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# Russia Site Visit Report

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AUGUST 2008

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This report was prepared by University Research Co., LLC (URC) and its subcontractor EnCompass LLC for review by the United States Agency for International Development (USAID) and was authored by Mary Gutmann, Tessie Tzavaras Catsambas, and Stephen McLaughlin. The data collection for this evaluation was carried out under the USAID-funded Quality Assurance Project; the final report was produced by the Health Care Improvement Project, which is made possible by the support of the American people through USAID.



# COLLABORATIVE EVALUATION SERIES

# RUSSIA SITE VISIT REPORT

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## 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.

The evaluation site visit described in this report was supported by the American people through the United States Agency for International Development (USAID) and its Bureau for Global Health, Office of Health, Infectious Diseases and Nutrition. The Quality Assurance Project (QAP), managed by University Research Co., LLC (URC) under Contract Number GPH-C-00-02-00004-00, supported the field work for this evaluation. In addition, report preparation was supported in part by the USAID Health Care Improvement (HCI) Project. The HCI Project is managed by URC under the terms of Contract No. GHN-I-01-07-00003-00. URC's subcontractors for the HCI Project include EnCompass LLC, Family Health International, Initiatives Inc., Johns Hopkins University Center for Communication Programs, and Management Systems International.

To learn more about the HCI Project's work to evaluate improvement collaboratives, please contact Dr. Lynne Franco at [lfranco@urc-chs.com](mailto:lfranco@urc-chs.com). For more information on HCI's broader work, please visit [www.hciproject.org](http://www.hciproject.org).

**Acknowledgement:** This report drew on invaluable comments from the QAP Russia team, particularly from Dr. Victor Boguslavsky, Ms. Kim Ethier, and Ms. Irina Kriukova. The EnCompass evaluation team extends its deep appreciation for all the support and extraordinary efforts made to accommodate the evaluation visit and activities. The evaluation would not have been possible without their support. The evaluation team also extends its thanks and appreciation to the quality improvement teams in St. Petersburg and Orenburg for their cooperation and willingness to share their experiences.

**Recommended citation:** Gutmann M, TT Catsambas, and S McLaughlin. 2008. Russia Site Visit Report. *Collaborative Evaluation Series*. Published by the USAID Health Care Improvement Project. Bethesda, MD: University Research Co., LLC (URC).

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## ABBREVIATIONS

AH	Arterial hypertension
AIHA	American International Health Alliance
ART	Antiretroviral therapy
ARV	Antiretroviral
CDC	Centers for Disease Control and Prevention
CPHRI	Central Public Health Research Institute
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
IDU	Intravenous drug user
IEC	Information, education, and communication
IHI	Institute for Healthcare Improvement
IPT	Isoniazid preventive therapy
IR	Intermediate Result
LS	Learning session
MOH	Ministry of Health
MOHSD	Ministry of Health and Social Development
MOHSS	Ministry of Health and Social Support (Saratov Oblast)
MSH	Management Sciences for Health
OI	Opportunistic infections
PDSA	Plan, study, do, act
PEPFAR	(U.S.) President's Emergency Plan for AIDS Relief
PIH	Pregnancy-induced hypertension
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission of HIV
QAP	Quality Assurance Project
STI	Sexually transmitted infection
TB	Tuberculosis
TCS	Treatment, care, and support
URC	University Research Co., LLC
US	United States
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing
WHO	World Health Organization

## EXECUTIVE SUMMARY

As part of a comprehensive plan to document and evaluate the implementation of health care improvement collaboratives in developing countries, the Quality Assurance Project (QAP), in collaboration with EnCompass LLC, launched a multi-country effort in 2005 to conduct a developmental, participatory evaluation of the implementation and outcomes of QAP-supported collaboratives in four to six countries in Africa, Latin America, and Europe. Field data collection in each country was guided by a single methodology that had been designed to explore aspects of the implementation of collaboratives and validate reported results. This report presents the findings of the field evaluation of the HIV/AIDS Treatment, Care, and Support (TCS) Collaborative in Russia.

QAP had worked in the Russian Federation since 1998, developing improvements in the areas of maternal and newborn care and hypertensive disease and then helping health authorities in 23 regions scale up those improvements. In 2003, the U.S. Agency for International Development Mission in Moscow asked QAP to shift its work to focus on HIV/AIDS and to work in coordination with the American International Health Alliance. In 2004, QAP developed the HIV/AIDS Treatment, Care, and Support Collaborative in partnership with the Russian Ministry of Health and Social Development, regional ministries of health, and municipal health administrations in four regions: Krasnogvardeisky District in St. Petersburg; the cities of Engels and Saratov in Saratov Oblast; the city of Togliatti in Samara Oblast; and Orenburg City in Orenburg Oblast. The goal was to design a model system of HIV/AIDS treatment, care, and support.

The collaborative's management structure was designed to address the interdisciplinary nature of HIV/AIDS treatment, recognizing that the system of care had to be strengthened to respond to the growing number and needs of people living with HIV/AIDS (PLWHA). The structure consisted of regional interdisciplinary, inter-facility teams representing all services and facilities involved in providing services related to the topic area and a regional coordinating committee that served as a forum for collaboration and decision making. Coordinating committees met regularly and had the authority to make or influence decisions to support the institutionalization of new practices.

The topic areas for improvement were chosen based on the results of a system analysis performed by the participating sites with assistance from QAP staff. Topic areas included: 1) access to care and patient retention, 2) coordination of care, 3) patient management and adherence to treatment, and 4) coordinated HIV and tuberculosis (TB) detection and treatment.

An interdisciplinary team was formed at each site (e.g., Krasnogvardeisky District) to address each priority area. The inter-facility characteristic of these teams was unique to the Russia TCS Collaborative and reflected the collaborative's emphasis on system strengthening and coordination.

The collaborative followed the Improvement Collaborative model of learning sessions separated by months-long action periods. Data on key indicators were collected on a monthly and quarterly basis and shared at the learning sessions. Every six months, a joint collaborative meeting was held to further facilitate the sharing—among all four regions—of lessons learned. Between March 2005 and September 2007, six learning sessions were conducted, involving over 500 primary and specialty care providers, health administrators, social service providers, and NGO representatives. Two roundtable meetings

were also held to focus specifically on TB-HIV co-infection. A series of regional trainings focused on the quality of voluntary counseling and testing (VCT) for HIV, reaching 238 local health providers.

The teams reported significant achievements in each of the four topic areas. By the second year of the project (2005), data from all four sites indicated significant progress in expanding the availability and quality of HIV/AIDS services. In 2006–2007, the number of individuals receiving antiretroviral therapy (ART) in Krasnogvardeisky District increased steadily. Engels reduced HIV test turnaround time in less than a year from eight-to-ten days to three or four. In Orenburg, turnaround time for HIV tests at the Oblast Drug Rehabilitation Hospital also steadily declined, such that in 2007 at least 50% of tests were returned within 48–96 hours. Similarly, the number of patients receiving voluntary testing for HIV at St. Petersburg's TB Dispensary #5 had almost doubled in 2006 compared to 2005.

The number of HIV-positive people who received counseling for TB-HIV co-infection or who were screened for TB also increased significantly. Those receiving such counseling increased from zero in April 2005 to 270 in April 2006 in Togliatti. Similarly, both males and females screened for TB in Engels increased significantly from January to December 2005.

Other important accomplishments were: re-organizing the referral systems and communication between facilities, creating case management positions and integrating them into existing systems, creating a TB specialist position at the Orenburg Oblast AIDS centers, enhancing the role of polyclinics in medical follow-up of HIV-infected patients, expanding screening for TB among HIV patients at the polyclinic level, and Initiating isoniazid preventive therapy among HIV-infected patients.

Many of these improvements were institutionalized through the development of normative documents (*prikazy*) that mandated the spread of the practice to other institutions and organizations throughout the region. For example, the Orenburg Oblast Ministry of Health (MOH) institutionalized new practices for pre- and post-test counseling, algorithms of care delivery to PLWHA, and information exchange through Order #76, which regulates HIV/AIDS care provided at the AIDS Center, Oblast Drug Rehabilitation Hospital, Oblast TB Hospital, City TB Dispensary, Pirogov Clinical Hospital, City Clinical Hospital #4, City Perinatology Center, and City Infectious Disease Hospital. Similarly, the new algorithms developed by the TB-HIV co-infection team in Engels were spread to all of the districts of Saratov Oblast as a result of an oblast MOH decree.

Although the original design of the TCS Collaborative did not have a pre-determined plan for expansion, the potential for spread and scale-up was clear two years into the demonstration project. In 2006, the USAID Mission asked QAP to focus its efforts on St. Petersburg and Orenburg Oblast. Authorities in both regions committed to scaling up the improvements developed in the pilot sites to the rest of each region. In St. Petersburg, the scale-up covers all 18 district of the city plus three districts of the surrounding Leningrad Oblast. In Orenburg, the scale-up targeted all of Orenburg City plus three cities in the oblast's Eastern Zone. In both regions, the focus of the scale-up is on increasing the number of patients on ART and expanding the role of the health care system in the provision of HIV/AIDS services, improving services for patients with TB-HIV co-infection, and increasing coordination of care. It is estimated that at least 15,000 persons with HIV/AIDS will benefit from the scale-up.

