WIN/MCHI from an external donor-funded project to the Institute for Family Health, a self-sustaining, indigenous, Russian nongovernmental organization, is also a success story that can encourage and inspire the legions of committed, hard-working public health professionals who have dedicated themselves to improving the health and well-being of their fellow citizens.

# INTRODUCTION

This case study presents the story of two sequential USAID-funded programs in the Russian Federation—the Women and Infants' Health (WIN) pilot project from 1999 to 2003 and the Maternal and Child Health Initiative (MCHI) from 2003 to 2006—and how WIN/MCHI, by integrating family planning across the spectrum of maternal and infant care, expanded access to and use of family planning counseling and services. WIN/MCHI chose strategies that stressed evidence-based medicine and also offered a complete paradigm shift from focus on the provider to focus on the client; the shift transformed the way maternal and infant services were delivered.

Both the achievements of these programs, as well as lessons learned during the pilot phase and scale-up phase, are detailed in this study. It will be most useful for program managers, policymakers, donors, and technical assistance providers in Eastern Europe and Eurasia.

Countries in this region share a common legacy of—

- reliance on abortion as a primary method for fertility control
- providers' reluctance to prescribe or offer modern contraception
- highly structured health delivery systems that focus on curative services rather than prevention and primary health care
- low fertility rates
- high rates of abortion and maternal mortality due to abortions.

In most cases, countries in the region are also undergoing dramatic health sector reforms.

Intended as a reference, this case study suggests ways to design and implement similar programs in other countries in the region where the WIN/MCHI approach and its evidence-based, client-centered focus could be a useful strategy. The intent is not only to provide information about the situation in the Russian Federation but also to show what was done, learned, and accomplished by WIN/MCHI by identifying key strategies that were essential to the success of the WIN/MCHI effort and by sharing lessons learned while implementing the program.

A companion case study from the Romanian Family Health Initiative (RFHI) is also available;[1] this case study offers a contrasting but complementary approach to the urban-focused, facility-based strategy used by WIN/MCHI. The RFHI approach focused on reaching rural clients and expanding access to family planning services and supplies by integrating family planning into primary health care delivery.

Qualitative and quantitative data were used to develop this case study; the sources included various documents from the WIN and MCHI projects; facility-based survey data from 13 of the 16 MCHI regions; interviews with USAID and MCHI staff, as well as with health officials at regional and facility levels; and health service providers and their clients. Specifically, for this case study, two authors conducted field visits to Krasnoyarsk and Vologda Oblasts (see photo 1). These regions are among the longest participants in the MCHI program; therefore, they have considerable practical experience in

[1] Gasco, Merce, Christopher Wright, Magdalena Pătruleasa, and Diane Hedgecock. 2006. *Romania: Scaling Up IntegratedFamily Planning Services: A Case Study.* Arlington, Va.: DELIVER, for the U.S. Agency for International Development.

integrating family planning into the full spectrum of maternal and child care. In addition, Vologda is experimenting with its integration into rural primary health care.

**Doctors and Chief OB/Gyn of Krasnoyarsk City meet during a follow-up visit at Maternity #5. (1)**

# FAMILY PLANNING INTEGRATION IN RUSSIA

## BACKGROUND

In area, the Russian Federation is the largest country in the world, stretching 11 time zones from west to east; it has the world's deepest lake and Europe's highest mountain and longest river. With a population of 143 million (July 2006 estimate), it is also the world's eighth most populous country. Russians are universally literate (100 percent) and are predominately urban residents (73 percent). Administratively, Russia is divided into 89 regions (48 oblasts, 21 republics, 9 autonomous okrugs, 7 krais, 2 federal cities, and 1 autonomous oblast). The population, while predominantly ethnically Russian, is quite diverse: Russian (80 percent), Tatar (4 percent), Ukrainian (2 percent), Bashkir (1 percent), Chuvash (1 percent), and other unspecified (12 percent).

Health care in the Russian Federation is primarily a state responsibility and the Ministry of Health (MOH) (now the Ministry of Health and Social Development [MOHSD]) is the largest health care provider. The MOH historically has been responsible for maintaining the overall infrastructure and for setting national priorities for health care, as well as for establishing norms and standards that dictate policies and practices across the entire nation. There has been a gradual shifting of responsibility for health care administration and financing to the regional and municipal levels, but the federal level remains the most important health policymaker.

In the early 1990s, the Government of the Russian Federation launched a nationwide family planning initiative aimed at promoting modern methods of contraception as culturally acceptable and accessible means of managing fertility, thereby reducing the historical reliance on abortion. A network of family planning centers and/or units was established to offer family planning services, but they were not integrated with other reproductive health services; instead, they were a separate, distinct vertical system of specialty clinics and units. As a result, family planning lacked the attention of other reproductive health service providers, and access to services was limited by both geography and organizational structure within the health system. In those days, family planning centers dealt with largely uninformed clients, whose demand for family planning services was relatively low.

Social and political acceptance of modern family planning was uncertain as various forces and groups opposed family planning on political, demographic, moral, and religious grounds. The well-documented population decline in Russia presented a challenging factor that opponents of family planning exploited aggressively, claiming that the national family planning program contributed to Russia's very low fertility rate. Opponents also spread misinformation about family planning's objectives and outcomes. In 1994, when then-Russian president Boris Yeltsin issued a decree creating a *Children of Russia* program that included establishing family planning centers in each region, organized opposition to family planning programs emerged, largely based on misinformation and myths. As a consequence, in 1998, the Duma—the lower house of Russia's parliament—ultimately withdrew financial support for the federal family planning program. Thus, the future of family planning provision became unclear as regions were left to determine if and how to finance family planning at the regional and municipal levels.

The longstanding conventional wisdom is that Russia and most of the former Soviet Union countries traditionally relied on voluntary induced abortion as the primary means of family planning. It is an accepted cultural norm, widely available and financially accessible. At the same time, studies show women in Russia almost universally hold strongly negative opinions about induced abortion and would

prefer to avoid it to prevent unintended births. At the same time, access to modern methods of contraception was limited because Russia did not have a well-developed service delivery infrastructure, and there were concerns about the safety and quality of contraceptives. The poor quality of contraceptives produced by and imported into Russia in the 1970s and 1980s had given both the public and health care providers a strong and enduring perception that contraceptives—hormonal methods in particular—were dangerous, ineffective, or both.

During the past 15 years, Russia has improved the health status of its women and children. For decades, the abortion levels in Russia have been among the world's highest; over the years, the official statistics on abortions suggest a steady decrease in both the crude abortion rate (CAR) and the total abortion rate (TAR). CAR dropped from 137.5 per 1,000 women aged 15–44 in 1985, to 116.9 in 1990, to 42.9 for women aged 15–49 in 2003 and to 40.5 in 2005. TAR decreased from 3.8 abortions per woman of reproductive age in 1985, to 3.4 in 1990, to 1.8 in 2000, and to 1.2 in 2005. Although considerably reduced, the levels of induced abortion still remain among the highest in the world and play a significant role in maternal morbidity and mortality and, in some instances, infertility.

At the same time, Russia's population has decreased every year since 1992, falling from 148 million to 143 million in 2006. The increases in the death rates seen in the Russian Federation over the past decade—especially among adult men—are unprecedented for an industrialized nation at peace. In addition, Russia's 2005 total fertility rate (TFR) of 1.4 children per woman is one of the lowest in the world. Also, the number of women of reproductive age (WRA) is projected to decrease by 16 percent between 2000 and 2015. Understandably, the resulting decline in the population has become one of the Russian government's major concerns.

**The Health Context and Policy Challenges In Russia**

- Over-medicalized health care system with outdated and non-evidence-based medical practices.
- Family planning in the context of very low birth rates and population decline.
- Competing priorities with family planning considered of low rank.
- Historical reliance on abortion as means of fertility control.

Although a nationwide Reproductive Health Survey (RHS) has never been done for Russia, several regional RHSs (1996, 1999) suggest that Russia has relatively high contraceptive prevalence rates (CPRs). Between 69–77 percent of couples are estimated to use some form of contraception (with the use of modern methods of contraception relatively modest and the use of traditional methods fairly high). This seeming contradiction—high abortion rates as well as high contraceptive prevalence rates—is explained in part by the high reliance on the less-effective traditional methods that result in more frequent unintended pregnancies together with the current strong desire for a small family size that has resulted in extremely low rates of childbearing.

The reproductive health sector has been largely disconnected from the health reform processes in Russia. While reform has emphasized strengthening primary health care, the process has been controversial. Acceptance of family medicine-based primary health care was especially resisted in urban health systems where specialists felt threatened by the integration of services, whereas primary health care services in rural areas have traditionally operated closer to a family medicine model. In Russia, reproductive health services remain predominantly the unique responsibility of gynecologists/obstetricians, who are for the most part based in maternities, hospitals, and polyclinics; thus, family planning has become predominantly part of this reproductive health service structure rather than an integral part of primary health care services.

The federally-mandated free package of obligatory services includes maternity care and abortion but not family planning services. Some regions cover family planning services with their own funds, including in some instances the provision of free contraceptives to high-risk groups. The definition of high-risk group varies but generally includes a combination of low-income women, students and adolescents, and specific vulnerable populations.

## PILOT PHASE

In 1995, the Russian Federation started a series of programs in family planning and reproductive health, which were supported by the international community and coincided with the country's national family planning program. The goal of the initial Women's Reproductive Health Program (WRHP) implemented in 1995–1999 was to decrease Russia's high rates of maternal mortality and morbidity by improving the family planning information and service delivery systems; and by increasing public knowledge about the use, safety, and health benefits of modern family planning methods, thereby resulting in greater adoption of modern methods of contraception as an alternative to repeat abortion. Implemented initially in six pilot regions, the program established six demonstration/training sites, and was then extended to eight additional oblasts along with a national IEC campaign that included television and radio spots, brochures, posters, and local promotional activities.

In 1999, building on the successes of the WRHP and recognizing the need to integrate family planning into the broader reproductive health care continuum, the WIN project was launched with an innovative design that addressed a broad spectrum of reproductive health services, not just family planning. Key program components promoted evidence-based, family-centered, client-friendly antenatal care; maternity care; essential care of the newborn; exclusive breastfeeding support; and family planning counseling and services, especially for postpartum and post-abortion clients. WIN's objectives were to provide a new evidence-based model for reproductive health care services and to increase access to, demand for, and quality of these services, as well as to increase the practice of preventive health behaviors among women in the community. To do this, WIN would work with existing health care facilities and involve health care providers, administrators, and authorities in the planning, policymaking, hands-on-training, and public education needed to achieve change.

**WIN Programmatic Components**

- Antenatal care
- Family planning/reproductive health
- Family-centered maternity care
- Exclusive breastfeeding
- Newborn care
- Infection control in maternities.

To thoroughly test this new programmatic approach, WIN focused on two pilot regions (Perm Oblast and Velikiy Novgorod in Novgorod Oblast), working closely with the MOH of the Russian Federation, the Health Care Department of Perm Oblast, and the Health Care Committee of Velikiy Novgorod City in Novgorod Oblast. In each region, WIN worked with a group of related facilities that deliver maternal and infant care: women's consultation clinics, maternity hospitals, family planning centers, and children's polyclinics.

The following principles guided all interventions:

- use of evidence-based medicine to enhance clinical practice and reduce unnecessary medical interventions
- implementation of quality assurance methods that involved both providers and clients
- promotion of a client-oriented focus to increase client satisfaction
- continuity and consistency in client-provider communications across service levels and across health care facilities.

