ATTACHMENT I

INSTITUTIONALIZING BEST PRACTICES IN MATERNAL AND CHILD HEALTH

Statement of Work (SOW)

A. INTRODUCTION

The overall goal of the work under this Task Order (TO) 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 Project is intended to increase contraceptive prevalence among women of reproductive age, thereby contributing to decreased abortion rates in the selected federal districts. To achieve the overall goal of decreased maternal and infant morbidity and mortality in the target federal districts, the tasks funded through this Task Order are expected to contribute to the following intermediate results:

- MCH best practices related to major causes of maternal and infant morbidity and mortality adopted by target federal districts and corresponding regions;
- Decreased abortion rates in regions within the selected federal districts;
- Increased modern contraceptive prevalence among women of reproductive age within the selected federal districts;
- Strengthened capacity of key federal and regional entities to deliver, disseminate and advocate for best practices in MCH and RH at the regional and federal level; and
- Strengthened capacity of health care providers including obstetrician-gynecologists, pediatricians, family doctors, midwives, nurses, including in rural areas, to deliver quality RH and MCH services and counseling.

USAID/Russia has supported successful, integrated MCH and RH activities at the regional level for many years. These activities have contributed to decreases in abortion levels and maternal and infant morbidity and mortality and to increases in modern contraceptive prevalence. Building on this success, this TO is designed to scale up the improvements in MCH and RH to the next level, by building centers of excellence at the federal district level to foster ownership and institutionalize and transfer best practices to Russia.

B. BACKGROUND

The year 2008 has been designated by the Government of Russia (GOR) and health officials as the "Year of the Family", increasing the focus on larger and healthier families. With decades of a declining population, as in the past, the GOR has publicly encouraged couples and families to have more children. In 2006 the GOR introduced, through the National Health Project, a financial incentive package, similar to those in several other European countries, to encourage families to have more children, including greater financial support for families with more than one child and foster families. For the first time in decades, the number of reported births in 2007 outweighed the number of abortions. However, there remains much to be done.

Russia has made important progress in improving maternal and child health over the past two decades, as illustrated by improvements in many key reproductive health indicators. For example, infant mortality has significantly decreased since the 1990's, falling from 16.5 per 1000 live births in 1998 to 10.2 in 2006, a decrease of almost 40% in just eight years. Similar improvements have been realized with maternal mortality, with a decline from 68.0 in 1980 to 23.0 in 2006, largely due to declines in abortion-related maternal deaths. The trend is similar for abortion rates, which have steeply declined from 113.9 abortions per 1,000 women of reproductive age (age 15-49) in 1990 to 40.6 among the same age cohort in 2006. The growing availability of modern contraceptives in the early 1990s and the sharp increase in contraceptive use among Russian women during this time was an important factor in the declining abortion rate. National modern contraceptive prevalence rates (MCPR) have also increased since the beginning of 1990s. Use of hormonal contraception, for example, increased from 1.7% in 1990 to 9.3% of women of reproductive age in 2005 due to the greater availability of modern contraceptives in the early 1990s, including through a government-supported family planning program (which ended in 1997).

Despite this progress, there remain significant challenges in the field of RH in Russia. Maternal mortality continues to be significantly higher than many European countries and there is significant variation at the regional level, with MMRs ranging from 17.9 to 37 deaths per 100,000 live births in various regions. The major known causes of maternal mortality continue to be abortion, hemorrhage, pregnancy-induced hypertension and sepsis. However, the majority of causes of maternal mortality constitute so-called "other causes of obstetric deaths" (accounting for 28.6% of maternal deaths in 2005). The lack of effective and up-to-date equipment and standard practices are also reported as concerns. There is significant regional variability in maternal mortality levels.

Russia has 86 territories which have been divided (comparatively recently) into seven federal districts according to geographic location: Russian Far East, Siberian, The Urals, North-West, Central, Volga and Southern. According to the Ministry of Health and Social Development (MOHSD), the Far East District had the highest maternal mortality rate as compared with other federal districts in 2005. There are currently five federal scientific research centers in the field of MCH based in Moscow, St. Petersburg, Ivanovo, Rostov-on-Don and Yekaterinburg. These federal centers help prepare guidelines and policy for the MOHSD at the federal and regional level. They are intended to serve as methodological and organizational centers for the regions in their respective federal districts; however, their role is often limited to providing high-tech care similar to that offered by perinatal centers at the regional or municipal levels.

Similarly, there is wide variation at the regional level in infant mortality rates. For example, infant mortality rates (infant deaths per 1000 live births) ranged from 7.5 to 14.2 in 2006 (the national figure is 10.2). Over half (51%) of all infant deaths occur in the perinatal period. There is, however, limited data about the specific causes of infant mortality during the perinatal period. Further, the same degree of variability at the regional level is true of contraceptive prevalence rates. For example, facility-based baseline surveys carried out in 2004 as part of the USAID-funded Maternal Child Health Initiative (MCHI) found a MCPR of just 25% among family planning clients in the Vologda region. With strong administration support in the region and technical assistance from USAID partners to introduce current RH clinical protocols and standards, the MCPR in Vologda increased to 41% by 2006.

Abortion continues to pose a one of the major challenges in the field of RH in Russia. Abortion continues to be one of the major drivers of maternal mortality (accounting for 16.8% of maternal deaths in 2005) alongside hemorrhage during pregnancy and birth (17% of maternal deaths), and the majority of infertility cases in Russia are attributable to complications caused by abortion and sexually transmitted infections (STIs). Abortion rates in Russia are still two or more times higher than those of many European countries. Although contraceptives were largely unavailable until the early 1990's, abortion has been legal in Russia since 1920 and continues to be a widespread means of regulating family size in Russia. In fact, post-revolutionary Russia was the first country in the world which permitted abortion at a woman' request and is still considered to have one of the most liberal abortion legislation. There are, however, some signs of improvement. In 2006 there were 107 abortions to every 100 live births in Russia; however, preliminary data from the MOHSD indicated that, for the first time in decades, there were fewer abortions than births during 2007 (106 births for every 100 abortions). There continues to be significant regional variation in abortion rates. In some regions of Russia, the ratio of abortions to live births was as high as 1.85 in 2006. Further, the abortion rate among Russian youth (under 18 years old) is showing troubling signs of increase and the ratio of births to abortions among this age group was 1:4 in 2006 (MOHSD).