A number of improvements have already been achieved in the short time since the start of improvement activities at the facility level in early 2007. Improvements include an increase in the number of patients

placed on ART and an increase in the percentage of diagnosed cases registered at the City AIDS Center, which contributes to better patient management and better clinical outcomes. In addition, the Orenburg Oblast MOH issued Order #666 in May 2007, stipulating the involvement of primary care in the process of care delivery to HIV patients.

A key element in the success of the scale-up is that the process is administered by the City Health Care Committee in St. Petersburg and the Orenburg Oblast Health Administration and local city health administrators. In this way, the scale-up is seen as part of local health administration activities and not as a separate project. The district health authorities also provide personnel time, budget resources, and make other contributions as evidence of their buy-in and commitment to the scale-up of the improvements in their respective districts.

The collaborative methodology has been particularly appropriate to address HIV/AIDS in Russia, where services are fragmented and systems are vertical. The collaborative work has enhanced system coordination through committees made up of local institutions and interdisciplinary teams of providers, outreach workers, and clients who are focused on specific problem areas. While the concept of interdisciplinary collaboration is not new in Russia, the collaborative methodology has operationalized the concept in a structured and purpose-oriented way.

# I. BACKGROUND

## A. Overview of the Quality Assurance Project

The Quality Assurance and Workforce Development Project (QAP), funded by the U.S. Agency for International Development (USAID), has as its mandate to apply modern quality improvement methods to health care systems in USAID-assisted countries. One such method, the health care Improvement Collaborative approach, developed in 1994 by the Institute for Healthcare Improvement (IHI), organizes teams from multiple sites to learn from each other as they seek to rapidly implement best practices and change ideas in a single topic area over a 12–18 month period.

In IHI's model, a collaborative brings together groups of practitioners from different health care organizations to work together on a common aim for improvement, which they do in a structured way and while exchanging information on their experiences. The impetus for this approach was to accelerate improvement in health care beyond what organizations could achieve by working separately and to make the improvements in multiple places simultaneously. Based on encouraging results from IHI's work, QAP began to adapt the collaborative approach for use in developing and middle-income countries.

In 1998, QAP started providing technical assistance in the Russian Federation to the Central Public Health Research Institute (CPHRI) to develop three health care improvement initiatives that drew on elements of IHI's collaborative model in the topic areas of pregnancy-induced hypertension, neonatal respiratory distress syndrome, and arterial hypertension. In 2002, QAP implemented its first true collaborative, using a model adapted from the IHI collaborative model to the context of the Russian health care system.

Based on the results obtained in Russia and on IHI's continued success with the collaborative approach, QAP made the collaborative approach the major implementation strategy for the QAP III contract that began in July 2002. Over the course of five years, QAP implemented 35 improvement collaboratives in 14 developing and middle-income countries. These collaboratives focused on a range of topic areas, including antiretroviral therapy (ART), prevention of mother-to-child transmission of HIV, malaria, essential obstetric and newborn care, family planning, and pediatric hospital care. The application of the collaborative approach to improve health care in developing countries is a state-of-the-art initiative to enhance evidence-based standards of care and build local capacity for improving quality of care.

## B. National Context of Health Care in Russia

Health care in Russia is mostly state run: Private health care clinics are few. In terms of administration, everything from hospital intake procedures to treatment protocols are regulated by decrees (*prikazy*) or other directives, such as “decisions” that emanate from different authority levels of the health system. The federal Ministry of Health and Social Development (MOHSD) sets national health standards and policies, while oblast and territory ministries do the same at the regional level. Cities have their own municipal health authorities that set policies for the city, and

large cities such as Moscow and St. Petersburg further devolve authority to district health administrators.

Russia's health care system is characterized by vertical systems of specialized care. Although the federal government is trying to increase the number of general practitioners, many specialized service providers are resisting this change. HIV/AIDS and tuberculosis services (Table 1) are provided through just two of these vertical systems, which have been impervious to change from the outside. However, in the late 1990s, Russian regions were given greater responsibility and resources to develop programs to address their health care needs. Federal, vertical programs such as those for TB and HIV continue, but in general the regions increasingly operated under their own

**Table 1. Care delivery for TB and HIV/AIDS patients, Russia**

Level of Care	TB Services	HIV/AIDS Services
Primary care level	TB is generally diagnosed by chest radiography and passive detection of symptomatic cases at a polyclinic. Once identified, a patient is referred to a TB dispensary for bacteriological confirmation. Where available, microscopy is performed at a polyclinic lab, but normally the results do not play an informative role in the final diagnosis. Lag time between the initial diagnosis and treatment start is sometimes two months.	Diagnosis occurs at a polyclinic or woman's consultation during medical examination due to illness, pregnancy, or mandatory examination. If HIV is suspected, the patient is counseled to take an HIV test. Test results are sometimes not available for 2–3 weeks. If someone is found to be HIV-positive, an infectious disease specialist at a polyclinic and an epidemiologist from a local sanitary epidemiological service implement an investigation of contacts. The patient is counseled to visit an AIDS center. It is often unclear who should be counseling the patient during the post-test period, which can generate delays.
Secondary care level	The referred patient undergoes a second microscopy test, which, if necessary, is followed by bacteriological confirmation at a TB dispensary. Once infection is confirmed, the patient is referred to a TB hospital for treatment.	Not applicable—referral is directly to the tertiary level.
Tertiary	The patient is treated at the city or oblast TB hospital. Treatment usually takes up to 6 months, longer in some cases. Once treatment is completed, the patient is discharged and referred to a local TB dispensary for follow-up in an ambulatory setting.	Confirmation of HIV status is given at the AIDS center. The patient is advised to undergo a thorough medical examination by center specialists ("dispensarization") and is urged to visit the center every 6 months. Dispensarization sometimes takes weeks. ART is administered by the AIDS center.

Source: Boguslavsky (2005).

mandates. QAP was able to take advantage of this change to engage doctors and regional health care facilities in trying different approaches to improve health care delivery and meet regional health care priorities.

## **C. Overview of the Quality Assurance Project in Russia**

QAP started its Russia activities in 1998 in collaboration with CPHRI, MOHSD, and the Tver and Tula oblast departments of health. Between 1998 and 2004, the QAP Russia program completed three phases. The goal of Phase I (1998–2000) was to adapt and use modern quality improvement (QI) methods for three demonstration projects in the two oblasts. In Tver Oblast, three facilities improved the system of care for women with pregnancy-induced hypertension, and five facilities improved that for neonatal respiratory distress syndrome. In Tula Oblast, five facilities worked to improve the system of care for patients with arterial hypertension. Evidence-based medicine, previously undervalued in Russia’s health care system, was the basis for all clinical improvements.

In Phase II (2000–2002) and based on the significantly improved health outcomes from Phase I, QAP developed a model for disseminating the improved systems of care to the entire oblast where the changes were developed. The approach drew on IHI’s Improvement Collaborative methodology. The improved systems expanded significantly: to 40 hospitals for pregnancy-induced hypertension, to 43 hospitals for neonatal respiratory distress syndrome, and to 289 clinics for arterial hypertension. These improvements, covering a population near 3 million, significantly improved health outcomes and reduced health care costs (Abdallah 2002; Abdallah et al. 2002). A key element of the dissemination strategy was that “champions” (participants who were most committed, knowledgeable, and enthusiastic) from Phase I led the activities in Phase II, including training, mentoring, and technical assistance.

In Phase III (2002–2004) and based on the successes in Tula and Tver in improving health care outcomes, reducing costs, and better patient experience with care, QAP began a national roll-out of improvement methods. In this phase, five national collaboratives were organized, involving 23 Russian territories; 56 QI teams worked on 15 clinical improvement areas. A unique feature of this phase was that the territories paid to participate (i.e., travel expenses), with QAP paying only for seminars and the participation of the collaborative directors, i.e., champions from earlier phases of the project. QAP provided oversight and guidance on the Improvement Collaborative approach and on the management of improvement activities at national scale.

In the fall of 2003, the USAID Mission in Moscow asked QAP and the American International Health Alliance (AIHA) to assume responsibility for the treatment, care, and support areas of the Mission’s HIV/AIDS strategy. QAP and AIHA developed a strategy to maximize the effectiveness of their combined strengths and USAID/Moscow resources. AIHA provided clinical training and exchanged health care providers between Russia and the U.S. Both activities enabled the transfer of best practices and evidence-based medicine to Russian health care settings. QAP guided Russian stakeholders in applying QI methods to design a model comprehensive system of treatment, care, and support for HIV-infected and AIDS patients. QAP used the Improvement Collaborative approach to enable the participating regions to share their ideas and experiences. The model was

implemented in one district of St. Petersburg and in limited regions in Samara, Saratov, and Orenburg oblasts: The intent was to establish the model in pilot regions and then spread it throughout these territories and beyond. QAP coordinated this work closely with the Federal AIDS Center, which has provided technical support to the teams and participated actively in learning sessions. This evaluation report focuses specifically on the HIV/AIDS Treatment, Care, and Support Collaborative.

Other QAP-initiated work in Russia, now implemented by the USAID Health Care Improvement Project, includes a collaborative to improve social services for HIV-positive mothers and a collaborative to expand access to ART among intravenous drug users, both implemented in St. Petersburg. Another collaborative to improve family planning services for people living with HIV/AIDS (PLWHA) was completed in September 2007.