WIN's goal was to introduce into the Russian health care sector a concept of maternal and infant health care as one interconnected system. WIN services were designed, publicized, and implemented as an integrated set of interventions to ensure continuity of care across facilities used by women and their families. For family planning, having received family planning counseling as part of antenatal care, a new mother would be offered family planning counseling and services postpartum before leaving the maternity hospital. Even if she did not have time or a reason to visit a women's consultation for her own

health care, the new mother would encounter the same family planning messages and services when visiting the children's polyclinic with her new baby. Abortion clients would also receive family planning counseling as an integral part of post-abortion care.

The WIN interventions fell into three main areas: (1) clinical and counseling training with follow-up supervision for obstetricians, gynecologists, neonatologists, pediatricians, midwives, and infant nurses; (2) community-based and facility-based IEC/BCC outreach for both families and providers; and (3) advocacy and policy promotion within facilities and at the municipal, oblast, and federal levels of health administration.

WIN held a very well-received Dissemination Conference in 2003, by which time 20 additional regions had indicated an interest in replicating the WIN model.

**WIN Implementation Strategy**

- Formal training (clinical and counseling) with follow-up
- IEC/BCC activities (community-based and facility-based)
- Advocacy and policy promotion
- Strong monitoring and evaluation component
- Special efforts on data collection, analysis, and data-based decisions.

## SCALE-UP PHASE

The 2003–2006 Maternal and Child Health Initiative was designed specifically to scale up WIN's success in piloting an evidence-based model for reproductive health care services. MCHI's stated objective was to ensure the adoption of internationally recognized maternal and child health standards and practices by targeted health facilities in Russia.

**MCHI Programmatic Components**

- Antenatal care
- Family planning/reproductive health
- Family-centered maternity care
- Exclusive breastfeeding
- Newborn care
- Infection control in maternities
- Neonatal resuscitation
- Youth-friendly services
- HIV/AIDS prevention/PMTCT.

Increasingly, as WIN was ending and MCHI was beginning, Russia and the world were becoming aware of Russia's worsening HIV/AIDS situation. In response, MCHI added HIV/AIDS centers to the network of MCHI participating facilities and incorporated family planning for HIV-positive women and the prevention of mother-to-child transmission (PMTCT) of HIV into its programmatic portfolio. Additionally, the newborn care component expanded to include neonatal resuscitation and specific attention was given to the provision of youth-friendly services. A comprehensive documentation and dissemination plan was developed and implemented to package and showcase the WIN/MCHI resources.

Beginning during WIN and continuing into MCHI, family planning was an essential core intervention. The specific reproductive health/family planning objectives of MCHI were to reduce the abortion rate, increase use of modern contraceptives to prevent unwanted pregnancies, and strengthen family planning services and capacity with a special focus on postpartum and post-abortion clients.

Additionally, as MCHI progressed, the opportunity developed to pursue MCHI's logical next step and to pilot the integration of family planning into primary health care services in selected rural areas.

## RESULTS

WIN/MCHI achieved significant results in replicating and institutionalizing the approach and interventions piloted initially by WIN, including the integration of family planning into the broad spectrum of maternal and infant care, especially postpartum and post-abortion services (see table 1). Integral to this success were the parallel and integrated improvements in both access to and demand for knowledge and services.

Both WIN and MCHI were designed with ambitious monitoring and evaluation (M&E) components—WIN especially so. Among other M&E activities, WIN conducted a baseline household population-based survey in 1999 and an endline survey in 2003. WIN also conducted baseline and endline surveys that captured the knowledge and reported practices of providers. Both WIN and MCHI conducted baseline and endline facility-based surveys that captured the experiences of clients.

The MCHI baseline surveys were conducted in 2004 and the endline surveys in 2006, a period of only two years. Unless otherwise indicated, the results shown below use data from the MCHI facility-based baseline and endline surveys that included 13 of the ultimate 16 MCHI regions. Because of the short time available to measure results, endline surveys were not done in three of the last regions to join MCHI (Khabarovsk Krai, Sakhalin Oblast, and Sakha Republic).

**Table 1. The 16 MCHI Regions**

| | |
|---|---|
| 1. | Perm Oblast (1999–WIN Region) |
| 2. | Velikiy Novgorod City in Novgorod Oblast (1999–WIN Region) |
| 3. | Barnaul City in Altai Krai (2003) |
| 4. | Irkutsk Oblast (2003) |
| 5. | Kaluga Oblast (2003) |
| 6. | Komi Republic (2003) |
| 7. | Krasnoyarsk City in Krasnoyarsk Krai (2003) |
| 8. | Murmansk Oblast (2003) |
| 9. | Omsk Oblast (2003) |
| 10. | Orenburg City in Orenburg Oblast (2003) |
| 11. | Tyumen Oblast (2003) |
| 12. | Vologda Oblast (2003) |
| 13. | Khabarovsk Krai (2004) |
| 14. | Primorsky Krai (2004) |
| 15. | Sakhalin Oblast (2005) |
| 16. | Sakha Republic (2005) |

## INCREASED ACCESS TO INTEGRATED FAMILY PLANNING SERVICES

MCHI began scaling up in 2003 by choosing 10 new regions to join the two original WIN regions. In 2004, MCHI added two additional regions and, in 2005, added another two, all in the Far East, bringing the total number of MCHI regions to 16. Table 1 shows the regions by name and the year they became part of WIN/MCHI. Figure 2 shows their geographic location within the expanse of the Russian Federation. The yellow region is Moscow, where the WIN/MCHI projects were headquartered; the pink regions are the two original WIN pilot regions; the orange regions are the first 10 MCHI regions; and the red regions are the four Far East regions added in 2004 and 2005.

**Figure 2. The MCHI Regions**


These 16 regions encompass 26 million people, or 18 percent of Russia's total population of 143 million.

In each region, WIN/MCHI worked with an urban-based set of related health care facilities that had the potential to reach a large number of women. In 10 of the regions, these facilities were a mix of region-level and municipal-level facilities; in the other six, the facilities were municipal-level only. Initially, the cluster of facilities included maternity hospitals, gynecological units, women's consultation clinics, family planning centers, and children's polyclinics. Over time, in response to Russia's growing HIV/AIDS epidemic, HIV/AIDS centers were added.

Ultimately, as shown in table 2, 198 facilities were directly involved in program activities related to family planning.

**Table 2. MCHI Participating Facilities**

| Type | Maternity | Gyn. Unit | Women's Consultation Clinic | Family Planning Center | Children's Polyclinic | HIV/ AIDS Center | Total |
|---|---|---|---|---|---|---|---|
| **Total** | 42 | 41 | 50 | 11 | 38 | 16 | 198 |

This is a radical change in scale compared to an average of only one to three facilities per region providing family planning counseling and/or services prior to WIN/MCHI. Anecdotally, many regions report plans and efforts underway to roll out the new services to encompass their entire regions. It has been estimated that, already, one region reaches more than 75 percent of its women of reproductive age, another six regions reach between 50 and 75 percent, and an additional six regions reach between 25 and 50 percent. Only three regions reach fewer than 25 percent. It is not known what percentage could be considered a *critical mass* after which roll-out would be assured, but the likelihood appears high, thus making the WIN/MCHI interventions even more institutionalized and sustainable. The program to date has been predominately urban-focused, but has created interest in, and favorable conditions for, expanding especially the family planning component into rural areas. In MCHI's final year, two regions—Tyumen Oblast and Vologda Oblast—began pilot programs targeting their rural areas.

**A Region's Story**

**At the time of the midterm evaluation, reporting on earlier visits to the participating facilities in his oblast:**
"I am truly amazed at what I've seen. We've gotten big changes at modest cost by investing in our human resources via your training."

**At the time of the MCHI final dissemination conference:**
"We have plans for the future whether or not the [MCHI] project continues. The project helped us train providers who can continue their work. Now we have a pool of trained experts, who will disseminate information to a wider group throughout the whole region. We will secure resources from regional and municipal budgets for this expansion." Head of the Health Department, Vologda Oblast

"MCHI has changed the very principles by which we provide care to women." Regional Coordinator, Vologda Oblast

## IMPROVED QUALITY OF FAMILY PLANNING SERVICES AND PRACTICES

The provision of quality family planning counseling and services was at the heart of the WIN/MCHI program design and implementation. Quality meant services provided by a trained provider following evidence-based protocols, informed choice through client-centered counseling and available relevant IEC materials, and access to a variety of modern contraceptive methods, within a system that monitors quality and makes adjustments as needed. Although key to all components, WIN/MCHI's explicit focus on the client was of paramount importance to the family planning component, given the crucial role of informed choice.

**Informed Choice**
…a voluntary, well-considered decision that an individual makes based on options, information, and understanding. The decision-making process should result in a free and informed decision by the individual about whether or not he or she desires to contracept and, if so, what method or procedure he or she will choose and consent to receive.

A key intended result was the integration of family planning counseling across the spectrum of maternal and infant care, especially into antenatal, postpartum, and post-abortion care services. Figure 3 and figure 4 show the positive changes in the percentage of clients receiving the new services and practices (all data presented here are from MCHI client surveys in 2004 and 2006).