Studies worldwide confirm that a critical aspect of reducing maternal morbidity and mortality is the involvement of other family members, including male partners, in FP, and the pregnancy and postpartum process. Similarly, involving partners and making FP information available to both women and men has proved to be an important factor in women's successful contraceptive use. In Russia, men's knowledge of, and involvement in, RH is often limited, although the introduction of best practices such as family-centered maternity care (FCMC) has increased partners' participation in FP, counseling and childbirth. Encouraging the more active involvement of partners and family members in the various aspects of women's health during pregnancy, during labor and delivery and in the postpartum period is, therefore, important. There are few specialists in male RH issues and no real system of men's health clinics (compared to the network of women's consultations). However, including a range of health care professionals such as family doctors and male reproductive health specialists in training on FP and RH has proven an effective way to increase male partners' participation in the FP and childbearing process to improve pregnancy outcomes.

Access to, and the quality of, FP and RH services remains uneven, particularly for vulnerable populations including populations in rural areas, high-risk women and youth. Recent research suggests that Russian youth increasingly want to delay marriage and postpone their first child. At the same time, however, the average age of desired sexual debut has remained steady at approximately 16 for Russian youth and a significant share of young people aged 15 to 24 report having sex before age 15 (17.2% of males and 8.2% of females, UNAIDS, 2007). Increased access to reproductive health information and services among young men and women of reproductive age (beginning at age 15) is, therefore, needed to meet the growing gap between the debut of sexual activity and the desired age at first childbirth. There is also a pressing need to expand the access of populations in rural areas to quality RH services. There are generally two predominant health care facilities that provide health care to rural populations – central regional hospitals in the rural centers and feldsher-obstetrical stations in villages. The regional hospitals provide basic RH services, mostly related to prenatal care and gynecology; however, they often fail to provide quality RH and FP counseling. The USAID-supported Maternal Child Health Initiative (MCHI) is working with these health care settings in several regions to ensure access of rural populations to quality RH/FP services through

training in FP/RH counseling, introducing of appropriate standard clinical monitoring across the facilities providing RH/FP services and ensuring availability of modern patient informational materials in the service sites.

The lack of integration between FP and other MCH and social service centers such as centers of social assistance to family and children in Russia poses a serious challenge. FP and RH services are generally available in separate health facilities, rather than being integrated into a range of maternal and child health services. The integration of FP and RH into social services is nascent, and the link to social services has not yet been established in most regions. Integrating FP into social services could help reach women at higher risk of negative pregnancy outcomes and child abandonment, who often do not access prenatal care. Prevention of substance abuse and domestic violence, which are often linked with each other, is another important issue in preventing unintended pregnancies and improving birth outcomes. In a recent UNFPA study in Russia on family violence, focus groups drew attention to women's particular vulnerabilities during pregnancy and post-partum period.

The inappropriate division of services, resources, skills and referrals between the primary, secondary and tertiary levels of maternal and newborn care also contributes to negative pregnancy outcomes. Regionalization is a concept of evidence-based data which suggests that the quality, effectiveness and accessibility of medical care can be maximized by division into three levels of care - primary, secondary and tertiary – and attributing each medical provider to a specific level of care and ensuring that providers at each level have the necessary knowledge, skills and equipment to fulfill their responsibilities. The USAID-funded MCHI is currently piloting this concept in two regions, Tyumen and Vologda, assessing how MCH and RH care is organized at the three levels of care and developing recommendations on how to optimize the delivery of care.

C. TECHNICAL FOCUS

To respond to these challenges, USAID will launch a $4-6M, three-year (36 months) Institutionalizing Best Practices in Maternal and Child Health project. This project will consist of several components, which are closely linked and mutually supportive:

• Family Planning
• Maternal and Infant Health
• Integration of Family Planning with STI/HIV Prevention and Treatment
• Integration of Family Planning into Social Services
• Effective Organization of Delivery of Maternal and Child Health Care

All services needed to carry out this project will be acquired through this Task Order under the Technical Assistance and Support Contract, Three (TASC3) Indefinite Quantity Contract (IQC) managed by USAID/Washington. Many of the activities envisioned under this Task Order are a follow-on to those undertaken by USAID/Russia in its current strategy, and will build on the results of the USAID health program to date. Areas of emphasis under this Task Order are as follows:

- There will be a strong emphasis on the dissemination of a comprehensive package of MCH guidelines, protocols and standards at the federal district level. This will involve strengthening the capacity of selected federal district entities to deliver,

disseminate, and advocate for up-to-date MCH/RH services/practices and policies at the federal and regional level.

- Improving MCH/RH policies will be a focus of the project. This will entail working with regional and federal district partners to develop and introduce relevant policies on improving MCH/RH care and to advocate for such policies at the federal and regional level.
- Expanding the consideration of infant morbidity and morality beyond the early neonatal period (up to seven days after birth) is another new area of emphasis.
- Disseminating recommendations on how to optimize the delivery of maternal and newborn health care at the regional level is new area of emphasis. This will build on current activities applying the concept of regionalization in two pilot regions to develop recommendations on optimization of MCH and RH care.
- Integrating FP into social services in up to three new regions is another new area of emphasis. This will entail an initial assessment of current practices to determine the feasibility of expanding the role of social workers to include basic FP counseling and appropriate referrals, and improving coordination between social workers and providers to reach populations vulnerable to negative health and social outcomes, including child abandonment and negative pregnancy outcomes.