## **D. Objectives of the Evaluation Site Visit**

EnCompass LLC was contracted to develop and conduct a formative, participatory evaluation of QAP collaboratives to foster understanding of the essential elements of the Improvement Collaborative model that can contribute to better health care outcomes. The purpose of the evaluation was to assess and report on the implementation and outcomes of QAP collaboratives in several countries. Relatively little was documented about how collaboratives were actually being implemented in developing and transitional countries and what new variations and adaptations evolve from the experience in different countries. The specific objectives of the multi-country evaluation were to:

- Document and describe the implementation of improvement collaboratives in developing and transitional countries,
- Identify the basic principles of collaboratives that cut across countries,
- Identify adaptations and variations in the emerging model, and
- Explain the rationale for the adaptations made by specific countries.

Questions addressed regarding the process and outcomes of collaboratives included:

1. Are the core components of a collaborative (use of evidence-based care, team concepts, learning sessions and action periods, monitoring systems and topic indicators, active collaboration among teams, spread concepts, etc.) appropriate and applicable in developing or transitional countries? What are the variations in the application of the collaborative model and what cultural, technical, and socio-political factors play a role in the emerging model?
2. Can significant improvements in the quality and outcome of care be demonstrated 12–18 months after inception of a collaborative?
3. How are the improvements in care shared or spread to other facilities and topic areas?
4. How does the QAP collaborative experience influence national policies and standards of care?

5. What factors promote the sustainability of collaboratives and ensure their continuation?

To address these and other questions, the evaluation methodology called for documentation of: (a) the history of the initiation, planning, structure, and evolution of each collaborative, special options considered, decisions taken, and changes made during the collaborative; (b) team work, probing into the factors affecting each team's performance; and c) outcomes of the QI strategies in terms of key indicators and benchmarks. Russia was the sixth and final country to be visited as part of this evaluation.

## II. EVALUATION DESIGN AND DATA COLLECTION

### A. Evaluation Staff and Procedures

Although recognizing QAP's extensive work in Russia since 1998, the primary focus of this evaluation was on the HIV/AIDS Treatment, Care, and Support (TCS) Collaborative, initiated in June 2004. The evaluation was conducted in two phases: 1) a field visit by Dr. Stephen McLaughlin, independent consultant for EnCompass LLC, in March 2007 and 2) a follow-up meeting in June 2007 of Kim Ethier, then-Country Manager of QAP Russia, and Dr. Mary Gutmann, Senior Research Specialist of EnCompass. Throughout his visit, Dr. McLaughlin was accompanied by Ms. Irina Kriukova, Project Coordinator of QAP Russia, who also served as interpreter. QAP Russia staff not only provided extensive materials and briefings to the evaluation team, but also accompanied Dr. McLaughlin to all the interviews and site visits. Ms. Ethier made a separate trip to Munich, Germany, to meet with Dr. Gutmann.

During his two-week visit, Dr. McLaughlin received a full briefing from QAP staff and met with Dr. Elena Gurvich, Senior Advisor, USAID, as well as Dr. Anna Korotkova, Deputy Director of CPHRI and former staff of the QAP Phase III project in Russia. He also visited Orenburg, where he met with the heads of facilities that were part of the TB-HIV team, the access and retention team, and the care coordination team. He also met with Dr. Vladislav Golikov, Deputy Minister of Health and the former chair of the Orenburg coordinating committee. Dr. McLaughlin visited St. Petersburg to attend the first Learning Session (LS) for the scale-up of the TCS Collaborative there. In addition, he met with heads of facilities participating in the TB-HIV, the access and retention, and the patient management and adherence teams. Table 2 provides a visit itinerary. Distance and time precluded visiting the sites in Saratov and Samara oblasts.

### B. Data Collection Methods and Tools

The following data collection methods were used in the evaluation of the TCS Collaborative:

**Document review:** Plans, memos, learning session agendas and evaluations, site visit reports, quarterly reports, collaborative indicator data, reports on training and learning sessions, training manuals, job aids for QI teams, and other papers on health issues were reviewed to document the collaborative. Key documents in Russian were translated to English for review. In addition, Dr. McLaughlin examined presentations, graphics, and other records when visiting facilities.

**Guided interviews:** A variety of interview methods was used and done through the interpreter, including: structured and unstructured discussions, individual interviews, and group discussions. Data were gathered in individual and group settings of no more than four and, in the case of URC staff, in both structured interviews and informal situations. A list of the individuals interviewed is in Appendix I.

**Table 2. Overview of the evaluation visit**

Date: Location	Activity
March 13, 2007: Moscow	<ul style="list-style-type: none"> <li>• Meetings with QAP staff, URC Moscow Office</li> <li>• Meeting with Elena Gurvich, Senior Advisor, USAID</li> </ul>
March 14–16, 2007: Orenburg	<ul style="list-style-type: none"> <li>• Meeting with representatives of               <ul style="list-style-type: none"> <li>○ TB-HIV team</li> <li>○ Access retention team</li> <li>○ Care coordination team</li> </ul> </li> <li>• Meeting with Deputy Minister of Health</li> <li>• Meeting with Minister of Health</li> </ul>
March 17–19, 2007: Moscow	<ul style="list-style-type: none"> <li>• Meeting with Dr. Anna Korotkova, Deputy Director, CPHRI and formerly of QAP in Russia</li> </ul>
March 20–22, 2007: St. Petersburg	<ul style="list-style-type: none"> <li>• Attended the first LS for TCS Collaborative scale-up</li> <li>• Attended voluntary counseling and testing (VCT) training of trainers</li> <li>• Meeting with representatives of               <ul style="list-style-type: none"> <li>○ TB-HIV team</li> <li>○ Access retention team</li> <li>○ Patient management and adherence team</li> </ul> </li> <li>• Meeting with the project HIV-TB expert, head of the Federal Center for HIV-TB Care</li> </ul>

**Direct observation:** Dr. McLaughlin visited four clinics and an oblast and district health ministry office: Russia’s confidentiality laws prohibited observation of treatment rooms or contact with patients. He attended a learning session of the spread collaborative for TB-HIV co-infection in St. Petersburg and a training session on VCT for clinicians, part of the spread collaborative.

## C. Data Analysis

Since most of the data were from interviews, group discussions, and documents, qualitative data analysis was used to identify patterns suggesting important findings. In addition, the report draws on exceptional stories and quotes to highlight trends and to provide a texture to the human experience with collaboratives.

When possible, the team gathered already-available quantitative data consisting of various health and system indicators. Comparison of baseline and project indicators revealed the outcomes of the

collaborative in numerical terms. These are described in Section III.B.12: “Outcomes and Achievements.”

Validation of the data was accomplished by 1) comparing data from different sources to evaluate internal and external consistency; 2) validating interview data through examination of records, files, and documents to confirm verbal reports of performance or outcomes; and 3) comparing findings among the evaluation team members and discussion about the potential sources of variance.

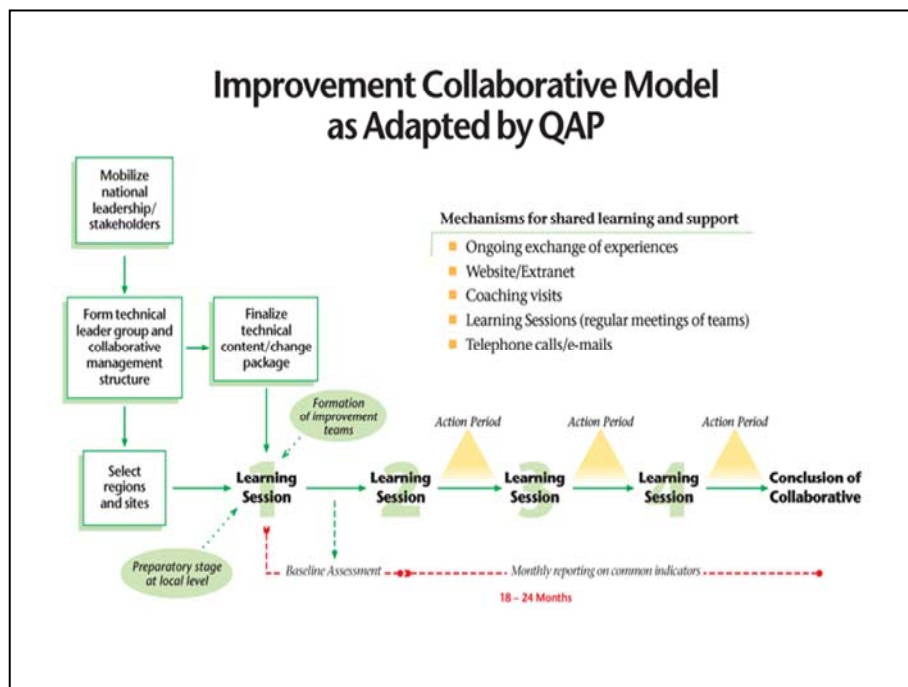
### III. FINDINGS

#### A. Framework for Evaluation Findings

The evaluation design and methodology were guided by a common understanding of the essential features of a collaborative, illustrated in QAP’s collaborative model (Figure 1). Evaluation questions were designed to elicit information on each of these essential features and how they were manifested in a collaborative. This and other site visit reports are organized with reference to the essential features. In this way, comparisons can be made across different collaboratives and different countries, using a common framework and set of terminology.