**Figure 3. Percentage of Clients Who Report Discussing Contraception with Medical Staff**

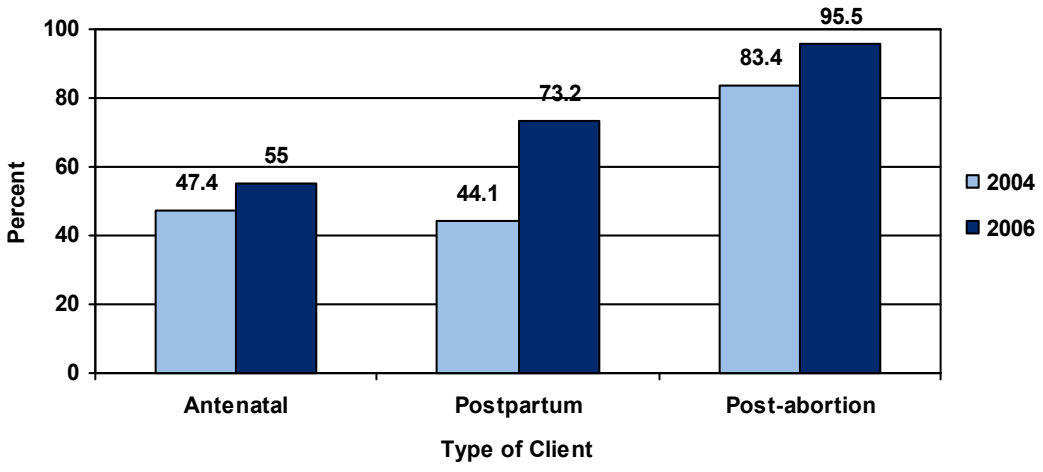
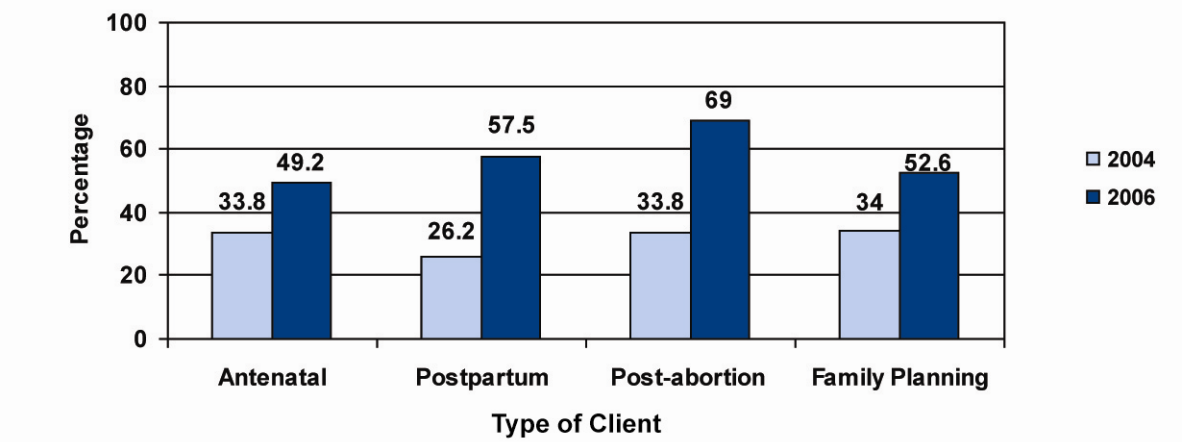
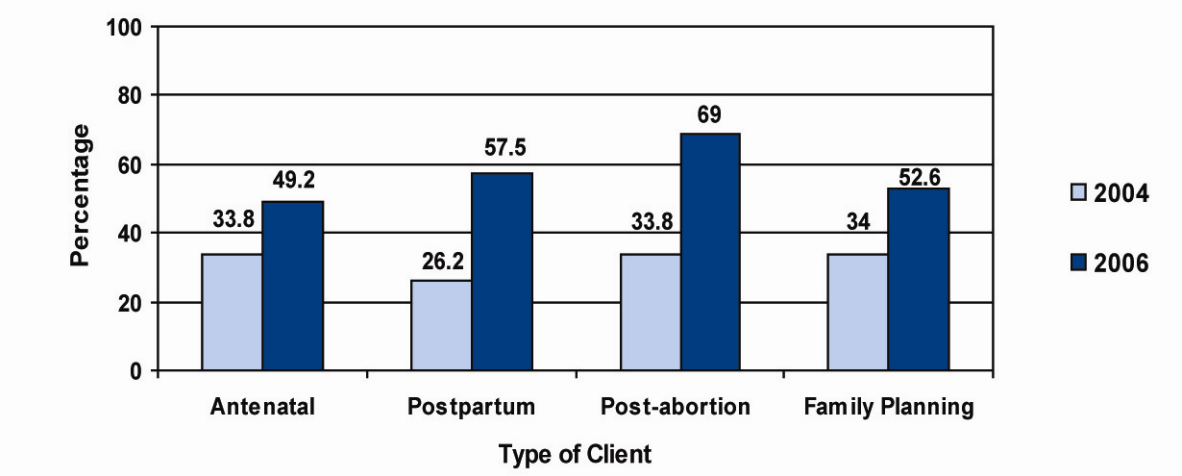


**Figure 4. Percentage of Clients Who Report Taking Away Educational Materials Related to Family Planning**




WIN/MCHI's client-centered approach aimed to reorient services based on client needs and preferences, with the level of client satisfaction a clear indicator of quality. Figure 5 shows the changes in the level of client satisfaction with various services.

**Figure 5. Percentage of Clients Who Would Recommend This Facility to a Friend**




## CHANGES IN CLIENT KNOWLEDGE AND BEHAVIORS

Client-oriented family planning counseling and services assumes the active involvement of clients in seeking information and services, making informed choices, and using their chosen methods consistently and correctly to avoid unwanted, unplanned, or mistimed pregnancies, which have a high likelihood of ending in abortion (see photo 2). WIN and MCHI both had ambitious IEC/BCC and training strategies to empower clients and help health professionals provide their clients with relevant counseling, information, and referrals.

Figure 6 and figure 7 suggest that planning one's family is becoming more the community norm and that consistent and correct method use is increasing.

**Client receives family planning counseling in Krasnoyarsk City. (2)**

**Figure 6. Percentage of Antenatal Clients Who Report Pregnancy Was Planned**

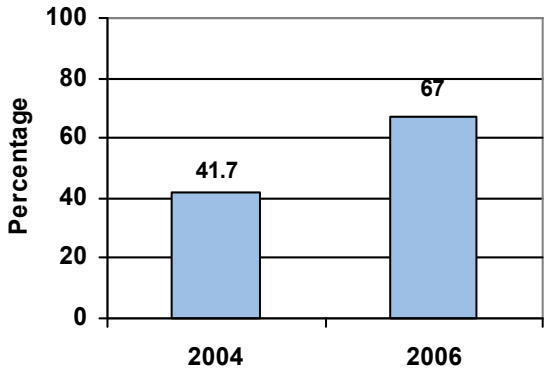
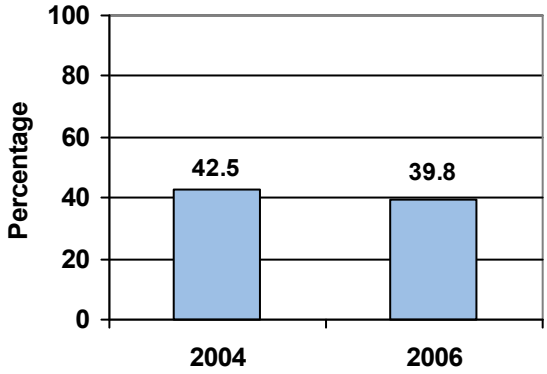
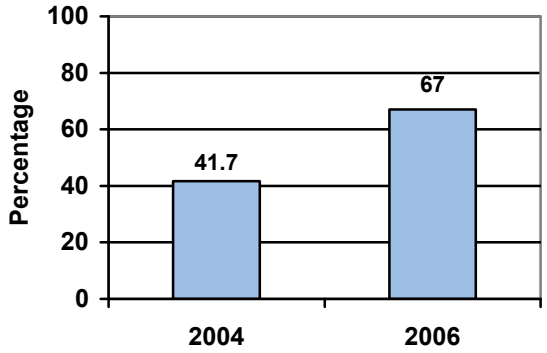



**Figure 7. Percentage of Abortion Clients Who Conceived While Using a Method**




An important aspect of post-abortion counseling is to increase clients' awareness of how quickly fertility returns and how soon after an abortion they are at risk of another unintended pregnancy. Figure 8 shows a considerable increase in post-abortion women knowing this important information.

**Figure 8. Percentage of Post-Abortion Women Who Knew Correct Timing of Return to Fertility**



## INCREASED USE OF FAMILY PLANNING/DECREASED USE OF ABORTIONS

Two years is not usually considered enough time to detect changes in indicators like CPR and abortion rates, which are also generally best measured using population-based surveys. Because of the almost revolutionary nature of the content and process of the original WIN interventions, WIN conducted baseline and endline population-based household surveys in the three urban areas where it worked. Because of the short period of time involved, MCHI did not continue these types of surveys.

In spite of the short period of time, the WIN population-based household surveys did show an increase in modern method use and a decrease in traditional method use (see table 3). Exposure to family planning messages was also higher in the endline household survey than in the baseline.

**Table 3. Changes in Contraceptive Prevalence Rate among Women in Union**

| | Using Modern Method | | Using Traditional Method | | Total Method Use | | Not Using Any Method | |
|---|---|---|---|---|---|---|---|---|
| | *1999 (%)* | *2003 (%)* | *1999 (%)* | *2003 (%)* | *1999 (%)* | *2003 (%)* | *1999 (%)* | *2003 (%)* |
| Perm Oblast: Perm City | 50 | 54 | 21 | 18 | 68 | 72 | 30 | 28 |
| Perm Oblast: Bereznicki | 48 | 57 | 20 | 13 | 68 | 70 | 32 | 29 |
| Novgorod Oblast: V. Novgorod | 52 | 63 | 22 | 16 | 74 | 79 | 27 | 22 |

Source: David, Patricia, and Natalia Vartapetova. 2003. *An Evaluation of the WIN Project: Evidence of Effectiveness*. Boston and Moscow: John Snow, Inc.

Results from the MCHI facility-based surveys, however, show encouraging increases in use and intent to use (see figure 9 and figure 10).

**Figure 9. Percentage of Clients of Reproductive Age Currently Using Modern Contraceptive Methods in Women's Consultation Clinics and Family Planning Centers**

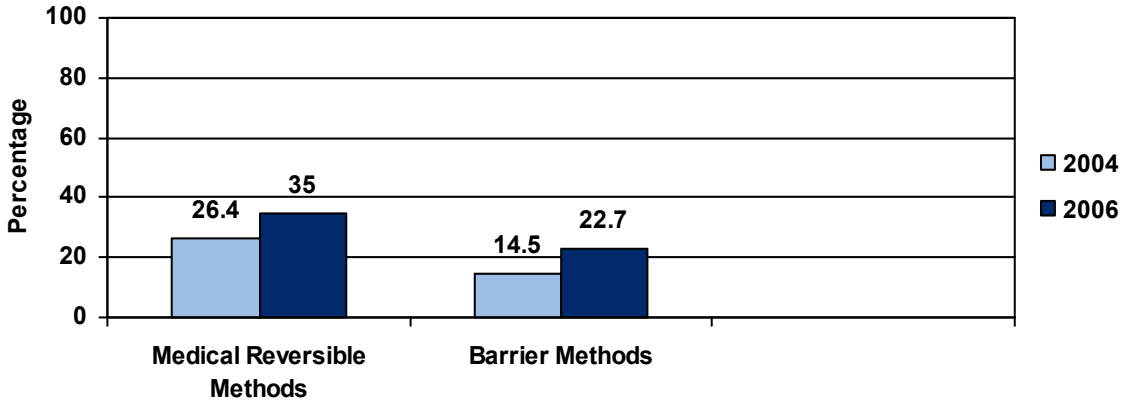
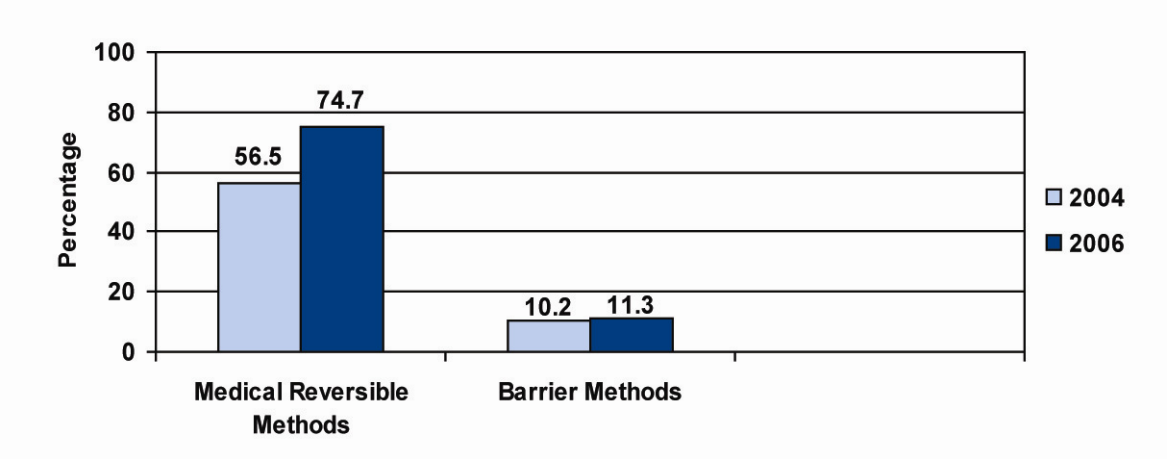
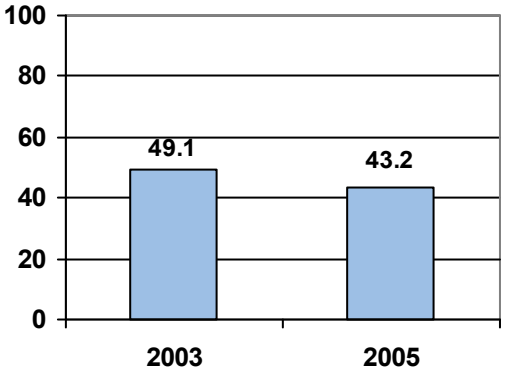


**Figure 10. Percentage of Abortion Clients Planning to Start Using a Modern Contraceptive Method**




The aggregate of official health statistics from the major urban areas of the first 14 WIN/MCHI regions (see figure 11) meanwhile suggests that abortion rates in the WIN/MCHI regions are decreasing.

