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EVALUATION

Final Performance Evaluation
USAID Maternal And Child Health Project

Evaluation Report

June 13, 2012

This publication was produced for review by the United States Agency for International Development (USAID). It was prepared under the Russia Monitoring & Evaluation Project (RMEP) by International Business &Technical Consultants, Inc. (IBTCI)

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MATERNAL AND CHILD HEALTH INITIATIVE FINAL EVALUATION REPORT

JUNE 13, 2012

International Business & Technical Consultants, Inc.
8618 Westwood Center Drive
Suite 220
Vienna, VA 22182
USA

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Russia Monitoring and Evaluation Project

Evaluation Team:

Alexey Kuzmin (team leader)

Annette Bongiovanni

Natalia Kosheleva

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Acronyms and Abbreviations

AAP	American Academy of Pediatricians
ACOG	American College of Obstetricians and Gynecologists
CPR	contraceptive prevalence rate
CVD	cardiovascular disease
ENMR	early neonatal mortality rate
ETOH	ethyl alcohol
FL	facilitative leadership
FP	family planning
GOR	Government of Russia
HCI	health care improvement
IBPMCH	Institutionalizing Best Practices in Maternal and Child Health (Activity 2)
IBTCI	International Business & Technical Consultants, Inc.
ICMB	Improving Care for Mothers and Babies (Activity 1)
IDU	injection drug users
IFH	Institute for Family Health
IHI	Institute for Healthcare Improvement
IMR	infant mortality rate
IR	Intermediate Results
JSI	John Snow, Inc.
KHMAO	Khanty-Mansiisky Autonomous Okrug
MCH	maternal and child health
MCHI	Maternal and Child Health Initiative
MCHP	Maternal and Child Health Project
MMR	maternal mortality ratio
MOSHD	Ministry of Health and Social Development
NCD	non-communicable diseases
NFCA	Natural Feeding Consultants Association
NMR	neonatal mortality ratio
OB/GYN	obstetrics and gynecology
OD	organization development
PHI	Public Health Institute
QA	quality assurance
QI	quality improvement
RH	reproductive health
RMEP	Russia Monitoring and Evaluation Project
ROC	Russian Orthodox Church
STI	sexually transmitted infections
TAR	total abortion rate
TFR	total fertility rate
ToT	training of trainers
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
URC	University Research Company
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

This report presents the findings, conclusions and recommendations of the final (summative) evaluation of the USAID Maternal and Child Health Initiative (hereinafter referred to as the Maternal and Child Health Project or MCHP). The evaluation was conducted by International Business and Technical Consultants, Inc. (IBTCI) as per the terms of the Russia Monitoring and Evaluation Program (RMEP) and based on the Notification of Performance Evaluation #1[1] sent to IBTCI on December 30, 2011.

The core activities of the USAID/Russia Maternal and Child Health Project are:

- Activity 1: Improving Care for Mothers and Babies (ICMB) implemented by University Research Co. (URC); and
- Activity 2: Institutionalizing Best Practices in Maternal and Child Health (IBPMCH) implemented by John Snow Inc. (JSI) and the Institute for Family Health (IFH).

MCHP aimed to reduce maternal and infant mortality; increase the use of modern contraceptives; and decrease abortion rates in selected regions across Russia. These objectives were achieved through training and technical assistance to healthcare providers; disseminating best practices of care during pregnancy, delivery and infanthood to local and regional health care facilities; and, institutionalizing these best practices in appropriate Russian institutions at the federal and okrug levels.

The purposes of this evaluation were:

- To assess the performance of USAID/Russia's key activities on maternal and child health;
- To evaluate the sustainability of activities and results; and
- To provide suggestions for the future direction of the USAID/Russia program design for reproductive and infant health.

The main evaluation questions were:

- To what extent did the two Implementing Partners (URC, JSI and IFH), achieve their goals/objectives?
- What was the performance of the Implementing Partners against the deliverables in their respective Scopes of Work, Work Plans and M&E Plans?
- What is the likelihood of the sustainability of their results beyond USAID assistance?
- What are the key lessons learned that should guide program design for future efforts in the field of Maternal and Child Health (MCH)/Family Planning and Reproductive Health?

The evaluation was conducted by a team of two Russian specialists in program evaluation and one US specialist in MCH care and the evaluation of MCH programs.

Evaluation data was collected through document review, direct observations at selected project sites, and semi-structured in-depth interviews with USAID staff, implementing partners, experts involved in MCHP implementation, specialists at the Departments of Health and health facilities, as well as beneficiary women in maternity hospitals in selected target regions. The Evaluation Team visited four out of six regions targeted by ICMB/Activity 1 (Tver, Ivanovo, Kostroma, and

[1] The Notification is included as Annex 1.

Yaroslavl oblasts), and six out of 10 regions targeted by IBPMCH/Activity 2 (Kurgan, Ekaterinburg, Tyumen, St. Petersburg (Leningrad), and Moscow oblasts and the city of Moscow).

Overall, the evaluation revealed that the implementing partners accomplished all of the key tasks of their activities with high quality, in a timely manner, and in accordance with the requirements of their respective Scopes of Work and Work Plans. Further, the evaluation found that in terms of sustainability, the implementing partners succeeded in developing the capacity to sustain the new clinical practices introduced during the course of the project. However, the activities were unable to develop capacity and institutionalize mechanisms to sustain the ability of beneficiaries to improve and build on these new practices. This is in part due to the fact that the Russian beneficiaries and practitioners have limited financial resources and access to cutting edge research in this field.

With regard to the MCHP design, after a careful review of activity documents from both URC and JSI/IFH, the Evaluation Team found inconsistencies in the activity descriptions and there was a lack of clarity in the logic of each activity. While both implementing agencies had distinct intervention models, the expected results for the two activities were not well described. The logic and causal relationships between the building blocks of the activities and how they would help achieve the activities' goals were not explicitly presented in the documents. For example, it is not clear how the introduction of best practices in IBPMCH will improve access to high quality services and improve the use of high quality services. In other words, the steps to achieve the goal (improving access and quality) are not clear vis-à-vis institutionalizing best practices. Further, the nine tasks that comprise the ICMB program do not link causally to the overall goal of the activity. However, subsequent to data collection, the Evaluation Team was able to reconstruct the logic for each activity in collaboration with key stakeholders to develop a coherent logical framework that better presents the activities' intent.

Project Findings

1. The evaluation revealed that maternal and infant mortality and morbidity decreased in most target MCHP regions. However, they also decreased in neighboring regions where MCHP was not implemented and the average national rates of maternal and infant mortality and morbidity also decreased. Due to the MCHP design (especially its focus on changes at the oblast level), it is impossible to make statistically valid inferences about causal attribution – whether the decrease can be attributed to the presence of MCHP, or vice versa, whether maternal and infant mortality and morbidity would have decreased at the same rate without MCHP. Hence, the evaluation focused on assessing the plausible contribution of MCHP to health outcomes within a more appropriate context, i.e. at a regional level, not a national level. As a result, the evaluation data confirmed the following:

    - MCHP made a plausible contribution to decreasing infant mortality in the target regions.
    - There is not enough data to confirm MCHP's contribution to decreasing maternal mortality in the target regions.
    - The number of abortions in the populations served by the MCHP participating facilities substantially decreased, and there is evidence confirming the project's plausible contribution to the decrease in the number of abortions in two project regions.

2. There was general consensus among healthcare professionals interviewed during the evaluation process that:
    - The reproductive health of young people (males and females) is alarmingly poor and needs special attention.
    - Many problems with mothers' and infants' health are caused by the reproductive health problems that emerged in the mothers' childhood and teenage period.
    - Maternal and infant mortality and morbidity are much higher among women at risk.
3. MCHP introduced evidence-based practices that address the major causes of maternal and infant morbidity and mortality to the healthcare providers in the target regions. These practices were adopted and successfully implemented by several dozen hospitals in the target regions. Project participants reported good clinical outcomes from the implementation of the new practices and intend to continue their use. This MCHP result can be considered sustainable.
4. A salient result of MCHP is the increased capacity of IFH, an implementing partner of IBPMCH or Activity 2. This result is also a significant contribution to the sustainability of the project and its outcomes.
5. MCHP made a major investment in the doctors and nurses dealing with MCH issues. Conventional wisdom in Russia has dictated that senior experts, especially those holding leadership positions in the Ministry of Health and Social Development (MOHSD) medical institutions define clinical practices. Traditionally, clinical practices were based less on scientific evidence and more on the personal experience of the opinion leaders. Both projects contributed to the change in the mindset among a number of Russian physicians who now look for objective evidence to support their clinical care practices. Both MCHP activities provided an impetus to the Russian medical community to break away from the traditional approach and to adopt a new approach based on seeking out relevant data, international standards, and best practices as the basis for improving health outcomes. MCHP also presented a strategy and provided resources for future professional development that can be implemented by participants, and participating institutions, on their own, or with some external support. Informal networks established in the course of MCHP also contributed to human capital development and are an important asset for the future endeavors.
6. New practices were embedded within the healthcare system most actively and successfully at the level of maternity hospitals, neonatal centers, and research centers. Departments of Mother and Child Health in all of the participating regions supported MCHP. In many cases they issued official documents recommending and/or approving the implementation of certain practices. The fact that MOHSD used some of the MCHP products to develop new policies and regulations suggests that the ministry appreciated the quality of these products. There is clearly potential for developing collaboration with the MOHSD.

Overall Lessons Learned

Both activities contributed to enhancing the quality of MCH and reproductive health (RH) services and, to some extent, enhancing the quality of healthcare management systems, including the business environment and business processes of managing the healthcare system – the operations, processes, organizational structure and functioning. Additionally, MCHP laid a foundation for future development and implementation of quality improvement methodologies;

though this process will face serious challenges and will require much more time, effort, resources, and leadership commitment to achieve further improvements.

Unintended Consequences

As a result of MCHP, four unintended, positive, consequences occurred.

1. Creation of MCH Informal Networks. At least three informal networks emerged as a result of MCHP: 1) Network of Friends of ICMB; 2) Network of IFH Friends, part of IBPMCH and with participants from IFH staff in the regions; and 3) the IBPMCH "Club," comprising an informal group of project participants who get together to discuss the most important issues related to their professional work. Some participants belong to two or even all three of the networks.
2. Increased Demand for MCHP in Russia. Information about MCHP and its positive reputation was widely disseminated throughout Russia reaching many, if not most, regions of Russia. This resulted in increased visibility of and publicity for the project. As a result, an increasing number of oblast-level authorities have been expressing their interest and readiness to participate in the project.
3. Enhanced Computer Skills. Participants were required to have a certain level of computer literacy to participate in MCHP. As a result, quite a few doctors report to have developed increased computer skills over the course of the project. They report to have better mastery of the Internet, can now produce PowerPoint presentations, and are able to use the computer to communicate more effectively and efficiently with their colleagues.
4. Career Development. Several respondents reported that their participation in MCHP provide them and others an opportunity to build their professional skills, which contributed to being promoted. While generalizations should not be made from only a unverified few cases, it is reasonable to surmise that out of several hundred project participants, some would have been promoted as a result in the professional development opportunities that were made available to them during the course of MCHP. This, in turn, may lead to the creation of a population of health administrators who know each other as a result of relationships built during MCHP and who have more influence to implement the best practices learned through MCHP.

Main Recommendations

The evaluation led to the following main recommendations for future programming for Implementing Partners and USAID/Russia.

Recommendation 1. This recommendation is directed towards the implementing partners. When designing an activity, start by developing a comprehensive logic model and develop realistic and measurable goals at all levels of the logical system. Make sure that causal relationships exist between the expected results for each link in the chain of results. Make sure that activities are logically harmonized with the project to which they contribute.

Recommendation 2. For future programming, USAID should maintain the quality of healthcare (including the quality of services and the quality of management systems) as a central tenet. This will (a) help align new projects with the current MOHSD agenda and its urgent needs; (b) open new opportunities for collaboration with the key local institutional partners such as the Public Health Institute (PHI); (c) enable future projects to build on the achievements of MCHP; and (d) allow for the use of assets developed by MCHP. Consider using the Quality Improvement (QI)

methodology introduced and implemented by URC and its partners for future programs as it will facilitate keeping the quality of healthcare as a central focus.

Recommendation 3. USAID and implementing partners should focus more on sustainability with future projects. During the project design phase, an in-depth analysis should be conducted to identify, explore, and describe all of the key factors that will contribute to project sustainability. Further, there should be an explicit emphasis on the financial sustainability of Russian implementing partners so they can continually build on the best practices instituted via future projects. MCHP did not include the provision of financial resources for Russian implementing partners and practitioners to carry on with improvements to and the introduction of new practices.

Recommendation 4. In the design of future programs, USAID and implementing partners should increase the focus on vulnerable groups such as youth and high-risk women. While, MCHP did implement activities directed at these vulnerable populations in selected regions, the success of these activities provides evidence that they should be replicated and further developed for additional regions, perhaps with even a national focus. Accordingly, future projects should continue to focus family planning and teen reproductive health, which are areas particularly salient for youth and high-risk women.

Recommendation 5. The Evaluation Team found that that there is a potential for increased cooperation with social services and civil society MCH programs. Hence, USAID and implementing partners should include a strengthened focus on such cooperation for future endeavors. In particular, there should be a focus on connecting vulnerable patients identified in hospitals with relevant community resources like NGOs, CSOs, and community-level support groups dedicated to working with vulnerable groups and/or specific problems.

Recommendation 6. USAID and implementing partners should maintain an emphasis on embedding evidence-based medicine within the healthcare system, especially at the regional and federal levels. This process of institutionalization can benefit greatly for improving healthcare management. Also, the Team recommends the development and delivery of specialized services such as trainings, conferences, and consultations for healthcare managers and leaders in the healthcare field to further build capacity. Collaboration with universities providing courses in healthcare management is another possible venue for intervention.

1. INTRODUCTION

1.1. Description of the Project Evaluated

The USAID/Russia funded Maternal and Child Health Initiative (hereinafter called Maternal and Child Health Project or MCHP) aimed to reduce maternal and infant mortality, increase the use of modern contraceptives, and decrease abortion rates in selected regions across Russia. These objectives were implemented through training and technical assistance for healthcare providers; disseminating best practices in care during pregnancy, delivery and infanthood at local and regional health care facilities; and institutionalizing these best practices in appropriate Russian institutions at the federal and okrug levels.

This summative evaluation covered the two MCHP activities:

- Activity 1: Improving Care for Mothers and Babies (ICMB) ICMB) implemented by University Research Co. (URC); and
- Activity 2: Institutionalizing Best Practices in Maternal and Child Health (IBPMCH) implemented by John Snow Inc. (JSI) and the Institute for Family Health (IFH).

Activity 1: ICMB was implemented from October 2008 to October 2011 by University Research Company (URC). The budget for this activity was $4.1 million. The overall goal of Activity 1 was to assist counterparts in six Russian regions to reduce rates of maternal and infant mortality and morbidity and to reduce abortion rates through more appropriate use of family planning and modern contraceptive methods. The activity also aided the introduction of relevant up-to-date regulations, standards and guidelines for issuance by the Ministry of Health and Social Development (MOHSD).

Activity 2: IBPMCH started in September 2008 and will end in September 2012. The budget for this activity was $8.37 million. The activity is implemented by John Snow, Inc. (JSI) and the Institute for Family Health (IFH). The goal of Activity 2 is to decrease maternal and infant morbidity and mortality in target regions. The two following federal entities served as partners during project implementation: the Kulakov Federal Center on Obstetrics, Gynecology and Perinatology (hereinafter Kulakov Center) in Moscow and the Federal State Research Institute for Maternity and Infancy in Ekaterinburg.

While IBPMCH was conducted under an RFP issued by USAID/Moscow, the Improving Care for Mothers and Babies (ICMB) initiative was carried out under the USAID Health Care Improvement Project, a five-year IQC task order contract issued by the Global Health Bureau. ICMB reported to both USAID/Moscow and USAID/Washington.

1.2. Purpose of the Evaluation[2]

This was the summative evaluation of the USAID Maternal and Child Health Project (MCHP). International Business and Technical Consultants, Inc. (IBTCI) was responsible for implementing this evaluation as per the terms of the Russia Monitoring and Evaluation Project (RMEP) and based on the Notification of Performance Evaluation #1[3] sent to IBTCI on December 30, 2011.

The purposes of this evaluation were:

[2] A detailed description of evaluation design and work plan is included into the Annex 2.
[3] The Notification is included as Annex 1.

- To assess the performance of the USAID/Russia key activities on maternal and child health;
- To evaluate the sustainability of activities and results; and
- To provide suggestions for the future directions of USAID/Russia program design for reproductive and infant health.

1.3. Evaluation Questions

The evaluation was commissioned to provide answers to the following questions:

1. Goals: To what extent did the two Implementing Partners achieve the goals/objectives in their respective Scopes of Work, Work Plans and M&E Plans, including but not limited to Required Indicators, Activity Extension Goals, Expected Results and the like?
2. Deliverables: What was the performance of the Implementing Partners against the deliverables in their respective Scopes of Work, Work Plans and M&E Plans?
3. Sustainability: What is the likelihood of sustainability of results beyond USAID assistance? What additional activity elements should be incorporated in current and future activities in order to strengthen sustainability?
4. Lessons Learned: What are the key lessons learned that should guide program design for future efforts in the field of MCH/ Family Planning and Reproductive Health? (What worked well? What could be improved? What were unintended consequences? What gaps existed and why? Gender gaps? Vulnerable population gaps? How are the activities perceived or valued by stakeholders and the population served? Did the activities strengthen the relation between government and civil society? Did the activities demonstrate a relationship between good governance and health outcomes, why/ why not?

1.4. Collaboration with the local partners and stakeholders

The key stakeholders were USAID-Russia (Health Office) and the implementing partners: JSI, represented in Russia by IFH, and URC (Moscow office). From the outset this evaluation was conducted in a collaborative manner. USAID and both implementing partners, together with the Evaluation Team, discussed evaluation methods, sampling, and work plan. The evaluators consulted with all three parties on interpretation of the key evaluation findings and possible scenarios for future programming.

1.5. Methodology

Overall approach

As mentioned above, the purpose of this evaluation was to evaluate two complex activities contributing to the same overarching goal. The questions to be addressed in the evaluation were not related to any pre-existing hypotheses; they were purely empirical. Answering the evaluation questions could lead to a gain in new knowledge but do not represent the testing of an existing model. Governed by an 'inductive' or 'discovery' orientation, rather than by a conception of inquiry, which requires specific hypotheses to be set up for testing at the start of the process, this evaluation used a 'progressive focusing' approach. This means that as the evaluators became engaged with the activities being evaluated, new issues emerged and some assumed a greater importance than others.

Information that was gathered to address the evaluation questions was mostly descriptive and derived from semi-structured interviews described below. Therefore, a considerable part of the data was based on the opinions, recollections, and experiences of people. Key sources of information included representatives from USAID, JSI, URC, IFH, local government entities in the regions, partner organizations and participants, and clients and beneficiaries of the activities. During the course of this evaluation the Evaluation Team (ET) remained open to any new relevant information and used rigorous inductive analysis to come to conclusions and recommendations. There were two kinds of documents available for review: descriptive and statistical. The latter set included quantitative monitoring data.

In summary, this evaluation had the following characteristics:

- The purpose of this evaluation was an in-depth study of two complex activities.
- The evaluation questions were purely empirical.
- The evaluation was based on an inductive analysis of mostly descriptive information.
- The evaluation design was relatively flexible to accommodate emergent issues.

Sampling strategy

Given the complex nature of the activities being evaluated as well as the above mentioned characteristics of the study, the evaluators proposed to adopt the purposeful sampling strategy based on the identification of information-rich cases – the sources from which they could learn most about the activities. The information rich cases that were selected for in-depth exploration represented a broad variety of approaches and activities used by the Implementing Partners in different environments. The Evaluation Team worked with JSI/IFH and URC staff to explore ethical and non-intrusive ways to reach MCHP beneficiaries. One of the methods for collecting data on the beneficiaries' opinions turned out to be internet based social networks.

Rationale for selecting regions for site visits

The key criteria for selecting the sites were information richness and diversity (in terms of geographic regions, social and economic environments, activities implemented, challenges met, and changes that occurred). This was consistent with the purposeful sampling strategy.

Four out of six target regions were selected to collect data on Activity #1 implemented by URC: Tver, Ivanovo, Kostroma, and Yaroslavl oblasts. To study Activity #2 implemented by JSI/IFH, evaluators visited six out of 10 target regions: Kurgan, Ekaterinburg, Tyumen, St. Petersburg (Leningrad), and Moscow oblasts and the city of Moscow. The rationale for selecting these locations was discussed with USAID, IFH and URC and is described in detail in Annex 2.

Data Collection Methods

Document Review[4]

The Evaluation Team reviewed activity-related documents made available to it by USAID and prepared by USAID and Implementing Partners (RFP, SOWs, Work Plans, M&E Plans, reports, and M&E data for the period from 2008) as well as statistical data (up to 2010) available from Roskomstat and its regional divisions. The Evaluation Team also explored online publications (including forums and social networks), media publications and videos produced in the course of the project.

[4] List of documents studied is included as Annex 4.

Direct observation

The evaluators had an opportunity to visit a number of hospitals and observe how new practices are implemented. The Team also attended a seminar conducted by IFH in Tyumen and observed a couple of sessions conducted by the IFH trainer and her two co-trainers trained by IFH in the course of this project.

Semi-structured in-depth individual and group interviews

The Team used semi-structured in-depth interviews to collect information from individuals. As the respondents' experiences were heterogeneous, the Team used a mixed approach to develop the interview instruments based on a combination of interview guides and informal conversational approaches. Most interviews were individual. In some cases the evaluators conducted interviews with small groups of two to four people. Sometimes small group interviews were followed by individual interviews with the selected group members to allow the collection of additional information in a setting more comfortable for the informants.

The interview guide approach used requires that interview topics and issues be specified in advance, while the interviewer can decide on the sequence and wording of questions in the course of the interview. The strength of this approach is that the interview guide increases the comprehensiveness of the data and makes data collection more systematic. The weakness of this approach is that important and salient topics may be inadvertently omitted.

When an informal conversational interview approach is used, questions emerge from the immediate context and are asked in the natural course of the conversation. There is no predetermination of question topics or wording. The strength of this approach comes from its ability to increase the salience and relevance of questions during an interview and those that emerge from observations. These can be matched to individuals and circumstances. The weaknesses of this approach are that it is less systematic and comprehensive and different information is collected from different people resulting in organizational and analytical challenges. Mixing these two approaches allowed us to minimize the weaknesses while benefiting from the strengths. The length of each semi-structured interview was about one to one and one-half hours.

Topics and issues covered in all interviews were as follows:

- How did the respondent become involved with the activity or activities?
- What was the respondent's involvement?
- What approaches to infuse best practices into the operation of Russia specialists worked well and why?
- What did not work well and why?
- What could have been done differently?
- How did the respondent's professional practice benefit from what s/he learned through the Activity?
- Will the respondent be able to continue using best practices learned through the Activity?

<u>Triangulation</u>

Triangulation refers to double or triple checking of results by using different methods, data sources and/or experts. To increase the accuracy and credibility of the evaluation findings, the Evaluation Team used several types of triangulation:

- Methodological triangulation – three methods for data collection were used;
- Data source triangulation – the data about the Initiative was collected from a variety of sources;
- Investigator triangulation – the Evaluation Team included three members, which allowed looking at the data from different perspectives.

Data analysis

Four distinct processes were involved in analyzing the data.[5]

1. *Description and analysis*: Describing and analyzing findings involves organizing raw data into a form that reveals basic patterns. The factual findings as revealed in actual data will be presented in a user-friendly fashion.
2. *Interpretation*: What do the results mean? What's the significance of the findings? Why did the findings turn out this way? What are possible explanations of the results? Interpretations go beyond the data to add context, determine meaning, and tease out substantive significance based on deduction or inference.
3. *Judgment*: Values are added to analysis and interpretations. Determining merit or worth means resolving to what extent and in what ways the results are positive or negative. What is good or bad, desirable or undesirable, in the outcomes?
4. *Recommendations*: The final step adds action to analysis, interpretation and judgment. What should be done? What are the action implications of the findings? Only recommendations that follow from and are grounded in the data ought to be formulated.

Protection of human subjects

It is important to ensure that evaluation participants are protected. The Evaluation Team made arrangements for all evaluation activities with the heads of participating entities. Evaluators explained the purpose and tasks of the study to them and to all interviewees. Verbal permissions from organizations and individuals to collect and use information were obtained. Informal rules of joint work were negotiated. When asked, evaluators always allowed people to see the interview questions in advance.