D. PREVIOUS AND CURRENT USAID/RUSSIA REPRODUCTIVE HEALTH ACTIVITIES

USAID/Russia has been working in the area of reproductive health since 1993. There are successful models of improving family health through continued support for an integrated maternal and child health program. USAID-funded programs played a visible role, contributing to improvements in maternal and child health, increases in contraceptive prevalence and corresponding decreases in abortion in selected regions.

*The Women and Infants' Health Project (WIN) (*June 1999 – September 2003): A comprehensive reproductive health project, WIN worked in two pilot regions (Perm and Novgorod) to improve maternal and newborn health care. The WIN project aimed to reduce maternal and infant morbidity and mortality by improving the effectiveness of selected women and infant health services, with special emphasis on reducing repeat abortions and unwanted pregnancies in selected sites. Interventions included promoting family-centered maternity care, essential care of the newborn, exclusive breastfeeding, and client-centered family planning services, especially for postpartum and post abortion clients. Other WIN activities focused on providing appropriate antenatal care, promoting healthy lifestyles, and preventing against domestic violence.

Institute for Family Health: The Maternal Child Health Initiative (MCHI) (September 2006 – December 2009): Implemented ultimately in 26 regions of the Russian Federation[1], the MCHI is introducing evidence-based models of maternal and child health (MCH) and

[1] Altai Krai, Irkutsk Oblast, Kaluga Oblast, Komi Republic, Krasnoyarsk Krai, Murmansk Oblast, Omsk Oblast, Orenburg Oblast, Tyumen Oblast, Vologda Oblast, Perm Oblast, Velikii Novgorod Oblast, Primorsky Krai, Khabarovsky Krai, Sakhalinskaya Oblast, Sakha Republic (Yakutia), Moscow Oblast, Kemerovo Oblast, Kurganskaya Oblast, Karelia Republic, Khanty-Mansiyskiy Region, Leningradskaya Oblast, Kurskaya Oblast, NizhnyNovgorod. Two other new regions will be selected during the next 1-2 months.

integrating family planning services into a spectrum of MCH care. The MCHI has developed a comprehensive package of MCH protocols, standards and guidelines. Based on internationally accepted best practices for RH and integrated FP, with a primary focus on urban centers, this package includes practices and protocols influencing some of the major causes of maternal and infant mortality in Russia, such as pregnancy-induced hypertension, hemorrhage, sepsis and others. The package addresses the improvement of prenatal care, labor and birth, and the postpartum period through the introduction of guidelines, protocols and standards on topics including FCMC which involves family members, including male partners, in pre- and post-natal care, and promotes evidence-based effective practices such as exclusive breastfeeding, client-centered family planning services (including for postpartum and post abortion clients), active management of third stage of labor, essential newborn care, post-abortion care, prevention of mother-to-child transmission of HIV (PMTCT), proper nutrition and the prevention of substance abuse (including smoking, drug and alcohol use) for the improvement of pregnancy outcomes. The MCHI project also plans to develop protocols and training materials on newborn and infant (up to one year old) care to address major issues related to infant morbidity and mortality beyond the early neonatal period. The MCHI project is also currently developing integrated guidelines on FP, sexually transmitted infections (STI) and HIV/AIDS prevention. Based on the guidelines, a training curriculum will be developed and tested by the end of 2008 and used to training health care providers in 10 regions. This model focuses on improving access to integrated FP and STI and HIV prevention counseling services and information, improving providers' knowledge and skills across a variety of facilities providing health care to women and their partners, and improving the consistency of FP and STI and HIV prevention messages provided in a range of facilities providing health care to women and their partners.

Johns Hopkins University, Healthy Russia 2020 (September 2002 – September 2009): The Healthy Russia 2020 (HR2020) project, implemented by John Hopkins in conjunction with a local Russian NGO, the Healthy Russia Foundation, includes reproductive health activities. HR2020's "Couples Campaign" promoted the use of family planning services among men and women in selected regions. HR2020 also supports the development of youth-friendly RH services in two regions, and promotes access to low-cost hormonal contraceptives, in partnership with the private sector.

Population Services International, PreventAIDS (September 2005 – March 2010): Building on its platform of HIV prevention activities among high-risk women, PSI integrated FP/RH messages and reached high-risk women in Samara and Saratov to prevent unwanted pregnancies. PSI is strengthening the RH content of the HIV prevention outreach activities in additional target regions to build in messages on FP and maternal/child health for women at high-risk of HIV and other STIs, including sex workers (SWs) and injecting drug users (IDUs) and their partners.

International Research and Exchanges Board (IREX)/Assistance to Russian Orphans (ARO) (September 2006 – August 2009): The ARO project, jointly implemented by IREX and the National Foundation for the Prevention to Cruelty Against Children (NFPCC), is working in nine regions[2] to support regional child welfare reforms, including preventing child abandonment and supporting the development of family-based care options for institutionalized children.

[2] Tomsk Oblast, Khabarovsk Krai, Vladivostok, Novosibirsk Oblast, Altai Krai, Krasnoyarsk Krai, Tambov Oblast, St. Petersburg City and Irkutskaya Oblast.

After 15 years of work in the field of FP, RH and MCH in Russia, USAID and its partners must move to institutionalize the best practices developed and transfer the capacity to monitor the quality of MCH to Russian partners. In the coming year, is appears likely that USAID/Russia will also support a complementary new project to address the root causes of maternal and neonatal mortality in at least three regions with high MMRs and IMRs and disseminate guidelines and organizational recommendations to improve the quality of maternal and newborn care in coordination with a federal partner. The Contractor shall work with existing partners, as appropriate, to accomplish the tasks outlined below.