**Figure 11. Number of Abortions per 1,000 Women of Reproductive Age (15–44) in Cities in Participating Regions (14 cities)**




The improvements in family planning counseling across a broad range of facilities, the wider access to improved services, and the provision of information through materials provided to facilities and clients, as well as through mass media campaigns, all support the conclusion that the WIN/MCHI activities have contributed to these documented changes.

**A Husband's Story**

"To prevent an unwanted pregnancy, my wife and I used withdrawal as a method of contraception," states Sergei Pavlov, a 25-year-old father of one child. "Neither of us liked this method and we found it to be ineffective. My wife had to have an abortion when it failed," he explained. Sergei and his wife had been married for five years and wanted to postpone having more children until they were financially stable.

Unwanted pregnancies resulting in abortions are common across Russia. Sergei and his wife, like many Russian couples, turned to abortion as a means of family planning because they were not familiar with modern methods of contraception. Family planning counseling was not included in the provision of medical or maternity services.

Sergei and his wife learned about MCHI's activities through a radio advertisement. After attending a class about family planning counseling for couples, they met privately with a doctor to learn about modern methods of contraception. "Now we've chosen an IUD as our method of contraception," says Sergei. "I am hopeful that my wife will never have to undergo an abortion again. Thank you for the counseling."

## STRATEGIC APPROACHES TO INTEGRATING FAMILY PLANNING

WIN/MCHI's goal was to introduce new evidence-based clinical practices into a historically inflexible health care system that was locked into largely outmoded practices, while meeting their strategic objectives and achieving demonstrable results. To do this, they used an approach that respected the existing Russian systems, structures, and professionals while, at the same time, provided training and education to ensure that the policymakers and providers could improve Russia's maternal and child health care. WIN/MCHI's implementation strategies focused on process as well as content; they included strategies that not only stressed evidence-based medicine but that also offered a total shift from focus on the provider to focus on the client. This paradigm shift transformed the way maternal and infant services were delivered.

The mandatory rules and guidelines for healthcare throughout Russia are communicated by the federal MOH through a system of ministerial orders, or *prikazes*. Because the prikazes are standardized throughout federal, regional, and local facilities, the health system does not readily allow innovations. Many prikazes have been in place for years. A health care facility can be officially punished for not following a prikaze. For many years, under the Soviet system, Russian medical science developed in isolation from the mainstream of international scientific information so that some Russian medical practices remained informed by a unique Russian approach or reflected Western standards of the 1950s and 1960s. In general, professional cultural norms in the Russian health care system have been governed by the absence of open discussion, a closed system of decision making, and a management culture that does not embrace a team approach or generally use data for decision making.

Traditionally, provider-client communications were poor with client satisfaction often ignored. Assumptions were made regarding the client's needs; decisions were made for the client; the client's input was not sought. As might be expected, given the prevailing impersonal style of provider/client relations, there was also a historical lack of research into client satisfaction.

Not surprisingly, foreign interventions that presented alternatives to accepted Russian practices often met resistance from Russian professionals. In this context, WIN initially and then MCHI were charged with providing a new evidence-based model for reproductive health care services and with increasing access to, demand for, and quality of these services, as well as with increasing the practice of preventive health behaviors among women in the community.

To do this, *WIN/MCHI chose strategies that not only stressed evidence-based medicine but that also offered a total paradigm shift from focus on the provider to focus on the client* as they worked with existing health care facilities and involved health care providers, administrators, and authorities in the planning, policymaking, hands-on training, and public education needed to achieve change.

From the beginning, there was no question that Russian physicians, nurses, midwives, and others wanted to provide the very best care they could; however, in addition to the natural human resistance to change, other factors also came into play:

- Providers needed to feel that their institutions would support them in offering the new services.
- Providers needed to know that clients were ready for the new services.
- Providers needed to see irrefutable evidence that the new practices were better than the ones they have used for years.
- The new services needed to be appropriate for implementation within the Russian system of health care, the individual facility, and the community.

### 1. ESTABLISH A SOUND POLICY CONTEXT AND A SHARED VISION

Throughout, WIN and MCHI both worked in close collaboration with the MOH of the Russian Federation and with the various oblast and municipal health departments. Initially, the MOH provided a vital endorsement—a Letter of Support to WIN. The letter stated that the MOH considered the participating facilities to be demonstration sites for future dissemination of a national strategy to improve MCH. This official recognition was crucial because many of the new clinical practices and administrative procedures that WIN/MCHI would introduce contradicted existing prikazes. WIN/MCHI worked continuously with the health administrations at facility, municipal, oblast, and federal levels to identify and resolve policy obstacles to program implementation and to develop and promote needed guidelines and protocols.

From the outset, gaining and securing political, organizational and financial support from regional and municipal health authorities became a fundamental condition to ensure success. This support was largely created during a multi-partner three-day Launch Conference held by WIN in 1999 that introduced key policymakers, administrators, academicians, and health care providers from the pilot regions to the concept of evidence-based international clinical standards. Presentations by Russian and international experts invited national, oblast, municipal, and facility-level health care professionals to explore applying the new clinical standards to their own maternal and child health care facilities. A similar launch conference in 2003 started the MCHI scale-up phase although, by then, many participants knew about and were eager to be part of the WIN/MCHI process. The launch conferences also united participants through a joint planning process that included development of regional work plans.

A set of working groups that introduced and incorporated the new concepts further expanded this strategy of inclusion. Technical working groups were established at various levels of policymaking, administration, and service provision that brought together professionals with different levels of authority, experience, and perspective; and they created an environment for exploring, implementing, and maintaining needed changes. Teamwork and coalition building were the principles guiding these working groups. For many Russian healthcare professionals at all levels, these concepts were new. The working groups provided a forum where participants learned about international health standards and could explore together the coming interventions and their roles in implementation. Technical Working Groups (TWGs) in each health care facility were responsible for maintaining program implementation through continued in-service trainings and by ensuring the continuous collection, analysis, and use of data by staff. The composition of the TWG was decided locally; MCHI did recommend including relevant heads of departments or their deputies and chief doctors or their deputies, as well as midwives, nurses, and representatives from the state sanitary and epidemiology commission.

In addition, each region had a Regional Coordinator selected by the region, often a deputy chief of the health care department and head of the department's maternal and child health unit; or each region had a chief specialist and a Regional Coordinating Team with representation from all participating facilities. Together the Regional Coordinator and the Regional Coordinating Team facilitated, supported, and supervised program activities at the regional and/or municipal levels. Importantly, a culture of open communication was promoted to spark discussions among the working groups and all stakeholders. Both WIN and MCHI also had national-level working groups that supported the regional innovations (many of which ran counter to existing MOH regulations), promoted and disseminated project results, conducted multiple site visits to monitor and support implementation, and continually reviewed progress to determine if program modifications were needed to better achieve desired outcomes.
These collaborative networks and this teamwork approach proved essential to program success by—

- encouraging communication and sharing among providers from different levels and facilities
- promoting collaboration between providers and health administrators
- ensuring shared ownership for innovations
- unifying services and information provided to clients.

### 2. BUILD IN A STRONG MONITORING AND EVALUATION PROCESS

From the beginning, planning for results was a key approach, with evaluation activities built into the program design, especially at the facility level. The challenge was to develop an innovative approach to the data collection, analysis, and decision-making process. Typically, a vast amount of data has been collected in Russian health care facilities, but the data were often not used for decision making. Moreover, if the resulting data were unfavorable, no recommendations and support for improvements were provided. Both WIN and MCHI had to address these pitfalls by developing an effective and responsive M&E system that—

- measured change in selected indicators of program effectiveness, outcomes, and impact
- monitored progress during the project in order to adjust project activities as necessary
- provided quantitative information on current practices and knowledge to guide interventions in the regions and *fine-tune* training programs
- provided a firm basis for policy discussions
- fostered ownership at all levels, especially the local level.

Because of the almost revolutionary nature of WIN's objectives and the keenly felt need to validate what WIN was attempting, a very ambitious M&E component was developed. WIN conducted a baseline household or population survey in 1999 and a similar endline survey in 2003. To support the shift to a more client-centered focus, WIN also conducted baseline and endline facility-based surveys of both providers and clients. The facility-based surveys for providers reflected the knowledge and reported practices of the average provider; the facility-based surveys for clients reflected the experiences of the average client in the entire network of participating facilities in any one region. (Data from the facility-based surveys cannot be disaggregated to the facility level because of sample size restrictions.)

A system to monitor key process and outcome indicators was also instituted in the participating health facilities, as well as at the municipal and oblast levels. This facility-monitoring system was a unique complement to the surveys with data being reported quarterly and separately for each participating facility.

A key lesson learned during the WIN project was that provider-derived data often differed from client-derived data, and that the client-derived data were the most useful and accurate in terms of assessing progress (or lack thereof). In response, MCHI decided to forgo the effort and expense of also surveying providers and—in what was a crucial move—shifted from internal measurement systems that focused on feedback from providers to systems that focused on feedback from clients. Also, whereas the population-based household surveys had been useful at the pilot stage, such surveys in the scale-up regions were not considered necessary.

The resulting system included pre-intervention/baseline and post-intervention/endline facility surveys, official health statistics, and follow-up (supervision) visits. The *facility-based survey for clients* measured a client's knowledge, attitudes, and experience with services before the planned interventions were introduced; they were measured again after the interventions had been implemented and became the best technical choice for evaluating real change in clinical practices and clients' responses to these changes (level of satisfaction, increased demand, better trust in providers, etc.). The surveys were performed by local staff under the supervision of local coordinators responsible for organizing data collection, data quality, data entry, and delivery of data to the MCHI M&E team. The MCHI M&E team provided guidance, technical and administrative support, training, and overall coordination, as well as data analysis and feedback on results.

Official *health statistics* were used to monitor service provision and health indicators in all target facilities. The Regional Coordinators collected statistical data (i.e., number of births, abortions, maternity care indicators, HIV prevalence, and MTCT data) annually at the facility, city, and regional levels.