Briefing and Dissemination of Evaluation Findings

This section describes overall approaches and key activities related to communication of evaluation findings to the key stakeholders and dissemination of evaluation results. A more detailed description of the time-bound evaluation milestones is included in the Evaluation Work Plan.[6] The Evaluation Team presented some key evaluation findings to IFH and URC representatives in the end of the field study to consult on the possible interpretations and double check some suggestions evaluators were going to make. The Evaluation Team presented draft key evaluation findings to USAID Health Office representatives in the form of a PowerPoint presentation. Feedback received during and after the presentation was considered in the draft report. A draft evaluation report was prepared in English and sent to USAID/Russia and Implementing Partners for review and commentary. The Final Report will be made public via the USAID website and the executive summary will be translated into Russian. Further

[5] Based on Patton, M. Q. (1997). *Utilization-focused evaluation: The new century text* (3rd ed.). Thousand Oaks, CA: Sage. (page 307)
[6] Annex 2

dissemination of evaluation results will be done with careful consideration of the local context and after consultations with the key stakeholders. For example, the evaluators are currently discussing an opportunity to make a presentation of the findings at the final project conference in Moscow.

To share the lessons learned, the Evaluation Team suggests writing an article in Russian presenting key findings of the evaluation. This article can be sent to all MCHP stakeholders and made public through Implementing Partners web-sites. It should be written together with the implementing partners indeed.

Given that this evaluation is conducted within the framework of a larger project that among other things should build the evaluation capacity in Russia, the Evaluation Team suggests writing an article in Russian on lessons learned about the M&E aspect of the Initiative and making it public via the online journal "Planning, Monitoring and Evaluation". This article can also be used as a case study for the training activities on M&E foreseen for USAID partners. The paper also could be presented at the conference of the International Programme Evaluation Network that covers the CIS region in September 2012. This opportunity has already been discussed with the IFH director and monitoring and evaluation specialist.

Challenges and limitations

Qualitative data allows a comprehensive and multifaceted understanding of people's experiences with the program. However, collecting such in-depth and detailed data is time consuming so evaluators were compelled to restrict the number of people they could interview.[7] Moreover, in relation to the sampling strategy, the entire population under study was relatively small and diverse, and so the Evaluation Team was not able to collect data from all the regions due to the time constraints. This is the logic behind using purposeful sampling strategy. It does not allow generalization, but allows extrapolation,[8] which is sufficient for the purposes of this evaluation.

Another challenge of the qualitative methodology is that an evaluator is an instrument of research and inevitably brings his/her perceptions and biases to the study. To minimize the possible distortion of the findings evaluators were constantly discussing and vetting within the Team, what possible biases each brings to the evaluation. The Team members monitored each other's neutrality about the MCHP. The Evaluation Team included representatives from Russia and the US, which helped the Team grasp MCHP's contexts (political, cultural, and socio-economic) and establish good rapport with respondents.

Subject matter expertise was needed to assess a healthcare program. Two out of the three Evaluation Team members were professional evaluation consultants with a solid knowledge of the region, USAID programs and some experience in healthcare. In addition to her evaluation and research experience, one Team member had strong healthcare background, both as a nurse and a USAID program officer who has extensive experience in designing, implementing, and evaluating international maternal and child health, family planning, reproductive health, and HIV/AIDS prevention programs.

[7] The Evaluation Team ended up conducting interviews with 92 people (see Annex 3).

[8] Extrapolation here is understood as an inference about the future (or about some hypothetical situation) based on known facts and observations.

Disclosure of conflict of interests

All Evaluation Team members provided a signed statement attesting to a lack of conflict of interest relative to the project being evaluated; this statement was signed prior to beginning work on this evaluation.

2. MATERNAL CHILD HEALTH PROJECT DESIGN

This chapter includes a design analysis of the two activities under evaluation to establish a foundation for the evaluation findings. The Evaluation Team includes this section to clarify and/or link USAID terminology with MCHP terminology and illustrate the MCHP design logic. It also provides suggestions for the future direction of the USAID/Russia program design for reproductive and infant health. Specifically, described below in sections 2.1 and 2.2 are a clarification of terminology and then a summary of the USAID policy regarding program design components. Section 2.3 describes the specific MCHP components. Section 2.4 is a reconstruction of the activities' logic and finally section 2.5 presents the implementation models for each activity.

2.1. Clarification of terminology

The evaluation Scope of Work states that the USAID/Russia Maternal and Child Health *Initiative* (MCHI) included two *activities*:

Activity 1: Improving Care for Mothers and Babies (ICMB); and
Activity 2: Institutionalizing Best Practices in Maternal and Child Health (IBPMCH).

A project is "a set of executed interventions, over an established timeline and budget intended to achieve a discrete development result (i.e. the project purpose) through resolving an associated problem." (USAID, 2012, 1)

"An *activity* is a component of a project that contributes to a project purpose. It typically refers to an award (such as a contract or cooperative agreement), or a component of a project such as policy dialogue that may be undertaken directly by Mission staff." (USAID, 2012, 1)

Hence, this evaluation is focused on two *activities*, both of which are subcomponents of the Maternal and Child Health *Project.*

2.2. USAID's Program, project and activity results frameworks

2.2.1. Program Results Framework

This section provides an overview of USAID's policy on programming.

Any program should be based on a "sound development hypothesis that describes the theory of change, logic, and causal relationships between the building blocks needed to achieve a long-term goal" (USAID, 2012, p.9). The development hypothesis "...explains why and how the proposed investments from USAID and others collectively lead to achieving the Development Objectives (DOs) and ultimately the Country Development Cooperation Strategy (CDCS) Goal" (ibid.).

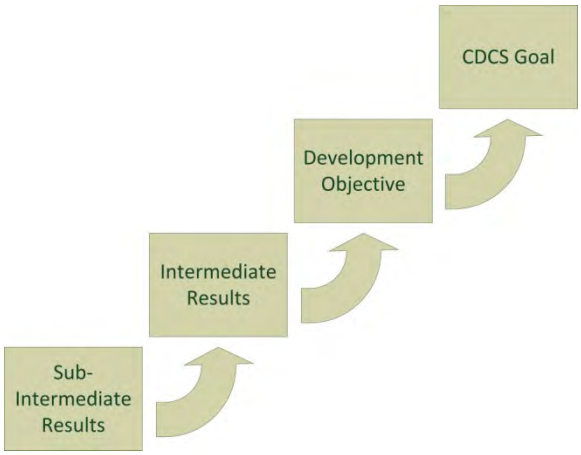
Through "if-then" statements the development hypothesis "explains relationships between each layer of results, upwards from the sub-Intermediate Results (sub-IRs), to the IRs, the DOs, and the CDCS Goal..." (See Figure 1) The Results Framework (RF) is a "graphical representation of

the development hypothesis and includes the CDCS Goal, Development Objectives (DOs), Intermediate Results (IR), sub-IRs, and performance indicators" (ibid.).

According to ADS 201, "The CDCS Goal is the highest-level impact to be advanced or achieved by USAID, the host country, civil society actors, and other development partners within the CDCS timeframe. The Mission is responsible for progressing toward the CDCS Goal as it advances toward achieving the DOs. The CDCS Goal should strike a balance between being ambitious and realistic (ibid., p. 9)."

The CDCS Goal is the reason for undertaking the program or program's mission. It is related to the program initiators' desire to contribute to solving some problem and improving a situation about which they are concerned. It is usually aimed at a major problem that cannot be resolved by a single activity. The CDCS Goal describes the program context and its general direction. The best result a program can achieve is to have contributed to the CDCS Goal.

Figure 1. USAID Program Results Framework



"Development Objectives (DOs) and Intermediate Results (IR): A DO is the most ambitious result that a Mission, together with its development partners, can materially affect, and for which USAID will be held accountable to demonstrate impact. The IRs are the set of results that together are sufficient to achieve the DOs" (ibid., p. 10).

A DO is the expected program result. In practice, various DOs can be related to the same CDCS Goal. A program specifies a DO by identifying how it contributes to the achievement of the CDCS Goal. In contrast to the CDCS Goal, the DO can be achieved if the program is well designed and successfully implemented, though unpredictable external factors beyond the program's control mean that 100% achievement can never be guaranteed.

Program Intermediate Results are specific expected results that depend primarily on the performance of program staff, i.e., they depend relatively less on external factors. A program's hypothesis is the stated or implied assumption that in the event all IRs are achieved, the DO will have been achieved.

To develop a comprehensive chain of reasoning, sub-IRs could be used. They fully depend on the performance of program staff. In the event all sub-IRs are achieved, the IRs will have been achieved.

2.2.2. Project Results Framework

New USAID programming policy points out that "the project design process is a continuum of activities and analyses that begins with the development of the Country Development Cooperation Strategy (CDCS) and concludes with the authorization of a project designed to achieve the results defined in the Results Framework (RF) of the CDCS, normally at the Intermediate Result (IR) level." (USAID, 2012, 2, p.30) Project design includes development of logical framework: "starting with the project purpose, an "if-then" objective tree analysis should be used as the basis for developing the … Logical Framework, covering outputs and inputs and including key assumptions." (ibid, p.36)

In fact, the project description should include a results framework similar to the Program Results Framework (Fig. 1). Specifically, it should include the following:

- a high-level goal - the reason for undertaking the project or *project's mission*;
- *a project purpose (goal)* - result that a Mission, together with its development partners, can materially affect, and for which USAID will be held accountable; and
- *project intermediate results (objectives)* or specific expected results that depend primarily on the performance of program staff, i.e., they depend relatively less on external factors.

2.2.3. Activity Results Framework

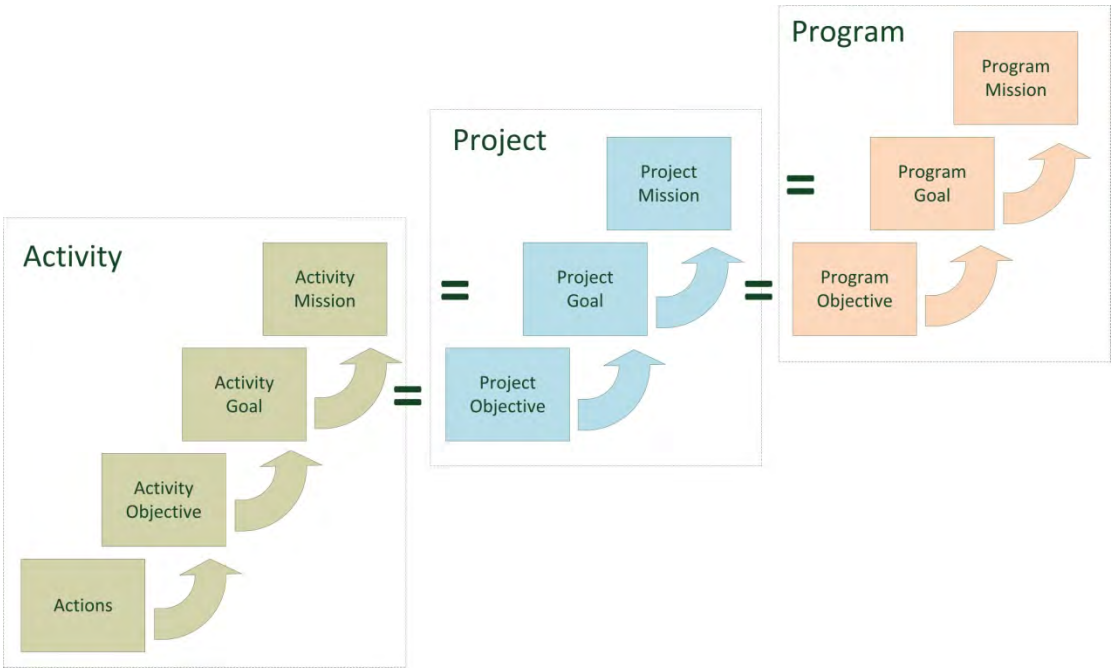
An *Activity* is a project component and can be considered a 'subproject', which contributes to the achievement of the project purpose. The 'subproject' title better reflects the nature of an activity in the context of USAID programming because activity should have certain project features, such as underlying logic and results framework. In particular, an activity should have

- *activity's mission* - the reason for undertaking the activity,
- *activity's purpose (goal)* - result that development partners, can materially affect, and for which they will be held accountable,
- *activity's objectives* - specific expected results that depend primarily on the performance of the implementing agency staff.

2.2.4. Logical harmonization of Activity, Project and Program

Programs, projects that constitute them, and activities that constitute projects should be logically harmonized (Kuzmin, 2011) as it is shown in the Figure 2. The program goal should be taken as the project mission. The project goal, on the one hand, should be identical to one of the program objectives and, on the other hand, it should be taken as an activity mission. An activity goal should duplicate one of the project objectives.

Figure 2. Logical connections between activity, project and program



USAID programming policy does not explicitly require logical harmonization between activities, projects and programs. According to our information, it does not require development of logical frameworks for activities. We propose this approach based on our own experience and research results. It does not contradict with USAID policy and could help implement results-based approach more effectively.

2.3. MCHP Activity models

This section describes each of the MCHP activities based on the program documentation provided to the Evaluation Team.

2.3.1. Activity 1 "Improving Care for Mothers and Babies" (ICMB)

ICMB's "overall goal is to assist counterparts in six Russian oblasts in reducing rates of maternal and infant mortality and morbidity, and to reduce abortion rates through more appropriate use of family planning and modern contraceptive methods." The overall goal statement is not well defined as it includes more than one expected result and more than one way to achieve one of the expected results (see Figure 4).

Activity documents (work plans) describe nine key tasks to be performed by the implementing agency in order to achieve the overall goal:

1) To identify the major problems in maternal health, infant health, and reproductive health.
2) To train providers of maternal and infant care and reproductive health care and leadership at the oblast level in basic quality improvement methods.
3) To initiate implementation of improvements in delivery of maternal and child health and family planning services.
4) To develop and test revised definitions of national indicators of quality maternal and child health care and family planning.

5) To develop and test Written Change Packages, norms, and standards that will allow widespread institutionalization of evidence-based standards and improvements in care.
6) To develop an online/CD-based training course in quality improvement methods.
7) To adapt Russian "Communicator" web portal to the real-time reporting, collection, and monitoring of data on MCH/reproductive health care processes and outcomes.
8) To identify and spread into target regions organizational improvements supporting coordination of medical and social services to prevent child abandonment.
9) To work with target regions to support and develop the effective organization of perinatal care on a regional level.

The nine tasks clearly demonstrate URC intents, but the causal relationships between these tasks and the overall goal are not described explicitly and are not self-evident.

Figure 3. ICMB activity model

Conclusions:

1) Neither activity description includes a comprehensive results framework.
2) Neither activity description is consistent.
3) Neither set of activity documents provides a clear logic description.

2.3.2. Activity 2 "Institutionalizing Best Practices in Maternal and Child Health" (IBPMCH)

This activity contributes to the Program Area, "Health" and to the program elements "Family Planning and Reproductive Health" and "Maternal and Child Health."

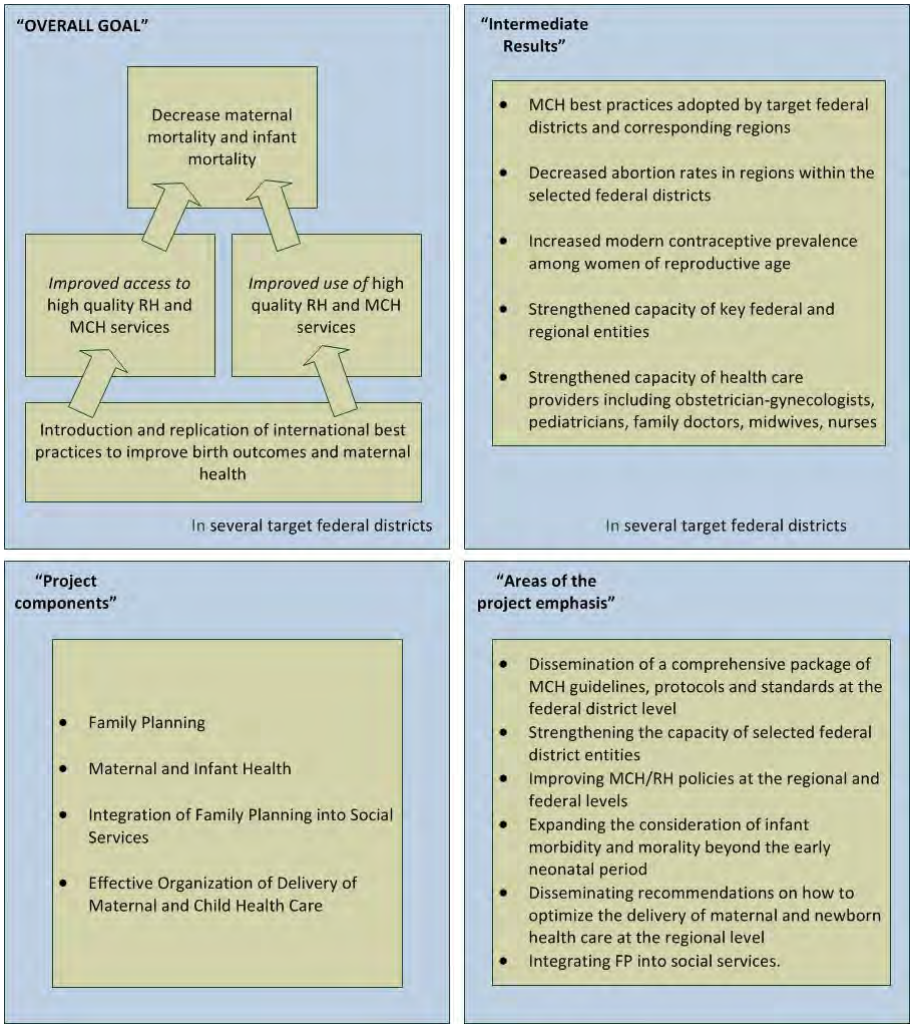
The *overall goal* of the activity is to decrease maternal and infant mortality in Russia by improving access to, and use of, high quality reproductive health (RH) and maternal and child health (MCH) services in target federal districts through the introduction and replication of international best practices to improve birth outcomes and maternal health.

The IBPMCH activity components are also included in the following:

- *Intermediate Results;*
- the five *project components; and*
- the six *areas of project emphasis.*

Figure 3 shows the IBPMCH activity model at a glance, pulled together based on the activity documents provided by the implementing partner.

Figure 4. IBPMCH activity model



The Evaluation Team has analyzed the activity model for IBPMCH to clarify the intentions of USAID and the implementing partners and concludes the following.

- The overall goal statement is not well defined. In USAID programming terminology, it looks more like a *development hypothesis* than an *expected result*, which is what a goal should be.
- The "causal relationships between the building blocks" are questionable as it is not clear how the introduction of best practices can improve access to high quality services and improve use of high quality services. Further, the meaning of "improved use" is not clear.
- There is no clear correlation between Intermediate Results and the Overall Goal, Project[9] Components, or Areas of Project Emphasis.
- Objectives are not explicitly included in the activity documents.

[9]It is important to note that both implementing agencies often use the term 'project' to describe their activities. This is natural because their 'activities' have all the features of stand-alone projects.

- *Project components* and *areas of the project emphasis* add to the overall picture but do not make it comprehensive. The relationship among these four blocks is not clear.
- As mentioned above, the use of the word *project* here is somewhat confusing.

2.4. Reconstruction of activities' logic.

Reconstructing activity/project/program logic is the development of a comprehensive chain of reasoning that links investments in an activity/project/program with the results by piecing together bits of evidence collected in the course of evaluation. The Evaluation Team undertook this exercise to provide a holistic and consistent description of each of the activities' logic to be used as a foundation for this evaluation and for future planning.

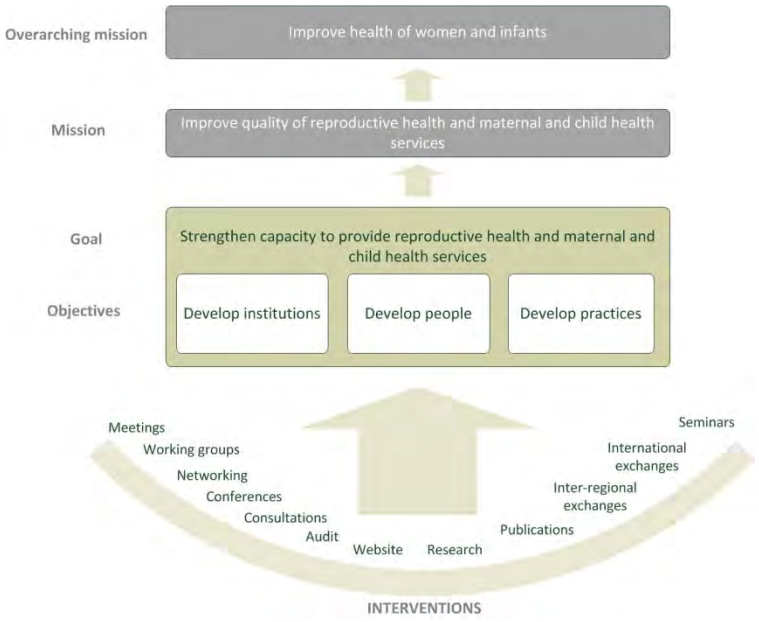
Logic reconstruction was first conducted separately for each of the MCHP activities. Although URC and IFH/JSI implementation models differ (the differences will be discussed later in this chapter), it became apparent that the two activities shared a common logic and results framework.

The proposed model (see Figure 5) is related only to the selected geographic areas where MCHP was implemented, not to the entire country.

The *Overarching Mission* is to improve the health of women and infants. Since this is a high-level strategic goal, which depends on numerous factors. While MCHP cannot *guarantee* the goal's achievement, it can *contribute* to its achievement.

The *Mission* of the activities is to improve the quality of reproductive health and maternal and child health services. The URC philosophy is based on quality improvement and its approach uses IHI's collaborative model of quality improvement in healthcare. The IFH/JSI activity's *overall goal* statement includes their intention to improve quality of services provided to mothers and infants. Although they do not have a formally documented model of quality improvement, it is at the heart of their project.

Figure 5. Activities' logic model (reconstructed)



The *Goal* of the activities is to strengthen capacity to provide reproductive health and maternal and child health services. If capacity is defined as the "combination of people, institutions and practices that permits countries to reach their development goals" (World Bank, 1998, p. 3), then the *objectives* could be described as: (a) development of institutions, (b) development of people (human capital), and (c) development of practices.

Both implementing agencies used a variety of *interventions* that contributed to achieving the *objectives*. These interventions and the actual results will be discussed in a separate chapter.

The underlying development hypothesis can be described as follows (see Box 1).

Box 1. Activities' Development Hypothesis

If we develop institutions, people (human capital) and practices, then we strengthen capacity to provide reproductive health and maternal and child health services.

If the capacity to provide reproductive health and maternal and child health services is strengthened, then the quality of reproductive health and maternal and child health services will improve.

If the quality of reproductive health and maternal and child health services improves then a contribution will be made to the improvement of the health of women and infants.

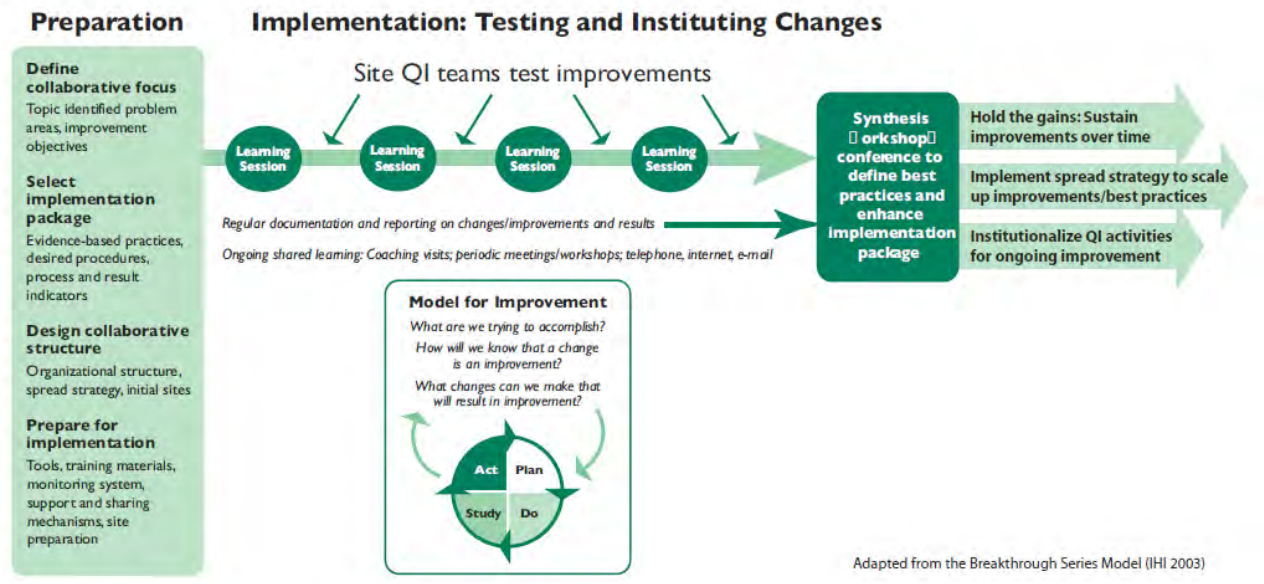
2.5. Implementation Models

2.5.1. URC Collaborative Model for Improvement

URC used the improvement collaborative approach, developed in the 1990s by the Institute for Healthcare Improvement (IHI, 2003) and adapted to the complex realities of Russia as well as several developing countries (Figure 6). The Quality Improvement (QI) model had been in the process of refinement for over a decade before URC adopted it in 1998 in the United Kingdom and the United States. Unlike more conventional models of USG global health development projects, the thrust of all health care improvement (HCI) activities and interventions is to improve the quality of care by transferring knowledge and skills.