Figure 1. QAP collaborative model

One of QAP’s challenges was to explain in Russian (and find an appropriate equivalent for) the word “collaborative.” In general, the words “cooperation” and “collaboration” are associated with the socialist traditions that have been largely discredited. After a long history of centralized authority, the QAP Russian model of collaboration deserves praise, according to one health administrator, for having turned the idea of collaboration into a practical tool for institutional change.



#### B. HIV/AIDS Treatment, Care, and Support Collaborative

In the fall of 2003, following a request by USAID/Moscow for QAP to focus on HIV/AIDS, QAP worked with key stakeholders—including USAID Moscow, MOHSD, regional ministries of health,

municipal health administrations, leaders of participating organizations, and consultants—to design the HIV/AIDS Treatment, Care and Support Collaborative. USAID asked QAP to work closely with AIHA, whose exchange program provided expertise in HIV/AIDS treatment and management by exchanging professionals between the U.S. and Russia. USAID saw the two organizations as providing complementary services and anticipated an opportunity to maximize the benefits of both organizations' approaches. QAP used QI methods, including the Improvement Collaborative approach, to enable practitioners from different health and non-health organizations to work together to improve services that exceed the scope of any particular institution or system. QI teams set up by QAP helped institutionalize best practices brought and shared by AIHA's U.S. partners.

The goal of the TCS Collaborative was to design a model system of HIV/AIDS treatment, care, and support that would involve patients, families, communities, drug treatment facilities, medical system institutions, social sector institutions, NGOs, and others. Additionally, the activity would contribute to stronger public/private partnerships by encouraging government health facilities to work on referral systems with local NGOs and community organizations, both for referring patients for treatment and to NGOs for social, psychological, and other support. Cross-cutting issues, such as TB-HIV co-infection, would also be addressed through involvement of specialized TB institutions and primary care providers.

## **1. Initial and Evolving Organizational Structure**

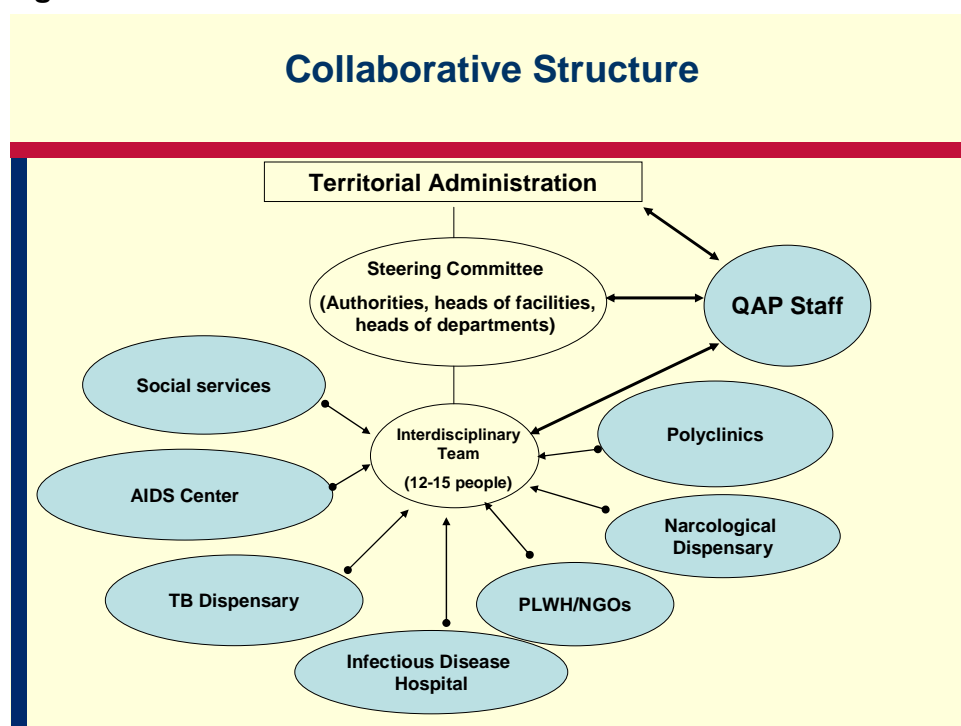
In June 2004, QAP and AIHA began project implementation with meetings to introduce the joint goals and the specific approaches of each project in each oblast. The meetings attracted leaders from the territory administration, health care sector, AIDS centers, authorities from social service and prison health systems, and NGOs. QAP conducted additional meetings in August and September 2004 to facilitate site selection in each oblast, assess the composition of QI teams, and identify professionals who might be invited to participate in coordinating committees. During subsequent months, QAP conducted one-day QI overview workshops for local health authorities and leaders of participating facilities. These were followed by a three-day QI core course for QI team members.

The positions of the participants varied somewhat among territories, but generally included representatives from medical institutions (AIDS centers, immunology, infectious disease control, primary care, TB services, narcology, maternal and child health, sexually transmitted infection [STI] clinics, youth clinics), social services (social welfare, child and family services, social workers, psychologists, youth committees), and NGOs (groups for PLWHA and risk reduction, youth, drug abuse services, etc.). By the end of 2004, QAP's Moscow staff had worked with practitioners at each site to conduct an analysis of the care delivery system for PLWHA, review current practices, and determine objectives for improvement.

The collaborative management structure was designed to address the interdisciplinary nature of HIV/AIDS care and recognize that the system of care had to be strengthened to respond adequately to the growing number and needs of PLWHA. Thus, the collaborative framework in each region had four interdisciplinary teams (one for each topic area) with representatives from all

relevant services and facilities working on the topic. Each territory also had a regional coordinating committee (sometimes referred to as a steering committee), which served as a forum for collaboration and decision making. The coordinating committees were generally made up of leadership from the territorial Ministry of Health (i.e., level of Orenburg Oblast or St. Petersburg) as well as the leadership from regions/districts/cities within that territory. Each of these committees typically had 15–17 members, including heads of participating facilities as well as officials from MOHSD; NGOs (including PLWHA); and in some cases, prison and police representatives. Committees met regularly and had the authority to make or influence decisions to support institutionalization of new practices. For example, these committees prepared a number of regulatory directives that have been approved by health and social sector authorities. Figure 2 illustrates the administrative structure of the HIV/AIDS TCS Collaborative.

**Figure 2. Administrative structure of the HIV/AIDS TCS Collaborative**



## 2. Collaborative Topic

The TCS Collaborative had two main objectives:

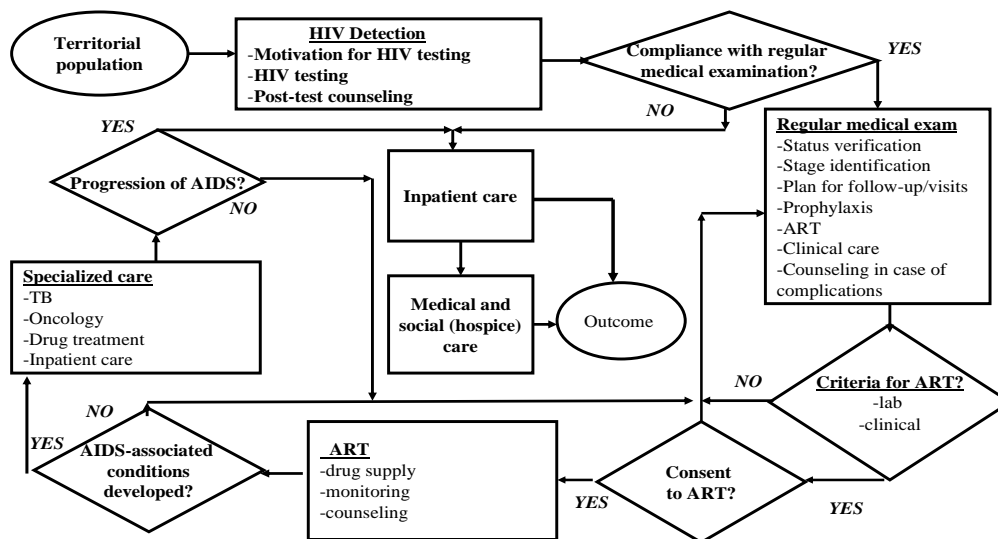
- To design a high quality, replicable HIV/AIDS treatment, care, and support system based on evidence and compatible with international standards and
- To establish a continuum of care involving patients, community, NGOs, primary care, AIDS centers, and hospitals.

The topic areas for improvement were chosen based on the results of a system analysis performed by the four participating regions with QAP assistance. The analysis was led by QAP Moscow staff

during October–December 2004 and involved over 200 officials, leaders, health care providers, representatives of the social support sector and psychological services, and NGOs.

The flowchart in Figure 3 summarizes the overall process of care, common in all four sites, which existed from HIV case detection to its progression to the AIDS stage.