*Follow-up* (supervision) visits were used to observe clinical practice changes, assess how the acquired knowledge and new techniques were applied in practice, help providers assess their own progress and facilitate continuous quality improvement, provide immediate technical support, and adjust program activities, if necessary. Data on policy changes in regions and facilities, the training process (number of trained staff, number of training events, training plans, knowledge of staff), and key implemented practices were collected during site visits. Data collection during these site visits used standardized supervision tools (forms and questionnaires) to record observations and responses of providers, as well as data retrieved from facility records. Collected information was used for immediate feedback and—if needed—assistance to the facilities and the Regional Coordinating Teams, and was also reported to the MCHI team for additional decisions on technical and administrative assistance.

A reporting system was developed to inform key stakeholders, including program and project managers, about the findings and observations for decision making and action. Thus, facility survey results were reported twice (baseline and endline reports), follow-up visits were reported quarterly, and health statistics reports were provided annually. In addition, information from these reports was actively used by regions and facilities to inform the professional community and the media about the progress and results of the program.

This innovative M&E system required training for all participating partners and individuals. To introduce the M&E system, MCHI conducted training on data collection and analysis, organization, and standard techniques of facility-based surveys and software use.

At times, Russian data proved more convincing to Russian professionals than data from abroad. For example, a cost-benefit study conducted by WIN demonstrated that the new practices that were key to providing family-centered maternity care resulted in significant financial savings to the participating facilities. Consequently, WIN/MCHI took advantage of opportunities whenever possible to disseminate locally generated Russia-specific data and results that supported the new, international evidence-based approaches. The built-in M&E system also generated *Russian* evidence that showed the effectiveness of the WIN/MCHI interventions. As WIN/MCHI continued, more Russian data became available that

demonstrated positive results and ultimately produced a unique set of Russian data that supported international data.

Developing and implementing an effective M&E system in each participating region enabled the programs to stay on track and achieve expected results. Such an M&E system with clear procedures, specific responsibilities assigned to designated individuals, and structural support as needed facilitated the process of data collection, evaluation, and decision making for further improvements. It also helped to set higher standards both formally in the planning process and informally in day-to-day interactions.

### 3. PROVIDE INTERNATIONAL STANDARD, EVIDENCE-BASED TRAINING

The effective introduction of the evidence-based practices planned first by WIN and then by MCHI required the development of training curricula (including new clinical guidelines) that used innovative training methodologies and the identification and development of a cadre of competent trainers.

**Effective Training Components**

- Evidence-based technical content
- Participatory training methods
- Adult learning approach
- Counseling skills
- Practical skills
- Follow up.

WIN/MCHI developed specific and explicit curricula for all its training activities—including M&E activities—often by adapting and updating existing courses created by the World Health Organization (WHO), United Nations Population Fund (UNFPA), United Nations Childrens' Fund (UNICEF), and other agencies; when needed, they also developed new training courses from scratch.

The process for the development and institutionalization of curricula, guidelines, and protocols was based on the concept of continuous quality improvement. By involving and fostering collaboration among providers, experts, and administrators, the guidelines and protocol development process and the curriculum development teamwork aimed to honor the experience and views of people who had been practicing *the Russian way* for a long time. The cooperation of facilities and health authorities in sanctioning providers' participation in these professional development activities helped convince the providers that the new approaches had institutional support.

The aim of the provider training was to increase evidence-based practices and reduce unnecessary medical interventions in providing antenatal, delivery, and neonatal care, and to improve postpartum and post-abortion contraceptive counseling and services. To ensure relevance and sustainability, the clinical guidelines and protocols that the training courses support are evidence-based, locally adapted, and supported and developed using MOH instructions and formats approved by MOH experts in the relevant topic area.

Most WIN/MCHI training took place on site in the participating facilities, which ensured that the training concurred with local realities while also fostering a sense of ownership and commitment to sustaining the new practices.

Utilizing basic principles of adult learning, the format of the training sessions was new to most health care providers. In addition to a new universe of skills, participants were introduced to new learning methods. Side by side with theory were opportunities to gain hands-on practice in clinical skills. Participants were given job aids and other materials to use in their facilities. Providers learned from the expert trainers, not only during formal training sessions, but also during follow-up site visits when the expert trainers worked with the providers to demonstrate practical techniques. The development of counseling and communication skills was incorporated into all training, not just training on family planning; this attention to counseling and communication played a huge role in improving provider/client relations, as well as provider/provider relations (see photo 3).

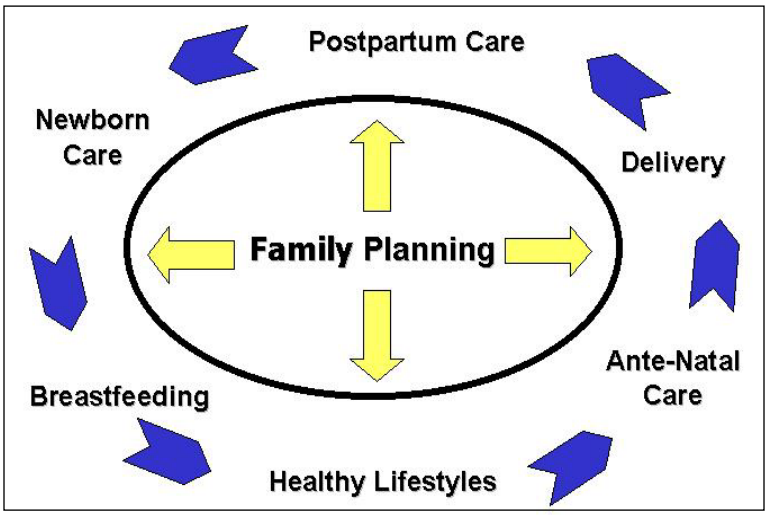
**Participants engage in group discussion at a Family-Centered Maternity Care Training Course in Perm City. (3)**

For those selected by the Regional Coordinating Teams to attend a WIN/MCHI course, the expectation was that they would be ready and willing to train others after completing the course. In many other health projects, this *cascade* training approach has been problematic, but here it worked quite well.

First, attendees were chosen in part based on their interest and willingness to share their experiences with others; this readiness to train others was an explicit criterion for selection. Secondly, most if not all MCHI courses included counseling and communication components.

The training provided using the core family planning curriculum was strengthened and complimented by also integrating family planning into other maternal and child health training courses. Training in healthy lifestyles, antenatal care, FCMC, postpartum care, newborn care, and breastfeeding all included relevant family planning components (see figure 12). This integration into the whole spectrum of training reemphasized the *horizontal* role of family planning in comprehensive reproductive health care while enhancing provider knowledge and skills.

**Figure 12. Family Planning as an Integral Component of the Whole Maternal and Child Health Care Spectrum**



A key concept in the WIN/ MCHI training approach was that training needs to be reinforced; consequently, follow-up visits were a key component of all training. To ensure correct implementation and sustainability of the new practices, post-training supervision visits were carried out by both Russian and international experts. At each visit, the entire range of WIN/MCHI-promoted services and practices were reviewed. These visits were not inspection visits. Rather, the role of the expert was to support collegial collaboration and knowledge transfer and provide on-site updates as needed. Follow-up visits always concluded with a meeting of the facility TWG and staff to discuss successes, challenges, and recommendations. Visiting experts also met with municipal and oblast officials to inform them of any recommendations.

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

Early on, WIN/MCHI recognized that Russian professionals tended to trust Russian clinical experts more than their counterparts from Europe and the United States. Certainly, foreign consultants internationally recognized by WHO and other respected professional organizations were easily involved as needed; however, as much as possible, Russian consultants—especially those previously trained in WRHP, WHO, UNICEF, and other international projects or who had been trained abroad—were engaged to present and support the new interventions. Initially these professionals were invited to be co-trainers or facilitators alongside the foreign consultants to refresh their knowledge base and match their skills to the needs of the program; they then became master trainers and course directors. As training progressed, the training process itself generated more potential trainers. These promising local providers were given additional training in evidence-based content and state-of-the-art adult education and training methodologies; they were often involved in curriculum development activities as well. Over time, WIN/MCHI nurtured the development of a very competent cadre of Russian master trainers and skilled local trainers prepared and able to transfer their knowledge to peers (see photo 4).

**Family planning training course in Tyumen on how to counsel clients and how to demonstrate the use of a condom. (4)**

Having been a key core WIN intervention when MCHI began scaling up, the focus of the very first training courses offered to the new regions was on family planning and the creation of a small group of local trainers for each region. Routine MCHI follow-up visits and a comprehensive midterm evaluation to review progress to date conducted in March/April 2005 found that MCHI had indeed placed needed emphasis on family planning, doing much to *horizontalize* and broadly integrate family planning services into maternal and child health care. The conclusion was that, given these efforts, it would be worth the time and resources to further reinforce these gains. Family planning was the *oldest* component of the WIN/MCHI project and consequently its existing curriculum was the oldest and needed refreshing.

A key component in informed choice is recognizing that women and couples have very different reproductive and contraceptive needs at different points in their life cycles and that no single method available today is likely to meet all those changing needs. Consequently, there is a great need for accurate information and supportive counseling at multiple life points; whether a couple wants to delay a first

birth, space a subsequent birth, or limit childbearing altogether will greatly affect the ultimate choices they make. With this in mind, a Family Planning Curriculum and Materials Working Group was formed to review and update curricular content to reflect the latest evidence-based standards. Recognizing that counseling skills needed continuous reinforcement, the content was structured with the counseling process as the organizational backbone of the course. Particular attention was given to the rationale for adopting evidence-based best practices and to the use of the *WHO Medical Eligibility Criteria for Contraceptive Use.* Attention was also given to the importance of informed choice, the health and human rights aspects of family planning, and family planning's key role within the *healthy lifestyle* concept. Additional information and materials were added on sexually transmitted infections (STIs), HIV/AIDS, and PMTCT, as well as an increased emphasis on emergency contraception. Provider bias and common misinterpretations and/or misunderstandings were addressed. Attention was also given to how providers can use mass media messages and available client materials to reinforce their counseling (see figure 13).

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

**Figure 13. Poster from Family Planning Mass Media Campaign**


To be as much like other MCHI curricula as possible, the curricular format was also updated with a comprehensive trainers' manual as well as a comprehensive participants' manual that included copies of all materials and slides used in presentations. The family planning training courses were deliberately designed to be user-friendly and accessible to newer trainers who might not be as experienced as the WIN/MCHI master trainers. A complete set of method-specific counseling cue cards was developed to complement the already existing method-specific flipchart.

### 4. DESIGN SUPPORTIVE/COMPLEMENTARY IEC/BCC MATERIALS AND ACTIVITIES

A major WIN/MCHI objective was to increase demand for the new services as well as to encourage good preventive health behaviors in the community. Effective, client-friendly, high-quality services will be used by people in need of such services only if the population is aware of these services, understands how they could benefit from these services, can afford them, and knows when and where to find them.

**Effective Components of IEC/BCC**

- Dissemination of materials
- Collaboration with mass media
- Facility-based initiatives
- Special events.

Qualitative research on the knowledge, attitudes, and practices of clients regarding their reproductive health needs and how they prepared for childbirth, spaced children, and prevented unwanted pregnancies was used to inform the design and implementation of a creative, effective, and appropriate IEC/BCC strategy. WIN/MCHI produced and disseminated appropriate health messages to inform and educate the population and also developed and produced materials and media for use within participating facilities. This multi-channeled approach used posters, flipcharts, booklets, brochures, television and radio spots, the Internet, and advocacy events.