The QI methodology has been applied to solve systematic issues that impede delivery of quality services. Through understanding the step-by-step approach to improving the quality of work, participants can move on to solve other pending issues. Monitoring change is a central tenet of the QI process. It allows providers to see the results of their changed practices, to continually assess whether they are achieving their intended outcomes, and if not, what part of the system needs to be changed.

Figure 6. URC Collaborative Model for Improvement[10]



URC identified potential improvement topics that included models developed through prior USAID-supported MCH projects, as well as priority areas specified in the Russian National Health Project. The project was implemented in cooperation with the Federal Public Health Institute (PHI), a long-term partner of the URC, as well as the Ivanovo Scientific Research Institute of Motherhood and Childhood and the Kulakov Center. Experts from these institutions were involved in the preparation of implementation (change) packages. Initially URC selected three target regions[11] in the Central Federal District and added three more[12] in 2010. Contacts with oblast authorities were managed by PHI. Oblast health authorities selected facilities to participate in the project. Each facility was asked to appoint an improvement team that it would send to the first learning session in the oblast capital city.

URC offered regions and facilities a choice between 10 evidence-based practices which had demonstrated effectiveness in Russia and been shown to be incompletely implemented in Russia. They selected from those for the demonstration (phase 1) collaborative. Following the demonstration collaborative, results were synthesized and written Change Packages prepared in draft based on those results. The detailed practices spelled out in the change packages were then rolled out to additional regions and facilities as part of a spread (phase 2) collaborative, which included improvement testing and learning session steps. At the conclusion of the phase 2 collaborative the draft change packages were revised and published.

At the first *learning session* teams were trained in QI methodology, presented with potential improvement topics, and then asked to select topics for their facilities. Facilities that selected the same improvement topic became members of a collaborative – a network of sites that learn together working on a common aim. The session ended with training on the use of a 'web-communicator' designed to help the teams share their working documents and results.

[10] USAID, 2009
[11] Yaroslavl, Kostroma and Tambov oblasts
[12] Tver, Ivanovo and Tula oblasts.

The first session was followed by a *series of action periods* interspersed between learning sessions. During action periods, the teams were to plan and implement improvement activities, monitor and analyze their results, and adjust activities if necessary. All plans made by the teams had to be documented and the documentation had to be upload to the 'communicator' to be reviewed by project experts. During each action period each facility was visited by a team of clinical and QI experts who helped the team focus its work. Experts were from PHI, Ivanovo Scientific Research Institute of Motherhood and Childhood, and Tver facilities. Learning sessions were face-to-face meetings during which team members shared their experiences through presentations and informal exchange.

2.5.2. IFH/JSI Model for Introducing Evidence-Based Best Practices

IFH/JSI followed an implicit model that is depicted in Figure 6 based on evidence collected in the course of the evaluation from various sources. This model was reviewed with the IFH director Natalia Vartapetova who has confirmed that it accurately reflects the IFH approach.

The main focus of the IFH/JSI work under this project was the introduction of Evidence-Based Best Practices.

The work cycle begins with selecting a topic – an area of practice that is in some way problematic and can be improved. IFH professional staff members with both strong research and management backgrounds and experience providing health care services to mothers and infants make this selection. The selection of a topic often includes consultations with healthcare professionals in the lead research institutions and IFH network from the selected regions.

The IFH team then studies best practices and decides how to proceed.

In most cases IFH forms a working group of the leading specialists from Russia in a group that could include up to 30 to 40 people. IFH facilitates the group's work to develop recommendations and clinical protocols or manuals on how to improve practices.

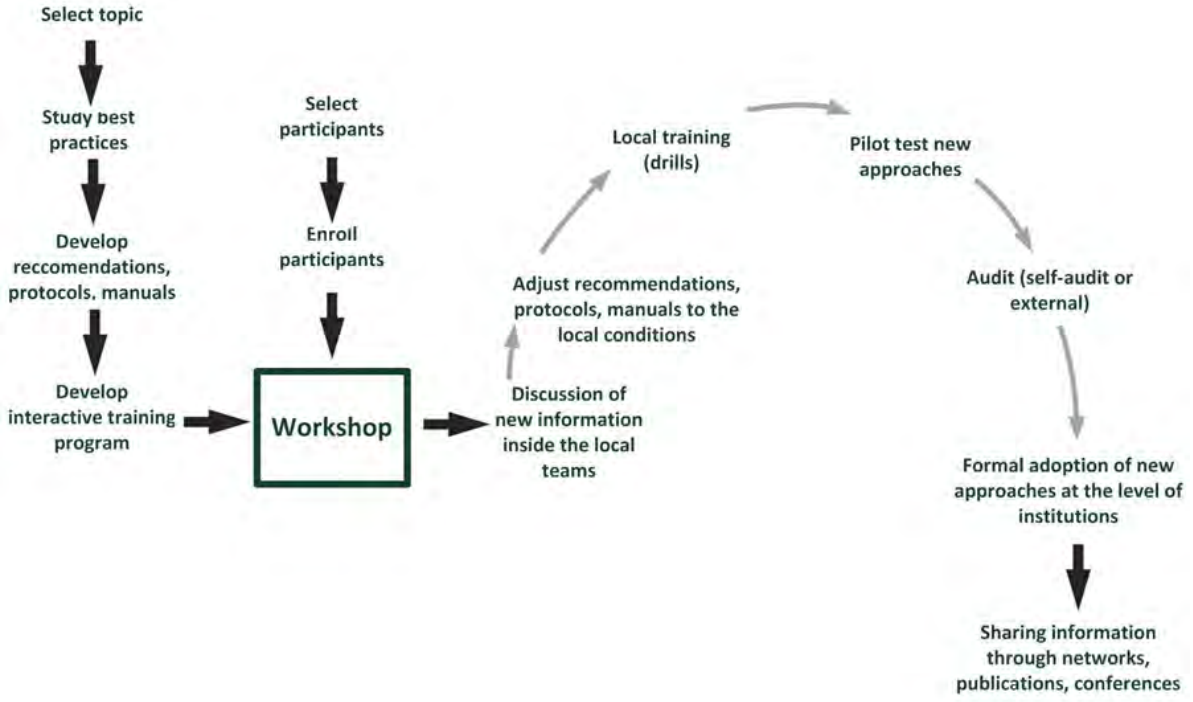
Meanwhile, the IFH staff develops an interactive training program to introduce evidence-based practice. The key element of the IFH/JSI model is an interactive workshop (usually five days long) where the transfer of knowledge from IFH/JSI to the participants occurs.

Participants are carefully selected with the assistance of regional authorities. Participants' interests as well as their opportunities for implementation of new practices are considered in the selection process. Thorough knowledge of the region helps identify the right people from the right healthcare institutions.

At the end of each workshop, participants develop their own action plans. Participants usually *present the new information* to their colleagues and have a *discussion* with them.

In most cases each institution has to *adjust new practices* to their own context and *train staff*.

Figure 7. IFH/JSI Model for Introducing Evidence-Based Best Practices



The new *approach is pilot-tested* and the quality of its implementation is *audited* by local staff or external auditors (who, in some cases, could be IFH specialists).

The next step is *formal adoption* of the new practice at the level of organization.

Finally, since participants are connected through an informal IFH network, they *share information* with colleagues, make formal presentations at various conferences, and publish articles in specialized journals.

Conclusions:

1) *Both implementing agencies have distinct intervention models. The URC model is explicit and well described; the JSI model is implicit.*
2) *The URC model is based on the IHI's quality improvement methodology and includes several learning sessions with practical teamwork in between. URC provides clear guidelines on how to implement changes and has a mentoring system that supports change activities.*
3) *The JSI/IFH model is built around interactive workshops as a means of knowledge transfer and relies on participants and their knowledge of local context to implement new practices.*
4) *Both models imply sharing new experience through various channels.*

Recommendation:

IFH should describe its intervention model and make it public.[13]

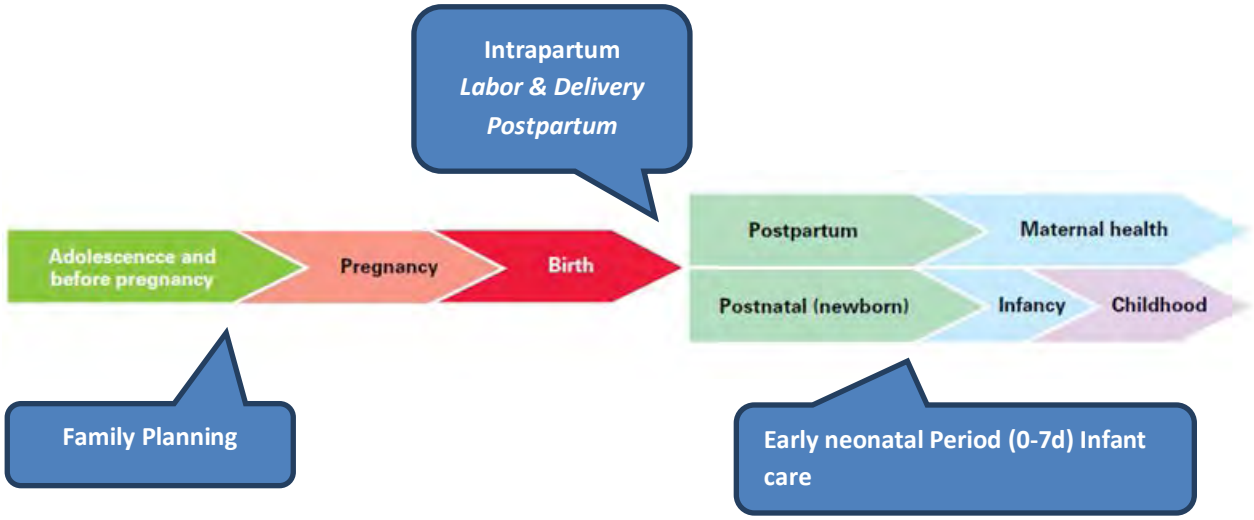
[13] This recommendation is addressed to the Institute for Family Health and could be considered by JSI.

3. PROJECT FINDINGS: GOALS AND DELIVERABLES

3.1. Focus of MCHP Interventions

The World Health Organization's (WHO) "lifecycle continuum of care" (WHO & UNICEF, 2009) approach is one that has been broadly adopted in the field of MNCH. Figure 8 below is an adaptation of this continuum putting the focus on the woman and child's stages of life. The entry points of MCHP interventions are indicated by the bubbles.

Figure 8. The lifecycle continuum of care and MCHP interventions



The MCHP has been focused on three strategic points in the life cycle: *the reproductive years, pregnancy, and the newborn*. Interventions at each of these points in time were appropriately focused on Russia's needs: family planning for women of reproductive age, the intrapartum period of pregnancy which includes labor and delivery and immediate postpartum (before discharge from the hospital) and during the early neonatal period for newborns.

3.2. Causality of the observed results

This section discusses the importance and meaning of statements concerning the causality of the project's results.[14] It also looks at the problems involved in trying to infer causality and proposes an approach (the so-called 'contribution analysis') that could be used to identify a plausible contribution of the project to the health outcomes that occurred in the target regions. The following sections 3.3 and 3.4 describe which health outcomes were most likely affected by the project under evaluation.

3.2.1. Do we know what would have happened had the project not been implemented?

MCHP was developed and implemented to result in positive changes. Is it correct to assume that without the project no change would be observed? No. Most likely, even without the project, the observed changes in the health outcomes would have occurred at some level. There are many other factors at play in addition to the impact of the project's activities. Such things as

[14] Two publications were used as a basis for this section: Mayne (1999) and Treasury Board of Canada (1998)

government programs, economic factors, social trends, and the like can all have an effect on the health outcomes.

By saying that a project produced or caused a certain result means that if the project had not been in place, that result would not have occurred. In order to make a causal inference ideally one should compare two situations that are identical in every respect, except for the project. Any difference between the two situations can be attributed to the project, since the situations were initially identical and were exposed to the same external influences. Such an ideal design cannot be perfectly implemented for the project under evaluation.

Another challenge related to inferences about the causality of the project results is the way those results were formulated. Both implementing agencies were aiming at decreasing maternal and infant mortality in the selected regions, which indeed are high-level outcomes that depend on numerous factors and are affected by the project indirectly.

We would also like to refer to the IFH comment on the draft of this report that states: "Absolute numbers[15] in the regions are so small and the project duration is so short that any changes at the regional level cannot be statistically significant." We fully agree with that and will discuss it in a greater detail in the following sections.

Thus, in this evaluation, we cannot assert what would have happened had the project not been implemented. Further, one cannot make statistically valid inferences about *causal attribution* – the probability that maternal and infant mortality and morbidity would not demonstrate the same decrease in the absence of MCHP. This is neither good nor bad, but it is important to consider this while discussing project results and especially while presenting them to the external audience.

3.2.2. Contribution analysis

While we are able to provide considerable evidence on the project's effects and significantly increase our understanding of how the project impacts certain outcomes, there will never be a 100 percent causal certainty. Instead, we analyzed the project's results based on how they *may* have contributed to certain outcomes. This in turn increases our knowledge of what the project accomplished, and how. It also increases our knowledge of the project's plausible contribution to achieving overall results.

Hence, "we may need to rethink what measurement can usefully mean. Measurement … is less about precision and more about increasing understanding and knowledge. It is about increasing what we know about what works in an area and thereby reducing uncertainty. This view of measurement implies that we can almost always measure things, and in particular the contribution a program is making. That is, we can almost always gather additional data and information that will increase our understanding about a program and its impacts, even if we cannot "prove" things in an absolute sense. We need to include softer and qualitative measurement tools in our concept of measurement..." (Mayne, 1999, p.5) Such approach is often labeled in the evaluation literature as 'contribution analysis.'

In order to implement contribution analysis one has to:

- Present the logic of the intervention;
- Identify changes that occurred;
- Gather additional relevant evidence when needed; and

[15] Infant and maternal mortality rates

- Discuss, and test alternative explanations of the changes that occurred.

3.2.3. Do we need to discuss causality if the project interventions are based on the internationally recognized best practices?

It depends on the context of the discussion. If one needs to select practices to be implemented (at the design stage of the project), then existing international experience could be a sufficient foundation for making decisions. If one needs to demonstrate project results, it is essential to make causal inferences about the project interventions implemented under specific circumstances.

The analogy here might be prescribing a new medicine to a patient. When the doctor chooses the medicine, s/he considers existing evidence on how the medicine worked in the past for other patients (research results included). But in each particular case, the doctor would carefully watch how the medicine works for the patient who indeed has unique features. The doctor would never assert that the medicine helps a particular patient only on the basis of existing international research without consideration of the patient's actual experience.

Conclusions:

1) *It is essential to discuss causality of project interventions implemented under specific circumstances to demonstrate project results.*
2) *It is impossible to make statistically valid inferences about the causal attribution of changes in maternal and infant mortality and morbidity rates to the presence or absence of MCHP actions.*
3) *It is possible to provide considerable evidence on the project's effects and to significantly increase understanding of how the project is impacting on health outcomes.*

3.3.Results of "Improving Care for Mothers and Babies" Activity

3.3.1. Accomplishment of the key tasks

The overall goal of the project implemented by URC was to assist counterparts in six Russian oblasts in reducing rates of maternal and infant mortality and morbidity, and to reduce abortion rates through more appropriate use of family planning and modern contraceptive methods.

To achieve this goal URC was supposed to accomplish nine key tasks. Based on the evaluation data collected, Table 1 shows the actual results achieved in accordance with each task.

Table 1. ICMB Activity key tasks and actual results

Key ICMB tasks	Main results
1) To **identify the major problems** in maternal health, infant health and reproductive health	The priority intervention areas were identified: 1) prevention of neonatal hypothermia; 2) labor management; 3) neonatal resuscitation; 4) regionalization of perinatal care, including prevention and management of preterm birth; 5) expansion of breastfeeding; 6) prevention of unplanned teen pregnancies, abortions and sexually transmitted infections
2) To **train providers** of maternal and infant care and reproductive health care and leadership at the oblast level in basic quality improvement methods	Representatives of 45 facilities from 6 oblasts trained in basic quality improvement methods.

3) To **initiate implementation of improvements** in delivery of maternal and child health and family planning services	- Preventing neonatal hypothermia (29 facilities) - Improving labor management with use of the partograph (21 facilities & all of Kostroma oblast[16]) - Primary neonatal resuscitation (6 oblasts & 18 pilot facilities) - Regionalization of perinatal care, including prevention & management of preterm birth (6 oblasts & 15 pilot facilities) - Expanding breastfeeding (16 facilities & all of Tambov oblast) - Prevention of unplanned teen pregnancies, abortions & STDs (10 facilities and all of Kostroma oblast) See Annex 7 for more details.
4) To develop and test revised **definitions of national indicators** of quality maternal and child health care and family planning	The project has developed a comprehensive system of process and health outcomes indicators that were used by participating facilities.
5) To **develop and test Written Change Packages, norms and standards** that will allow widespread institutionalization of evidence-based standards and improvements in care	The project developed 6 Written Change Packages. 4 of them were finalized and published on www.healthquality.ru: - Use of partograph; - Prevention of hypothermia; - Prevention of unwanted pregnancies, abortions and STDs among teens; - Broadening implementation of breastfeeding practices
6) To **develop an online/CD based training course** in quality improvement methods.	An online 72-hour course was developed and is available online free of charge.
7) To **adapt Russian "Communicator" web portal**	Russian "Communicator" was developed to support the real-time reporting, collection and monitoring of data on MCH/reproductive health care processes and outcomes.
8) To identify and spread into target regions organizational improvements supporting **coordination of medical and social services to prevent child abandonment**	The project has supported the introduction of a model of early child abandonment prevention through cooperation between health, social and education institutions in Tambov region.
9) To work with target regions to support and develop the **effective organization of perinatal care on a regional level**	The project worked with Departments of health of 5 out of 6 target oblasts to make improvements in the organization of perinatal care. Regionalization of care – assistance provided with implementation of principles introduced by the MOHSD.

3.3.2. ICMB Activity and Infant Mortality

According to the Scope of Work one of the expected results of the ICMB project was a five percent decrease (from the baseline) in infant mortality rates in target regions.

Figure 9 shows the infant mortality rates in six oblasts targeted by the project and – for comparison - in three nearby oblasts. Three oblasts where the project started working in late 2010 and early 2011 can also serve as a comparison group for the first three target regions over the first two years of project implementation. Activities in the first three regions started only in May 2009 so no significant changes could be expected in 2009.

[16]When oblasts are mentioned here, it means that the respective Oblast Department or Health issued an official directive that applies to all the healthcare facilities in that oblast

Figure 9. Changes in infant mortality[17] (%) from baseline[18] during the period of project implementation (2009-2011) in target and comparison regions.

(Source: Roscomstat)

By the end of the project the infant mortality was below the baseline in four out of six target regions and in all three comparison regions. None of the three target regions where the project was implemented for three years demonstrated a steady decrease of infant mortality rate over those three years, while two of the three comparison oblasts (Vladimir and Ryazan) did.

It is important to note that all the practices implemented by the project facilities were evidence-based. Notably there is solid research evidence confirming that they are effective if implemented properly. Internal auditing and monitoring is a part of the QI process used by the facilities participating in the ICMB project. Thus, implementation of the new practices was under control.

Representatives of the project facilities visited by the Evaluation Team reported that they observed a decrease in the number of infant deaths after the new practices were implemented, subsequently associating the decrease with the introduction of new practices. For example, the Perinatal Center of the Kostroma Oblast Hospital introduced practices aimed at the prevention of respiratory ailments among newborns. The number of deaths from respiratory distress syndrome, the cause of neonatal mortality targeted by the project, decreased from five in 2009 to zero in 2011 (Table 2). But the increase of deaths because of congenital problems offset the positive effect created by the project.

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

[18] For target regions of Kostroma, Tambov and Yaroslavl and comparison regions of Smolensk, Vladimir and Ryazan, the baselines reflect the infant mortality rate in 2008, For the Ivanovo, Tver and Tula regions that joined the project in late 2010 or early 2011, the baselines reflect the infant mortality rate in 2010

Most facilities visited by the evaluators believe that the new practices helped decrease the number of infant deaths, but facility specific statistics were not available to evaluators as there was an agreement with the implementing agencies that evaluators will not ask for such statistics to avoid tension and further complications.

Table 2. Neonatal mortality at the Perinatal Center of the Kostroma Oblast Hospital in 2009-2011

Year	Total number of neonatal deaths	Number of neonatal deaths because of respiratory distress syndrome
2009	10	5
2010	3	2
2011	4[19]	0

Four out of six collaboratives established by the project were promoting practices mitigating the causes of perinatal and early neonatal mortality. The fifth collaborative's focus was on expanding breastfeeding, which affects infant mortality and child health. The sixth collaborative introduced practices aimed at prevention of pregnancies, abortions and STDs among teens. None of the collaboratives was addressing the causes of infant mortality outside maternity hospitals, which contribute to the overall infant mortality rate. For example, the number of infant deaths in Kostroma region increased from 53 in 2010 to 57 in 2011. This increase resulted from increased neonatal mortality caused by congenial problems as well as by other reasons, i.e. two infants were murdered by their mothers and one infant died in a fire.

Figure 9 compares dynamics of infant mortality in the target oblasts and the neighboring oblasts that were used for comparison. The decrease in infant mortality turns out to be somewhat similar and does not depend on whether or not oblast was covered by the MCHP.

The extent of the project's intervention into participating facilities was uneven. Annex 8 shows that only two out of 43 participating maternity facilities (five percent) were involved in five collaboratives. The majority – 27 facilities (63 percent - participated only in one or two collaboratives. In part, the low number of facilities participating in five collaborative can be explained by the observation that the facilities have such a large amount of work to do, which limits their ability to fully participate in more than one or two collaborative.

Further, the project did not reach all maternity facilities in target regions. The data on the project reach (defined as the percentage or proportion of the target audience involved in a given intervention or part of an intervention) was not readily available for the Evaluation Team from the project documentation. The Team managed to calculate these data for three target oblasts using materials available in the project library at www.healthquality.ru (see Table 3).

Prikaz #808 adopted by the Russian Ministry of Health and Social Protection in 2009 has divided maternity hospitals into three groups based on their capacity to provide medical care for mothers and babies. Group 1 facilities can offer only simple basic care; because they do not have critical care equipment, they should service only mothers with low risk of complications and negative health outcomes. Group 2 serves mothers with the medium risk of complications and Group 3 – with high risk.

[19]Two infants died because of congenital anomaly, and two because of congenital pneumonia.

Table 3 shows that the ICMB activity achieved the highest reach to Group 2 facilities that service women with medium risk of complications. The available data also indicates that the majority of births in the target regions were taking place in the facilities involved in the project.

Table 3. Project reach in Kostroma, Yaroslavl and Tambov regions.