E. STRATEGIC GOALS AND OBJECTIVES

This Project will contribute to USAID/Russia's Operational Plan "Investing in People" objective, "Health" program area and "Family Planning/Reproductive Health" and "Maternal Child Health" program elements.

F. EXPECTED RESULTS

Despite the progress made over the past two decades in Russia, the need for continued health system development and enhancement of the skills of a range of health care providers remains, as many Russian health care facilities continue to use out-dated and non-evidence-based practices. This Project is intended to encourage the use of current standard practices for integrated family health at the regional level. The Contractor will need to work closely with regional counterparts, the local Ministry of Health (MOH) and relevant institutions at the federal and federal regional level to introduce and institutionalize standards and practices that have proven successful through models of integrated family health developed in Russia.

To address the strategic goals and objective, upon the completion of the project the following results and outputs will be achieved:

Overall goal: Decreased maternal and infant morbidity and mortality in the target federal districts.

Intermediate Results

1. **Abortion rates in regions within selected federal districts decreased**

    a. ***sub-intermediate result:*** modern contraceptive use among women of reproductive age (15- 49 years old) increased

Required Indicators:

- abortion rates within selected federal district decreased by 2% annually from baseline
- modern contraceptive use among women of reproductive age (15- 49 years old) increased by 2% annually from baseline
- number of counseling visits for FP/RH as a result of USG assistance
- number of people trained in FP/RH with USG funds
- number of USG-assisted service delivery points providing FP counseling or services

- all other indicators as approved in the Performance Monitoring Plan

2. MCH best practices related to major causes of maternal and infant morbidity and mortality adopted by target regions/federal districts

Required Indicators:

- number of newborns receiving essential newborn care through USG-supported programs
- number of people trained in maternal/newborn health through USG supported programs
- number of women receiving active management of the third stage of labor through USG-supported programs
- number of antenatal care visits by skilled providers from USG-assisted facilities
- all other indicators as approved in the Performance Monitoring Plan

3. Strengthened capacity of key federal district and regional entities to deliver, disseminate, and advocate for up-to-date MCH/RH services/practices and policies at the federal and regional level

Required Indicators:

- number of regional and/or federal entities/research institutes adopting and delivering up-to-date MCH /RH services and policies
- number of regional and/or federal entities disseminating and advocating for up-to-date MCH /RH services and policies
- number of new effective MCH/RH policies adopted at the regional and federal level
- number of medical and para-medical practitioners within the selected federal districts trained in evidence-based clinical guidelines
- all other indicators as approved in the Performance Monitoring Plan

G. TASKS

To achieve the expected results, the Contractor shall carry out the following tasks over the course of the contract:

Task One: Establish Partnership to Create Federal District-Level Hub on MCH Best Practices in two Federal Districts

A. To facilitate dissemination and foster sustainability of the improvements made in maternal and child health under the Maternal and Child Health Initiative (MCHI), the Contractor shall identify at least one appropriate institute, research center or organization at the federal district level in each of two federal districts to help disseminate evidence-based clinical guidelines and best practices developed at the regional level through prior and ongoing USAID-supported activities. The Contactor shall work with a federal entity (or entities) such as one of the five federal scientific research centers in the field of MCH. At least one of the proposed federal institutes shall be located outside of Moscow and St. Petersburg. The Contractor shall identify the rationale and criteria for selection of the federal districts and federal district-level partners. Selection criteria will be agreed upon with input from the MOHSD and the

USAID/Russia Health Office. Support – including, for example, political and in-kind support in the form of salary support for health care providers who will participate in trainings on MCH best practices – from the federal district-level partners and regional level within the federal districts shall be included among the selection criteria. Priority shall be considered for federal districts with high rates of infant and maternal mortality, and abortion rates.

Deliverable: Within 2 months of the effective date of the Task Order, the Contractor will present to USAID/Russia for approval the selection criteria and rationale for selecting a federal district level institute in each of two federal districts.

Deliverable: Within 3 months of the effective date of the Task Order, the Contractor will present to USAID/Russia for approval the proposed institute(s), research center(s) or organization(s) at the federal district level in two federal districts selected, including an assessment of the opportunities for partnership with private sector companies in the selected federal districts and the support to be provided by the proposed federal district level partners.

B. Once approved by USAID, the Contractor shall establish a partnership with a minimum of one federal institute, research center or organization(s) at the federal district level in each of the two selected federal districts. The Contactor shall work with a federal entity (or entities) such as one of the five federal scientific research centers in the field of MCH on defining and realizing their leadership role in promoting the best international practices in RH/MCH and advocating for policy changes at the federal and district level. The Contractor shall propose a plan to develop the capacity of the selected federal entity to disseminate MCH best practices to the regional level and to use data on the quality of MCH care for decision making at the regional level.

Deliverable: Partnership with at least one federal institute, research center or organization(s) at the federal district level established in two federal districts within 4 months of the effective date of the Task Order.

Deliverable: Plan to develop the capacity of the selected federal entity in each of the two federal districts to disseminate best practices in MCH and use data on the quality of MCH care for decision making, including proposed indicators to measure the strengthened capacity of the federal entities, presented to USAID/Russia for approval within 4 months of the effective date of the Task Order.

Task Two: Dissemination of Basic Package of MCH Protocols and Guidelines

A. The Contractor shall propose 4-5 new regions within each of the two selected federal districts where the comprehensive package of MCH protocols, standards and guidelines developed under the MCHI will be disseminated in partnership with the selected federal entity in each of the two federal districts. The Contractor shall identify the rationale and criteria for selection of the regions within the selected federal district. Selection criteria will be agreed upon with input from the MOHSD and the USAID/Russia Health Office. Support and leveraging from the regional level shall be included among the selection criteria. Priority shall be considered for regions with high rates of infant and maternal mortality, and abortion rates.