Information dissemination also played an important role in nurturing the policy environment. In addition to public media campaigns, an effort was made to continuously engage policymakers' and professionals' interest in evidence-based clinical practices by sharing results as they became available. Conferences, presentations, and publications helped to disseminate results and spark dialogues that led to policy changes. These activities—both within Russia and internationally—provided an ongoing educational forum for national and local-level health professionals and policymakers.

The concepts of behavior change communication and strategic design, as well as tools like qualitative research and pretesting—the core of modern social marketing—were all relatively new to Russia. WIN/MCHI provided a variety of seminars and workshops on IEC/BCC skills and community mobilization to build the capacity of regions, facilities, and providers to design and implement strategic communication activities.

The regions and participating facilities played a critical role in IEC/BCC implementation. They did not simply respond to what WIN/MCHI provided; they also became innovators and activists in the area of health promotion and public education by trying creative approaches and investing resources.

"We have a system and team in the city, but each facility contributed something new and unique. Facility staff created a positive environment by changing wall colors, hanging privacy curtains in changing rooms, and using all available media to disseminate information—TV, audio, posters. One by one, many different forms and questionnaires were developed and we made a suggestion box for clients' feedback near the registration desk. This approach made a huge difference in creating a welcoming environment." *Director, Health Department, Krasnoyarsk City*

Many regions successfully involved mass media in creating and disseminating family planning and other reproductive health messages across different population groups. Local television channels and radio stations aired multiple programs (talk shows, roundtables, interviews, etc.) on the WIN/MCHI interventions and activities, including modern methods of contraception and the importance of family planning. Some facilities also developed their own video materials for clients to view while waiting in the clinics or during their postpartum stay (see photo 5).

In addition to their role in creating demand for services, the development and wide dissemination of IEC/BCC materials on family planning particularly is vital for several specific reasons: first, the key need to support and ensure informed choice; and second, correct IEC/BCC materials, can effectively address the stigmas, misconceptions, and myths that universally plague the subject of family planning.

Although Russia's overall CPR appears to be high, modern method use has been relatively low. A high percentage of pregnancies are unwanted, unplanned,

**Classes for pregnant women, Krasnoyarsk City. (5)**

or mistimed; the majority of which end in abortion. In qualitative research that WIN used to shape its family planning campaign, frequent method switching was identified as a concern. Women described their method of choosing a contraceptive as *trial and error* and many noted "it never occurred to them" to seek professional advice before choosing a method. WIN concluded that the relatively low rate of modern method use and frequent method switching suggested in part a need for comprehensive information as well as a need for strengthened counseling relationships between clients and providers.

In response, a two-phase communication campaign was designed to help women shift from their reliance on traditional methods (which have a high failure rate and often lead to abortion) to more reliable modern methods, using messages in the media, print materials, community events, and counseling aids for health providers The campaign was tied into training and capacity building activities in facilities that increased the providers' ability to give quality counseling on family planning issues.

One of the cultural challenges that WIN/MCHI had to face was that, in Russian society as in many societies, open discussion of sexuality is considered inappropriate. Russian men, especially, are embarrassed to talk about family planning or sex with their partners, or with service providers who work in this area. The commonly held belief is that women are responsible for contraception, a belief often reinforced by health care professionals.

Increasing access to reproductive health information and services for men was an explicit MCHI objective. To increase male involvement, an innovative multi-media "Couples Campaign" (implemented by the USAID-funded Healthy Russia 2020 program) was designed to change male attitudes and behaviors related to family planning by emphasizing mutual care for partners, including the risk for STIs and HIV, and the importance of communication about reproductive health issues between couples (see photo 6). Two key messages were formulated:

- Male reproductive health is as important as female reproductive health.
- Both a man and a woman are equally responsible for their family and its health.

The campaign included radio and TV spots and talk shows, print materials for men and women, booklets for service providers, magazine and newspaper articles, and advocacy events (see photo 7). The MCHI regions also received training in utilizing and supporting campaign events and materials.

Various community events also proved to be effective and low-cost outreach methods for promoting family planning. Regions organized health-related *festival* events like a *family day* or a *healthy day*. For example, one such event with performances and competitions was organized in one of the villages of Vologda Oblast. The organizers set up kiosks to disseminate information materials about family planning to the several hundred people who attended the festival.

**Couple in Krasnoyarsk City being counseled on family planning. (6)**


**Interview and Hotline on HIV/AIDS prevention and PMTCT with the head of MCHI at the local TV channel in Irkutsk Oblast. (7)**

In general, IEC/BCC remains an innovative area for the entire health sector in Russia. Regional experiences suggest that integration with the public information service of the local government, establishment of a health sector-specific public information service, and collaboration with multi-sectoral public education initiatives are effective ways of promoting health issues, including family planning.

One other factor was important to the success of the IEC approach: the broad involvement of reproductive health professionals from different levels. Their participation was essential in developing consistent and uniform messages and resulted in strengthening public education skills across the reproductive health community.

### 5. DEVELOP A SOUND PLAN FOR SCALING UP

In close collaboration with national and regional experts, MCHI's first major task was to outline an explicit strategy for scaling up and implementing WIN's key core interventions in additional regions by building on the achievements and lessons learned during the preceding WIN project. Given the Russian Federation's geographic size and decentralized nature, it was assumed from the beginning that scaling up would be a multi-step process.

As the pilot phase of WIN had progressed, the importance of local team building, multidisciplinary discussions, and securing the support of health authorities at the national, oblast, city, and facility levels became increasingly evident. One of the lessons learned during the WIN project was that the various pilot sites/regions showed uneven commitment and insufficient support from key decision makers at the regional level; this was thought to be due to the manner in which the pilot sites had been chosen.

In response, a working group that included the MCHI team, representatives from the WIN pilot regions, local experts, and others who knew the existing challenges in the regions was formed. This working group concluded that a competitive selection process could help ensure that participating regions would demonstrate the commitment and determination needed to make the expansion succeed.

Next, the working group developed site selection criteria and a scoring system for evaluating regions (see table 4). The criteria were structured and weighted by priority and reflected a comprehensive set of requirements that the working group felt would be likely determinants of program success.

**Table 4. Selection Criteria and Scoring System for Evaluating Regions**

| Selection Criteria for MCHI Sites | Scores |
|---|---|
| • Supportive environment among health administrative leadership and policymakers (a written document to be submitted) | **12** |
| • Existence of own resources such as—<br>− have a way to communicate (telephone, email, Internet, fax)<br>− guaranteed salaries for the time facility representatives participate in training events<br>− can provide partial reimbursement of transport and trip expenses for the region representatives<br>− can provide spaces to conduct seminars and meetings. | **12**<br>**3**<br>**3**<br>**3**<br>**3** |
| • Existence of facilities in urban areas with potential to reach large population groups and who wish to collaborate with the project; ability to provide continuity between Maternities, Women's Consultations, Family Planning Centers, and Children's Polyclinics | **11** |
| • Existence of a preliminary plan (with a description of key trends in work, noting the priorities) to participate in the project | **10** |
| • Experience implementing new practices; existence of new orders, recommendations, and publications, corresponding to modern international standards | **9** |
| • Existence of a Statistical Analytical Center/Group to provide data collection and monitoring within the framework of the project | **8** |

**Table 4. Selection Criteria and Scoring System for Evaluating Regions (continued)**

| Selection Criteria for MCHI Sites | Scores |
|---|---|
| • Existence of other organizations to assist with leveraging resources or funds for sustainability | **7** |
| • Experience working with mass media | **6** |
| • Existence of a medical school in region (and supportive environment within) | **5** |
| • Support from professional societies (a written document to be submitted) | **4** |
| • Experience working with international projects and donors | **4** |
| • Opportunity for collaboration and coordination with other current programs | **3** |
| • Data on key demographic and health indicators: population density, birth rate, mortality, infant mortality, perinatal mortality, neonatal mortality, maternal mortality/per 100,000 live births, absolute abortion number, abortion rate/per 1,000 women of fertile age for the period of 2000–2002.<br>• Data on HIV/AIDS prevalence | **Yes/No** |
| • Data on economic development level of the region | **Yes/No** |

To select sites, MCHI coordinated planning among multiple partners and groups: the Federal Ministry of Health and Social Development, USAID/Russia, the MCHI Technical Advisory Committee, and others. Final selections were made using the agreed-upon criteria in table 4 to evaluate the strengths and weaknesses of the applications from the regions. Out of Russian's 89 regions, 39 initially applied and 10 were selected. Later, in 2004 and 2005, four additional regions in the Far East were added, which together with the original two WIN regions made a total of 16 MCHI regions.

## 6. PLAN FOR DISSEMINATION AND REPLICATION FROM THE BEGINNING

Part of the original WIN strategy was the creation of a model and resources for replication. The successes of WIN/MCHI have been aided substantially by their concerted efforts to constantly document and disseminate results and best practices in multiple ways. They have done this through the—

- ongoing training of health care providers and the ongoing involvement of the health administrations at facility, municipal, oblast, and federal levels
- use of multiple media channels
- inclusion of faculty members from regional medical schools in all aspects of project implementation
- publication of articles in peer review and other professional journals in Russia and abroad
- active participation of WIN/MCHI and regional representatives in Russian and international conferences
- open welcoming of visits to participating facilities by medical professionals from other Russian regions and other countries
- sponsoring of inclusive WIN/MCHI launch and dissemination conferences

**Comprehensive Replication Packages**

- Family planning/reproductive health/HIV/AIDS prevention
- Family-centered maternity care/PMTCT
- Breastfeeding/baby-friendly initiative/HIV/AIDS prevention
- Newborn care and breastfeeding/PMTCT
- Neonatal resuscitation
- Infection/HIV control in maternities
- antenatal/PMTCT
- Youth-friendly services/HIV prevention.

- development of the WIN Replication Guide: *A Guide to Implementing Effective Health Care for Women and Infants*
- creation of multiple replication packages
- use of the Internet.

Although not in MCHI's original scope of work, MCHI came to see the additional opportunities for replication and dissemination that the Internet could provide and, in response, added a website to its objectives. The MCHI website was launched in January 2006 in Russian and English as www.jsi.ru. The website enables anyone—from Russia, the Eastern European/Eurasia (EE/EA) region, and the rest of the world—to download complete sets of replication packages for the various components, training materials, communications materials, plans, and success stories.

#### Final Dissemination Conference

A three-day MCHI Final Dissemination Conference was conducted in mid-May 2006 with more than 30 Russian regions represented among the more than 300 participants. Additional participants came from a range of EE/EA countries including Albania, Georgia, Kazakhstan, Romania, and Ukraine, as well as from various international donor organizations. During the first two days of the conference, regional representatives presented their results and achievements in the various WIN/MCHI component areas; the session on PMTCT also constituted part of the concurrently held Eastern European and Central Asian HIV/AIDS Conference. During the breaks, the regions presented displays that highlighted their implementation experiences and showcased materials developed and used by each region. The third day of the conference was devoted to master classes on the key components, with the family planning master class highlighting the new family planning curriculum.

#### Creating a Legacy Organization

From its inception, it was MCHI's intent that a *legacy* Russian organization would be identified that would partner with MCHI to implement the current scope of work and that would then be able to continue similar replication efforts after MCHI ended. After due consideration, MCHI chose the Russian Society of Obstetricians/Gynecologists (RSOG), a non-commercial professional membership organization and a registered nongovernmental organization (NGO), as their prime Russian partner. As MCHI progressed, it became clear that working with RSOG had led to a broader dissemination of MCHI innovations through professional channels than working solely through the MOH. However, while RSOG was a very appropriate and worthy partner for current efforts, RSOG would not be able to continue or expand the scale up unaided. Providing the level and extent of the capacity building that RSOG would need to allow them to continue MCHI-type interventions was beyond the resources (time, human, financial) of MCHI, nor could RSOG absorb such intense capacity building efforts, even if available.