Kostroma region

Group/ Level of risk	Total # of facilities	# of project facilities	Project reach
1 - Low	9	4	44%
2 - Medium	2	2	100%
3 - High	0	0	

Yaroslavl region

Group/ Level of risk	# of facilities	# of project facilities	Project reach	# of births in 2010	Perinatal mortality rate in 2010	Early neonatal mortality rate in 2010
1 - Low	9	0	0%	696	3,15	1,4
2 - Medium	9	5	56%	11964	4,11	1,2
3 - High	1	0	0%	1678	18,05	3,5

Tambov region

Group/ Level of risk	# of facilities	# of project facilities	Project reach	# of births in 2010	Perinatal mortality rate in 2010	Early neonatal mortality rate in 2010
1 - Low	19	0	0%	1011	5,9	1,9
2 - Medium	6	6	100%	6267	4,3	0,8
3 - High	1	1	100%	2755	9	0,7

If regionalization works properly, Group 1 facilities should have the lowest perinatal and early neonatal mortality rates while Group 3 facilities should have the highest. The data in Table 3 do not follow this pattern (except for perinatal mortality rates in Yaroslavl region). But several interviewed physicians mentioned that based on the information they received in the course of professional exchanges with colleagues, they were sure that Tambov had the most effectively working regionalization system. As all interviewed staff at the participating facilities said that the ICMB activity gave them a strong impetus for adopting best clinical and organizational practices that eventually lead to improved health outcomes for mothers and babies, it is plausible to assume that Group 2 facilities have lower infant mortality rates than Group 1 facilities because of the ICMB activity intervention. The fact that infant mortality rates are much lower in Group 3 facility in Tambov region that was involved in the initiative compared to Group 3 facility in Yaroslavl region that was not involved in the initiative also suggests plausible contribution of the ICMB activity to decrease of infant mortality in participating facilities.

Some other important factors that affect infant mortality should be considered as well.

Factors that most likely contributed to decrease of infant mortality

- GOR efforts to support healthcare institutions – an example is the National Priority Health Project purchased modern resuscitation equipment.
- New Federal regulations and protocol on resuscitation.

- Efforts of local medical staff.

According to some informants in the regions factors that potentially could increase infant mortality in some regions include natural disasters such as wildfires that covered a number of cities with smoke for a considerable amount of time in 2010. Some respondents believed that the increase of congenital anomalies in early 2011 was due to exposure of pregnant women to this smoke in summer 2010.[20]

3.3.3. ICMB Activity and Maternal Mortality

According to the Scope of Work, the project was expected to decrease maternal mortality rates in target regions by five percent (from the baseline). Table 4 shows the rates of maternal mortality in the target regions from 2007 to 2010. The absolute number of deaths is low. For example the rate of 49 deaths per 100,000 live births in 2009 in Kostroma region includes four actual deaths of mothers.[21] In 2006-2009 there were 15 maternal deaths in the Kostroma region, or 3.75 cases per year. In the Yaroslavl region in 2001 there were two maternal deaths; in the Tambov region there was one. Given the low number of maternal deaths, a five percent change in the maternal mortality rate can happen without any changes in the absolute number of maternal deaths. And maternal death is already such a rare event, that it would not be reasonable to analyze the project effect on the number of maternal deaths.

Table 4. Maternal mortality ratio[22] in target regions from 2007 to 2010

	2007	2008	2009	2010	Change between 2008 and 2010
Russian Federation	**22**	**20,7**	**22**	**16,5**	**-20%**
Kostroma oblast	40,2	51	49	49,4	-3%
Tambov oblast	40,4	19,7	9,9	9,7	-51%
Yaroslavl oblast	53,5	44	27,9	13,9	-68%
Ivanovo oblast	18,8	18	17,6	18,1	1%
Tver oblast	14,2	6,8	13,3	20,2	197%
Tula oblast	15,2	14,2	20,3	13,6	-4%

(Source: Roscomstat)

3.3.4. ICMB Activity and Abortion Rates

According to the Scope of Work the activity was expected to decrease abortion rates in target regions by five percent (from the baseline). A decrease in abortion rates in three regions targeted by the activity from 2009 to 2010 is noticeably higher than in comparison regions (see Table 5).

The activity included training of trainers on reproductive health counseling and support visits to clinics on reproductive health counseling. In phase 1, there were two target groups, teens age 17 and under and women at high medical and social risk. In phase 2, Kostroma oblast participated oblast-wide.

[20]This is an illustrative statement – just an expert opinion, no statistical evidence is available. We included it to demonstrate the range of potential factors that could affect health outcomes.
[21]Medical and demographic situation in the Kostroma region in 2009. Retrieved on April 9, 2012, from 44.rospotrebnadzor.ru/img/news/files/320.doc
[22]number of deaths per 100,000 live births

Facilities involved in this collaborative achieved a decrease in teen abortion rates in the areas that they serve. For example, the Kostroma Center for Family Planning & Reproduction reported that the project helped them to reduce the absolute number of pregnancies in girls of less than 15 years old in Kostroma from 139 in 2009 to 73 in 2011, thus contributing to a decrease in the number of abortions in this age group. But given that in 2009 there were 7704 abortions in the Kostroma region, the effect of this facility on the overall picture in the oblast was relatively small.

An internal activity audit found spill-over effects to the general women's consultation population. Among four clinics that established youth-friendly services, 88 percent of eligible women age 18+ were found in August 2010 to have received reproductive health counseling. (Pregnant women and women with infertility problems were considered not eligible). Kostroma, Tambov and Yaroslavl oblast also addressed the quality of pre- and post-abortion counseling. Mid-2011 client survey conducted by the implementing agency found that rates of pre-and post-abortion counseling on family planning reached over 90 percent of abortion clients and that 91 percent of clients surveyed said they planned to use a specific contraceptive method in the future.

Table 5. Number of abortions per 100,000 births in target and comparison oblasts from 2007 to 2010

		2007	2008	2009	2010	Change between 2008 and 2010
	Russian Federation	**92**	**81**	**74**	**67**	**-17%**
Project regions	Kostroma oblast	124	116	95	82	-29%
	Tambov oblast	103	94	85	77	-18%
	Yaroslavl oblast	122	114	91	80	-30%
Comparison regions	Ivanovo oblast	102	89	89	88	-1%
	Tver oblast	110	104	95	92	-12%
	Tula oblast	109	95	85	81	-15%
	Smolensk oblast	108	98	85	81	-17%
	Vladimir oblast	100	93	85	79	-15%
	Ryazan oblast	94	78	63	62	-21%

(Source: Roscomstat)

While these changes cannot be attributed exclusively to the activity under evaluation, there is enough evidence that confirms the activity's plausible contribution to the decrease of the abortion rates in Kostroma and Tambov oblasts. Yaroslavl region was less actively involved in the activity, and no facility in the Yaroslavl region joined this collaborative.

3.4. Results of "Institutionalizing Best Practices in Maternal and Child Health" Activity

The overall goal of this activity implemented by JSI/IFH was to decrease maternal and infant morbidity and mortality in the target federal districts.

3.4.1. Accomplishment of the key tasks

In order to achieve the overall IBPMCH goal five key tasks needed to be accomplished by JSI/IFH. Table 6 describes those tasks and the actual results achieved by the implementing agency in accordance with each task.

Table 6. IBPMCH Project key tasks and actual results

Key IBPMCH tasks	Main results
Task 1. Establish partnership with federal-level centers to support their leadership role in operationalizing MCH best practices in two federal districts.	Partnerships established with Kulakov Federal Center for Obstetrics, Gynecology and Perinatology in Moscow (Kulakov Center) and the Federal State Research Institute for Maternity and Infancy in Yekaterinburg (Urals Institute). Key areas for collaboration: - Promotion of evidence-based care - Implementation of best practices - Development of training and resource capacities of two federal centers - Collaboration with ACOG Collaboration with Kulakov Institute: joint research, writing projects, clinical audit, training etc. Urals Federal Research Institute for Protections of Mothers and Babies: - Adopted best practices at its maternity facility - Adopted clinical audit approach - Uses best practice in training courses - Uses best practices learned from ACOG
Task 2. MCH best practices related to major causes of maternal and infant morbidity and mortality adopted by target regions/federal districts.	Conducted assessments of the quality of perinatal care in various types of health facilities, their preparedness to provide emergency care and the practical skills of specialists. Conducted over 20 training courses on Family-Centered Maternity Care, Family Planning, Antenatal Care, Emergency Obstetric Care, Breastfeeding, Pediatric Care and Neonatal Resuscitation in project regions and for the Federal Centers. Over 600 health workers participated. Project staff and experts reinforced the trainings through supportive supervision (follow-up visits, e-mail communications). Tyumen and Vologda Regions were designated as training sites and started their activities by hosting visits from other regions.
Task 3. Disseminate recommendations on optimizing the delivery of MCH/RH care at regional (oblast) level	Two regions (Leningrad and Kurgan) selected for targeted technical assistance to build frameworks for a three-tiered (regionalized) system of MCH care. A two-day international conference on Regionalization of Perinatal Care organized in Tver (May 2010) in collaboration with URC, Kulakov Center and others. URC played the key role in organizing and funding the conference. Consultations provided for the two selected regions on specifying the number of health facilities needed at each of the three levels of care, the scope of services at each level, equipment and staffing plans, transportation pathways and training needs. A four-day workshop on development of guidelines on regionalization of perinatal care conducted.
Task 4. Develop an integrated model of Family Planning and social services in up to three regions within the two selected federal districts	Khanty-Mansiysk Autonomous Okrug (KHMAO) and Tyumen Region were designated as sites for implementation. Conducted study of evidence-base and legal framework for integration of health and social services in MCH/RH; international best practices to improve MCH outcomes among high-risk women. Definition of high-risk women developed. Tool to assess current practice in providing health and social services developed and pilot-tested. The assessments were conducted in Tyumen Region and KHMAO. Workshop conducted on Medical and Social Assistance to High-Risk Women.

	A questionnaire was drafted for use by health providers in women's consultations, maternities and children's polyclinics when interviewing women to assess clients' risk according to social status.
Task 5. Develop sustainability plan.	The project developed a Sustainability Plan that was approved by USAID. A more detailed discussion of sustainability issues is included into the following chapter of this report.

3.4.2. Infant Mortality in the IBPMCH Activity Regions

As mentioned above, infant mortality nationally and in the project regions has shown a downward trend since 2007. The national rate has dropped from 9.4 to 7.5 (almost 20 percent) from 2007 to 2010 and the rate in the project regions has also fallen by almost 20 percent (from 8.3 to 6.6) between 2007 and 2010 (Table 7).

Table 7. Infant mortality nationally and in the project regions

	2007	2008	2009	2010
Russian Federation	9.4	8.5	8.1	7.5
IBP-MCH Regions	8.3	8.0	7.4	6.6

(Source: IFH/JSI Mid-Term Report)

At the regional level (see Table 9), Kurgan Region has shown the greatest decrease, at 27 percent (from 12 to 8.7), but it also continues to show the highest rate overall among the project regions. Kurgan and Chelyabinsk are the only regions with an infant mortality rate higher than the latest reported national rate of 7.5 in 2010.

Table 8. Infant mortality rates in target oblasts in 2007 to 2010

	Joined the project in	2007	2008	2009	2010	Change from 2009 to 2010
Russian Federation		**9.4**	**8.5**	**8.1**	**7.5**	-7.4%
Vologda oblast	2004	9	7.7	7.8	7.4	-5.1%
Leningrad oblast	2008	7.6	7.9	5.5	6.1	10.9%
Moscow oblast	2008	8	7.5	7.4	6.7	-9.5%
Moscow	2010	6.9	6.3	6.7	6.1	-9.0%
Kurgan oblast	2007	12	10.1	10.5	8.7	-17.1%
Sverdlovsk oblast	2009	7.8	7.6	6.4	6.1	-4.7%
Tumen oblast	2004	7.4	7.1	6.1	6.2	1.6%
Khanty-Mansisk okrug	2007	5.6	5.2	4	4.3	7.5%
Yamalo-Nenetsk okrug	2012	13.3	11.4	10.7	12.2	14.0%
Chelyabinsk oblast	2011	9.1	8.7	8.4	7.6	-9.5%

(Source: Roscomstat)

3.4.3. Maternal Mortality in the IBPMCH Activity Regions

Overall, IBPMCH regions have presented a marked downward trend in maternal mortality from 2007 to 2010 (41.8 percent or from 19.6 to 11.4). The available data show lower maternal mortality in IBPMCH regions from 2007 to 2010 compared to the Russian Federation as whole.

Table 9. Maternal mortality ratios nationally and in the activity regions

	2007	2008	2009	2010
Russian Federation	24.2	22.6	25.6	18.6
IBP-MCH Regions	19.6	17.3	11.2	11.4

(Source: IFH/JSI Mid-Term Report)

However, the disaggregated regional-level data (Table 10) show downward trends only in Tyumen, KHMAO and Sverdlovsk, while the other seven project regions show sharp increases in 2009 and 2010 that have been attributed[23] to the virulent flu epidemics of those years.

Table 10. Maternal mortality ratios in target oblasts in 2007 – 2010

	Joined the project in	2007	2008	2009	2010	Change between 2009 and 2010
Russian Federation		**22**	**20,7**	**22**	**16.5**	-25%
Moscow oblast	2008	20.4	14.2	12.1	11.7	-3%
Moscow	2010	16.8	15.8	14.6	17.9	23%
Vologda oblast	2004	21.2	6.8	13.2	39.7	201%
Leningrad oblast	2008	7.3	28	33.3	6.7	-80%
Kurgan oblast	2007	35.8	33.8	25.1	25.4	1%
Sverdlovsk oblast	2009	17.8	25.8	21.3	15.6	-27%
Tumen oblast	2004	8.3	19.6	11.3	5.5	-51%
Khanty-Mansisk okrug	2007	9.1	21.6	12.6	8	-37%
Yamalo-Nenetsk okrug	2012	0	25.3	12.2	0	-100%
Chelyabinsk oblast	2011	21.8	15.6	35.1	17.2	-51%

(Source: Roscomstat)

3.4.4. IBPMCH Activity and infant and maternal mortality

In order to discuss possible project contribution to the decrease of infant and maternal mortality in the project regions, we use arguments developed for the ICMB Activity earlier.

New practices addressed the key causes of infant and maternal mortality in the target regions identified by the project at the initial assessment stage.

All of the practices implemented by the activity were evidence-based and should have produced good results if implemented properly. The activity is consistent at implementing an evidence-based approach. All of the clinical protocols and guidelines developed by the activity were based on a thorough study of the best evidence - nationally and internationally. In particular, implementation of Task 4 included such a study related to high-risk women.

Proper implementation of the new practices was confirmed by the auditing mechanisms. The project developed auditing methodology and auditing tools specific to each of the practices. Many of the project participants were trained to use those tools and implemented them. It is important to note that the use of a clinical audit (self-audit) was not mandatory for the project

[23] By some experts interviewed in the course of evaluation. This is an illustrative statement – just an expert opinion, no statistical evidence is available. We included it to demonstrate the range of potential factors that could affect health outcomes.

participants although it was strongly recommended and promoted by the project team and its partners. External clinical audits conducted by the project team demonstrated feasibility of the proposed approach and its effectiveness.

Audits identified the overall levels of fidelity to the practices (see Table 11) and provided specific recommendations on how to improve the situation in the institution that is being audited.

Table 11. Fidelity[24] to essential neonatal practices at selected medical facilities in target oblasts

Region	Facility	Fidelity (%)
Moscow	Maternity hospital #4	75.0
Moscow oblast	Moscow oblast center (Balashikha)	62.9
Sverdlovsk oblast	Ekaterinburg city perinatal center	88.6
	Sverdlovsk oblast perinatal center	76.4
Tumen oblast	Maternity hospital #3	97.1
	Tumen oblast perinatal center	95.7
Yamalo-Nenetsk okrug	Noyabrsk maternity hospital	31.4

(Source: Results of clinical audits conducted by IFH staff)

Physicians at the facilities participating in the project asserted that they observed decrease in the number of infant deaths as a result of implementation of new practices. Maternal deaths appeared to be extremely sensitive issue and it was not addressed by our informants.

According to our respondents and project documents several regions such as Kurgan, Tyumen, Khanty-Mansisk okrug and Yamalo-Nenetsk okrug the new practices were implemented by the facilities where the vast majorities of births occurred[25].

Table 12. Activity reach to maternity hospitals in selected target oblasts

Oblast	Joined the project in	Total # of maternity hospitals	# of facilities reached by the project	Project reach, %
Sverdlovsk oblast	2009	53	9	17%
Chelyabinks oblast	2011	43	8	19%
Khanty-Mansisk okrug	2007	22	22	100%
Yamalo-Nenetsk okrug	2012	12	10	83%
Vologda oblast	2004	31	7	23%

Intra-regional coverage was the best in the Ural Federal okrug where all six oblasts participated in the project (Table 13).

Table 13. Activity reach in the target Federal Districts

Federal District	Total # of oblasts	# of oblasts reached by the project	Project reach, %
Central	18	2	11%
North-Western	11	2	18%
Urals	6	6	100%

[24] Extent to which facilities properly use essential neonatal practices introduced by a project
[25] With 100% coverage in Khanty-Mansisk okrug

Other important factors that could affect infant and maternal mortality in the IBPMCH activity regions are similar to the ones described for ICMB activity and are not region specific.

Conclusions:

1) *All of the key ICMB and IBPMCH tasks were accomplished in a timely manner and in accordance with the respective Scopes of Work and Work Plans requirements.*
2) *It is impossible to make statistically valid inferences about causal attribution, i.e. whether maternal and infant mortality and morbidity would demonstrate the same decrease in the absence of MCHP. Because of this technical limitation, the focus of the evaluation has to be on assessing the plausible contribution of MCHP to health outcomes within an appropriate context, i.e. at a regional level, not a national level.*
3) *The evaluation revealed evidence in favor of MCHP's contribution to the decrease of infant mortality in the target regions as a result of the following:*
    - *New practices identified by the project addressed key causes of infant mortality.*
    - *All of the practices implemented by the project were evidence-based and should have produced expected results if implemented properly.*
    - *Proper implementation of the new practices was confirmed by the auditing mechanisms established by the projects.*
    - *Physicians at the facilities participating in the project asserted that they observed a decrease in the number of infant deaths as a result of implementation of new practices.*
    - *In several regions the new practices were implemented by the facilities where the vast majorities of births occurred.*
4) *Several factors that were outside of the project's control also contributed to a decrease in infant mortality in target regions:*
    - *GOR undertakes some major efforts such as National Priority Health Project to support healthcare institutions and decrease infant mortality.*
    - *MOHSD implements new regulations and clinical protocols that decrease infant mortality.*
    - *Local medical staff works hard towards the same goal.*
    - *Infant mortality decrease is an overall trend in Russia.*
    - *On the oblast level project effect was diluted by the fact that the project reached only part of the maternity facilities.*
5) *There is not enough evidence to confirm MCHP's contribution to decreasing maternal mortality in the target regions.*
6) *Sufficient evidence exists to confirm the project's plausible contribution to the decrease of the abortion rates in Kostroma and Tambov oblasts.*

Recommendations:[26]

- *Both USAID and implementing agencies should pay special attention to the formulation of the expected results of the project/activities. The purpose of the project/activity should be formulated so that USAID, together with implementing partners, can materially affect it, and*

[26] These recommendations are directed towards USAID and both implementing partners.

for which USAID/implementing agencies will be held accountable. If the desired result cannot be achieved by a single project/activity, it should be considered the project/activity mission (higher level expected result) rather than project/activity purpose (lower level expected result).

- *While presenting results of MCHP, USAID and implementing partners should be very careful with causal inferences related to the health status of infants and women in the target regions and should use 'contribution' rather than 'attribution' arguments.*
- *Consider using indicators such as reach, dose and fidelity to monitor the projects' performance (see Annex 9 for more information).*

4. SUSTAINABILITY

4.1. Two aspects of sustainability

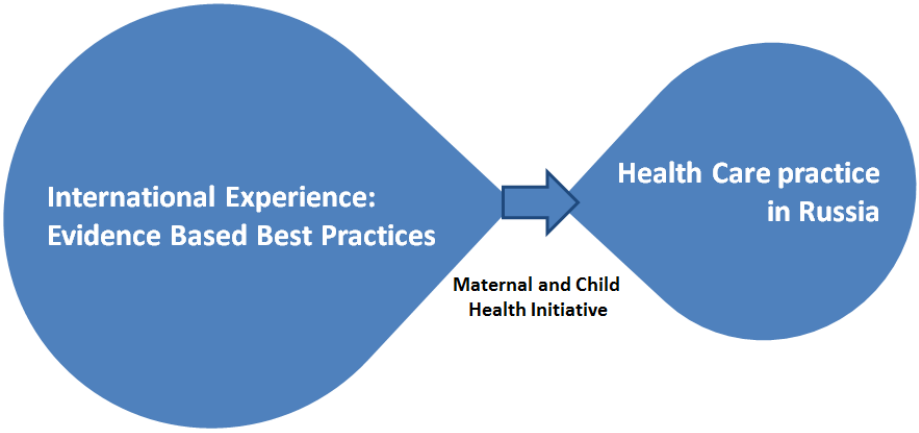
In order to discuss sustainability of MCHP it is important to consider the following two dimensions of sustainability for the project:

- the ability of individual participants and participating institutions to sustain *new practices* implemented in the course of the project; and
- the ability of individual participants and participating institutions to sustain *new approaches to continuous improvement of practices*.

Both projects under MCHP supported the introduction and implementation of evidence-based practices and succeeded in that area. Information on the new practices that were implemented over the course of the project by numerous healthcare organizations was provided in the previous chapter. Since implementation of those practices was formally approved by the federal and/or regional healthcare authorities as well as healthcare providers at the local level, these changes could be considered sustainable. Clients have new expectations resulting from the implementation of the new practices; the clients are getting used to the new approaches which are an additional sustainability factor. It is hard to imagine any reason for cancelling those new evidence-based approaches that contributed to the improvement of the quality of healthcare services.

But both projects not only introduced new practices; they modeled a way for improving practices in the future. This is extremely important because the body of knowledge in the healthcare field is developing rapidly. In order to stay on the cutting edge and continue to provide high quality services, healthcare providers have to revise and update their practices on a regular basis. To do that they need to stay connected to the global evidence base. This will be problematic for the majority of the projects' participants as the only channel that connected them with the global body of knowledge were the two projects that had enough resources to review the most recent publications (in English), translate them into Russian and share them with the participants through the learning sessions/workshops, newsletters, conferences, regular e-mail updates and websites. Most healthcare professionals participating in the two MCHP activities are extremely busy (often overwhelmed) and have no time to surf the web; most of them cannot read English texts; and, finally, many of them – especially in the smaller cities in the regions – have no regular access to internet. Thus, as soon as the MCHP is over, most project participants will lose their connection with (see Figure 9) the international body of knowledge.

Figure 10. MCHP as an information channel: the bottle neck



Evidence-based medicine is defined as "the integration of best research evidence with clinical expertise and patient values" (Sackett et al., 2000). Even the most motivated doctors in Russia will not be able to implement this approach without one of its essential elements – the best research evidence. No Russian research institution is ready at this point in time to serve as an information channel instead of MCHP. Hence, the ability of individual participants and participating institutions to sustain new approaches to continuous improvement of practices has not been developed.

4.2.Introduction of Quality Improvement methodology

The QI methodology introduced by URC requires a separate discussion in the context of sustainability of MCHP outcomes.

There are several factors that contributed to developing capacity to sustain usage of the QI methodology in Russia:

- The QI methodology is very well described (Russian publications are available).
- With the support of URC, the Public Health Institute (PHI) developed a website[27] that is providing information free of charge on QI (including an online training course).
- An online "Communicator" for QI teams is available at the above mentioned website as a tool for information sharing.
- In the past, URC trained a number of Russian QI experts (in Moscow, Ivanovo and Tver in particular) who have an in-depth understanding of the QI methodology, are committed to using QI in their work and are able, equipped and willing to share this methodology with the others.
- PHI established a new unit within its structure, the Center for Health Quality Improvement.
- PHI leadership demonstrates a commitment to using and promoting QI methodology and even declares readiness to look for funding to support QI implementation. They already received two government contracts to develop recommendations on methodology for quality assessment in the Russian healthcare system.

[27] http://www.healthquality.ru/open/index_con.php

- Institutions and healthcare professionals that participated in the project implemented by URC liked the project and are willing to stay involved and connected.
- MCHP identified quite a few healthcare organizations with highly motivated and capable leaders willing to make things better.
- URC has a representative office in Moscow and is potentially available for consultations on QI.
- The President and Prime-Minister of Russia officially stated many times that the quality of healthcare services is and will stay one of the key national strategic priorities; it has also been included into the program statements of the newly elected President of Russia. Funds are already allocated by the GOR to develop national indicators of healthcare quality.