**Figure 3. Analysis of the process for HIV case detection and treatment, 2004**



The analysis helped to identify several impediments to quality care that needed to be addressed in order to adequately respond to the growing needs of PLWHA. These included:

- Primary care providers had little knowledge of the criteria for referring patients for HIV testing.
- A patient needed an appointment with the infectious disease specialist in order to be referred for HIV testing, posing an additional barrier to timely testing.
- Labs were remote, presenting a transportation problem in sending samples and receiving results.
- Laboratory testing practices, such as test turnaround time, were not unified and differed across regions.
- Confidentiality was not properly ensured in the organization of delivery and filing of test results.
- AIDS centers did not inform referring specialists whether a referred patient went to the center, was registered, and received services (e.g., medical exams, ART if needed).
- If treatment of the primary complaint had been completed at the primary care level when the HIV test results returned from the laboratory, they were sent to archives for storage. In some regions, previous test records were not recalled during subsequent patient visits, so patients may have been retested.

In addition, follow-up and care of HIV-positive patients were problematic. Patients were often lost to follow-up and there was a lack of information exchange between AIDS centers and institutions of the general health care system. There was an insufficient level of detection and treatment of opportunistic infections (OIs) due in part to lack of both providers' clinical knowledge of OIs and financial means to purchase drugs to treat them. The number of HIV-positive people complying with the AIDS center medical plan for follow-up and visits was unknown, and criteria had not been defined for ART administration, evaluation of abstinence from prohibited drugs, and estimation of adherence. In addition, social support services for PLWHA were limited in all stages of clinical care delivery.

These findings guided QAP and key stakeholders in identifying four priority areas for improvement:

1. Access and patient retention,
2. Coordination of care,
3. Patient management and adherence to treatment, and
4. Coordinated HIV and TB co-infection detection and treatment.

The areas and the key goals within each were confirmed at a joint strategic planning meeting that AIHA and URC held in January 2005. This meeting included U.S., Russian, and international HIV experts as well as top leaders from project sites and Russia. The meeting was a key event that set the stage for further work together. Key stakeholders—i.e., QAP staff, AIHA staff and U.S. partners, international experts, Russian federal experts, and Russian regional health officials and key specialists—all agreed to the priority areas and formulated a common vision of goals and objectives. QAP and AIHA hosted a three-day strategic planning meeting in St. Petersburg in early 2005, bringing together key Russian health care policymakers; experts from USAID, the World Health Organization (WHO), the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the Joint United Nations Programme on HIV/AIDS (UNAIDS), UNICEF, and other international organizations; and clinicians, epidemiologists, and service providers from Russia and the U.S. The purpose was two-fold: to develop a shared vision and integrated models for effectively providing care, treatment, and support services to PLWHA and to promote continuity and synergy between various organizations and extant programs.

### **3. Evidence-based Standards of Care**

Although the collaborative's objective was to establish systems of care that would improve access to and coordination of quality care for PLWHA rather than on compliance with clinical care standards, several strategies were used to introduce and integrate internationally established best practices and standards of care into the planning and design of the collaborative's QI activities.

WHO's Innovative Care for Chronic Conditions Framework served as a basis for the prototype. In this framework, care and support become primarily the responsibility of the empowered patient, supported by his/her family and community. The prototype incorporates the clinical content of HIV/AIDS care, the organization of the care system to deliver this care, and the policies pertaining to it. QAP encouraged links between the health system and social support for patients, including organizations that served high risk populations. Organization of care addressed critical options such as developing a vertical HIV/AIDS care and support system versus its integration with primary

care services. QAP also proposed the involvement of experts from the New York State AIDS Institute, which is uniquely experienced in applying QI methods to AIDS care in the U.S.

In October 2005, QAP conducted a two-day roundtable in Moscow on coordinating TB-HIV co-infection detection and treatment for members of the inter-disciplinary TB-HIV teams in participating sites. The roundtable provided a forum where sites could exchange ideas on TB-HIV detection and treatment; solicit advice, feedback, and answers from experts on the teams' work; update participants on Russia's TB-HIV co-infection situation, including major federal regulations and efforts regarding care delivery to patients with TB-HIV; and share relevant international experiences and identify best practices that could be adapted. Leading international and national experts presented on rates of TB-HIV co-infection in Russia, efforts to deliver services, and implementation of federal regulations.

In addition, AIHA's exchange program provided expertise in HIV/AIDS treatment and management. For example, after receiving training by experts from AIHA's program on how AIDS case management is handled in the U.S., QAP staff facilitated sessions where teams began to plan how to implement such management in Russia, including organization of work, roles and responsibilities, qualifications, and the location of a proposed case manager position. U.S. partners gave the teams feedback on their work. The team working on care coordination in Engels decided to create a case manager function at the Narcological Dispensary. The team presented its ideas to the Head of the Health Committee and Deputy Head of Social Affairs in Engels, who found the financial and administrative resources to create the position.

Participants in the strategic planning process were thus exposed to an overview of best practices for treatment and care and case management models used by American medical partners in AIHA. The planning phase benefited from the input of Russian experts from the Federal AIDS Center and Federal Center for TB-HIV of the MOHSD. In addition, for clinical content in other topic areas, QAP drew on Dr. Bruce Agins of the New York State AIDS Institute, Federal AIDS Center experts, the Russian head TB-HIV specialist, and WHO experts.

#### **4. Site Selection**

The goal of the collaborative was to develop a well-coordinated territorial model based on high quality HIV/AIDS treatment, care, and support, including ART when appropriate, that could be scaled up and replicated in other Russian territories. The collaborative had two phases: a design phase that would last 18–24 months followed by a scale-up phase, which is now underway and could continue for two to three years. During the design phase, a selected number of geographically dispersed sites representing all medical services involved in HIV/AIDS care, selected social service institutions, and NGOs were chosen in each of four territories. During the scale-up phase, the model would be spread to the remaining sites in each territory and to other territories as feasible.

The participating oblasts were selected with USAID and MOHSD guidance. Later in the process, participating facilities at the regional/oblast level were proposed by the regional ministries of health. A number of programmatic and logistical factors were considered, but the determining factor was

leadership and willingness to work with the issue of HIV/AIDS, demonstrated at a municipal level. QAP had worked closely with USAID to conduct site visits, which led to the final selection of the following four sites:

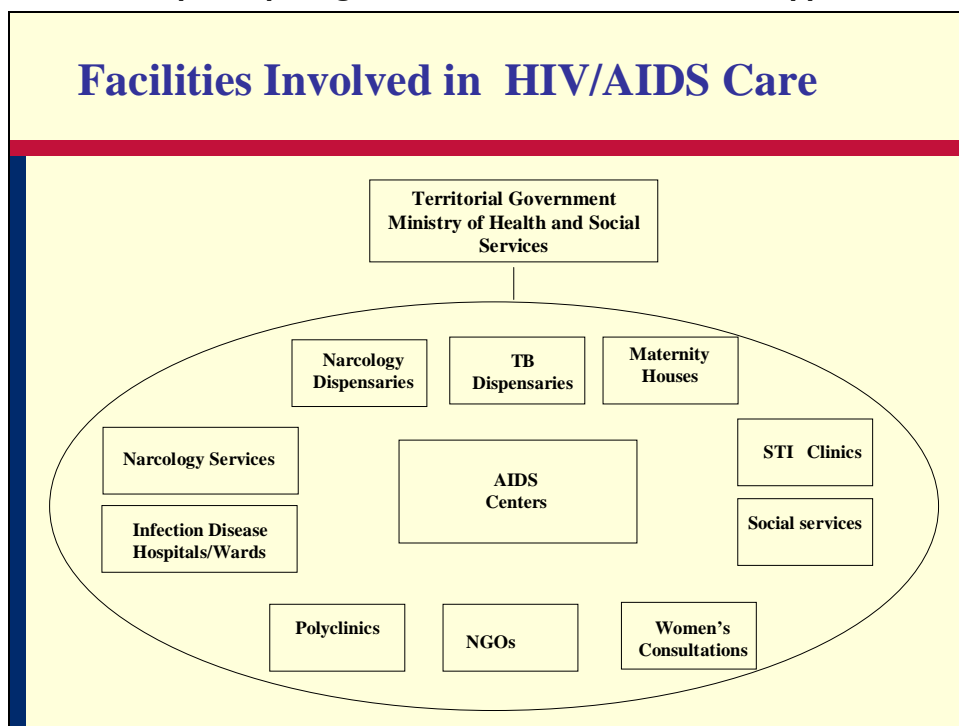
- Krasnogvardeisky District, St. Petersburg;
- The cities of Engels and Saratov in Saratov Oblast;
- The city of Togliatti in Samara Oblast; and
- The city of Orenburg in Orenburg Oblast.

The sheer geographic size of Russia is a challenge. Orenburg city is the capital of its oblast, and Engels adjoins the city of Saratov, the administrative center of Saratov Oblast. However, Togliatti is 1.5 hours away from Samara, the administrative center of Samara Oblast. While all these cities are much larger administrative entities than a single district of St. Petersburg, the latter's entire population far exceeds any of the other cities' populations and, in fact, all their oblasts' populations. Orenburg Oblast is a huge, remote area with a widely dispersed population; it suffers from considerable drug trafficking via nearby Kazakhstan and has few NGOs to help alleviate the problem. St. Petersburg, in contrast, is afflicted with a large commercial sex industry and many intravenous drug users but also benefits from many NGOs dedicated to these problems.