Concurrently and spontaneously, the MCHI staff—all of whom were Russian nationals—began discussing the possibility of them becoming the *legacy organization*. Staff turnover had been minimal and most had been together since WIN's beginning. As a team and individually, they were well-recognized and well-respected throughout Russia as change agents for client-centered, evidence-based MCH.

With full support from JSI, the MCHI staff registered as an indigenous Russian NGO to be called the Institute for Family Health (IFH). While IFH was being registered, the Russian Federation's Federal Service for Surveillance in Consumer Rights Protection and Human Welfare organized an open national competition to implement their National Health Project in HIV/AIDS, including PMTCT; MCHI was invited to bid. MCHI partnered with Russia's oldest and largest national medical education institution, the Sechenov Moscow Medical Academy, to prepare a proposal. In March 2006, the pair was awarded the 20 million rubles (U.S.$800,000) grant to improve PMTCT and family planning practices among HIV-positive women in 15 regions (a group that did not include the Far East regions) and disseminate the national PMTCT Guidelines developed by MCHI.

Once registered, the Institute for Family Health then submitted two concept papers and a proposal to USAID/Russia. All three were awarded to IFH as part of a three-year U.S.$7.5 million (187.5 million roubles) co-operative agreement called Maternal Child Health Initiative II. In addition to expanding the work carried out under the original MCHI contract, MCHI II will also extend the work done for the Federal Service for Surveillance in Consumer Rights Protection and Human Welfare's National Health Project in HIV/ AIDS to two key Far East regions—Irkutsk Oblast and Primorsky Krai. The third component of MCHI II is particularly interesting, as it involves significant matching funds from the local government partner. Omsk Oblast will provide 150 million rubles (U.S.$6 million) working with IFH to essentially roll out the MCHI interventions throughout the entire Oblast.

IFH has also submitted other proposals to other donors, which are pending, and anticipates that there will be further tenders offered for bid by the Government of the Russian Federation. IFH intends to bid on these tenders as well as seek opportunities for funding for additional reproductive health projects from a variety of donor sources (e.g., the European Union, WHO, UNICEF, UNAIDS). IFH expects to submit four to six proposals per year and configure its staffing accordingly for effective program implementation and management of funding sources. Currently, IFH is developing a marketing strategy to disseminate its capabilities to a wide range of potential donors.

## 7. CONTINUE TO INNOVATE AND ANTICIPATE NEXT STEPS

In keeping with WIN's original innovative design and intent, WIN/MCHI regularly monitored the implementation progress. They also remained sensitive to changing external realities in order to adapt to changing needs and to respond proactively.

### Addressing Family Planning for HIV-positive Women//PMTCT

In response to the increasing prevalence of HIV/AIDS in Russia, MCHI began incorporating PMTCT into its scope of work. The first step was to begin integrating HIV/AIDS and PMTCT information into the MCHI training materials and to include the HIV/AIDS centers in the network of participating facilities. MCHI served as the coordinator for the development of clinical/organizational PMTCT guidelines that have now received official approval from the MOH and have been widely disseminated.

To better understand the challenges related to family planning and PMTCT among HIV-positive women, MCHI increasingly recognized the need to know more about (1) family planning method use among HIV-positive women, and (2) existing PMTCT practices. To develop evidence-based strategies for improving the quality of family planning and PMTCT services for HIV-positive women, additional Russia-specific data-based information was needed. A study to collect the data was designed and carried out. The objectives were to collect quantitative information on (1) the awareness of family planning options among HIV-positive women who recently delivered or had an abortion; (2) the use of modern contraceptive methods by HIV-positive women; (3) the involvement of HIV-positive women's partners in making decisions about family planning issues; (4) health care workers' counseling of HIV-positive women on family planning; (5) HIV testing practices; and (6) PMTCT practices in the antepartum, peri-partum, and postpartum periods. The study also looked at social and demographic factors and the prevalence of STIs and other risk factors. Additionally, the prevalence of stigma and discrimination by health care workers of HIV-positive women was investigated, as well as the HIV-positive women's level of satisfaction with the health care provided to them. Based on the analysis of the data collected, a set of Reproductive Health Guidelines for HIV-positive Women was developed.

### Expanding Family Planning into Rural Areas

The WIN/MCHI interventions by design were urban-focused and facility-based. However, for the participating regions, their long-term intent would be for their entire population to have access to the new services. In MCHI's final year, MCHI began working on a pilot with two regions—Tyumen Oblast and Vologda Oblast—to roll out family planning services to rural areas by integrating family planning into the primary health care system.

The rural pilot started with joint assessment and planning meetings in each region. The next step was to use relevant, successful rural models in other post-Soviet countries as motivation and inspiration. Consequently, representatives from Tyumen and Vologda Oblasts—rural administrators as well as health providers—participated in a study tour to Romania to visit the Romanian Family Health Initiative (RFHI). The participants discussed firsthand the challenges and opportunities encountered during the planning and implementation of their very successful nationwide project that was designed to bring family planning services to Romania's rural areas. The Russian delegation was able to become acquainted firsthand with the complete array of RFHI activities and they learned from peers what worked and what didn't work.

When the new family planning curriculum was launched through a training-of-trainers (TOT) in January 2006, teams from Vologda and Tyumen Oblasts made up the majority of the prospective trainers to ensure that these regions would have the increased training capacity they would need.

Again, the need for additional Russia-specific data was recognized; in fact, the lack of relevant rural data on which to base an implementation strategy was striking. In response, MCHI helped arrange for a locally conducted population-based household survey (including a male component) in Vologda Oblast similar to those conducted during the WIN project.

# WHAT WE LEARNED

## STRATEGIC APPROACHES AND RECOMMENDATIONS

### Use Pilots to Demonstrate Results and Build Support

The pilot phase—WIN—was essential for testing approaches, building evidence for what works, and gaining the trust and confidence of both the program partners and the providers who participated in the program. It also allowed for the development and refinement of key tools: curricula, a solid M&E system, a cadre of expert trainers, and IEC/BCC materials.

The subsequent successful scale up in multiple stages from 2003 to 2006 during MCHI (initially in 10 regions, then in two additional Far East regions, then in two more additional Far East regions) resulted in large part from the demand that was created and the lessons learned during the implementation of the WIN pilot phase in the two initial regions from 1999 to 2003.

### Integrate Family Planning into the Broader Maternal and Child Health Context

Horizontalizing family planning across the continuum of comprehensive maternal and infant care helps to make it everyone's responsibility and supports family planning as a public health and community norm—it becomes the concern of everyone, not just the *niche* concern of a few. While usually sensible in any country, this approach was particularly appropriate in Russia where family planning has been and will continue to be a sensitive political issue. Also, because family planning is not a *new* topic compared with other components, it initially lacked interest from service providers and was not uniformly understood and supported at many levels. In fact, *selling* family planning by itself would have been very difficult. As part of a broader effort to improve a whole spectrum of maternal and child health practices, family planning was more easily recognized as a key component that merited strengthening; the regions applying for inclusion in MCHI were attracted by the opportunity to address the whole set of maternal and child health services, including family planning.

"The project has shown that we can implement any program. There is no way back as we ourselves have changed." *Chief Physician, Maternity Hospital #2, Krasnoyarsk City at MCHI's Final Dissemination Conference*

Integrating family planning also increases the opportunities to reach different groups of potential clients at different points in their reproductive lives. This multi-opportunity approach helps ensure access to appropriate family planning services within the health care delivery network and enhances continuity of care. The WIN/MCHI dual emphasis on consistent

messages and integrated services helped to avert misunderstandings while expanding the availability of counseling and services.

#### Focus on Process as Well as Content

The WIN/MCHI process (participatory, interactive, kind, respectful) was as important as the content. Much of WIN/MCHI's success and sustainability was due to keeping the goals and objectives closely aligned not only with the health care needs, but also with the traditions, resources, and realities of the existing Russian maternal and child health care system. Throughout, explicit efforts were made to carry out implementation in a participatory, transparent, low-hierarchical manner. In effect, an effort was made to model with the regions the client-centered, mother-friendly, baby-friendly, youth-friendly, family-friendly approach that WIN/MCHI was striving to introduce into Russia's reproductive health services. The training component especially modeled this approach. The participatory, interactive training techniques were widely appreciated as was the interdisciplinary approach modeled by the composition of the trainers, as well as by the mix of participants in the courses. Course participants described the trainers as being kind, respectful, interactive, energetic, professional, and accessible—welcome compliments given the effort that both WIN and MCHI devoted to developing a strong cadre of all-Russian trainers.

In terms of content, the evidence-based approach became a credo; it supported the health care professionals in their roles as change agents as they introduced and implemented evidence-based practices. At the regional level, this dual focus on both process and content was very empowering and contributed substantially to the high degree of capacity building that occurred.

#### Shift the Paradigm to Focus on the Client

The paradigm shift from focus on the provider to focus on the client changed the way services were delivered. It encouraged greater trust between clients and providers, and resulted in a deeper understanding on the part of both providers and clients of what constituted high-quality services. In addition to the baseline and endline facility-based client surveys, many participating facilities introduced more frequent survey mechanisms to monitor client satisfaction, needs, expectations, etc.

#### Use an Innovative Selection Process for Scale Up

The selection process and criteria (incorporating an element of self-selection that promoted commitment and built in readiness) worked extremely well and were key contributors to the robustness of the WIN/MCHI interventions. Selecting regions based on specific criteria ensured that regions with strong leadership and the willingness and motivation to change and implement innovative practices were chosen. These regions have become champions and are models for other regions; they are sources of indigenous evidence that the range of evidence-based interventions that WIN/MCHI introduced, including family planning, can have positive health and social impact.

The competitive element was innovative and positive. The competitive selection of replication regions led to partnering with regions that demonstrated political commitment, motivation to succeed, and an ability to change. Requiring letters of support from municipal and regional authorities and from the regional RSOG branch helped instill a broad sense of ownership from the beginning. The requirement that the facilities chosen be an interrelated set of maternities, women's consultation clinics, children's polyclinics, family planning centers, and HIV/AIDS center helped to horizontalize previously vertical institutions and standardize the content and continuity of care.

The modest co-financing requirement turned out to be unexpectedly motivating. In many ways, the WIN/ MCHI approach and content was, for Russia, an idea whose time had come. The health professionals involved seemed to know instinctively that their existing approach needed rethinking. The MCHI *process* (participatory, interactive, kind, respectful, and evidence-based) provided the needed forum while the integrated programmatic *content* provided the major messages that Russian counterparts were waiting to hear. For most of WIN and MCHI, Russia was steadily growing economically, and the WIN/ MCHI

interventions were able to attract financial support to support the enthusiasm of the regional and municipal teams. As a result, the regional-, municipal-, and facility-level contributions (financially and in-kind) were far in excess of what was initially expected. Leveraging was substantial and was a clear manifestation of the outstanding support that WIN/MCHI received at every level. Leveraged resources allowed regions to more rapidly and thoroughly implement the WIN/MCHI practices and helped establish a strong sense of ownership.