Deliverable: Within two months of the effective date of the Task Order, the Contractor will present to USAID/Russia for approval the selection criteria and rationale for the 4-5 regions proposed within each of two federal districts.

Deliverable: Within three months of the effective date of the Task Order, the Contractor will present to USAID/Russia for approval a list of proposed regions in each of the two federal districts.

B. The Contractor will assess the status of relevant MCH practices and health outcomes in the 4-5 regions selected in each of the two federal districts. This assessment will form the basis of the plan to disseminate MCH protocols, standards and guidelines. Based on the above assessment, the Contractor shall propose a plan to disseminate the comprehensive package of MCH protocols, standards and guidelines developed under the MCHI to 4-5 new regions within each of the two selected federal districts and to the federal level.[3] The package developed under MCHI includes practices and protocols influencing some of the major causes of maternal and infant mortality in Russia, such as pregnancy-induced hypertension, hemorrhage, sepsis and others, and also includes guidelines on improving access to integrated FP, STIs and HIV/AIDS prevention. The package shall be adapted to the specific regions, as needed, and updated as appropriate. Upon completion, the protocols and training materials on newborn and infant (up to one year old) care to address major issues related to infant morbidity and mortality beyond the early neonatal period now under development shall be included in the comprehensive package for dissemination. The dissemination plan should specify what health care facilities in the selected regions will be included in the roll out, and the types and approximate numbers of various types of health care providers – including obstetrician-gynecologists, pediatricians, family doctors, midwives, nurses and male reproductive health specialists such as andrologists – who will be trained in MCH best practices.

Deliverable: Within four months of the effective date of the Task Order, the Contractor will develop and present a Dissemination Plan to USAID/Russia for approval.

C. Jointly with the selected institute(s), center(s) or organization(s) at the federal district level, the Contractor shall roll out the package of MCH protocols, guidelines and standards to the 4-5 regions selected in each of the two federal districts. The roll-out will involve training a wide range of health care providers in MCH best practices, protocols and guidelines and developing a cadre of Russian experts in the selected regions to serve as trainers. The applicants shall demonstrate the process of integration of MCH/RH best practices in the target health care facilities, for example, through follow-up control visits by experts and setting up a quality control system, and demonstrate how it is going to institutionalize the MCH package in the target federal districts.

Deliverable: Package of MCH protocol, guidelines and standards rolled out to 4-5 regions in each of the two selected federal districts by the completion of the Task

[3] The package of protocol, guidelines and standards developed under the MCHI is available in the "Further Information" section.

Order. An estimated 2-3 tiers of health care facilities in each capital city comprised of a maternity hospital, women's consultation, family planning center, children's policlinic, and other appropriate facilities in a region trained in the evidence-based protocols and guidelines, and protocols and guidelines integrated by the end of the Task Order. A minimum of 2-3 urban centers and their rural areas in each region trained in the evidence-based protocols and guidelines and integration of the protocols and guidelines demonstrated by the completion of the Task Order.

D. The Contractor shall develop, propose and implement a process of region-to-region exchanges among health care providers from regions across Russia and the selected federal district(s) with the goal of disseminating and learning about the best practical models and policies related to MCH/RH. These exchanges may include participants from the five federal scientific research centers in the field of MCH. The exchange program shall draw on regional experts trained in best practices through prior and current USAID-funded activities and will support the exchange of regional experts to help further disseminate and institutionalize best practices. These exchanges shall be based on region-specific needs. The Contractor shall identify the rationale and criteria for selection of the regions within the federal district. Selection criteria will be agreed upon with input from the MOHSD and the USAID/Russia Health Office. Support from the regional administration shall be included among the selection criteria and could include, for example, a willingness to pay salaries for regional experts from government health facilities who will participate in region-to-region exchanges, free venues for and assistance in organizing training events.

Deliverable: Within four months of the effective date of the Task Order, region-to-region exchange program designed and presented to USAID/Russia for approval, including selection criteria for proposed participants.

Deliverable: By the completion of the Task Order, a minimum of 10 region-to-region exchanges completed.

Task Three: Disseminate recommendations on optimizing the delivery of MCH/RH care at regional (oblast) level

Through the partnership established under Task One, the Contractor shall disseminate recommendations on how to optimize the delivery of MCH/RH care at the regional (*oblast*) level. The Contractor will draw on the recommendations on the optimal division of resources, skills and services between the primary, secondary and tertiary levels of care now being developed through the regional and city level system of regionalization piloted in two regions (Vologda and Tyumen) as part of the current USAID-supported MCHI.

Deliverable: Recommendations on optimal delivery of MCH/RH care at regional level disseminated to 4-5 regions within each of the two selected federal districts by the completion of the Task Order.

Task Four: Develop an integrated model of FP and social services in up to three regions within the two selected federal districts

A. The Contractor shall select up to three regions within the selected federal districts where an integrated model of FP and social services could be piloted. The Contractor

shall identify the rationale and criteria for selection of the regions within the federal district. Selection criteria will be agreed upon with input from the MOHSD and the USAID/Russia Health Office. The Contractor should consider selecting regions where there already exists some link between health and social services; for example, Tomsk and Irkutsk. Support from the regional administration shall be included among the selection criteria and could include, for example, a willingness to pay salaries for regional experts from government health facilities who will participate in developing and piloting the model, and free venues for and assistance in organizing training events. The final list of pilot regions will be approved by USAID.

Deliverable: Proposal identifying up to three regions within the selected federal districts where an integrated model of FP and social services could be piloted, including rationale and selection criteria delivered to USAID for approval within 12 months of the effective date of the Task Order.