## **5. Nature and Composition of Teams**

An interdisciplinary team was formed at each participating site (city or district selected for the pilot phase) to address each of the four priority improvement areas (i.e., access and patient retention, coordination of care and care management, patient management and adherence, and TB-HIV), incorporating all relevant services and facilities within the project area. For example, the TB-HIV team in each region may have included the oblast or city AIDS center, TB clinic, TB hospital, polyclinic-level infectious disease specialists, narcology services, an NGO focused on vulnerable populations, and a PLWHA representative. Since the AIDS centers were the primary facilities addressing HIV/AIDS, they were included in each site. However, the emphasis was on a comprehensive approach to HIV/AIDS care and treatment that involved other facilities as well. For example, in St. Petersburg, the team was working on improving the district's facilities' abilities to provide HIV and coordinate care—and did so with the participation and support of the AIDS Center. Figure 4 depicts the types of facilities that participated in the improvement collaborative.

**Figure 4. Facilities participating in the Treatment, Care, and Support Collaborative**



Each team had a leader who convened and facilitated team meetings with the assistance of the project field coordinator and maintained frequent contact with QAP's Moscow-based staff. The teams were responsible for testing and implementing improvements in the system of treatment, care, and support for HIV/AIDS. Facility-based teams also formed to make internal changes—such as improved referral systems and coordination between services—based on the improvements made across the system of care.

The collaborative teams initially had as many as 30 members. The patient access and retention teams, in particular, included non-medical representatives from the Ministry of Social Protection and from NGOs. Membership later settled at around 15 or fewer individuals who were the most active team members. Respondents reported that as some members dropped out, others took their place. It was estimated that about a third of the current members were original members. A senior quality assurance manager offered one explanation for the changing membership: “You need different kinds of people at different stages. At first, you need ‘generators’ who can see the problem. Later, when you have identified the problem, you need people who can work hard and be implementers. A team is vibrant and constantly changing.”

The establishment of 16 interdisciplinary, inter-facility teams was unique to the Russia TCS Collaborative and reflects the emphasis on system strengthening and coordination as a major collaborative goal. Oversight of these teams was provided by the regional coordination committees, which could influence decisions on interdisciplinary coordination and resource use and which served as an important link to regional authorities for institutionalizing best practices and

improvement strategies (Figure 2 shows team composition). Table 3 provides the framework for the TCS collaborative for the four regions.

**Table 3. Framework for the TCS Collaborative**

<b>Topic</b>	<b>St. Petersburg</b>	<b>Orenburg</b>	<b>Samara</b>	<b>Saratov</b>
QI leadership	Coordinating committee	Coordinating committee	Coordinating committee	Coordinating committee
Access and patient retention	Interdisciplinary teams	Interdisciplinary teams	Interdisciplinary teams	Interdisciplinary teams
Coordination of care and case management	Interdisciplinary teams	Interdisciplinary teams	Interdisciplinary teams	Interdisciplinary teams
Patient management and adherence to ART	Interdisciplinary teams	Interdisciplinary teams	Interdisciplinary teams	Interdisciplinary teams
HIV and TB	Interdisciplinary teams	Interdisciplinary teams	Interdisciplinary teams	Interdisciplinary teams

## 6. Team Function

Teams varied widely in how they functioned. In terms of meeting frequency, for example, most of the teams examined by the evaluator met monthly or at least more often than quarterly to further their progress. The number of times they met appeared to be related to the need for a meeting rather than any set schedule. One access and retention team met 13 times since its formation as a planning team in 2005; others met less frequently. Given that these were interfacility teams, the members had to travel to a central location for meetings, and they needed a “directive” to authorize their participation in team meetings that took them away from their clinical duties. When possible, teams communicated by phone, fax, and email, reducing the frequency of physical meetings together.

With time, the three teams on access and retention, patient management, and care coordination merged to form the combined HIV/AIDS treatment, care, and support team or ART team. This was the result of a natural progression of work that required close collaboration and coordination between different teams. For example, retention of patients depended on the coordination of several medical and social services that affected the patients’ likelihood of being effectively treated. This became clear in the action phase, when team members needed to draw on outside resources that required contact with other institutions. According to several respondents, the merger also came after progress had already been made within those narrower dimensions and teams were ready to address broader problems. Mergers took place after attrition and thus restored team size to that of the formerly separate teams.

## 7. Team Coaching and Support

Coaching was provided by QAP Moscow-based advisors, QAP/AIHA regional coordinators, and peer leaders from other facilities. QAP Moscow staff frequently visited all four territories to

monitor and oversee the process; identify problems, needs, and expectations; and assist teams. Coaches provided technical support, advocated for the collaborative, and kept the local MOH informed and on board.

A national specialist on TB-HIV co-infection credited the Senior QA Adviser with facilitating negotiations between city and national stakeholders in selecting a candidate for an important medical position in St. Petersburg. “[The Senior QA Adviser] established cooperation between the TB and HIV services, and this cooperation created friendly terms on which to build cooperation and information-sharing. This made it easier for the three parties to agree on a new lead TB-HIV co-infection coordinator for St. Petersburg.”

In the TCS Collaborative demonstration phase, QAP advisors provided all the coaching, but as the work expanded into more regions and the number of teams increased, additional regional coaches were added. During the scale-up phase, QAP focused its technical assistance on developing a cadre of coaches and collaborative directors in St. Petersburg. One coach was trained to manage teams in each district. Coaches were chosen from within the district health administration system. As part of the current scale-up collaborative in St. Petersburg, there are 42 teams in 21 participating districts (18 districts in St. Petersburg and three in Leningrad Oblast) managed by 21 coaches. Coaches also serve as teams’ formal leaders. Each coach is required to oversee two teams: one for treatment and care and one for TB-HIV. In Orenburg, the system of coaches was modified: The Orenburg Oblast MOH nominated a project coordinator from the city health administration of each city participating in the collaborative to monitor project implementation. The Deputy MOH oversees the entire implementation, while a responsible specialist from Orsk AIDS Center, Novotroitsk AIDS Center, and Gai Central Hospital manages the work in their cities and reports to the MOH project coordinator. Coaches and team leaders play a vital role in providing guidance and encouragement to teams and serving as a liaison with the district health committees/MOH at the regional level.

## **8. Learning Sessions and Training Events**

The TCS Collaborative conducted six learning sessions, allowing teams to share their experiences, learn about the latest medical practices and knowledge from outside authorities, acquire more understanding of collaboration, and plan their next steps. These sessions consisted of a plenary session; team presentations; team meetings; QI training; discussion of data and information systems; and review of best practices, models, or clinical content on topics (QAP/Russia 2005). Plenary sessions dealt with clinical or organizational topics, often through presentations given by URC-sponsored national and international medical experts. Team presentations were normally 15 minutes and covered the progress of each team, followed by a period of general discussion moderated by the Senior QA Adviser.

Data on key indicators were reported and shared monthly. Every six months, either a joint learning session involving all four sites or a topical roundtable meeting was held to further facilitate sharing of lessons among the four oblasts. Because of the distance and cost of bringing all four sites together, some learning sessions were held with teams in one site and sometimes with multiple sites together.

Between learning sessions (during action periods), QAP staff made regular technical support visits to all four sites. To the extent possible, the learning sessions and site visits were coordinated with the AIHA U.S. partner visits, although this was difficult due to the voluntary nature of the exchange program.

During March–May 2005, QAP held the first LS in each territory. It was designed to familiarize participants with the project strategy that had been developed during the strategic planning meeting, introduce the Improvement Collaborative approach and other QI methods, teach clinical content, and develop suggestions for improvements in each priority area.

QAP Moscow-based staff conducted the second learning session in June 2005. This interregional meeting allowed representatives of all four territories to exchange ideas, experiences, and problems and to develop possible solutions. Each territory made a presentation on its progress, and the team members discussed relevant issues in a facilitative forum. Then there were topic-specific breakout sessions where the teams met to discuss their topic area. Such sharing was a key motivational factor.

December 2005 witnessed the third learning session, in St. Petersburg, bringing together representatives from all teams to design organizational plans for providing ART. Each region presented its current situation with respect to ART delivery. Dr. Oleg Yurin, Deputy Head of the Federal AIDS Center, updated participants on MOHSD plans for ART roll-out in 2006–2007. He also served as an expert for the teams, advising them on key elements that should be part of their organizational plans. This and other presentations by national and international experts were followed by facilitated question and answer sessions, when experts shared their experience and personal vision regarding different issues, such as ART inclusion criteria, strategies to improve adherence, and recruitment of intravenous drug users (IDUs) into ART. Each of the four multidisciplinary teams agreed on a unified ideal readiness plan, tailored it to their local environment, identified local needs and possible resources, and developed action plans and timelines.

In March 2006, the fourth learning session, in Moscow, focused on TB-HIV co-infection. Participants included the four TB-HIV teams and representatives from Kaliningrad, Tomsk, Altai Krai, Chelyabinsk, the Russian Health Care Foundation, the federal center for TB care delivery to HIV clients, USAID, AIHA, WHO, CDC (U.S. Centers for Disease Control and Prevention), Open Health Institute, AIDS Foundation East-West, and URC staff from South Africa. Participants exchanged ideas on TB-HIV detection and treatment for HIV clients; the teams in each region later began testing those ideas.