All of these factors constitute a good foundation for future development and implementation of QI methodology in the Russian healthcare institutions. At the same time there are certain limitations and blocks that prevent such development. Those limitations and blocks are:

- Not all local experts trained by URC are able to provide high quality trainings on QI. It is least likely that even the best local trainers without enough training practice will be able to maintain the quality of their work. They also need to participate in the ToT courses on a regular basis. Currently there are no funds available either for local trainings, or for ToTs.
- Implementation of the QI methodology is a major organizational development (OD) effort that naturally faces certain challenges.[28] It should be undertaken with consideration of OD principles and by using most effective and relevant OD approaches. Otherwise sustainable organizational change will not be possible. There were no OD people involved in the current project. Local experts trained by URC are doctors and researchers but not OD specialists.
- PHI has very limited human and financial resources that could be used for QI promotion.
- Activities of the GOR in the area of healthcare improvement are currently limited by capital investments and development of systems for inspection and auditing. Human capital development and system improvement are not adapted as priorities.
- The existing health care system in Russia is based on control and punishment rather than on commitment to continuous improvement. Open information sharing on how the things are is not encouraged. This is a serious barrier for QI as, according to the guru of QI Edwards Deming, “quality is impossible if people are afraid to tell the truth.”

4.3. Institute for Family Health as a sustainability factor

Created with USAID assistance, IFH became a unique Russian NGO that combines strong research background with practical knowledge and systems to share within the Russian healthcare community. IFH is recognized by the lead Russian academic institutions and by

[28]OD literature mentions such challenges as: lack of management commitment, inability to establish a quality culture, lack of employee buy buy-in, non-supportive measurement systems, lack of quality training, underinvestment in the quality initiative, poorly communicated and unrealistic expectations and the lack of organizational alignment.

hundreds of Russian healthcare practitioners all over the country. It is very well positioned to work at the federal level and to provide policy advice to the GOR and MOHSD in particular.

IFH has all of the characteristics of an organization that is often called a "think tank." (see Annex 10 for more details) By identifying and positioning itself as a think tank, IFH may develop new marketing and fundraising strategies. Experience of the economic think tanks supported by the USAID-funded SETT program a few years ago might help IFH develop a new vision. In its sustainability plan, IFH rightly says: "Last but by no means least, IFH itself is a central part of our strategy to spread best practices in MCH/RH, since it was set up – thanks to USAID assistance – as an indigenous Russian organization to disseminate best practices in public health." We fully agree with this statement and would like to add that growing IFH capacity is an outstanding result of the MCH project.

Conclusions:

1) *MCHP succeeded in developing capacity to sustain new clinical practices implemented throughout the project.*
2) *MCHP did not succeed at developing capacity and mechanisms to sustain new approaches to continuous improvement of practices. One of the key problems here is limited access of Russian practitioners to the best research evidence.*
3) *There are several factors that constitute a foundation for future development and implementation of QI methodology, but this process will face serious challenges and will require much more time, effort, resources and leadership commitment to achieve substantial improvements.*
4) *Growing IFH capacity is a salient result of the MCHP and an important factor of sustainability of its outcomes.*

Recommendations:

- *Put special emphasis on developing a mechanism to provide access of Russian health care practitioners to the international body of knowledge – evidence-based best practices.*[29]
- *Keep the quality of healthcare as a central tenet of future programming. This will be in line with the current MOHSD agenda and its urgent needs; will open new opportunities for collaboration with the key local institutional partners such as PHI; will build the next program on the achievements of MCHP; and will allow the use of assets developed by MCHP*[30].
- *Consider IFH's potential in the capacity of a think tank while developing its strategy.*[31]

[29] This recommendation is addressed to USAID and both implementing partners.
[30] This recommendation is addressed to USAID.
[31] This recommendation is addressed to IFH.

5. LESSONS LEARNED

5.1. Program elements that worked particularly well

5.1.1. Interactive trainings

Participants enthusiastically accepted interactive training and requested. There are several important reasons for this high level of interest. For example, doctors and nurses in Russia are used to 'traditional' ways of teaching, i.e. lectures and seminars that do not include participation and interaction. Even today, when the principles of adult learning are well known and interactive training methodologies are widely practiced throughout Russia, medical schools, for the most part, still practice old, non-interactive ways of teaching. The approach proposed by MCHP was, therefore, an eye-opening experience for the majority of participants, who discovered a new and decidedly engaging way of learning.

The trainings provided a large amount of new information and most participants reported on how rich the trainings were in terms of new learning. The package of training materials and texts for future reading was an important success factor.

The trainers, especially the lead IFH trainers, were another reason for success. The IFH lead trainers have the following qualifications:

- strong professional backgrounds in the subjects they teach;
- advanced skills and rich experience conducting interactive trainings;
- natural teaching gifts and enthusiasm about what they teach; and
- personal charisma and enjoyment of what they do.

Conclusion: the trainings worked extremely well due to the interactive training methodology, the quality of the information offered, and the high-level of the trainers.

Recommendation: the introduction of interactive training methods into Russia's medical schools might be an important strategic task and could substantially increase the quality of educational programs for healthcare professionals.[32]

5.1.2. Teleconferences

Monthly teleconferences for OB/GYNs and neonatologists in participating regions conducted by URC were successful and very well accepted by participants. According to URC, those teleconferences proved so popular that they are being continued at several levels: by the Kulakov Center with an expanded number of regions, by the Ivanovo Institute and within Tver Oblast by the Oblast Health Department and Tver State Medical Academy.

> *Recommendation: this form of information dissemination on the new practices proved effective. Another way to disseminate information would be through webinars.*

5.1.3. Publications

Most project participants, especially in the regions, spoke highly of MCHP publications that included materials such as the *Written Change Package*, as well as clinical protocols, manuals and guidelines, newsletters, leaflets for clients, online articles, and e-mail updates.

The quality of all publications was high. Some publications, such as the recently published book *Evidence-based Medicine: Manual for the Beginners*, are unique for Russia. As mentioned

[32] This recommendation is addressed to USAID

above, MCHP publications provided a link between Russian healthcare practitioners and the vast international body of medical knowledge and practice.

The fact that MCHP publications are often used and cited by various government entities at the local, regional (oblast), and federal (MOHSD) levels is another sign of their quality and importance.

Conclusion: MCHP publications became an important factor in developing capacity to provide high quality MCH services and changing participants' mindsets because they provided new information of value to readers in their environment, in a professional manner, in various user-friendly formats, and (e) at no cost.

Recommendations:

- *Keep the publications component in future healthcare programs*[33].
- *Pay special attention to how to make publishing sustainable when USAID funding is no longer available.*[34]

5.1.4. Facilitative leadership

Both implementing agencies used effective facilitative leadership approaches.

Facilitative leadership is the polar opposite of the centralized, command-and-control, transactional leadership style that is typical of many organizations. Facilitative leadership requires communication skills, social skills and a collaborative approach.[35] It is now often viewed as a broad strategy that has been described as "the behaviors that enhance the collective ability…to adapt, solve problems, and improve performance" (Conley & Goldman, 1994). An emphasis on "collective ability" is the key to this strategy and the facilitative leader's role is to ensure the widest possible involvement of people at all levels, especially in informal networks.

The facilitative leadership style helped both URC and JSI/IFH involve numerous stakeholders representing different organizations in collaborative activities that resulted in numerous high quality products. Most respondents shared the opinion that if the facilitator role had not been integral to MCHP leadership, these results could not have been achieved. The facilitators' use of informal networks helped MCHP develop collaboration among participants and created a sound foundation for future endeavors. (See the section on unintended consequences below in this chapter for more details).

Conclusion: a facilitative leadership style helped to effectively implement MCHP.

Recommendation: take full advantage of this leadership style in future endeavors, especially if and when various stakeholders with different interests need to be involved[36].

5.2. Program elements that did not work particularly well and opportunities for improvement

5.2.1. Collaboration with the MOHSD

The Federal Ministry of Health and Social Development was an extremely important stakeholder for MCHP. Unfortunately, for reasons that neither MCHP nor USAID were able to influence,

[33]This recommendation is addressed to USAID.
[34]This recommendation is addressed to both implementing partners.
[35]http://www.strategies-for-managing-change.com/facilitative-leadership.html
[36]This recommendation is addressed to both implementing partners.

collaboration with MOHSD did not develop as well as expected. USAID and its implementing partners worked with the ministry through their institutional partners, Kulakov Institute and PHI.

The MOHSD has a very small staff. Therefore they tend to work through their affiliated entities in developing policies and collaborations. Under a new policy developed right at the beginning of US FY 2009, Minister Tatiana Golikova instructed the 49 chief specialists (who are affiliated with these institutes) to develop new clinical protocols and regulations for the organization of care. The regulations have the force of law and are somewhat difficult to change. However, in a major shift, the clinical protocols now take the form of "methodological letters" approved by the deputy minister, which therefore are more flexible and easier to change as the evidence base evolves (although they still unfortunately are not required to be evidence-based and do not include direct citations of the literature).

At about the same time, the MOHSD changed its policy to require MOHSD approval of international collaborative projects. For instance, when approving ICMB, the MOHSD instructed URC to work under the supervision of the chief OB-GYN specialist, Dr. Leila Adamyan, and chief neonatologist, Dr. Elena Baibarina, who are affiliated with the Kulakov Center. In practice Dr. Baibarina supervised ICMB activity and several key Kulakov Center specialists participated. URC sent periodic reports to the deputy director of the MOHSD MCH Department, Oleg Filippov. Dr. Filippov read all those materials and participated in the final activity conference. Hence, collaboration with MOHSD was somewhat indirect.

By the time this evaluation was being conducted MCHP results were appreciated by the MOHSD and even used in the ministry's policy-making process (development of "methodological letters"). MCHP has had strong support from the participating regions from the beginning. The GOR adopted healthcare quality as one of its current strategic priorities.

Today, the situation for developing collaboration with the ministry is demonstrably better than at the beginning of the MCHP.

Conclusion: collaboration with the MOHSD did not develop as well as it could have.

Recommendation:

- *Maintain and develop collaboration with the MOHSD affiliated entities (the lead research institutes).*[37]
- *Be consistent in developing dialogue and collaboration with MOHSD.*[38]

5.2.2. Sustainability planning

As it was mentioned in Chapter 4, some of the project's results such as evidence-based practices implemented by participating facilities and technical skills of the project participants are sustainable, and some - such as continuous process improvement - are not.

The key challenges for sustainability are financial sustainability of the implementing partners whose work is not currently securely funded by either private foundations or GOR, and the lack of support from the GOR (MOHSD) that has not taken the process over. While we understand all of the complexities of the situation and appreciate USAID's and the implementing partners' efforts to achieve sustainable results, it will be fair to conclude that at this point in time the two key challenges for sustainability were not met.

[37] This recommendation is addressed to USAID and both implementing partners.
[38] This recommendation is addressed to USAID.

Conclusions:

1) *Sustainability plans developed and carried out by the implementing partners have achieved sustainability of practices, technical skills and capacity.*
2) *The key challenge for implementing partners is their financial sustainability.*

Recommendation: in future endeavors, increase focus on sustainability from the very beginning with an explicit emphasis on financial sustainability.

5.2.3. Performance of the newly trained trainers

IFH selected participants willing to work as trainers and subsequently trained them to conduct IFH interactive courses. Most of the newly prepared trainers were invited to co-facilitate trainings two times per year with more experienced IFH trainers. The new trainers were employed full time in healthcare institutions, but because they had to use personal vacation time to conduct courses, they felt that they could not afford to train more than twice per year. Though they were all experienced doctors, they had neither the opportunities nor the time to master skills as trainers.

Without improving the performance of the new trainers, their trainings will not be as effective as they could be.

Conclusion:

1) *IFH systematically worked on identifying, preparing and coaching new trainers.*
2) *Under real-life circumstances, however, this approach was not sufficient to prepare a cadre of trainers capable of performing at the same level as the lead IFH trainers and conducting high quality trainings on their own.*

Recommendations:[39]

- *Continue selecting gifted and motivated people among project participants to prepare new trainers.*
- *Keep conducting training of trainer courses for the existing trainers.*
- *Implement quality assurance mechanisms to assess performance of the new trainers.*

5.3. Unintended Consequences

5.3.1. Informal networks

At least three informal networks emerged as a result of MCHP.

The *ICMB Network of Friends of Project*[40] emerged in the project regions. The reason for these people coming together is so they could stay in touch with each other and with the MCHP or its successor. If this network is not maintained, it will most likely split into several pieces with two to three entities in each.

Network of IFH Friends is based in the regions. Interestingly, this network was formed around the Russian NGO and its staff rather than the project IBPMCH staff. Since the project is still active, the network is also still active, i.e. people receive e-mail updates, ask questions, receive answers, and feel connected. This network seems to be a great asset for IFH. Maintaining this

[39] These recommendations are addressed to IFH
[40] URC

network will not require substantial funding and if IFH decides to maintain it – on-going support should be easy.

The IBPMCH *"Club"* was established by the most active project participants. This is an informal group whose members discuss the most important issues related to their professional work. The group works without any IFH support and will be maintained by the participants themselves.

Some people belong to two or even all three networks, which creates links between them. Some people would also like to be connected with the other networks, but MCHP did not have this additional goal and no activities were implemented aimed at achieving this result.

Conclusions:

1) *Informal networks created in the course of MCHP are potentially important assets for the future endeavors.*
2) *The two networks formed around the IFH project are not connected with the network formed around the project implemented by URC. Many people belonging to different networks expressed interest in becoming connected.*
3) *The networks need to be maintained in order to sustain their value as project assets.*

Recommendations:

- *Consider informal networks an asset for future programs*[41]
- *Get them connected*[42]
- *Maintain them*[43]

5.3.2. Growing demand in the regions

Information on MCHP reached many, if not most, regions of Russia. Since the reputation of MCHP is very positive, more and more regional (oblast level) authorities are expressing their interest and readiness to participate. The demand is very high and it will be prudent to decide how to make use of the momentum.

5.3.3. Computer skills development

Participation in MCHP required a certain level of computer literacy. Quite a few doctors reported developing increased computer skills during the course of the project, i.e. they have better mastery of the Internet, know how to make PowerPoint presentations, and can use the computer to communicate with their colleagues.

5.3.4. Career development

In several cases, the evaluators were told that MCHP gave people an opportunity to demonstrate their potential and had been promoted as a result. It is dangerous to generalize from a few cases whose particulars have not been verified, but it is reasonably certain that out of several hundred project participants, some will be promoted simply because professional people tend to grow over time. This tendency in a professional population means that in a few years, potentially many

[41] This recommendation is addressed to USAID and both implementing partners.
[42] This recommendation is addressed to both implementing partners.
[43] This recommendation is addressed to both implementing partners.

friends of the project will be in administrative positions in their respective healthcare institutions and will have more influence to implement approaches they learned through MCHP.

5.4. MCHP and Vulnerable Groups

One of the tasks of the "Institutionalizing Best Practices in Maternal and Child Health" Project (IFH/JSI) was to present the best synergistic medical and social practices to the Khanty-Mansiisky Autonomous Okrug and the Tyumen Region to make appropriate family planning, prenatal, and postnatal care available for *high-risk women*. JSI/IFH developed a questionnaire for use by health providers interviewing women to assess their risk according to social status. A pilot study assessed the effectiveness of this questionnaire in identifying social risk factors. The 12 main determinants of maternal and infant morbidity and mortality, child abandonment, and barriers to appropriate family planning, prenatal and postnatal care identified by the study are: (a) the mother is less than 20 years of age, (b) poverty, (c) low educational attainment, (d) unemployment, (e) late and irregular antenatal care, (f) family violence, (g) single parenthood, (h) homelessness, (i) migration, (j) serious disease, (k) disability, and (l) alcohol and drug dependency. The study results became the basis for developing *Algorithms of Medical and Social Care for High Risk Women*, including the standardized questionnaire for risk assessment and comprehensive recommendations on social and health collaborative care to improve women and infants health.

The "Improving Care for Mothers and Babies" Project included activities aimed at preventing abortion and increasing the number of annual preventive care visits by *women with high levels of social and medical risk*. Improvement efforts included community outreach and efforts to identify high-risk social groups in Yaroslavl and Tambov. The project also promoted the UNICEF Youth-Friendly Clinic model in Yaroslavl, Kostroma, and Tambov to address the needs of another vulnerable group, teenagers. The project worked on the *prevention of unwanted pregnancies and STDs among teens*.

In all of the interviews with physicians and healthcare managers, evaluators asked questions about the status of reproductive health of young people and importance of work with women at risk. Unfortunately official statistics on these issues is not available due to the reasons discussed above. Hence, we rely on the opinions of the several dozen healthcare professionals who were interviewed during the evaluation process. There was general consensus among our respondents that:

- reproductive health of young people (males and females) is alarmingly low and needs special attention;
- many problems with mothers' and infants' health are caused by the reproductive health problems that emerged in the mothers' childhood and teenage period; and
- maternal and infant mortality and morbidity are much higher among women at risk.

Adults with chronic diseases were not considered one of the target vulnerable populations for MCHP. Including this population thus represents an opportunity for the future.

Conclusions:

1) *MCHP included activities aimed at two vulnerable groups: high risk women and youth. Those activities were successfully implemented only in the selected regions while the issues associated with both of these vulnerable groups exist everywhere in Russia.*

2) *Youth reproductive health and the health status of high-risk women are important factors that cause maternal and infant mortality and morbidity in Russia.*

Recommendations:[44]

- *The work related to reproductive health counseling and family planning among youth should continue.*
- *The focus on high-risk women should be kept and work with this group should continue.*
- *The Evaluation Team suggests considering a new technical focus on chronic disease prevention and treatment.* (See Annex 8 for more details.)

5.5. MCHP and Civil Society

A number of leading research centers developed the following definition of civil society:

> [The] wide array of non-governmental and not-for-profit organizations that have a presence in public life, expressing the interests and values of their members or others, based on ethical, cultural, political, scientific, religious or philanthropic considerations. Civil Society Organizations (CSOs) therefore refer to a wide array of organizations: community groups, non-governmental organizations (NGOs), labour unions, indigenous groups, charitable organizations, faith-based organizations, professional associations, and foundations.[45]

MCHP was focused on professional healthcare providers and government entities, and did not intend to work with civil society organizations. There is no evidence of any influence of MCHP on the relationships between government and civil society.

It might be useful for future programming, however, to discuss potential areas of collaboration between initiatives such as MCHP and CSOs.

5.5.1. Professional associations

Professional associations and societies are CSOs that (a) unite representatives of the same profession, (b) express the interests of the profession, (c) contribute to the development of the profession, and (d) protect and support their members. In many cases professional associations are in charge of certification and development of professional norms, principles, guidelines, and standards. It is a common practice for the leading OB/GYN associations, for instance, to form working groups and develop evidence-based clinical protocols.

There are several national-level professional associations in Russia related to maternal and child health, for example:

- Russian Society of Obstetricians-Gynecologists (founded in 1993, 35,000 members)
- Russian Association of Specialists in Perinatal Medicine (founded in 1994, about 1,000 members)
- Russian Association of Obstetricians-Gynecologists (exists only on VKontakte, the Russian equivalent of LinkedIn; at the inception stage, no data)
- Russian Union of Pediatricians (includes neonatologists)
- Russian Association of Nurses

[44] These recommendations are addressed to USAID

[45] This definition has been adopted by the World Bank, see http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/CSO/0,,contentMDK:20101499~menuPK:244752~pagePK:220503~piPK:220476~theSitePK:228717,00.html

The major association in this context is arguably the Russian Society of Obstetricians-Gynecologists, which has branches in all the regions of Russia. It is important to mention though that this association differs from the leading international associations in North America, Europe, and Australia. The Russian association has been created in a top-down manner; it is not an independent, self-organizing, proactive professional community. For over a decade there was no rotation of leadership. It has a very close relationship with the government. Its web page is located on the website of the Kulakov Center. According to our respondents, being a professional 'monopoly' has resulted in this association not being dynamic and active.

The Russian Association of Nurses is also huge and is organized in accordance with the same principles as the Russian Society of OB/GYNs. Oblast-level associations seem to be more active. The Kemerovo Oblast Association of OB/GYN, which was registered in 1992 as a regional NGO, is a good example. It now has 425 members from 26 cities in the Kemerovo Oblast and is highly respected both by the regional authorities and the professional community. One of the clear indications of its recognition is the association's participation in the development of clinical protocols at the oblast level. The association has very good links with the oblast government and its website[46] is on the web portal of the oblast Department of Health.

An interesting new initiative that should be mentioned here is creation in 2010 of the so-called National Medical Chamber (NMC) lead by Dr. Leonid Roshal. The intent of the initiative was to establish a nationwide, nongovernmental organization with regional chapters that would "unite all the healthcare professional community in Russia on the principles of self-regulation to improve the national healthcare system."[47] Respondents from the regions were somewhat skeptical about it and it is hard to say how this organization will develop.

Conclusions:

1) *Professional associations of doctors (OB/GYN) and nurses are representative of a class of civil society organizations that are relevant to initiatives such as MCHP.*
2) *Such associations traditionally have very good relationships with government entities in Russia and there is no need to improve these relationships. Creation of new professional OB/GYN associations in Russia without government support seems highly improbable at this point in time.*
3) *Regional associations are more active than national associations.*
4) *Russian professional associations can benefit from partnering with leading international associations to learn from them about how professional organizations can function, develop, and be governed.*

Recommendations:[48]

- *Identify the most active regional-level associations and develop collaborations with them.*
- *Create opportunities for representatives of those associations to learn about the development of professional organizations outside Russia.*
- *Consider collaboration with the National Medical Chamber.*

[46] http://www.kuzdrav.ru/drupal/node/207
[47] http://www.nacmedpalata.ru/?action=show&id=6
[48] These recommendations are addressed to USAID and both implementing partners.

5.5.2. Internet-based social networks

Several grassroots CSOs were formed by women as social networks or virtual support groups. These networks provide feedback on the quality of services provided by maternity hospitals, including the names of doctors and nurses, ratings of maternity hospitals, and individual stories. After registration and authorization—free of charge—one can create an account and participate in the life of the community, including asking and answering questions, uploading photos, etc. The most well-known networks of this kind[49] are:

- www.rodim.ru
- www.rodi.ru
- www.roddom.ru
- www.roddoma.ru

Interestingly, many doctors with whom we talked are aware of these online communities. They read what their clients say on a regular basis, even in the smaller cities, and take this feedback into consideration.

These social networks are independent and mission driven. They do not need substantial financial resources and are using volunteers extensively to maintain their virtual spaces.

Conclusion: Internet-based social networks are a good example of very effective self-organized, independent, and sustainable CSOs.

Recommendation: consider these networks at least for information dissemination and for recruiting volunteers for MCH related activities.

5.5.3. The "Tender Mother" case

This is an example of the potential for collaboration with civil society. Directors of several maternity hospitals in Tyumen mentioned a group of women called "Tender Mother" whose members provide consultations on breastfeeding. They come to the hospitals, get permission from the administration, and then consult young mothers on how to feed their babies. According to the doctors, they provide high quality consultations in a very professional manner.

"Tender Mother" is a Tyumen-based NGO established in 2006 by professional neonatologists and psychologists. All of the consultants who work with "Tender Mother" belong to the Russian Natural Feeding Consultants Association (NFCA).[50] They provide face-to-face consultations, online and phone consultations, conduct workshops, and disseminate information on breast feeding via their website.[51] Some of their consultations and seminars are free of charge, but in most cases they charge for services. An individual consultation at home, for example, costs about $30.

Conclusions:

1) *There are already CSOs in Russia working in arenas related to MCH.*
2) *There may also be potential for establishing new CSOs that will work in arenas related to MCH.*

[49] All in Russian
[50] http://www.akev.ru/content/blogcategory/20/48/
[51] http://lasmama.ru/consultants/tyumen/

3) *Health care institutions in Russia can be open to collaboration with professional CSOs that can prove their credibility.*

Recommendation[52]*:*

- *Consider involvement of the existing CSOs, such as NFCA, or supporting creation of new CSOs specialized in MCH. Quality assurance and professionalism of CSOs should be the top priorities.*

5.5.4. Community Foundations

Russian Community Foundations are another growing resource for potential collaboration. There are several dozen community foundations throughout Russia and their number is still growing.[53] Community foundations (CFs) are instruments of civil society designed to pool donations into a coordinated investment and grant making facility dedicated primarily to the social improvement of a given place.[54] CFs know the local needs, local resources, and local donors, and may serve as a vehicle for connecting CSOs with healthcare institutions. The director of one of the oldest CFs in Tyumen confirmed that healthcare, particularly MCH, is one of the areas of her community foundation activities.

5.5.5. Russian Orthodox Church

MCHP demonstrated that productive collaboration with the Russian Orthodox Church (ROC) is possible, at least in preventing abortions and child abandonment. The ROC has its own programs aimed at strengthening institution of the family. In Sharya, in the Kostroma oblast, priests from the ROC counseled teens on the importance of planning their families. It is important to note that ROC views on certain reproductive health issues may differ radically from what the initiatives supported by USAID are trying to accomplish. Thoughtful and careful negotiations are needed to find common approaches and develop collaboration with the ROC.