B. Within the selected regions, the Contractor shall assess current practice regarding the integration between FP and social services. The Contractor will present this assessment to USAID, with recommendations about developing an integrated model of social services and FP. The assessment shall demonstrate an understanding of issues such as abandonment prevention, substance abuse and family-based violence and shall evaluate existing linkages and referrals systems between health and social services in the selected regions. The assessment will also identify potential partners with experience working with social services to jointly implement this component.

Deliverable: Assessment of FP/social service integration completed in selected regions and presented to USAID/Russia within 14 months of the effective date of the Task Order.

C. The Contractor shall develop and pilot an integrated social services model that improves access to and referral for FP services social service agencies such as family and children centers in the selected regions. This would include expanding the role of social workers to include basic FP counseling and appropriate referrals in urban areas of the pilot regions, improving coordination between social workers and providers to reach populations and families vulnerable to negative health and social outcomes, including child abandonment and negative pregnancy outcomes. The integrated model will include a case management approach to improve the access of at-risk women to prenatal and postnatal care. In the development of this approach, the Contractor shall consider the outreach and intensive social rehabilitation necessary for the timely enrolment of at-risk women in prenatal care, referral systems at health and social welfare facilities, peer support, early abandonment prevention for newborns at maternity hospitals, psychological and social support to mothers in crisis and mothers whose newborn children are diagnosed as having impairments, and developmental assistance for young children residing in hospitals and other health care institutions. Issues such as the prevention of substance abuse and family-based violence shall inform the Contractor's approach. Collaboration with and use of communication and informational materials developed under other USAID-supported activities is encouraged to accomplish this task.

Deliverable: Case management and referral system established between health care and social service agencies such as centers of social assistance to family and children,

and appropriate staff from health care and social service facilities trained in three regions within the selected federal districts by the end of the Task Order.

Task Five: Sustainability Plan

The Contractor shall develop a sustainability plan outlining how the improvements made at the federal district and regional level will be used to advocate for change at the federal level and within non-participating federal districts. The sustainability plan will also address how the cadre of Russian experts at the federal district and regional level could disseminate the best practices and experiences developed under this Task Order with federal and/or regional government funds.

Deliverable: Sustainability Plan delivered to USAID for approval within 12 months of the effective date of the Task Order.

Deliverable: Dissemination conference including relevant MCH experts from both participating and non-participating federal districts and the federal level held by the completion of the Task Order.

H. RELATION TO MISSION'S RESULT FRAMEWORK

The MCH project directly supports Mission Strategy by reducing abortion rates, improving health of women and infants by integrating evidence-based internationally-recognized practices and protocols in health care facilities serving women, children and their families. This project contributes to Program Area, "Health" and Program elements "Family Planning and Reproductive Health and "Maternal and Child Health". This program is within the Missions' Strategy and Operational Plan, including the time frame and funding.

I. TYPE OF CONTRACT

The Government contemplates award of a Cost-Plus-Fixed Fee (CPFF) Completion Form Task Order resulting from this solicitation.

J. TASK ORDER PERIOD

The period of performance is estimated to be 36 months, through September 30, 2011.

K. TASK ORDER ADMINISTRATION DATA

1. Contracting Officer's Authority

The Contracting Officer is the only person authorized to make or approve any changes in the requirements if this Task Order and notwithstanding any provisions contained elsewhere in this Task Order, the said authority remains solely in the Contracting Officer. In the event the Contractor makes any changes at the direction of any person other then the Contracting

Officer, the change shall be considered to have been made without authority and no adjustment shall be made in the contract terms and conditions, including price.

2. Technical Direction

USAID/Russia Health Office shall provide technical oversight to the Contractor through the designated CTO. The Contracting Officer shall issue a letter appointing the CTO for the Task Order and provide a copy of the designation letter to the Contractor.

3. Acceptance and Approval

In order receive payment, all deliverables must be accepted and approved by the CTO.

4. Invoices

One (1) original of each invoice shall be submitted on an SF-1034 Public Voucher for Purchases and Services Other Than Personal to the USAID/Russia Office of Financial Management. One copy of the voucher and the invoice shall also be submitted to the Contracting Officer and the CTO.

Electronic submission of invoices is encouraged. Submit invoices to the Office of Financial Management to this address: Moscow Vouchers@usaid.gov

The SF-1034 must be signed, and it must be submitted along with the invoice and any other documentation in Adobe.

Paper Invoices shall be sent to the following address:

Office of Financial Management
USAID/Russia, c/o American Embassy Moscow
19/23 Novinsky Bulvar
Moscow 121099 Russian Federation

If submitting invoices electronically, do not send a paper copy.

L. SPECIAL TASK ORDER REQUIREMENTS

1. The Task Order will be implemented in two selected federal districts. The main duty post is expected to be Moscow. The COP will be based in Moscow. The Contractor staff is expected to travel to other locations within Russian Federation, as required, to complete the assigned tasks.

2. The Contractor is responsible for all logistics support.

3. Authorized geographic codes

The authorized Geographic Codes for procurement of goods and services under the proposed award are 000 (United States) and 110 (NIS). The countries of Eastern Europe are not included in these Geographic Codes.

As provided for in 22 CFR 228.02, the criteria for source and origin waivers for assistance provided under the FREEDOM Support Act are stated in section 498B(h)(2) of the Foreign Assistance Act of 1961, subject to any further restrictions imposed by agreement or regulation. The basic criteria in section 498B(h)(2) are: (A) the provision of the assistance requires commodities or services of a type that are not produced in and available for purchase in any country specified in the authorized Geographic Codes; or (B) that procurement in another country is necessary to meet unforeseen circumstances -- such as emergency situations -- where it is important to permit procurement in a country not specified in the authorized Geographic Codes, or to promote efficiency in the use of United States foreign assistance resources, including to avoid impairment of foreign assistance objectives. An additional requirement for waivers of type (A) to countries in a Code not included in Code 941 is that the commodities or services are also of a type that are not produced in and available for purchase in any country specified in Code 941.