The fifth learning session, in Moscow in June 2006, brought together 91 participants from the four regions (St. Petersburg; Engels, Saratov Oblast; Togliatti, Samara Oblast; and Orenburg), NGOs of PLWHA, GFATM Round IV recipient regions, the Federal AIDS Center, the Russian Health Care Foundation, WHO, USAID, AIHA, Open Health Institute, and other international organizations. The focus was to review the status of preparedness for ART scale-up, further elaborate on regional plans using inputs from colleagues and various experts, and agree on measures to track progress in enrolling patients in ART. Each region presented on its current situation with respect to ART

delivery as well as specific improvements in each topic area (access and retention, care coordination, patient management, and TB-HIV co-infection detection and treatment) that served as the basis for ART scale-up within their territories. The discussion included: recruiting IDUs into ART; treating substance abuse; treating Hepatitis C virus co-infection and OIs; irregular drug supply; participation of PLWHA in decision making at all levels, including the development of clinical guidelines; involving primary care specialists in ART provision; preventing professional burn-out; stigma toward PLWHA and reverse stigma toward the medical community; use of peer-to-peer counselors and better cooperation with NGOs; focusing on the process of enrolling eligible patients and forming adherence support groups, rather than simply waiting for the drugs to arrive; and indicators for measuring ART scale-up progress. The session also served to further cooperation and synergy among the four participating territories, the GFATM Round IV recipient regions, medical and PLWHA communities, and international organizations.

The year 2005 also ushered in another major technical intervention: a series of regional trainings to improve HIV counseling and testing. The Healthy Russia Foundation trained trainers in all four territories and provided training materials in trainings co-sponsored by QAP and AIHA. First, regional trainings on counseling led by local trainers in Saratov and St. Petersburg were held in November 2005 through February 2006. In St. Petersburg, 17 participants attended the training, including general practitioners, nurses, infectious disease specialists, midwives, obstetricians, a pediatrician, and a psychologist, all from various polyclinics and centers. Following the initial round of trainings, USAID gave QAP responsibility for organizing follow-up trainings and implementing VCT into practice. From May to September 2006, four VCT trainings were conducted in each of the four regions, reaching 238 local health providers.

As stated, either a learning session or a topical roundtable was held at least every few months. Learning sessions followed the Improvement Collaborative model, and all team members (or representatives from teams with different medical specialties, social workers, and NGO staff) met to share their progress, learn best practices, meet as teams to develop plans for the next action period, etc. Roundtables were much smaller, more focused meetings and were used to address a specific clinical issue such as isoniazid preventive therapy (IPT) or testing for TB among HIV-positive patients. Two roundtable meetings focused specifically on TB-HIV co-infection and were designed to generate a common understanding of clinical issues, including the proper order for screening tests and when to give TB preventive treatment. The timeline of training activities for the TCS collaborative was as follows:

- June 2004: one-day introduction meeting for authorities
- August/September 2004: site visits to all facilities involved
- October 2004: one-day meeting for facility heads (introduction to QI)
- November/December 2004: three-day training for facility representatives
- January 2005: strategic planning meeting (change package)
- March/April 2005: first LS in each region; team development
- June 2005: second LS: interregional
- October 2005: third LS (roundtable on TB-HIV): interregional
- December 2005: third LS on ART scale-up readiness: interregional

- March 2006: fourth LS (roundtable on TB-HIV): interregional
- June 2006: fifth LS on ART scale-up readiness: interregional

## 9. Action Periods

QAP's work from 2004 to 2006 sought to establish a solid foundation for more integrated and higher quality HIV/AIDS services in the four sites. QAP applied the collaborative methodology to increase the pace of improvement through active sharing of experiences among teams. Leaders and teams were trained in the aims and methods of the TCS Collaborative, conducted their baseline assessments, and analyzed their current processes during October 2004–February 2005; actual improvement activities began in March 2005.

Four interdisciplinary teams—one for each topic area—were established at each project site to address the four topic areas. Institution heads assigned staff to participate in these teams. It was the responsibility of the teams to test and implement various improvement changes during action periods and monitor results. Some of the areas of focus, by topic area, were:

*“The collaborative approach was quite comprehensive compared to other intervention programs. At the beginning, we didn’t know what collaboration meant. In the process, people became completely different. In the East, there is a saying ‘If you want a man to eat for a day, you give him a fish. If you want him to eat for a lifetime, you teach him how to fish.’ QAP never gave us fish but instead gave us a scientific approach that we have used to solve important problems. We came up with our own solutions.”*

– HIV/AIDS TCS team member, St. Petersburg

- Teams working on *access and patient retention* developed leaflets, flyers, and booklets for PLWHA; they also introduced/improved pre- and post-test counseling at the primary care level.
- Teams working on *care coordination* addressed issues related to information exchange between AIDS centers and general medical networks, case management, training of social workers in HIV/AIDS issues and appropriate care delivery, and designing standardized discharge and referral forms and a common database on HIV-positive clients.
- Teams addressing *patient management and adherence* identified several areas for improvement, including: criteria definition for ART administration and monitoring; system of supportive training based on desk audits; reducing stigma among medical staff; improved cooperation between the AIDS center infectious disease specialists and psychologists to improve adherence; and detection of and assistance with depression in patients on ART.
- Teams working on *TB-HIV co-infection* focused on preventive treatment of TB among HIV patients, patient flow at facilities to avoid infection, and implementation of MOHSD guidelines for patient records.

In this descriptive discussion, it is difficult to reflect the many challenges and difficulties teams faced in addressing some of these issues. For example, beginning preventive TB treatment took a) several meetings and agreements on proper schemes; b) developing a chart to monitor patients; c) organizing the who, what, where, when, and how of administering preventive treatment and re-

organizing pharmaceutical purchasing; and d) storage and delivery. Even the smallest changes required considerable time, resources, and commitment to bring them about and make them sustainable.

“Plan, do, study and act” or PDSA was widely used to test the effects of small changes before they were fully implemented. According to the Senior QA Advisers, PDSA was introduced during the system analysis phase and continued throughout the entire improvement process. Along with PDSA came training in the component skills of chart/graph construction and report preparation for documenting the results of any change. PDSA offered both the abstract and practical method for unpacking large, complex problems and formulating new procedures supported by corroborated quantitative and qualitative data.

While PDSA guided teams in the development of improvements in health care services, to implement certain changes and/or ensure that those changes would stay in place, QAP and project teams worked with local governments to bring about legally binding policies through the issuance of decrees. Such directives ensured that providers were allowed to implement certain changes and/or that the changes would be sustained. The Orenburg TB-HIV co-infection team’s choice of re-organizing communication between the TB dispensary and the AIDS center started as an experiment and evolved into a formal policy change that allowed co-treatment of TB and HIV while avoiding adverse drug interactions.

## **10. Topic Indicators and Measurement**

The collaborative’s goals are relevant to a number of USAID strategic objectives and intermediate results that seek to prevent HIV transmission and/or improve care for HIV/AIDS patients. The system of care involves all entry points along the continuum of care for these patients and other stakeholders, including families, community members, NGOs, medical facilities, social services, outreach programs for IDUs, etc.

The organization of care for HIV/AIDS patients is a complex challenge. Here, the collaborative’s model of health care delivery for these patients initially focused on the institutions and health care systems delivering these services. The issues involve practical details such as organizing care that is responsive to the needs of patients with a chronic, stigmatized illness and working effectively with families, community organizations, and social service agencies. A list of indicators the collaborative developed for the Mission’s Strategic Objective 4, Intermediate Results 4.1, is in Table 4.

**Table 4. USAID/Russia HIV/AIDS objectives and indicators**

<b>USAID/Russia Strategic Objective: Reduce rate of HIV transmission in selected locations</b>	
<b>Intermediate Result 4.1: Improve quality and access to treatment, care, and support programs</b>	
<b>Goal: A high quality, replicable HIV/AIDS treatment, care, and support system based on evidence and compatible with international standards</b>	
<b>Indicator</b>	<b>Primary Data Source</b>
<b>Objective 1: Improved patient management and adherence to treatment</b>	
1.1. Number of providers in compliance with the HIV/AIDS treatment guidelines	Desk audits, monthly reports
1.2. Number of patients on antiretrovirals (ARVs) receiving adherence counseling	Desk audits, monthly reports
<b>Objective 2: Improved access and patient retention</b>	
2.1. Number of patients visiting medical facilities on a regular basis	Facility records, monthly reports
2.2. Number of patients with one appointment who return for a second appointment	Facility records, monthly reports
2.3. Number of substance users who receive HIV/AIDS services	Facility records, monthly reports
2.4. Turnaround time from labs less than 48 hours after sample collection	Facility records, monthly reports
2.5. Number of VCT clients who receive both pre-test and post-test counseling at the same site	Facility records, monthly reports
<b>Objective 3: Improved coordination for TB-HIV co-infection detection and treatment</b>	
3.1. Number of TB patients offered VCT for HIV	Facility records, monthly reports
3.2. Number of HIV-positive patients screened for TB	Facility records, monthly reports
3.3. Percentage of HIV-positive TB patients who are offered VCT	Facility records, monthly reports
3.4. Number of HIV patients with latent TB infection receiving prophylaxis	Desk audits, facility records, monthly reports
3.5. Number of TB-HIV patients with complete records as per national norms	Desk audits, facility records, monthly reports
<b>Objective 4: Improved coordination of care</b>	
4.1. Number or percentage of HIV-positive clients who receive referrals to social services	Facility records, monthly reports
4.2. Number of patients who made an appointment with a case manager	Facility records, monthly reports

A summary of PEPFAR and other indicator data from the TCS Collaborative is in Appendix 2. The indicators were agreed upon by Russian counterparts and stakeholders, and attempts were made to harmonize the PEPFAR, WHO 3x5, and Global Fund indicators, which should provide a basis for effective measurement and international comparisons.