5.6. MCHP and Good Governance

The original question included in the evaluation SOW – "Did the MCHP activities demonstrate a relationship between good governance and health outcomes?" – cannot be answered with any level of confidence. The causal relationship between an intervention and its outcomes is the subject for an impact evaluation that must be precisely designed in very particular ways. After consultations with the key stakeholders, the evaluators reframed the original question and proposed discussing whether there was a connection between MCHP and governance improvement. Hence, the following two questions will be answered in this section:

- Did MCHP contribute to improving governance?
- Is there any connection between MCHP and good governance?

To a great extent the answer depends on how "good governance" is defined.

"Governance" is "the process of decision-making and the process by which decisions are implemented (or not implemented)."[55] Governance can be used in several contexts such as corporate governance, international governance, national governance, and local governance.

[52]These recommendation is addressed to USAID
[53]List of Russian Community Foundations http://www.cafrussia.ru/programs/fms/fms_contacts/ (includes contact information)
[54]http://en.wikipedia.org/wiki/Community_foundation
[55]http://www.unescap.org/pdd/prs/ProjectActivities/Ongoing/gg/governance.asp

One of the most commonly used definitions of "good governance" has been provided by UNESCAP:

> Good governance has 8 major characteristics. It is participatory, consensus oriented, accountable, transparent, responsive, effective and efficient, equitable and inclusive and follows the rule of law. It assures that corruption is minimized, the views of minorities are taken into account and that the voices of the most vulnerable in society are heard in decision-making. It is also responsive to the present and future needs of society.[56]

Table 14. Good governance and MCHP

Characteristics of good governance	*How it relates to MCHP*
1. Rule of Law. Good governance requires fair legal frameworks that are enforced by an impartial regulatory body, for the full protection of stakeholders.	- Better protection of doctors if they follow officially approved clinical protocols and use informed consent forms. - Better protection of patients: guaranteed level of service quality (protocols).
2. Transparency. Transparency means that information should be provided in easily understandable forms and media; that it should be freely available and directly accessible to those who will be affected by governance policies and practices, as well as the outcomes resulting there from; and that any decisions taken and their enforcement are in compliance with established rules and regulations.	- New protocols, recommendations, manuals are products of participatory processes - Informed consent forms - More open communication between patient and doctor due to the doctors' better counseling skills. - Information materials for the patients available in various forms. - URC Communicator for information sharing - IFH web-site - IPH website - *Statistics are still only partially open – very sensitive.*
3. Responsiveness. Good governance requires that organizations and their processes are designed to serve the best interests of stakeholders within a reasonable timeframe.	- Patient-centered philosophy and approaches promoted - Client satisfaction forms
4. Consensus Oriented. Good governance requires consultation to understand the different interests of stakeholders in order to reach a broad consensus of what is in the best interest of the entire stakeholder group and how this can be achieved in a sustainable and prudent manner.	- New protocols, recommendations, manuals are products of participatory processes - Various forms of team work at different levels
5. Equity and Inclusiveness. The organization that provides the opportunity for its stakeholders to maintain, enhance, or generally improve their well-being provides the most compelling message regarding its reason for existence and value to society.	- Joint workshops for nurses and doctors - Client has a voice - Component related to high-risk women (vulnerable)
6. Effectiveness and Efficiency. Good governance means that the processes implemented by the organization to produce favorable results meet the needs of its stakeholders, while making the best use of resources – human, technological, financial, natural and environmental – at its disposal.	- New practices are oriented towards lower risk and better results for the clients - Money saving due to de-medicalization
7. Accountability. Accountability is a key tenet of good governance. Who is accountable for what should be documented in policy statements. In general, an organization is accountable to those who will be affected by its decisions or actions as well as the applicable rules	- Continuous measurement and open reporting and discussion of process and outcome indicators (URC).

[56] Ibid.

of law.	
8. Participation. Participation by both men and women, either directly or through legitimate representatives, is a key cornerstone of good governance. Participation needs to be informed and organized, including freedom of expression and assiduous concern for the best interests of the organization and society in general.	N/A

Conclusions:

1) *MCHP made contributions to governance improvement at federal, regional and local levels by improving the following governance characteristics: rule of law, transparency, responsiveness, orientation towards consensus, equity and inclusiveness, effectiveness and efficiency.*
2) *MCHP did not improve the following governance characteristics: accountability and participation by both men and women. The latter could hardly be changed due to the focus and nature of the initiative.*

6. MAIN CONCLUSIONS AND RECOMMENDATIONS

6.1. Main conclusions

6.1.1. Flaws in the activities' logic

A careful review of the activity documents from both URC and JSI/IFH revealed inconsistencies in descriptions and lack of clarity in activities' logic. While both implementing agencies had distinct intervention models, and it was quite clear what they intended to do, the chains of expected results for the two activities were not well described. The logic and causal relationships between the building blocks needed to achieve activities' goals were not explicitly presented in the documents. Nevertheless, an analysis based on data collected during the evaluation allowed us to reconstruct the activities logic in collaboration with key stakeholders and to develop a coherent logical framework that better presents the activities' intent.

6.1.2. MCHP and health outcomes: plausible contribution rather than demonstrable causation

Maternal and infant mortality and morbidity decreased in the target MCHP regions. However, it also decreased in neighboring regions where MCHP was not implemented. In fact, the average rates of maternal and infant mortality and morbidity decreased across Russia as well. It is impossible to make statistically valid inferences about *causal attribution* – the probability that maternal and infant mortality and morbidity would not demonstrate the same decrease in the absence of MCHP. Because of this technical limitation, the focus has to be on assessing the *plausible contribution* of MCHP to health outcomes within an appropriate context: at a regional level, not a national level. Evaluation data can confirm MCHP's plausible contribution to decreasing *infant mortality* in the target regions, but there is not enough data to confirm MCHP's contribution to decreasing *maternal mortality* in the target regions. Abortion ratios were substantially decreased in the populations served by the participating facilities, and there is evidence confirming project's plausible contribution to the decrease of abortion ratios in two participating regions.

6.1.3. New clinical practices: introduced and implemented successfully

MCHP introduced evidence-based practices that address the major causes of maternal and infant morbidity and mortality to the healthcare providers in the target regions. These practices were adopted and successfully implemented by several dozen hospitals in the target regions. Project participants report good clinical outcomes from the implementation of the new practices and intend to continue their use. This MCHP result can be considered sustainable.

6.1.4. Human capital of healthcare providers: developed substantially

MCHP made a major investment in the doctors and nurses dealing with MCH issues. Conventional wisdom in Russia has dictated that senior experts, especially those holding leadership positions in MOHSD medical institutions, define clinical practices. Traditionally, clinical practices were based less on scientific evidence and more on the personal experience of the opinion leader. Both projects contributed to a change in the mindset among some Russian physicians who now look for objective evidence to support their clinical care practices. Both projects contributed to the momentum to the movement to break away from the traditional approach and to adopt a new approach based on seeking out relevant data, international standards, and best practices as the basis for improving health outcomes. MCHP also presented a strategy and provided resources for future professional development that can be implemented by participants and participating institutions on their own with some external support. Informal networks established in the course of MCHP also contributed to human capital development and are an important asset for the future endeavors.

6.1.5. Institutionalization of practices: most successful at the level of organizations

New practices were embedded within the healthcare system most actively and successfully at the level of organizations such as maternity hospitals, neonatal centers, and research centers. Authorities from organizations such as Departments of Mother and Child Health in all of the participating regions supported MCHP and in many cases issued official documents recommending and/or approving implementation of certain practices. The fact that MOHSD used some of the MCHP products to develop new policies and regulations suggests that the ministry appreciated the quality of these products. There is clearly potential for developing collaboration with the MOHSD.

6.1.6. Quality improvement: opportunities and challenges

Evidence-based best practices, by their nature, are of the highest quality of international standards of care. This was specifically an inherent part of the MCH Project. “Improved Quality of MCH/RH Services” was one of the Intermediate Results in the MCH Project Results Framework. Both activities contributed to improvement of the quality of MCH/RH services and - to some extent – to the improvement of the quality of healthcare management systems, which is the business environment and business processes of managing the healthcare system – the operations, processes, organizational structure and functioning. MCHP laid a foundation for future development and implementation of quality improvement methodologies, but this process will face serious challenges and will require much more time, effort, resources, and leadership commitment to achieve substantial improvements.

6.2. Main recommendations

Recommendation 1. This recommendation is directed towards the implementing partners. When designing an activity, start by developing a comprehensive logic model and develop realistic and measurable goals at all levels of the logical system. Make sure that causal relationships exist between the expected results for each link in the chain of results. Make sure that activities are logically harmonized with the project to which they contribute.

Recommendation 2. For future programming, USAID should maintain the quality of healthcare (including the quality of services and the quality of management systems) as a central program tenet. This will (a) help align new projects with the current MOHSD agenda and its urgent needs; (b) open new opportunities for collaboration with the key local institutional partners such as the Public Health Institute (PHI); (c) enable future projects to build on the achievements of MCHP; and (d) allow for the use of assets developed by MCHP. Consider using the Quality Improvement (QI) methodology introduced and implemented by URC and its partners for future programs as it will facilitate keeping the quality of healthcare as a central focus.

Recommendation 3. USAID and implementing partners should focus more on sustainability with future projects. During the project design phase, an in-depth analysis should be conducted to identify, explore, and describe all of the key factors that will contribute to project sustainability. Further, there should be an explicit emphasis on the financial sustainability of Russian implementing partners so they can continually build on the best practices instituted via future projects. MCHP did not include the provision of financial resources for Russian implementing partners and practitioners to carry on with improvements to and the introduction of new practices.

Recommendation 4. In the design of future programs, USAID and implementing partners should increase the focus on vulnerable groups such as youth and high-risk women. While, MCHP did implement activities directed at these vulnerable populations in selected regions, the success of these activities provides evidence that they should be replicated and further developed for additional regions, perhaps with even a national focus. Accordingly, future projects should continue to focus family planning and teen reproductive health, which are areas particularly salient for youth and high-risk women.

Recommendation 5. The Evaluation Team found that that there is a potential for increased cooperation with social services and civil society MCH programs. USAID and implementing partners should include a strengthened focus on such cooperation for future endeavors. In particular, there should be a focus on connecting vulnerable patients identified in hospitals with relevant community resources like NGOs, CSOs, and community-level support groups dedicated to working with vulnerable groups and/or specific problems.

Recommendation 6. USAID and implementing partners should maintain an emphasis on embedding evidence-based medicine within the healthcare system, especially at the regional and federal levels. This process of institutionalization can benefit greatly for improving healthcare management. Also, the Team recommends the development and delivery of specialized services such as trainings, conferences, and consultations for healthcare managers and leaders in the healthcare field to further build capacity. Collaboration with universities providing courses in healthcare management is another possible venue for intervention

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Annex 1. Evaluation Scope of Work (Notification of Performance Evaluation)

Maternal and Child Health Initiative
Notification of Performance Evaluation #1

International Business & Technical Consultants, Inc.
Contract # AID-RAN-I-00-09-00016 Order # AID-118-TO-11-00004 Task #2

Activity to be Evaluated:	**Initial and Final Funding Years:**
Maternal and Child Health Initiative Office of Health	FY08 - FY11
Type of Evaluation: ___ Mid-Term (Formative) X Final (Summative) ___ Impact (*Post-Facto)*	**Purpose and Intended Use of the Evaluation:** To assess performance of USAID/Russia key activities on maternal and child health; evaluate sustainability of activities and results, and; provide suggestions for the future direction of USAID/Russia program design for reproductive and infant health. **Key Stakeholders:** Office of Health Director, Maternal & Infant Health Team, Family Planning/Reproductive Health Design Team, Kulakov Center (federal)

Revision:	New	
Date:	Dec. 30, 2011	
Approvals:	L. Petrosian	Technical Officer, Office of Health
	S. Hoza	Activity Officer, Office of Health
	W. Slater	Director, Office of Health
	V. Biryukova	Contracting Officer Representative

Evaluation of Activity #1

Activity Description:	Improving Care for Mothers and Babies
Activity Dates:	October 2008 - October 2011
Implementing Partner:	University Research Co. (URC)
Regions:	Tambov, Yaroslavl, Kostroma, Ivanovo, Tula, Tver
Life Funding:	$ 4,100,000

Activity Purpose: This recently completed activity assisted counterparts in six Russian regions to reduce rates of maternal and infant mortality and morbidity and to reduce abortion rates through more appropriate use of family planning and modern contraceptive methods.

Activity Description: This activity advanced the successes and models previously developed through USAID maternal and child health activities, and disseminated successful international models, such as UNICEF's "Baby-Friendly Hospitals" and "Youth-Friendly Clinics," as well as the WHO partograph and associated guidelines for preventing pregnancy complications. The activity also aided the introduction of relevant up-to-date regulations, standards, and guidelines for issuance by the Ministry of Health and Social Development (MOHSD). Improvement teams in the six activity regions focused on six clinical goals in the area of reproductive health, obstetrics and pediatrics.

URC Contact Information:
Victor Boguslavsky, Regional Director
8, 4th Dobryninsky Pereulok, office D0301, Moscow, 119049, Russia
Tel/Fax: (495) 797-9410

USAID
FROM THE AMERICAN PEOPLE

Evaluation of Activity #2

Activity Description:	Institutionalizing Best Practices in Maternal and Child Health
Activity Dates:	September 2008 – September 2012
Implementing Partner:	John Snow, Inc. (JSI) - Institute for Family Health (IFH)
Regions:	The Urals Federal Okrug (6 regions), Leningrad Oblast; Vologda Oblast; Tyumen Oblast; Moscow City and Moscow Oblast
Life of Activity Funding:	$8,370,989

Activity Purpose: The purpose of this activity is to decrease maternal and infant mortality in Russia by expanding high quality reproductive health and maternal and child health services in targeted federal districts, strengthening the capacity of federal and regional institutions which are addressing these issues.

Activity Description: This activity seeks to improve birth outcomes and maternal health by introducing best practices (IBP) in reproductive health (RH) and maternal and child health (MCH) through trainings and technical assistance for health care providers in Russia. These best practices include care during pregnancy, delivery, and infanthood, and both women's and men's reproductive health. The IBP-MCH activity also supports the role of key federal and regional institutions in the delivery, dissemination, and advocacy for best practices in MCH and RH at the regional and federal level. The implementing partners work with two leading MCH institutes at the federal level, the Kulakov Federal Center for Obstetrics, Gynecology, and Perinatology and the Urals Research Center of Maternal and Child Health, to support their role in training health care providers based on newly-developed guidelines under review by the MOHSD, and to further disseminate these best practices to surrounding regions.

JSI Contact Information:
Natalia Vartapetova, Activity Director
Institute for Family Health
Koroviy Val 7, Office 175-176, Moscow 117049, Russia
Tel: (495) 937-3623; (495) 935-7609
Fax: (495) 937-3680

Performance Information Existing Sources:

The following performance information sources will be available for the evaluation team:

Attachments:

- URC Scope of Work, Oct. 2010 – Oct. 2011, Contract #GHN-I-01-07-00003-00
- URC Work Plan, Dec. 2008
- URC Monitoring & Evaluation (M&E) Plan, "Targets and Actuals FY09-11"

- JSI Statement of Work, section C, Contract #GHS-I-00-07-00002-00
- JSI Deliverables, section F.6, Contract #GHS-I-00-07-00002-00
- JSI Implementation Plan, December 2010
- JSI Work Plan, Sept. 2011
- JSI Monitoring & Evaluation Plan, March 2011

Documents Available Upon Request Shall Include, but not be limited to:

- Partner Quarterly Reports
- Sustainability Plan for JSI
- Plan for Professional Exchanges for JSI
- Final Partner Report for URC

Evaluation Questions:

The evaluation team members will conduct interviews, collect data, and review the existing information sources in order to provide answers to the following questions:

1) Goals: To what extent did the two Implementing Partners achieve the goals / objectives in their respective Scopes of Work (SOW), Work Plan, and M&E Plan, including but not limited to Required Indicators, Activity Extension Goals, Expected Results, and the like?

2) Deliverables: What was the performance of the Implementing Partners against the deliverables in their respective SOW, Work Plan, and M&E Plan?

3) Sustainability: What is the likelihood of sustainability of results beyond USAID assistance? What additional activity elements should be incorporated in current and future activities in order to strengthen sustainability?

4) Lessons Learned: What are the key lessons learned that should guide program design for future efforts in the field of MCH / Family Planning and Reproductive Health? (What worked well? What could be improved? What were unintended consequences? What gaps existed and why? Gender gaps? Vulnerable population gaps? How are the activities perceived or valued by stakeholders and the population served? Did the activities strengthen the relationship between government and civil society? Did the activities demonstrate a relationship between good governance and health outcomes, why /why not?)

Evaluation Methods:

The overall methodology for the evaluation is a combination of document review, interviews (both in Russia and in Washington), site visits, briefing sessions, and a final report. Where feasible and as determined by USAID/Russia, the evaluation team will begin its work in Washington, D.C. by reviewing available documents and meeting with appropriate USAID/W and contractor staff. All team members will travel to Russia from the U.S. to meet with USAID/Russia and the staff of both activities before conducting site visits including key stakeholders such as government representatives. The evaluation team will conduct mid-assessment meetings as needed. All team members will depart Russia from Moscow to allow for a briefing with USAID/Russia and others as appropriate.

Deliverables:

1. **Evaluation Design**: due Jan 31, 2012 (30 days from this written notification of evaluation). The Contractor shall develop a written Evaluation Design for each evaluation activity defined herein and submit it to USAID/Russia for approval. The design shall include, but not be limited to:
   - Methodology (including strengths and limitations)
   - Data plan: sources, instruments and procedures for collecting, monitoring, analyzing, storing, transmitting, and reporting information; as well as documentation of data quality (validity, reliability, timeliness, precision, integrity)
   - Questions that the evaluation shall address
   - Local partners and stakeholders
   - Briefings and Dissemination plan

   The design requires written approval from USAID/Russia. Any changes to the Evaluation Design must be approved in advance in writing by USAID/Russia followed by formal change revision to the document.

2. **Evaluation Work Plan**: due Jan 31, 2012 (30 days from this written notification of evaluation). The Contractor shall develop a written individual Evaluation Work Plan for each evaluation activity defined herein and submit to USAID/Russia for approval. The work plan shall include, but not be limited to:
   - Team: titles, names, level of effort, roles, responsibilities, qualifications, and identification of subcontractors. The work plan shall include language that the evaluation team members are considered Key Personnel for this evaluation and that no Key Personnel shall be removed from the team nor shall the level of effort, roles, or responsibilities be changed without prior written approval of USAID/Russia.
   - Schedule: including information collection, interviews, site visits, travel / logistics, and the like
   - Logistics information including criteria and site selections; planned meetings with host country government officials at the national, regional and local levels; planned meetings with USAID/Russia contractors and grantees implementing FP/RH activities in-country; planned meetings with health service providers at selected sites; and meetings with USAID program staff to update progress of the evaluation.

- Stakeholder review mechanism for the Evaluation Briefing and Draft Evaluation Report
- Deliverables schedule
- Budget

The Evaluation Work Plan requires written approval from USAID/Russia prior to any international travel. Any changes to the Evaluation Work Plan must be approved in advance in writing by USAID/Russia followed by formal change revision to the document.

3. **Evaluation Briefing**: due prior to departure from Russia. The Contractor shall present major and / or preliminary findings to USAID/Russia and / or key stakeholders while in-country for each evaluation activity defined herein. During the briefing, the Contractor shall present and review with USAID/Russia a proposed outline of the Final Evaluation Report.

4. **Draft Evaluation Report**: due prior to departure from Russia. The Contractor shall incorporate comments from USAID/Russia and key stakeholders made during the Evaluation Briefing and submit a written Draft Evaluation Report for each evaluation activity to USAID/Russia for approval. The draft report shall include all sections of the Final Evaluation Report (see below) except that the annexes may merely be referenced and need not be included; the electronic file of data may merely provide the definition of readable format and structure of organization, and; the submission of the final report to the Development Experience Clearinghouse may simply be stated. The Contractor shall hold a review of the report with USAID/Russia and key stakeholders prior to departure.

   The Draft Evaluation Report requires written approval from USAID/Russia, which shall be provided within 15 working days after receipt of the document. Any changes to the Draft Evaluation Report must be approved in advance in writing by USAID/Russia followed by change revision to the draft document.

5. **Final Evaluation Report**: due within 15 working days from receipt of written comments by USAID/Russia to the Draft Evaluation Report. The Contractor shall submit a Final Evaluation Report for each evaluation activity to USAID/Russia for approval. Each Final Evaluation Report shall be submitted as 5 hard copies and 1 electronic copy, with all annexes.

   The report shall adhere to the following format:
   - Cover Sheet with a descriptive title that includes the Activity Description and Implementing Partner being evaluated, author's name(s) and title(s), contract number, Contractor's name, date of publication, revision number, and any other report requirements as per the Contractor's statement of work and contract terms and conditions.
   - Table of Contents including list of figures and tables.
   - Executive Summary shall state the purpose, background, main evaluation questions, methods, findings, conclusions, recommendations and lessons learned. The Executive Summary shall be appropriate for broad dissemination, and shall be translated into Russian language with the Russian text included in the document. The English version of the Executive Summary shall not exceed 3 pages.
   - Body of the report shall include thorough descriptions of the justification for the evaluation;

a description of the evaluation design and limitations; the environment in which the team operated; the methodology used including the adherence to data quality standards (ADS 203 and 578) and limitations, a data quality assessment, the data analysis elements, and statistical significance; as well as the major findings, conclusions, and recommendations against the Partner SOW, Work Plan, M&E Plan objectives and deliverables; as well as lessons learned that will be useful future activities. The body of the report shall not exceed 30 pages.

- Glossary of terms and acronyms
- Annexes a separate annex shall include, but not be limited to: scope document, the Evaluation Design, Evaluation Work Plans, lists of persons consulted (name, title, company), source materials, tools used, background supplemental materials useful for a fuller understanding of the report, a bibliography of significant documents used to consult, any site visit photos.
- Electronic File of Quantitative Data shall be provided in easily readable format, organized and fully documented for use by an independent evaluator.

Development Experience Clearinghouse: due 30 calendar days after USAID/Russia approval of the Final Evaluation Report. The Contractor shall make publically available the Final Evaluation Report for each evaluation activity through the Development Experience Clearinghouse and confirm in writing to USAID/Russia.

All deliverables shall be submitted in writing in the English language.

Evaluation Team Composition:

Evaluation team members are Key Personnel as identified in and governed by the Evaluation Work Plan for each evaluation activity defined herein. The Contractor shall define the evaluation team in the Work Plan, such description shall include, but not be limited to:

- team member title
- name
- roles and responsibilities to include, but not be limited to, the design and management of the evaluation, and evaluation deliverables
- qualifications and experience to include, but not be limited to: USAID programs; health program design, implementation, management; maternal and child health; M&E; Russia health, government, civil society, economy, reforms, and language.

The evaluation team may be accompanied and reinforced by USAID/Russia and/or USAID/Washington staff as available during the evaluation, including site visits in Russia.

Annex 2. Evaluation Design and Work plan

EVALUATION DESIGN

Purpose of the Evaluation

This is the final (summative) evaluation of the USAID Maternal and Child Health Initiative (MCHI). International Business and Technical Consultants, Inc. (IBTCI) is responsible for implementing this evaluation as per the terms of the Russia Monitoring Program (RMEP) and based on the Notification of Performance Evaluation #1[57] sent to IBTCI on December 30, 2011.

The purpose of this evaluation is:

- To assess performance of the USAID/Russia key activities on maternal and child health:
- To evaluate sustainability of activities and results; and
- To provide suggestions for the future directions of USAID/Russia program design for reproductive and infant health.

The evaluation will be conducted in accordance with the January 2011 USAID Evaluation Policy.

Description of the Program to be Evaluated

The USAID/Russia Maternal and Child Health Initiative (MCHI) aimed to reduce maternal and infant mortality, increase the use of modern contraceptives, and decrease abortion rates in selected regions across Russia. These objectives were implemented through training and technical assistance for healthcare providers; disseminating best practices in care during pregnancy, delivery and infanthood at local and regional health care facilities; and institutionalizing these best practices in appropriate Russian institutions at the federal and okrug levels.

This evaluation covers the two MCHI activities:

- Activity 1: Improving Care for Mothers and Babies
- Activity 2: Institutionalizing Best Practices in Maternal and Child Health

Activity 1: Improving Care for Mothers and Babies was implemented from October 2008 to October 2011 by University Research Company (URC).