#### Define Stakeholders Broadly and Keep Them Actively Involved

WIN/MCHI basically created a community of change agents. The active involvement of a variety of stakeholders—health officials, policymakers responsible for decision making and resource allocation, and experts and providers from all levels of the health system—was cultivated from the very beginning. This helped establish full ownership for the innovative changes being introduced and helped motivate many to work towards the expansion and sustainability of the program.

Especially during the pilot phase, emphasis was placed on short-term results. Making positive trends and successful results visible was essential for retaining the support of key decision makers and partners. Short-term wins can build a momentum to convert neutral parties into supporters and reluctant supporters into active implementers.

Working groups at the national, regional, and facility levels played a critical part in the participatory decision making and implementation, particularly because they promoted leadership by stakeholders with various degrees of authority and areas of expertise. Many of these working groups evolved into regular, self-sustaining teams that guide and monitor program activities.

It is crucial to get the right people who are ready to lead, change, and work in teams. The competitive site selection process helped considerably in this regard. During meetings, trainings, and program activities, WIN/MCHI sought out and identified opportunities to build relationships and help form strong teams—formally and informally—at all levels of program implementation.

#### Learn from Others—Reach Out While Also Sharing

Building on the successes of WIN and adapting additional materials from CDC, WHO, UNFPA, and UNICEF enabled MCHI to promote evidence-based interventions more rapidly and more efficiently. Selectively using international content and training experts at the beginning allowed the ultimate development of the desired cohort of Russian expert trainers.

The exchange of knowledge and experiences between peers from different regions greatly contributed to replication success by building new contacts and relationships and developing networks within the health community across Russia (see photo 8).

**Doctors demonstrate the MCHI IEC materials for medical providers and clients at a follow-up visit, Women's Consultation Center, Krasnoyarsk City. (8)**

Sharing results and challenges with colleagues in other countries also enriched the implementation process. This was done informally and formally, through visits and conferences, as well as study tours, such as the study tour to Romania to visit the Romanian Family Health Initiative in preparation for piloting the rural family planning initiative.

### Continually Revisit Both the Content and the Process

Management expert Peter Drucker once said, "Management is doing things right; leadership is doing the right things." WIN/MCHI exhibited strong leadership skills as well as strong management skills by continually revisiting both the content and process of their interventions. In terms of doing the right thing, for example, MCHI smoothly incorporated PMTCT as a major new component and thus was able to be responsive to evolving external needs. They also quickly recognized the lack of available information and designed a PMTCT + FP Study to provide needed data for decision making to inform the development of relevant policy and service standards. Again, when beginning the rural family planning pilot, the need for additional Russia-specific data was recognized; in response, MCHI helped arrange for a locally conducted population-based household survey (including a male component) in Vologda Oblast similar to those conducted during the WIN project.

> "Professional exchange allowed us to break isolation and implement new practices." *Head, Health Service Department, Krasnoyarsk City*

Also, in terms of doing things right, MCHI conducted an internal mid-term evaluation which, among other actions, led to the decision to revise and update the family planning curriculum with counseling skills as its organizational backbone. They also expanded content about evidence-based best practices using the *WHO Medical Eligibility Criteria for Contraceptive Use*; informed choice; the health and human rights aspects of family planning; emergency contraception; STIs; HIV/AIDS; and PMTCT.

## CHALLENGES AND LESSONS LEARNED

WIN and MCHI were both complex, multi-faceted undertakings. Many of the challenges faced by WIN/MCHI were due to time limitations rather than ineffectual strategies or lack of interest and commitment. Several important areas were addressed that were beyond the scope of the core intent when WIN was designed.

### Changing Pre-Service and Post-Graduate Training

Influencing the Russian professional medical community has been a great challenge. Much work remains to be done before the WIN/MCHI interventions are disseminated and accepted throughout Russia, and before federal standards fully reflect evidence-based best practices.

WIN/MCHI had an explicit intent to initiate the introduction of internationally recognized, evidence-based standards for selected maternal child health interventions into the pre-service and post-graduate curricula of training institutions for physicians, nurses, and midwives. The existence of a medical school in the region was one of the MCHI selection criteria. Faculty from these institutions did participate in many of the WIN/MCHI training courses and other activities. However, while many of these medical training institutions expressed the intent to incorporate WIN/MCHI materials into their curricula, these efforts are constrained by the lack of wider faculty motivation and interest. There is also a considerable disconnect between actual clinical practice and training institutions. In addition, interactive training techniques—an essential component in the WIN/MCHI training approach—are not skills commonly found in the faculties of Russia's medical training institutions. Some important first steps were taken, but to move beyond these first steps will require a much more focused and explicit program to which Russian institutions would likely be highly receptive.

### Addressing the Special Needs of Youth

Another important frontier in evidence-based programming is youth reproductive health. Again, WIN/MCHI had an explicit intent to support youth-friendly services and comprehensive reproductive health programs for youth. This group usually has specific characteristics not addressed by programs designed primarily for adults and thus merits its own special focus. In Russia, as in most industrialized countries, youth are at increased risk of unwanted pregnancy, abortion, STIs, and HIV infection (including an increased biological vulnerability to STIs/HIV/AIDS) and other negative health outcomes.

By design, because of its maternal child health and reproductive health mandates, WIN/MCHI would have been expected to reach thousands of youth, especially those between the ages of 15 and 24. Youth received reproductive health services and related counseling through maternity houses, pediatric polyclinics, women's consultation centers, and specialized family planning and HIV/AIDS centers in all sites. All types of sites are frequented by youth, in varying degrees, in different regions. In fact, MCHI's 2004 Baseline Facility Survey showed that, in about half of the MCHI regions, youth aged 15–24 were the majority of both antenatal and family planning clients but less than the majority of abortion clients.

Again, WIN/MCHI took important first steps in this area. A small cadre of providers was trained on youth-friendly services and almost all regions explicitly introduced the concept of youth-friendly services. Clearly, there was great interest in youth and a strong recognition of the importance of addressing youth's special needs, but to truly do justice to youth reproductive health would require a much more focused and substantial intervention.

#### Collecting Data That Are Needed and Used

For maximum effectiveness, a sound M&E system with explicit indicators needs to be an integral part of program design. This means that a thorough and systematic attempt must be made to specify exactly what data is needed and how and when it will be collected. Often, data needs are underestimated and it is very difficult to go back and later try to capture what is needed. Because of its almost revolutionary nature, WIN developed a very ambitious M&E system which, for practical purposes, was scaled back during MCHI's scale up phase. MCHI also found, as it expanded, that it was collecting more data during the follow-up visits than it had time to analyze and use.

On the other hand, during MCHI's midterm evaluation, it was found that the regional-, municipal-, and facility-level contributions (financial and in-kind) were far in excess of what was initially expected. The suggestion was made that it could be informative and useful to attempt to capture the degree to which MCHI had leveraged resources in the participating regions. Consequently, in 2006, in five regions a serious attempt was made to do that. While it was clear that the various contributions were laudable and considerable, it also became clear that it was not possible to go back region by region and comparably measure the contributions accurately and systematically. These efforts highlighted the importance of M&E systems that begin data collection in the very early stages of implementation.

#### Leaving a Legacy

This challenge turned out to be one of WIN/MCHI's biggest success stories. When it became clear that RSOG, while a valuable and worthy implementation partner, would not be able continue or expand the WIN/MCHI interventions alone, there was initially no other obvious legacy organization. The fact that the WIN/MCHI staff have now registered themselves as an indigenous Russian NGO—the Institute for Family Health—and that they have already attracted considerable national and international funding speaks to their professionalism and reputation as well as to their flexibility and responsiveness.

# CONCLUSION

The impact of the pilot phase 1999–2003 Women and Infants' Health project and the scale-up phase 2003–2006 Maternal and Child Health Initiative has been significant. WIN/MCHI's innovative design helped regional and municipal government-supported health facilities adopt internationally recognized, client-centered, evidence-based maternal and child health standards and practices in multiple areas: antenatal care, FCMC, essential newborn care, exclusive breastfeeding, and family planning counseling and services, especially for postpartum and post-abortion clients. Attention was also given to family planning for HIV-positive women and the PMTCT of HIV. The adoption and integration of these internationally recognized, evidence-based standards occurred at a very impressive pace across an impressive range of political and health institutions, and actively involved an impressive number of people over an impressive geographic area.

WIN/MCHI's interlinking components and multi-level focus gave it the strength, breadth, adaptability, and flexibility to create results that reflect more than the sum of its parts.

Both sustainability and replicability are key WIN/MCHI success stories. The capacity building that occurred at the regional level is impressive, and the potential for further expansion within the target regions is great. By identifying and supporting *catalyst* institutions and individuals, WIN/MCHI has helped multi-level leadership implement bold, rapid, substantive changes, and has created a community of change agents.

**See for yourself!!**
www.jsi.ru.

The WIN/MCHI design, content, and implementation process could be a very useful model (and already has been in Ukraine and Georgia) for similar work in other countries, especially in former Communist-block countries, offering innovative ideas and practical approaches that program managers and policymakers can adapt. Additionally, it could be a very useful model for the incorporation of other evidence-based, internationally recognized standards of care into the Russian or other health care systems (e.g., additional reproductive health, family planning, and HIV/AIDS interventions; tobacco; tuberculosis). Because of its client-centered, client-friendly approach, the WIN/MCHI model would also be a good model for reaching traditionally hard-to-reach and/or stigmatized populations (groups in prisons or drug rehabilitation centers, institutionalized youth) in need of these same services.

The transformation of WIN/MCHI from an external donor-funded project to the Institute for Family Health, a self-sustaining indigenous Russian NGO, is also a success story that will hopefully encourage and inspire the legions of committed, hard-working public health professionals who have dedicated themselves to improving the health and well-being of their fellow citizens.

# APPENDIX A

# ADDITIONAL RESOURCES

Additional information about technical components of the Russian Maternal Child Health Initiative can be found online in Russian and English. The Web addresses are shown below.

## RUSSIAN MATERNAL CHILD HEALTH INITIATIVE

www.jsi.ru.

### Family Planning Training For Primary Health Care Providers

Family Planning Trainer's Guide
Family Planning Participant Manual

### Antenatal Care Training Course

Antenatal Care Curriculum Trainer's Guide

Antenatal Care Curriculum Participant Manual

Antenatal Care Slides

### Family-Centered Maternity Care (FCMC) Training Course

FCMC Facilitator's Guide
FCMC Participant Manual
FCMC Handouts

### Guidelines

Clinical-Organizational Guidelines on Prevention of HIV Mother-to-Child Transmission

Clinical Guidelines on Breastfeeding (Executive Summary)

- The full text of the Guidelines is available only in Russian.

Clinical Guidelines on Organization of Infection Control System in Maternities in the Context of Evidence-based Perinatal Practices (Executive Summary)

- The full text of the Guidelines is available only in Russian.

Clinical Guidelines on Postabortion Care (Executive Summary)

- The full text of the Guidelines is available only in Russian.

Youth programming Guidelines (Executive Summary)

- The full text of the Guidelines is available only in Russian.

### IEC Materials

All project IEC materials are available only in Russian, including—

- posters for medical facilities
- leaflets for medical providers
- booklets and flyers for women.

## WORLD HEALTH ORGANIZATION

Who Medical Eligibility Criteria for Contraceptive Use

http://www.who.int/reproductive-health/publications/mec/index.htm

For more information, please visit deliver.jsi.com.

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