Offerors must ensure that all proposed services and commodities procurements meet the source, origin and nationality requirements. If services, including consultants and trainers, or commodities not complying with Geographic Codes 000 or 110 are to be procured, offerors must request and justify a waiver and the need for such waiver(s) must be noted in the business management proposal. All waivers must be approved by the USAID/Russia Mission Director.

4. To the greatest extent possible, the Contractor should maximize resources by using local health care providers and experts and subcontractors appropriate to the circumstances.

5. In addition to the requirements of AIDAR 752.7035, the Contractor shall obtain prior CTO authorization for all public notices, press releases, interviews and other media contacts.

6. Gender Integration

Although the primary focus of this project is improving women's access to and use of reproductive health and maternal and child health services in selected regions, gender integration is a significant component of the proposed project. The new project must, therefore, include specific interventions that target both female and male beneficiaries. Men can play a critical role in supporting women's reproductive health needs, as partners actively participating in pregnancy and delivery and in decision-making around family planning and contraceptive use. Men's own reproductive health needs are an equally important component of improving birth outcomes. The participation of male partners and families in general should be encouraged under a comprehensive family-centered maternal care approach. Activities on maternal and child health, including family planning services, should encourage greater participation by male partners and also ensure that this approach is adopted by relevant healthcare providers.

7. Environmental Review

Activities under this award have been reviewed for environmental compliance. No further environmental review is required unless the Contractor proposes to undertake activities not specified in the Statement of Work. If the Contractor proposes changes to the activities specified in the Statement of Work, it must notify the Contracting Officer in advance and in writing. Examples of common situations which require additional environment review and mitigating measures include but are not limited to: refurbishment (painting, retrofitting, etc.), renovation or construction of facilities; rehabilitation or construction of infrastructure; and agricultural activities.

8. Environmental Mitigating Measures

The Contractor shall encourage, promote, and monitor adherence to protocols concerning the proper handling, storage, use, and disposal of the following materials:

- General medical equipment, including ventilators, infusion pumps, infant monitors, and diagnostic equipment;
- Medical supplies likely to be contaminated with blood or other body fluids, including sharps (this requires special protocol) catheters, bandages, sutures, syringes, and scalpels;
- Pharmaceuticals, including over-the-counter, and medications;
- Controlled substances; and
- Packaging materials.

The Contractor shall contact facility, local, oblast, and national officials as appropriate to design, implement, and apply appropriate medical waste use, storage, and disposal practices.

The Contractor shall:

- Briefly examine the storage, use and disposal practices of each participating facility;
- Provide information, operational manuals, and training as appropriate;
- Assist facilities to strengthen medical waste use, storage and disposal practices; and
- Periodically monitor implementation of those practices.

The Contractor shall apply, at a minimum, practicable guidance found in Chapter 16: "Minimal programmes for health-care waste management," *Safe Management of Wastes from Health Care Activities*, edited by A. Prüss, E. Giroult, P. Rushbrook. Geneva, WHO, August 1999 or the *WHO Healthcare Waste Management Handbook* (September 1997 draft and as revised).

The Contractor shall include actions taken to comply with these mitigating measures in its performance reporting.

9. Information Technology Requirement

The Contractor shall comply with the requirements contained in ADS 548 which require review and approval by the Office of Information Resource Management (M/IRM) in USAID/W of information technology components in which the life-cycle cost of

commodities or services (e.g., installation, maintenance, and technical assistance) exceeds $100,000.

10. Third Country Participant Training

Participant training conducted in countries other than the U.S. or the cooperating country must comply with the requirements for third country training set forth in ADS 253.3.2. A nationality waiver may be required for training providers from countries outside the authorized geographic code.

11. Government Furnished Facilities or Properties

(a) The Contractor and any employee or consultant of the Contractor is prohibited from using U.S. Government facilities (such as office space or equipment) or U.S. Government clerical or technical personnel in the performance of the services specified in the Task Order unless the use of Government facilities or personnel is specifically authorized in the Task Order or is authorized in advance, in writing, by the CO.

(b) If at any time it is determined that the Contractor, or any of its employees or consultants, have used U.S. Government facilities or personnel either in performance of the contract itself, or in advance, without authorization in, in writing, by the Contracting Officer, then the amount payable under the contract shall be reduced by an amount equal to the value of the U.S. Government facilities or personnel used by the Contractor, as determined by the Contracting Officer.

(c) If the parties fail to agree on an adjustment made pursuant to this clause it shall be considered a "dispute" and shall be dealt with under the terms of the "Disputes" clauses of the Contract.

12. Confidential and Intellectual Property

All reports generated and data collected during this project shall be considered the property of USAID and shall not be reproduced, disseminated or discussed in open forum, other than for the purposes of completing the tasks described in this document, without the express written approval of a duly-authorized representative of USAID. All findings, conclusions, and recommendations shall be considered confidential and proprietary.

13. Authorized Work Day/Week

No overtime or premium pay is authorized under this Task Order.

14. Annual Inventory of Commodities

In accordance with AIDAR 752.245-70, the Contractor will submit an annual report on all non-expandable property. The form/format to be used in preparing this report may be found in AIDAR 752.245-70.

M. BRANDING STRATEGY

Branding and Marking under this contract shall comply with the policies found at Automated Directives System (ADS) Chapter 320 (version from January 8, 2007), or any successor policy, and with the USAID Graphics Standard Manual at www.usaid.gov/branding.

Project Name: Institutionalizing Best Practices in Maternal and Child Health

Positioning: USAID/Russia has supported successful, integrated MCH and RH projects at the regional level for many years. These projects contributed to decreases in abortion levels and maternal and infant morbidity and mortality, as well as to increases in modern contraceptive prevalence. This project is designed to scale up these improvements in MCH and RH to the next level, by building centers of excellence at the federal district level to foster ownership and institutionalize and transfer best practices to Russia.