The overall goal of Activity 1 was to assist counterparts in six Russian regions to reduce rates of maternal and infant mortality and morbidity and to reduce abortion rates through more appropriate use of family planning and modern contraceptive methods. Activity 1 included the following six strategic areas:

1. Reproductive Health: Prevention of unwanted pregnancies, abortions, and STDs among teens (region-wide in Kostroma and Tambov regions and 10 individual facilities);

[57] The Notification is included as Annex 1.

2. Obstetrics: Optimizing labor management through use of the partograph (region-wide in Kostroma region and 21 individual facilities);
3. Neonatology: Prevention of hypothermia and respiratory ailments among newborns (in 24 individual facilities);
4. Neonatology: Broadening implementation of breastfeeding practices (region-wide in Tambov region and 16 individual facilities);
5. Neonatology: Improvement of primary neonatal resuscitation and transport (region-wide in Yaroslavl, Kostroma, Tambov, Ivanovo, Tver and Tula regions and 18 individual facilities); and
6. Regionalization of perinatal care: Prevention and management of preterm birth, improvement of transport for pregnant women and newborns, computerized monitoring system (region-wide in Kostroma, Tambov and Tver region and 15 individual facilities).

The activity also aided the introduction of relevant up-to-date regulations, standards and guidelines for issuance by the Ministry of Health and Social Development (MOHSD).

Activity 2: Institutionalizing Best Practices in Maternal and Child Health started in September 2008 and will end in September 2012. The activity is implemented by John Snow, Inc. (JSI) and the Institute for Family Health (IFH).

The goal of the Activity 2 is to decrease maternal and infant morbidity and mortality in target Federal Districts in order to achieve five intermediate results:

1. MCH best practices related to major causes of maternal and infant morbidity and mortality based on newly-developed Maternal and Child Health (MCH) protocols are adopted by the Ministry of Health and Social Development (MOHSD) and operationalized by key partners in target federal districts and corresponding regions;
2. Decreased abortion rates in regions within the selected federal districts;
3. Increased modern contraceptive prevalence among women of reproductive age within the selected federal districts;
4. Strengthened capacity of key federal and regional entities to deliver, disseminate and advocate for best practices in MCH and reproductive health (RH) at the regional and federal level; and
5. Strengthened capacity of health care providers including obstetrician-gynecologists, pediatricians, family doctors, midwives, and nurses, including in rural areas, to deliver quality RH and MCH services and counseling.

Activity 2 targeted six regions in the Urals Federal District (Chelyabinsk region, Yekaterinburg region, Yamalo-Nenezkiy Autonomous Region, Khanty-Mansiyski Autonomous Region, Kurgan region, Tyumen region), two regions in the Northwestern Federal District (Leningrad region, Vologda region) and two regions in the Central Federal District (Moscow City and Moscow region). The two following federal entities served as partners during project implementation: the Kulakov Federal Center on Obstetrics, Gynecology and Perinatology in Moscow and the Federal State Research Institute for Maternity and Infancy in Ekaterinburg.

Activity 2 includes five tasks:

Task 1: Establish partnerships with federal-level centers to support their leadership role in operationalizing MCH best practices in two Federal Districts. Under this task, the Activity works with the Kulakov Federal Center on Obstetrics, Gynecology and Perinatology in Moscow and the Federal State Research Institute for Maternity and Infancy in Yekaterinburg.

Task 2: Operationalization and dissemination of approved MCH guidelines and best practices. Under this task, the Activity provides training on breastfeeding, emergency obstetric care, antenatal care, family centered maternity care, family planning, medical audit in obstetric facilities, etc.

Task 3: Utilize experience on optimizing the delivery of MCH/RH care at regional (oblast) level to promote the GOR's three-tiered system of MCH care. Two regions - Leningrad and Kurgan regions – were selected for targeted technical assistance, provided in collaboration with the Federal Centers, to build frameworks for a three-tiered system of MCH care.

Task 4: Improve MCH outcomes among high-risk women through improving access to appropriate family planning (FP), prenatal and postnatal care, in 1-2 regions in the Urals Federal District. Tyumen region and Khanty-Mansysk Autonomous Region were selected for implementation of this task.

Task 5: Sustainability Plan.

Evaluation Questions

The evaluation will provide answers to the following questions:

5. Goals: To what extent did the two Implementing Partners achieve the goals/objectives in their respective Scopes of Work, Work Plans and M&E Plans, including but not limited to Required Indicators, Activity Extension Goals, Expected Results and the like?
6. Deliverables: What was the performance of the Implementing Partners against the deliverables in their respective Scopes of Work, Work Plans and M&E Plans?
7. Sustainability: What is the likelihood of sustainability of results beyond USAID assistance? What additional activity elements should be incorporated in current and future activities in order to strengthen sustainability?
8. Lessons Learned: What are the key lessons learned that should guide program design for future efforts in the field of MCH/ Family Planning and Reproductive Health? (What worked well? What could be improved? What were unintended consequences? What gaps existed and why? Gender gaps? Vulnerable population gaps? How are the activities perceived or valued by stakeholders and the population served? Did the activities strengthen the relation between government and civil society? Did the activities demonstrate a relationship between good governance and health outcomes, why/ why not?

Local partners and stakeholders

The key stakeholders are USAID-Russia and the two implementing partners: JSI and URC. Both agencies are represented in Moscow. Their representative offices are the key local partners.

Methodology

Overall approach

This section briefly explains the rationale for choosing the methods used in this study.

As mentioned above, the purpose of this evaluation is the in-depth study of two complex activities contributing to the same overarching goal. The questions to be addressed in the evaluation are not related to any existing hypotheses, they are purely empirical. Answering these evaluation questions will allow us to gain new knowledge but not to test an existing model or hypothesis.

In the course of this evaluation the evaluators will remain open to any information and use rigorous inductive analysis to come to conclusions and recommendations.

Governed by an 'inductive' or 'discovery' orientation, rather than by a conception of inquiry, which requires specific hypotheses to be set up for testing at the start of the process, this evaluation will use a so-called 'progressive focusing' approach. This means that as the evaluators become engaged with the activities being evaluated, new issues may emerge and some will assume a greater importance than others.

Information that will be gathered to address the evaluation questions will be mostly descriptive and derived from semi-structured interviews described below. Therefore, a considerable part of the data will be based on the opinions, recollections, and experiences of people. Key sources of information include identified representatives from USAID, JSI, URC, local government entities in the regions, partner organizations and participants, and clients and beneficiaries of the activities. There are two kinds of documents available for review: descriptive and statistical. The latter include quantitative monitoring data.

In summary, this evaluation will have the following characteristics:

- The purpose of this evaluation is an in-depth study of two complex activities.
- The evaluation questions are purely empirical.
- The evaluation is based on an inductive analysis of mostly descriptive information.
- The evaluation design will be relatively flexible to accommodate emergent issues.

Sampling strategy

Given the complex nature of the activities being evaluated as well as the above mentioned characteristics of the study, the evaluators propose to adopt the purposeful sampling strategy based on the identification of information-rich cases – the sources from which we can learn most about the activities. The information rich cases that will be selected for in-depth exploration represent a broad variety of approaches and activities used by the Implementing Partners in different environments. The Evaluation Team will work with JSI and URC staff to explore ethical and non-intrusive ways to reach MCHI beneficiaries (if possible).

Rationale for selecting regions for site visits

The key criteria for selecting the sites are information richness and diversity (in the terms of geographic regions, social and economic environments, activities implemented, challenges met, and changes that occurred). This is consistent with the purposeful sampling strategy.

Site	Rationale for selection
Activity 1 The Evaluation Team will visit 4 out of 6 target regions.	
Tver	URC has a long history of cooperation with the region in the area of MCH. Tver Medical Academy has become a center for dissemination of best practices dissemination. This region participated in the regionalization of perinatal care and improvement of resuscitation collaboratives of the Activity 1.
Ivanovo	Ivanovo Scientific Research Institute for Motherhood and Childhood is one of the key partners, a center for dissemination of best practices.
Kostroma	Kostroma region was involved in 4 out of 6 collaboratives. It is the only region that had region-wide collaboration on optimization of labor management through the use of partograph.
Kostroma region -Sharya	Sharya city hospital is a model center for the URC program as it depicts all of the best practices and is sharing them with other centers.
Yaroslavl	Yaroslavl was the region where the project approach did not seem to work extremely well and was not fully adopted by the local administration.
Activity 2 The Evaluation Team will visit 5 out of 11 target regions. Other regions will be covered through telephone interviews (if feasible).	
Moscow	Kulakov Center is one if two key partners of Activity 2 and is the center for dissemination of best practices. Kulakov Center, Maternity Department of City Clinical Hospital № 15 of Moscow, Moscow Maternity Clinic # 4 are the sites where Activity 2 used audit model to improve the quality care for mothers and babies.
Moscow region	Perinatal Center of Moscow region is another site where Activity 2 used audit model to improve the quality care for mothers and babies.
Ekaterinburg	Capital of the Ural Federal District. Relatively new to the project. Federal State Research Institute for Maternity and Infancy is one of two key partners of the Activity 2 and the center for dissemination of best practices.
Tumen	Center of Excellence established in the course of the project. One of two regions selected to improve MCH outcomes among high-risk women through improving access to appropriate FP, prenatal and postnatal care.
Kurgan	Relatively poor mostly rural area with a large number of small maternity hospitals. The project helps them develop a system of 'regionalization' which is one of the key project tasks (#3). Kurgan as opposed to most other project sites does not have a local medical school.
Leningrad region – St. Petersburg	Leningrad region is one of two regions where the Activity 2 utilizes experience with optimizing the delivery of MCH/RH care at regional (oblast) level to promote the GOR's three-tiered system of MCH care.

Sources of Information (to be further developed in collaboration with the key stakeholders)

Sources	Type of collected data	Relates to	
		Activity 1	Activity 2
USAID staff	Qual	**X**	**X**
SOWs, Work Plans, M&E Plans, Reports, M&E data collected by Implementing Partners	Qual/Quant	**X**	**X**
Statistical information published by Roskomstat	Quant	**X**	**X**
Staff of Implementing Partners (in USA and Russia)	Qual	**X**	**X**
Russian Ministry of Health and Social Development	Qual	**X**	**X**
Federal and regional MCH institutes:			
Federal Research Institute for Health Care Organization and Information of the Russian MOHSD	Qual	**X**	
Scientific Center for Obstetrics, Gynecology and Perinatology named for Academic V.I. Kulakov	Qual	**X**	**X**
Ivanovo Scientific Research Institute for Motherhood and Childhood	Qual	**X**	
Tver State Medical Academy	Qual	**X**	**X**
Urals research Center of Maternal and Child Health	Qual		**X**
Experts from other research institutes	Qual	**X**	**X**
Staff of regional health departments	Qual	**X**	**X**
Staff of facilities where quality improvement teams approach was used	Qual	**X**	
Staff of facilities involved in care for high-risk women and regionalization of MCH	Qual		**X**
Participants of seminars on best practices	Qual		**X**
Civil society organization	Qual	**X**	
High-risk women offered FP services, prenatal and postnatal care	Qual		**X**
US expert organizations:			
American Academy of Pediatrics	Qual	**X**	
American College of Obstetricians and Gynecologists	Qual		**X**

Data Collection Methods

Document Review

The Evaluation Team will review activity-related documents made available to the evaluators by USAID and prepared by USAID and Implementing Partners (RFA, SOWs, Work Plans, M&E Plans, reports, and M&E data for the period from 2008) as well as statistical data (up to 2010) available from Roskomstat and its regional divisions.

Direct observation

In some cases it might be possible to directly observe activities such as seminars.

Semi-structured in-depth individual and group interviews

The Evaluation Team will use semi-structured in-depth interviews to collect information from individuals. As experiences of the respondents will be heterogeneous, the Team will use a mixed approach to developing the interview instrumentation based on a combination of interview guides and informal conversational approaches. See Annex 2 for the working list of key informants to be interviewed.

The interview guide approach requires that interview topics and issues are specified in advance, while the interviewer can decide on the sequence and wording of questions in the course of the interview. The strength of this approach is that the interview guide increases the comprehensiveness of the data and makes data collection more systematic. The weakness of this approach is that important and salient topics may be inadvertently omitted.

When the informal conversational interview approach is used, questions emerge from the immediate context and are asked in the natural course of the conversation. There is no predetermination of question topics or wording. The strength of this approach comes from its ability to increase the salience and relevance of questions during an interview and those that emerge from observations. These can be matched to individuals and circumstances. The weaknesses of this approach are that it is less systematic and comprehensive and different information is collected from different people resulting in organizational and analytical challenges.

Mixing these two approaches will allow us to minimize the weakness while benefiting from the strengths.

Topics and issues that will be covered in all interviews are as follows:

- How did the respondent become involved with the activity(ies)?
- What was the respondent's involvement?
- What approaches to infuse best practices into the operation of Russia specialists worked well and why?
- What did not work well and why?
- What could have been done differently?
- How did the respondent's professional practice benefit from what s/he learned through the Activity?
- Will the respondent be able to continue using best practices learned through the Activity?

The length of each semi-structured interview will be about 1-1.5 hours. We expect that most interviews will be with individuals, though in some cases we may conduct group interviews.

Triangulation

Triangulation refers to double or triple checking results by using different methods, data sources and/or experts. To increase the accuracy and credibility of the evaluation findings, the Evaluation Team will use several types of triangulation:

- Methodological triangulation – three methods for data collection will be used;
- Data source triangulation – the data about the Initiative will be collected from a variety of sources;
- Investigator triangulation – the Evaluation Team includes three members, which allows looking at the data from different perspectives.

Data analysis

Four distinct processes will be involved in making sense out of evaluation findings[58].

1. *Description and analysis*: Describing and analyzing findings involves organizing raw data into a form that reveals basic patterns. The factual findings as revealed in actual data will be presented in a user-friendly fashion.
2. *Interpretation*: What do the results mean? What's the significance of the findings? Why did the findings turn out this way? What are possible explanations of the results? Interpretations go beyond the data to add context, determine meaning, and tease out substantive significance based on deduction or inference.
3. *Judgment*: Values are added to analysis and interpretations. Determining merit or worth means resolving to what extent and in what ways the results are positive or negative. What is good or bad, desirable or undesirable, in the outcomes?
4. *Recommendations*: The final step adds action to analysis, interpretation and judgment. What should be done? What are the action implications of the findings? Only recommendations that follow from and are grounded in the data ought to be formulated.

Protection of human subjects

It is important to *ensure that evaluation participants are protected*. The evaluation team will make arrangements for all evaluation activities with the heads of participating entities. Evaluators will explain the purpose and tasks of the study to them and to all interviewees. Verbal permissions from organizations and individuals to collect and use information will be obtained. Informal rules of joint work will be negotiated. When asked, evaluators will always allow people to see the interview questions in advance.

Briefing and Dissemination of Evaluation Findings

This section describes overall approaches and key activities related to communication of evaluation findings to the key stakeholders and dissemination of evaluation results. A more detailed description of the time-bound evaluation milestones is included in the Evaluation Work plan.

[58] Based on Patton, M. Q. (1997). *Utilization-focused evaluation: The new century text* (3rd ed.). Thousand Oaks, CA: Sage. (page 307)

The evaluation team will present draft key evaluation findings to USAID, JSI and URC representatives in the form of a PowerPoint presentation. Feedback received during and after the presentation will be considered in the draft report.

A draft evaluation report will be prepared in English and sent to USAID/Russia and Implementing Partners for review and commentary.

The Evaluation Team understands that the Final Report will be made public via the USAID website and the executive summary will be translated into Russian.

Dissemination of evaluation results will be done with careful consideration of the local context and after consultations with the key stakeholders.

At this point in time we would like to propose two options to be considered:

- To share the lessons learned, the Evaluation Team suggests writing an article in Russian presenting key findings of the evaluation. This article can be sent to all MCHI stakeholders and made public through Implementing Partners web-sites.
- Given that this evaluation is conducted within the framework of a larger project that among other things should build the evaluation capacity in Russia, the Evaluation Team suggests writing an article in Russian on lessons learned about the M&E aspect of the Initiative and making it public via the online journal "Planning, Monitoring and Evaluation". This article can also be used as a case study for the training activities on M&E foreseen for USAID partners. The paper also could be presented at the conference of the International Programme Evaluation Network that covers the CIS region in September 2012.

Challenges and limitations

Qualitative data allows a comprehensive and multifaceted understanding of people's experiences with the program. However, collecting such in-depth and detailed data is time consuming so evaluators are compelled to restrict the number of people whom evaluators can interview. Moreover, in relation to the sampling strategy, the entire population under study was relatively small and diverse, and the evaluation team is not able to collect data from all the regions due to the time constraints. This is the logic behind using purposeful sampling strategy. It does not allow generalization, but allows extrapolation,[59] which is sufficient for the purposes of this evaluation.

Another challenge of the qualitative methodology is that an evaluator is an instrument of research and inevitably brings his/her perceptions and values to the study. To minimize the possible distortion of the findings evaluators will be constantly discussing within the team what values they bring to this study. The team members will monitor each other's neutrality about the MCHI. The evaluation team includes representatives from Russia and the US, which will help

[59] Extrapolation here is understood as an inference about the future (or about some hypothetical situation) based on known facts and observations.

them grasp MCHI's contexts (political, cultural, socio-economic) and establish good rapport with respondents.

EVALUATION WORK PLAN

Evaluation Team[60]

The Evaluation team members are considered Key Personnel for this evaluation. No Key Personnel shall be removed from the Team nor shall their level of effort, roles or responsibilities be changed without prior written approval of USAID/Russia. See Annex 3 for the complete CVs of the evaluation team.

Alexey Kuzmin, Team Leader, LOE – 32 days

Dr. Kuzmin will lead the Evaluation Team. He will participate in document review, collection of information through semi-structured interviews in Moscow and several regions, data analysis and report writing. He will be responsible for briefing USAID/Russia on evaluation progress and presenting evaluation findings.

Dr. Kuzmin has extensive experience as evaluation team leader and is skilled working with international teams. He has conducted over 100 evaluations of projects and programs in Russia, CIS, and Central and Eastern Europe and his clients include USAID, UN agencies, international development agencies, private foundations, NGOs, businesses, and government entities. Dr. Kuzmin is co-founder and director general of Process Consulting Company, a Moscow-based evaluation consulting firm. He combines a deep knowledge of evaluation theory with extensive evaluation experience at the country, multi-country, and regional level. His key specializations include: Program and Project Evaluation, Organizational Assessment (Diagnostics), organizational change design and implementation, Customer Oriented Interactive Training Design, and Project Management. A Russian based in Moscow, Dr. Kuzmin holds a PhD in Organizational Behavior and Development.

Annette Bongiovanni, Health Care Expert/ Evaluation Consultant, LOE – 24 days

Ms. Bongiovanni will participate in document review, collection of information through semi-structured interviews in DC, Moscow and three other regions in Russia, and data analysis and report writing.

Ms. Bongiovanni is a seasoned development professional and clinical nurse skilled in the management, evaluation, and operations research of global health programs. She has more than 30 years of experience in international and domestic health care primarily at the service delivery and policy levels. Ms. Bongiovanni also has extensive practice and project manager experience and has been a resident advisor on an array of projects focused on family planning, reproductive health, nutrition, maternal, neonatal and child health, and HIV/AIDS. She most recently served as Director of Health Practice for the QED Group, and has also been the Reproductive Health Coordinator for the AED/Linkages project and was the Johns Hopkins Child Survival Fellow for

[60] Detailed CVs of the team members are enclosed as Annex 3.

the USAID Bureau for Latin America and the Caribbean. Recent relevant consultancies include an evaluation of the effectiveness of USAID/Nicaragua's maternal and child health program.

Natalia Kosheleva, Evaluation Consultant, LOE – 20 days

Ms. Kosheleva will be involved in document review, collection of information through semi-structured interviews in Moscow and several regions, conduct phone interviews, and participate in data analysis and report writing.

Ms. Kosheleva, based in Moscow, has served as team member and team leader on numerous evaluation projects for a wide variety of donor agencies, including USAID, UN agencies, and the Russian Red Cross. She has consulted for Process consulting since 2006. Her health-related experience includes an evaluation of the School for Patients program (Russian Red Cross) and of the Youth Friendly Clinics Project (UNICEF-Russia). She holds MAs in Public Administration and Physical Geography and is a member of the American Evaluation Association. Her post-graduate study includes focus group moderator training, mixed methods evaluation, and interviewing techniques and content analysis for program evaluation.

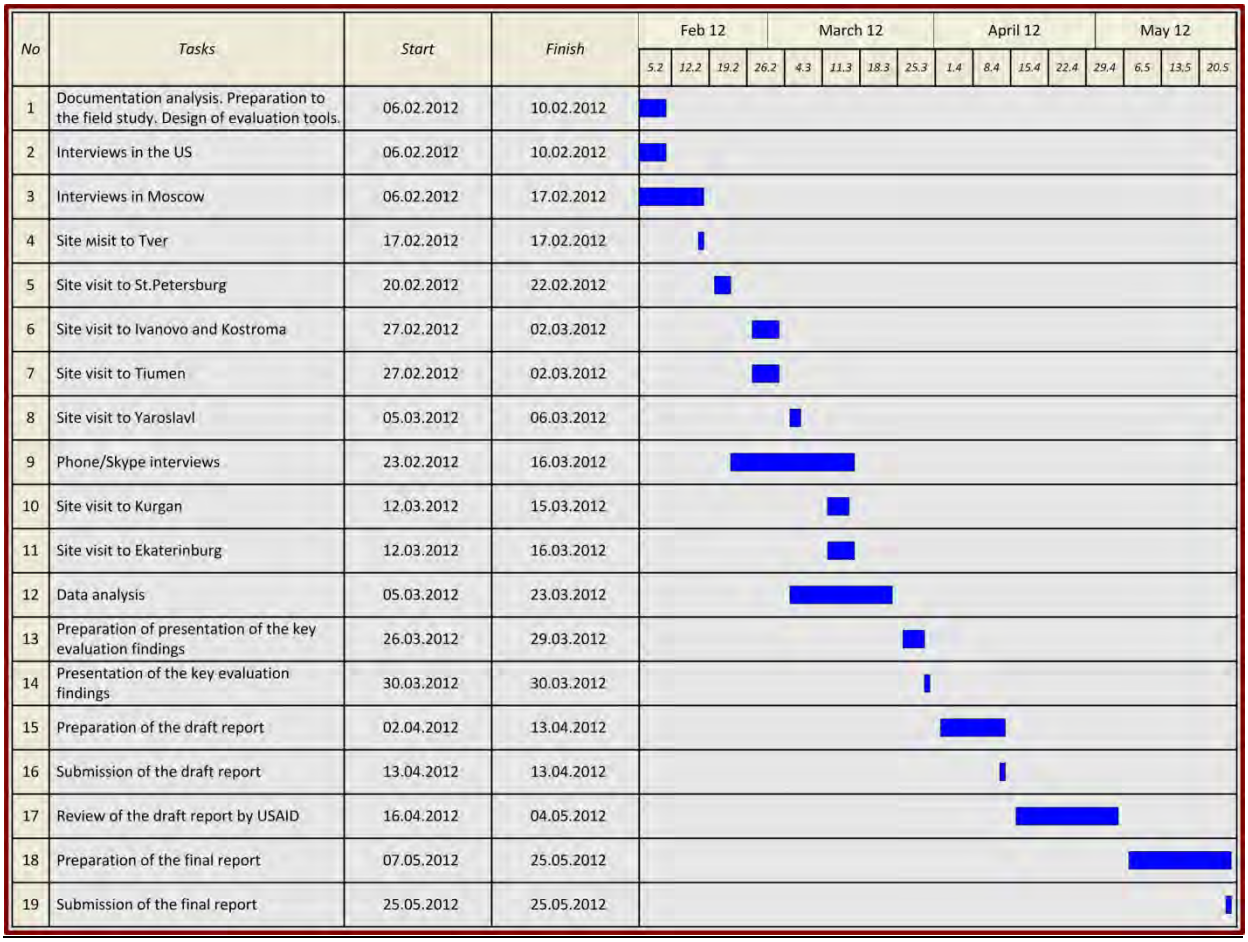
Responsibilities of the team members

Team members / **Tasks**	Kuzmin	Kosheleva	Bongiovanni
Designing evaluation tools	+	+	+
Interviews in the US			+
Data collection in Moscow	+	+	+
Data collection in Moscow district	+		+
Data collection in Tver and St. Petersburg			+
Data collection in Kurgan, Kostroma, Ivanovo and Yaroslavl		+	
Data collection in Tyumen and Ekaterinburg	+		
Data analysis	+	+	+
Report writing	+	+	+

Evaluation Schedule

This is a tentative evaluation schedule. The evaluation team will communicate with the respondents in the regions to finalize actual travel dates and the interview schedule.

The rationale for selecting the sites visits is described in more detail in the Methodology section of the above Evaluation Design. In sum, the key criteria for selecting those sites were information richness and diversity – vis-à-vis the geographic regions, social and economic environments, activities implemented, challenges met, and changes that occurred.



No	Tasks	Start	Finish
1	Documentation analysis. Preparation to the field study. Design of evaluation tools.	06.02.2012	10.02.2012
2	Interviews in the US	06.02.2012	10.02.2012
3	Interviews in Moscow	06.02.2012	17.02.2012
4	Site visit to Tver	17.02.2012	17.02.2012
5	Site visit to St.Petersburg	20.02.2012	22.02.2012
6	Site visit to Ivanovo and Kostroma	27.02.2012	02.03.2012
7	Site visit to Tiumen	27.02.2012	02.03.2012
8	Site visit to Yaroslavl	05.03.2012	06.03.2012
9	Phone/Skype interviews	23.02.2012	16.03.2012
10	Site visit to Kurgan	12.03.2012	15.03.2012
11	Site visit to Ekaterinburg	12.03.2012	16.03.2012
12	Data analysis	05.03.2012	23.03.2012
13	Preparation of presentation of the key evaluation findings	26.03.2012	29.03.2012
14	Presentation of the key evaluation findings	30.03.2012	30.03.2012
15	Preparation of the draft report	02.04.2012	13.04.2012
16	Submission of the draft report	13.04.2012	13.04.2012
17	Review of the draft report by USAID	16.04.2012	04.05.2012
18	Preparation of the final report	07.05.2012	25.05.2012
19	Submission of the final report	25.05.2012	25.05.2012

Deliverables schedule

- **Key evaluation findings** will be presented to USAID, URC and JSI on March 30, 2012 (Friday) in a power point presentation.
- **Draft Report** will be submitted on April 13, 2012
- **Final report** will be submitted within 3 working weeks after receiving comments on the draft report from USAID and implementing partners (tentatively – by May 25, 2012)

Stakeholder review mechanism and collaboration with the key stakeholders

The evaluation team will work in close collaboration with the key stakeholders (USAID, JSI and URC) from the very beginning. For example, the stakeholders were involved in preparation of Evaluation Design and Evaluation Work Plan and provided advice on various issues such as sampling, data collection methods, identification of key informants and evaluation schedule. If USAID concurs, the draft evaluation reports will be sent to them for review and commentary. All of their comments will be discussed and considered by the evaluation team.

Annex 3. List of persons consulted

#	Name	Title	Company
USA			
1.	James R. Heiby	Medical Officer COTR, Health Care Improvement Project	USAID
2.	Nicole Simmons	Project Director, "Improving Care for Mothers and Babies" (former)	University Research Co., LLC
3.	Asta-Maria Kenney	Senior Advisor	John Snow, Inc.
4.	Kenneth J. Olivola	Director, International Division	John Snow, Inc.
Moscow			
5.	Lara Petrosian,	Technical Officer, Office of Health	USAID/Russia
6.	Suzanne Hoza	Activity Officer, Office of Health	USAID/Russia
7.	William Slater	Director, Office of Health	USAID/Russia
8.	Victor Boguslavsky	Country Director	University Research Co., LLC
9.	Irina Isaeva	Deputy Country Director	University Research Co., LLC
10.	Irina Kriukova	Knowledge Management Director	University Research Co., LLC
11.	Olga Chernobrovkina	Quality Improvement Director	University Research Co., LLC
12.	Natalia Vartapetova	Director	Institute for Family Health
13.	Anna Karpushkina	Deputy Director on Public Health	Institute for Family Health
14.	Oleg Shabskiy	Lead Clinical Care Specialist	Institute for Family Health
15.	Elena Sheshko	Reproductive Health and Family Planning Specialist	Institute for Family Health
16.	Elena Safronova	Specialist on Clinical Issues	Institute for Family Health
17.	Alexander Galiusov	Monitoring and Evaluation Specialist	Institute for Family Health
18.	Eugenia Ivanova	Training Coordinator	Institute for Family Health
19.	Elena Khlamova	PR Manager	Institute for Family Health
20.	Tatiana Ivanova	Communications Manager	Institute for Family Health
21.	Irina Riumina	Head of Neonatal Pathology Department	Scientific Center for Obstetrics, Gynecology and Perinatology named for Academic V.I. Kulakov (Kulakov Center)
22.	Vladimir Starodubov	Director	Federal Research Institute for Health Care Organization and Information of the

			Russian MOHSD (Public Health Institute)
23.	Anna Korotkova,	Deputy Director for International Affairs, Head of the Federal Center for Health Quality Improvement	Public Health Institute
24.	Natalia Ivanasheva	Head of the IT for international cooperation departments	Public Health Institute
25.	Zulfia Izhaeva	M&E Specialist for International Programs	Public Health Institute
26.	Olga Sharapova	Director	Moscow Maternity Clinic # 4
27.	Nina Kuznetsova	Chief Obstetrician, Director of Labor and Delivery	Moscow Maternity Clinic # 4
Ivanovo			
28.	Elena Boiko	Head of Clinical and Diagnostic Department	Ivanovo Scientific Research Institute for Motherhood and Childhood (ISRIMC)
29.	Irina Panova	Head of Obstetrics and Gynecology Department	ISRIMC
30.	Larissa Bykovskaya	Head of Admission Department, Obstetric Clinic	ISRIMC
31.	Valentina Krasnova	Chief Clinical Specialist	ISRIMC
32.	Natalia Shilova	Researcher	ISRIMC
33.	Ekaterina Matveeva	Research Coordinator	ISRIMC
34.	Sergey Nazarov	Deputy Director for research	ISRIMC
St. Petersburg and Leningrad oblast			
35.	Petr Surovtsev	Head of MC Care Department	Leningrad oblast Administration
36.	Anton Mikhailov	Director	St. Petersburg School of Perinatal Medicine and Reproductive Health, Maternity Hospital #17
37.	Valerie Ysinofsky	Director	Kirishi Central Regional Hospital
38.	Irina Diasamidze	Deputy Director on Obstetrics	Kirishi Central Regional Hospital
Tver			
39.	Lidia Samoshkina	Head of Department for the Reorganization of Mother and Child Care	Tver Oblast Administration
40.	Boris Kapitonov	Head of Anesthesiology and Resuscitation Department	Tver Oblast Children's Hospital
Kurgan and Kurgan Oblast			
41.	Svetlana Kosareva	Deputy Director	Kurgan Oblast Hospital
42.	Irina Goryachok	Deputy Director on Obstetrics and Gynecology	Kurgan Oblast Hospital
43.	Natalia Nagibina	Deputy Director	Kurgan Childrens' Outpatient Hospital #1
44.	Valery Kholodkov	Director of Obstetrics and Gynecology	Kurgan City Hospital #2

45.	Irina Kornilova	Director	Women's Consultation, Kurgan City Hospital #2
46.	Natalia Lagutina	Head of Department	Shadrinsk Maternity Clinic
47.	Peter Dzigunov	Director	Kargapol Central Regional Hospital
48.	Alla Fefilova	Head of Department	Kargapol Central Regional Hospital
49.	Valentina Dzigunova	Gynecologist	Kargapol Central Regional Hospital
50.	Nadezhda Deriagina	Nurse, Maternity Unit	Kargapol Central Regional Hospital
51.	Andrey Ustinov	Director	Shumikha Central Regional Hospital
52.	Liudmila Ustinova	Obstetrician-Gynecologist	Shumikha Central Regional Hospital
53.	Marina Cherenok	Neonatologist	Shumikha Central Regional Hospital
54.	Nadezhda Grigorieva	Obstetrician-Gynecologist	Shumikha Central Regional Hospital
55.	Nadezhda Leonova	Nurse	Shumikha Central Regional Hospital
56.	Natalia Kofanova	Chief Specialist on Mother and Child Health, Department of Health	Kurgan Oblast Administration
Tyumen and Tyumen Oblast			
57.	Tatiana Popkova	Head of Obstetrics Department	Tyumen Oblast Perinatal Center
58.	Irina Antoniuk	Obstetrician	Tyumen Oblast Perinatal Center
59.	Raisa Kulikova	Chief Nurse, President of Tyumen Oblast Association of Nurses	Tyumen Oblast Perinatal Center
60.	Olga Gorbunova	Chief Specialist on Mother and Child Health, Department of Health	Tyumen Oblast Administration
61.	Nadezhda Novoselova	Chief Nurse	Tyumen City Maternity Clinic #3
62.	Elena Kosorukova	Deputy Director	Tyumen City Maternity Clinic #3
63.	Margarita Griboyedova	Director	Tyumen City Maternity Clinic #2
64.	Olga Kaidalova	Deputy Director	Tyumen City Maternity Clinic #2
65.	Marat Bashirov	Director	Tobolsk Regional Perinatal Center
66.	Alexander Makarov	Deputy Director	Tobolsk Regional Perinatal Center
67.	Vera Barova	Director	Tyumen City Community Foundation
Kostroma and Kostroma Oblast			
68.	Anna Lebededva	Obstetrician	Kostroma Clinical Center "Mother and Baby"

69.	Irina Komarova	Director	Kostroma City Maternity Hospital #1
70.	Elena Novozhilova	Deputy Director	Kostroma City Maternity Hospital #1
71.	Galina Ipatova	Chief Obstetrician	Kostroma City Maternity Hospital #1
72.	Tatiana Sokolova	Deputy Director	Kostroma Oblast Perinatal Center
73.	Eduard Kuskas	Head of Department of Mother and Child Health	Kostroma Oblast Administration
74.	Victor Pochtoyev	Director	Sharya Central Regional Hospital
75.	Pavel Sharanov	Head of Obstetrics Department	Sharya Central Regional Hospital
76.	Alexander Pleshkov	Deputy Director	Sharya Central Regional Hospital
77.	Marina Sozinova	Obstetrician, Social Work Specialist	Sharya Central Regional Hospital
78.	Tatiana Kraeva	Chief Obstetrician	Sharya Central Regional Hospital
79.	Galina Kovrigina	Nurse	Sharya Central Regional Hospital
80.	Natalia V'yalitsina	Head of Department serving children at educational institutions	Sharya Central Regional Hospital
81.	Gennadi V'yalitsin	Childrens' Gynecologist	Sharya Central Regional Hospital
82.	Galina Smirnova	Nurse	Sharya Central Regional Hospital
Yaroslavl and Yaroslavl Oblast			
83.	Anna Karpova	Deputy Director	Yaroslavl Oblast Perinatal Center
84.	Nina Galaganova	Head of Neonatal Department	Yaroslavl City Hospital #2
85.	Andrey Surovtsev	Obstetrician- Gynecologist	Yaroslavl City Hospital #2
86.	Elena Gorodova	Neonatologist	Tutayev Central Regional Hospital
87.	Natalia Olendar	Head of Department of Mother and Child Health	Yaroslavl Oblast Administration
Khanty-Mansiisky Okrug			
88.	Tamara Ovechklina	Deputy Director of Health Department on Mother and Child Health	Khanty-Mansiisky Okrug Administration
Yamalo-Nenetski Okrug			
89.	Olga Gerashenko	Head of Health Care Organization Unit	Department of Health, Yamalo-Nenetski Okrug Administration
Vologda Oblast			
90.	Elena Vologdina	Head of Protection of Mother and Child Health Unit	Department of Health, Volodga Oblast Administration
Chelyabinsk Oblast			

91.	Irina Ogoshkova	Head of Protection of Mother and Child Health Department	Ministry of Health, Chelyabinsk Oblast
92.	Victoria Sakharova	Deputy Head of Protection of Mother and Child Health Department	Department of Health, Chelyabinsk City Administration

Annex 4. List of documents studied

USAID

MCH Project Results Framework (the evaluation team did not have the project document – just one diagram with the results framework).

URC

1. ANNUAL SUMMARY REPORT. Fiscal year 2011
2. Work Plan Dec 2008
3. Work plan. October 2009 - December 2010
4. Work plan. October 2010 – October 2011
5. Scope of Work. October 2010 – October 2011. Health Care Improvement Project. Improving Care for Mothers and Babies and Prevention and Control of Arterial Hypertension
6. Presentation for assessor Jan 2012
7. QUARTERLY REPORT. January-March 2010
8. QUARTERLY REPORT. APRIL-JUNE 2010
9. QUARTERLY REPORT. JULY-SEPTEMBER 2010
10. QUARTERLY REPORT. OCTOBER-DECEMBER 2010
11. QUARTERLY REPORT. JANUARY-MARCH 2011
12. QUARTERLY REPORT. APRIL-JUNE 2011
13. QUARTERLY REPORT. JULY-SEPTEMBER 2011
14. Targets and Actuals for HCI's activity "Improving care for mothers and babies" FY09-11

JSI

15. JSI Contract SOW and Deliverables
16. Project Implementation Plan. December 2010
17. Monitoring and Evaluation Plan. March, 2011
18. Project Year Four Work Plan. September 2011
19. Project Region-to-Region Exchange Program. March, 2011
20. Plan for US-Russia Study Tours. March, 2011
21. Quarterly Report. January - March 2010
22. Quarterly Report. April - June 2010
23. Quarterly Report. July - September 2010
24. Quarterly Report. October - December 2010
25. Quarterly Report. January - March 2011
26. Quarterly Report. April - June 2011
27. Quarterly Report. July - September 2011
28. Sustainability Plan. March 2011

Annex 5. Bibliography of significant publications used to consult

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Sukhih, G., & Vartapetova, N. (Eds.). (2011). *Evidence Based Medicine. Manual for beginners.* Moscow: Institute for Family Health. (in Russian)

Treasury Board of Canada. (1998). *Program evaluation methods: Measurement and attribution of program results. Third Edition.* Retrieved April 20, 2012, from http://www.tbs-sct.gc.ca/cee/pubs/meth/pem-mep-eng.doc.

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Annex 6. Glossary

Maternal mortality ratio (MMR) is the number of deaths of pregnant women during pregnancy and within 42 days of the termination of their pregnancy no matter the length of their gestational period per 100,000 live births

Perinatal period begins at 22 weeks of gestation and ends at 7 days after birth

Live birth is any birth whereby the neonate is born showing any sign of life such as breathing, heart beating, pulsation of the umbilical cord and/or movement of voluntary muscles. The newborn is considered a live birth regardless of whether the umbilical cord has been cut or if the placenta has been expulsed from the mother.

Neonatal mortality rate (NMR) is the number of deaths between birth and 28 days of life per 1,000 live births.

Early neonatal mortality rate (ENMR) is the number of deaths of live births during the first seven days of life per 1,000 live births. The ENMR is a sub-set of the NMR.

Annex 7. Participation in Quality Improvement Collaboratives (URC)

Oblast (# of participating facilities)	Medical Facility	**Reproductive Health**: Prevention of unwanted pregnancies, abortions and STDs among teens	**Obstetrics:** Optimizing labor management through use of the partograph	**Neonatology:** Prevention of hypothermia and respiratory ailments among newborns	**Neonatology:** Broadening implementation of breastfeeding practices	**Neonatology:** Improvement of primary neonatal resuscitation and transport	**Regionalization of Perinatal Care.** Includes: Prevention and Management of Preterm Birth, Improvement of Transport for Pregnant Women and Newborns, Computerized Monitoring System
Kostroma (7)	Galich City Hospital	+	+	+	+		+
	Kostroma Center for Family Planning & Reproduction	+					
	Kostroma City Maternity Hospital No. 1		+	+			
	Kostroma Oblast Hospital		+	+		+	+
	Manturovo City Hospital	+	+	+			
	Nerekhta Central District Hospital		+	+	+	+	+
	Sharya Central District Hospital	+	+	+	+	+	+
Tambov (9)	Luki Hospital		+		+		
	Michurinsk City Hospital No. 2		+	+	+		+
	Morshansk Central District Hospital		+		+		+
	Rasskazovo Central District Hospital		+	+	+		+
	Tambov City Hospital No. 3			+			+
	Tambov City Polyclinic No. 5	+					
	Tambov Oblast Children's Hospital			+	+	+	
	Tambov Oblast Hospital						+
	Uvarovo Central District Hospital		+	+		+	
Yaroslavl (5)	Pereslavl-Zalessky City Hospital			+			
	Rostov Central District Hospital			+		+	
	Tutaev Central District Hospital		+	+		+	
	Uglich Central District Hospital			+		+	
	Yaroslavl City Clinical Hospital No. 2		+			+	
Ivanovo (5)	Ivanovo City Clinical Hospital No. 8	+					
	Ivanovo City Maternity Hospital No. 1		+	+		+	
	Ivanovo City Maternity Hospital No. 4			+	+	+	
	Kineshma Central District Hospital	+	+			+	
	Teykovo Central District Hospital			+			
Tula (13)	Aleksiiniy Maternity Hospital		+	+			
	Bogoroditskaya Central District Hospital				+		
	Efremovskaya Central District Hospital		+		+		
	Family Planning Center, Tula City	+					

	Hospital No. 2						
	Kireevskaya Central District Hospital		+	+			
	Novomoskovsk Maternity Hospital		+	+			
	Novomoskovskaya Children's Hospital				+		
	Schekinskaya Central District Hospital			+			
	Schekinskaya City Children's Hospital	+			+		
	Tula City Children's Hospital No. 3				+		
	Tula City Maternity Hospital No. 1	+	+	+	+		
	Tula Oblast Children's Hospital			+	+		
	Tula Oblast Perinatal Center		+	+			
Tver (6)	Bezhetsk Central District Hospital					+	+
	Nelidovo Central District Hospital					+	+
	Rzhev Central District Hospital					+	+
	Torzhok Central District Hospital					+	+
	Tver City Maternity Hospital No. 1					+	+
	Tver Oblast Perinatal Center					+	+

Annex 8. New technical focus on Chronic Disease Prevention and Treatment

This annex suggests considering new technical focus on Chronic Disease Prevention and Treatment (if necessary).

Rationale and vision

Chronic diseases comprise a much bigger burden of disease. Non-communicable diseases (NCD) have been receiving a lot of attention as countries are facing the dual burden of communicable (HIV/AIDS, TB, other infectious diseases) and illness related to primary health care conditions among mothers and children. Russia is already contending with chronic diseases in hospitals but less certain is the degree to which they address prevention and risk mitigation at the community level (raising awareness of substance abuse and health outcomes). They can build upon the work in the newly established preventative health centers launched two years ago (at least in St. Petersburg Oblast) where they screen, diagnosis and refer patients at the community level. These centers also convene community meetings where they advocate for preventative health. Follow-up in the home would be needed by social workers through the Department of Social Services in close coordination with medical personnel who identify patients discharged home with chronic diseases. These people need education on how to prevent further exacerbation of their illnesses through diet, exercise and stress reduction and minimizing substance use. In the future, Russia could educate neighboring countries in the Commonwealth of Independent States whom they would receive on study tours. USAID's emphasis should ideally be on the preventative side of the equation, however, in order to make this idea appealing to their Russian colleagues in the MOHSD, they might need to add a curative component in which case the emphasis should be quality improvement and in line with the recent QI interventions focused on MCH.

Illustrative Interventions

- prevention messages for ETOH, tobacco, nutrition, DOTs (especially identification of cases and compliance)
- IEC for clients and job aides for providers
- Collaboration with social workers
- Interpersonal Communication (IPC) tutorials
- Psycho-social support
- Pre-service education (at college level for nursing and medicine) is always important but we appreciate that it entails working with another ministry and might be beyond USAID's manageable interest.
- The medical director of Kostroma intends to use the QI method for non-communicable diseases (NCD) which includes chronic diseases.

For this program component it is proposed to designate adults with Chronic Disease (preventive and curative) as primary beneficiaries with an emphasis on:

- substance abusers (ETOH (alcohol), tobacco, IDU (Moscow & St. Petersburg)
- Persons living with HIV/AIDS
- people with chronic diseases such as cardiovascular disease, diabetes, and cancer

Annex 9. Performance indicators: reach, dose and fidelity

This approach was proposed by Linnan and Steckler (2002).

Reach measures the share of project target audience that participates in an intervention. Useful performance indicators for MCH intervention would be the share of maternity facilities involved in the project in the target region, the share of births, mothers or infant receiving services at project facilities.

Dose measures the amount of intervention "units" delivered by the project or received by its participants. For the *Improving Care for Mothers and Babies* project the dose could be measured as a number of collaboratives per facility – absolute for individual facility and average for all participating facilities.

Fidelity can measure if and to what extent participating facilities use practices introduced by a project properly. Then expected results for the projects can be expressed in terms of expected reach, dose and fidelity.

Annex 10. What is a think tank?

A think tank (or policy institute) is an organization that conducts research and engages in advocacy. Most think tanks are non-profit organizations. Other think tanks are funded by governments, advocacy groups, or businesses, or derive revenue from consulting or research work related to their projects.

The key function of a think tank, according to Paul Dickson (1971), is "to act as a bridge between knowledge and power."

The nature of think tanks and understanding of their core mission developed since then. Ray Struyk (1999) presents a classification of the potential functions of the think tank.

According to Struyk, Economic Think Tank/Consulting Firm can serve as:

1. A source, evaluator and advocate of socially valuable economic policy proposals;
2. An evaluator of existing economic policies, processes and programs;
3. A source of personnel for higher-level government positions;
4. A source of information to news organizations about current economic policy/program issues.

The "traditional" TT characteristics presented in Diane Stone's (1996) book include:

- Organizational Independence and Permanency
- Self-determination of Research Agendas
- Policy Focus (Output is Policy/Political Relevant Knowledge)
- Public Purpose (Social Orientation or Purpose)
- Expertise and Professionalism
- Organizational Yield or Output[61]

According to Diane Stone, "Think and Do (Activist) Think Tanks" is also one of the "new characteristics" of the think tanks. Judith Bell, President of PolicyLink (USA) continues: "A think-tank can be many things – but the best think tanks are ones that don't just think. They are places where the solutions to America's challenges are seen through the eyes of the people facing those challenges. They are places where making the idea real is just as important as having the idea in the first place. They are places that don't assume they have all the answers – and listen to the voices and ideas of regular people in crafting strong, workable solutions."

[61]This output includes publications (of all sorts), press citations personal appearances, testimony and seminars, conferences, etc.

Annex 11. Disclosure of Conflict of Interest

Disclosure of Conflict of Interest

Name	Annette Bongiovanni
Title	Consultant
Organization	Independent Contractor for IBTSCI
Evaluation Position?	☐ Team Leader ■ Team member
Evaluation Award Number *(contract or other instrument, if applicable)*	
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	Russia MCH Evaluation: Improving Care for Mothers and Babies, University Research Corporation Institutionalizing Best Practices for MCH, John Snow, Int'l
I have real or potential conflicts of interest to disclose.	☐ Yes ■ No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to:* 1. *Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.* 2. *Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.* 3. *Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.* 4. *Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.* 5. *Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.* 6. *Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.*	

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change.

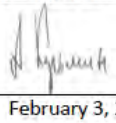
Signature:	Annette Bongiovanni
Date:	January 24, 2012

1

Disclosure of Conflict of Interest

Name	Alexey Kuzmin
Title	Dr.
Organization	IBTCI
Evaluation Position?	■ Team Leader ☐ Team member
Evaluation Award Number *(contract or other instrument, if applicable)*	Contracted under RAN-I-00-09-00016, Order No. AID-118-TO-11-00004 Russia Monitoring and Evaluation Project
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	USAID Maternal and Child Health Initiative
I have real or potential conflicts of interest to disclose.	☐ Yes ■ No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to:* 1. *Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.* 2. *Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.* 3. *Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.* 4. *Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.* 5. *Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.* 6. *Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.*	

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change.

Signature:	
Date:	February 3, 2012

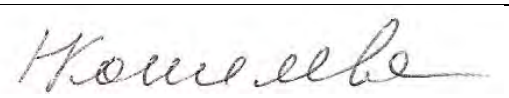
1

Disclosure of Conflict of Interest

Name	Natalia Kosheleva
Title	Evaluation Consultant
Organization	IBTCI
Evaluation Position?	☐ Team Leader ■ Team member
Evaluation Award Number *(contract or other instrument, if applicable)*	RAN-I-00-09-00016-00, Order No. AID-118-TO-11-00004 Russia Monitoring and Evaluation Project
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	USAID Maternal and Child Health Initiative
I have real or potential conflicts of interest to disclose.	☐ Yes ■ No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to:* 1. *Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.* 2. *Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.* 3. *Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.* 4. *Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being*	

evaluated. 5. *Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.* 6. *Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.*	

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change.

Signature:	
Date:	06 Aug 2012