The project must be referred to as USAID's and all materials and communications must be positioned as from the American People, using the USAID Identity. Use of the Russian USAID logo is preferred on materials targeted primarily for Russian audiences.

When appropriate, the contractor may co-brand and co-mark materials and communications being jointly sponsored by USAID and the host-country government (the Russian Ministry of Health and Social Development or other federal/regional government agencies). In these cases, all identities must be of equal size and standing, following USAID regulations.

The corporate identity or logo of the contractor must not be used on any project materials. Marking is not required on contractor vehicles, offices, office supplies, or other commodities used solely for administration of this contract. These rules apply to all subcontractors as well.

Prospective contractors may include requests for specific, programmatic exceptions to marking requirements in their Marking Plan, if needed.

Level of visibility: The contractor will ensure that the project receives broad visibility amongst its beneficiaries, the healthcare sector, and relevant government agencies in Russia. In consultation with USAID, the contractor may identify other groups as target audiences.

The fact that the project is made possible by the American people through USAID should have a high level of visibility. In cases where the audience needs to recognize the leadership and responsiveness of the Russian Ministry of Health and Social Department and/or other Russian government partners, visibility should be shared.

Other organizations to be acknowledged: No other organizations are required to be acknowledged. However, to foster local ownership in activities, USAID may approve the acknowledgement of other Russian and/or international institutions on a case-by-case basis.

Anticipated elements of marking plan: Deliverables to be marked include, but are not limited to: products and equipment; external communications (studies, reports, publications, posters, DVDs and other informative and promotional products); and events (trainings, workshops, conferences, fairs, and other public meetings).

All publications funded by USAID must follow the agency's brand standards and include the disclaimer: The views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

N. REPORTING REQUIREMENTS

The cover page of all reports prepared by the Contractor, pursuant to AIDAR 752.242.70, shall include a descriptive title, the author's name(s), the project name, the project number, the contract and task order number, the Contractor's name, the name of the USAID technical office and the CTO, and the publication or issuance date of the report.

The Contractor shall be responsible for delivery of draft reports, schedules, plans, and other documents that are described below. Such documents as schedules or plans that do not readily conform to the foregoing format will be presented in a form to be agreed to by the CTO. All written documents will be provided in English on diskette or CD in Microsoft Word 98 or newer version.

All reports must be submitted in a hard or electronic copy to the following address:

U.S. Agency for International Development
Office of Health
19/23 Novinsky Bulvar
Moscow 12099
Russian Federation

Life-of-Project Implementation Plan. Within 60 days of award, the Contractor shall provide to USAID for approval a life-of-project work plan for the task order. This work plan shall include a description of the principal tasks and assistance activities to be undertaken by the Contractor over the life of the task order, include a description of what each assistance activity or combination of activities is expected to accomplish and to what extent those accomplishments will contribute to the achievement of the overall targets and benchmarks for the project, a proposed schedule for such activities, a listing of the principal counterparts for each proposed activity, and a description and estimate of the amounts of short-term expertise, training and other support resources that would be required to provide the assistance proposed.

The Contractor shall update the implementation plan annually, or more frequently as conditions warrant, due no later than 30 days before the beginning of the succeeding year. USAID/Russia will review and provide final approval.

As part of the Implementation Plan, the Contractor shall submit a **Performance Monitoring and Evaluation Plan (PMEP)** to measure the impact and outcomes of the project as indicated under "Expected Results" and "Tasks". The plan shall include how each of the results will be measured and how the data will be collected. The M&E component will include a proposal on the development of facility-based surveys in the target regions (including an initial baseline assessment) to be supplemented by population-based surveys at the regional level, both from target regions and from control region(s). The Contractor shall propose an appropriate set of indicators to be reviewed and approved by USAID. The plan shall further discuss quality control efforts to ensure good data collection, periodic analysis of

data collected, and periodic quantitative and qualitative reports of data analysis—including baseline, interim, and final reports.

Quarterly Performance Reports

Quarterly performance reports will present progress on all activities and will include the following information, at a minimum:

- Brief outline of project purpose and project approach;
- Brief description of significant events during the reporting period;
- Status of activities of each task as defined in the Work Plan;
- Status of overall project progress per impact indicators as defined in the Work Plan and the performance monitoring plan;
- List of reports/deliverables completed in the reporting period;
- Performance problems during the reporting period;
- Status of budget expenditures;
- List of major activities planned for next quarter including indicators and associated targets;
- Any relevant information that has affected or will affect project progress.
- all evaluation and monitoring data developed for the project.

Mid-Term and Final Reports. Within 30 days after the mid-term and 30 days after the completion of the Task Order, the contractor shall submit a report that highlights accomplishments against the implementation plan, gives the status of the expected results, addresses lessons learned during implementation, and suggests solutions for resolving constraints identified. Both reports shall address and demonstrate how Russian partners will continue activities beyond the completion of the project to ensure project sustainability.

Demobilization Plan. Four months prior to the completion date of the task order, the Contractor shall submit a Demobilization Plan to the CTO. The Demobilization Plan shall include, at a minimum, an illustrative Property Disposition Plan; a plan for the phase out of in-country operations; a delivery schedule for all reports or other deliverables required under the task order; and a timeline for completing all required actions in the Demobilization Plan, including the submission date of the final Property Disposition Plan to the cognizant Contracting Officer. Both the illustrative and final Property Disposition Plans shall address all requirements under U.S. and Russian law for the transfer of property and shall include the inventory schedule required by FAR 52.245-5, a plan for the disposition of property to eligible parties and a timeline for disposition of such property. The Demobilization Plan shall be approved in writing by the Contracting Officer.