## 11. Outcomes and Achievements

Since the collaborative's launch in 2004, the interdisciplinary teams in each region have continued to test, implement, institutionalize, and scale-up improvements in HIV/AIDS treatment and care, as well as identify new priorities, such as developing and implementing regional ART readiness plans. According to QAP Russia figures, the quality improvement activities in Krasnogvardeisky (St. Petersburg) had benefited almost 900 HIV-positive individuals and in Orenburg, over 5,000 by fall 2006. The key results achieved with QAP assistance are summarized below by topic area.

### **Improved Access and Better Coordination of Care**

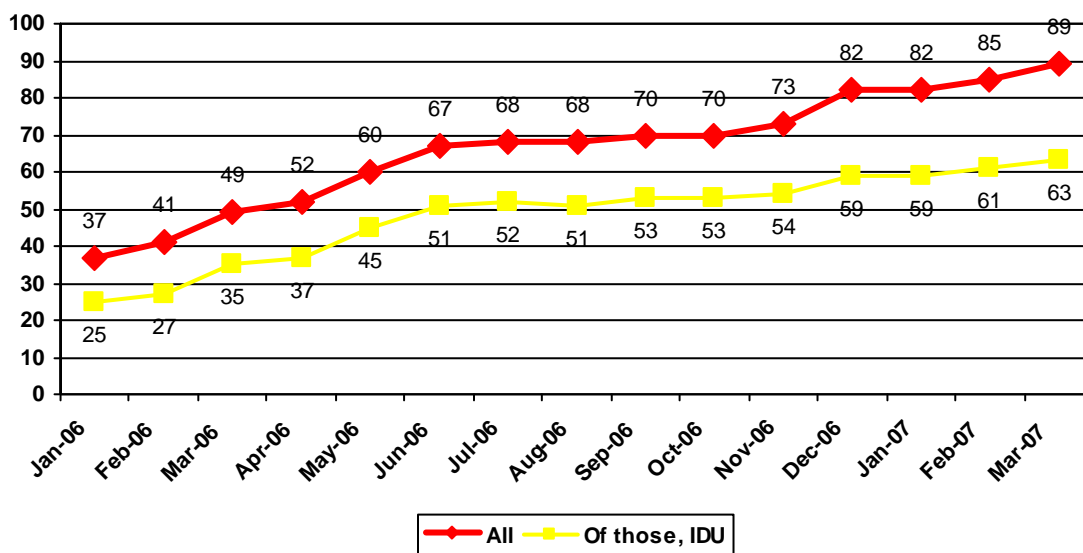
By the second year of the project (2005), data from all four locations indicated significant progress in expanding the availability of quality HIV/AIDS services. Table 5 compares 2004 baseline and August 2005 data on key indicators.

**Table 5. Russia HIV/AIDS treatment, care, and support indicators**

<b>Activity Level Indicators</b>	<b>Location</b>	<b>2004 Baseline</b>	<b>August 2005</b>
SO3.2: Percentage of HIV-positive individuals accessing quality HIV/AIDS treatment, care, and support programs	Togliatti	62.3	63.3
	Orenburg	49.1	56.3
	St. Petersburg	44.2	(6 months) 37.3
	Engels	79.6	81.0
IR 2.3.1: Number of HIV/AIDS and TB counselors trained in and implementing quality TB-HIV co-infection services	Togliatti	0	38
	Orenburg	0	80
	St. Petersburg	0	59
	Engels	0	75
IR 2.3.2: Number of public or NGO partner health care facilities able to deliver appropriate palliative care and treatment for OIs and referral for HIV-infected patients according to national standards	Togliatti	0	17
	Orenburg	0	11
	St. Petersburg	0	19
	Engels	0	23

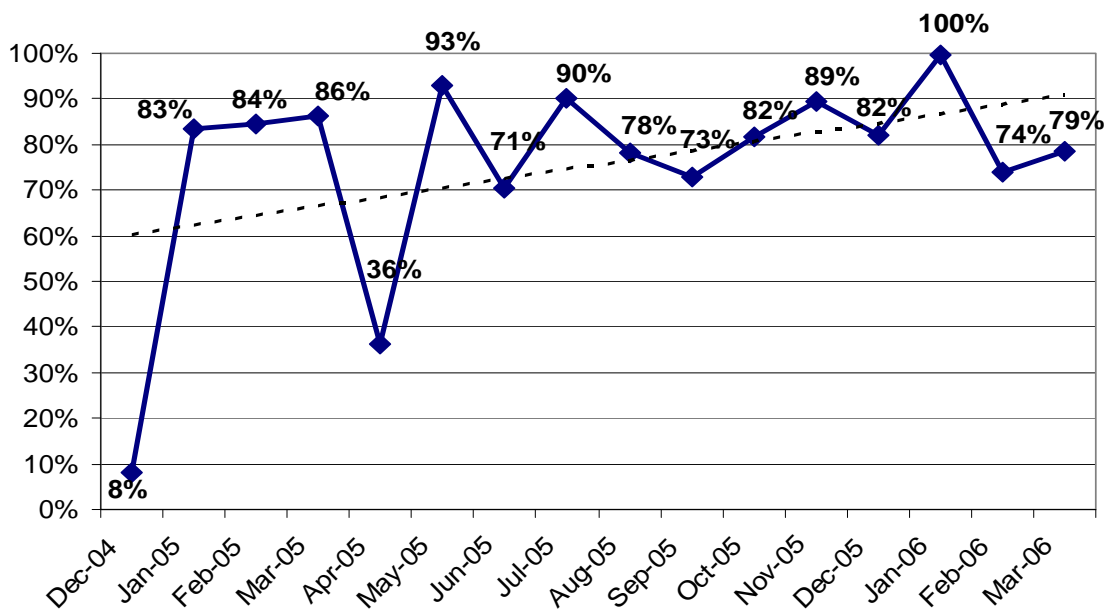
Figure 5 shows a steady increase in the number of individuals receiving ART in Krasnogvardeisky District from 2006 to 2007.

**Figure 5. Number of HIV patients (including IDUs) receiving ART in Krasnogvardeisky District, St. Petersburg, 2006–2007**



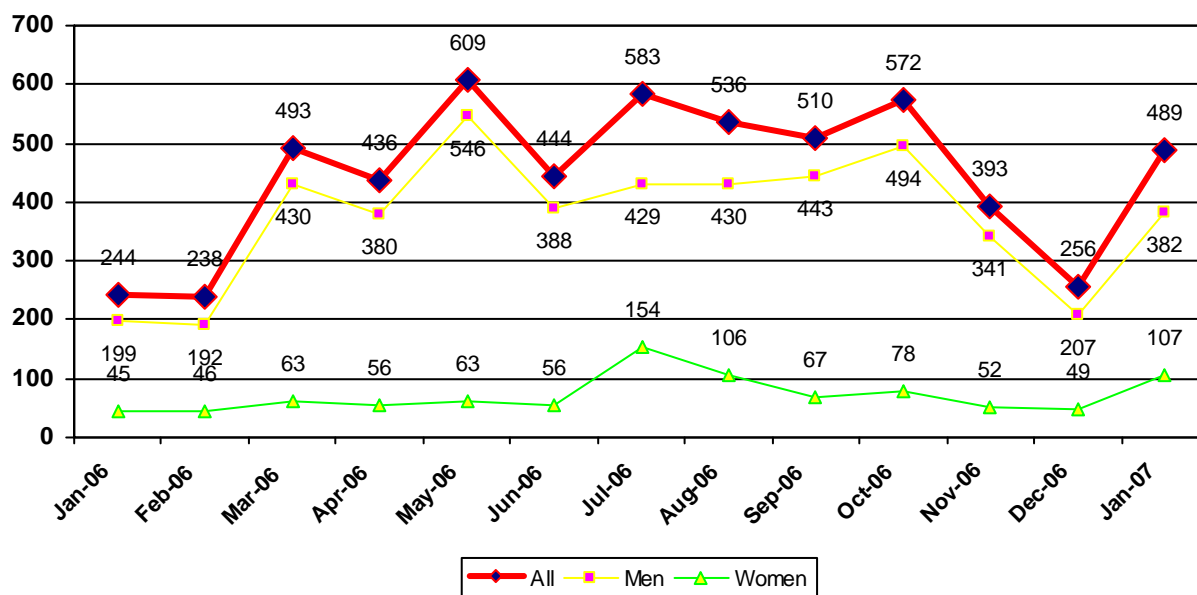
Turnaround time for HIV laboratory tests also improved significantly since the start of the project, as shown in Figure 6.

**Figure 6. HIV test results received within 48 hours, Engels, Saratov Oblast, December, 2004–March 2006**



The use of pre-test counseling was a significant change contributing to better patient management. Figure 7 shows the increase in the number of patients receiving pre-test counseling in Orenburg between January 2006 and January 2007.

**Figure 7. Number of patients receiving HIV pre-test counseling at the Oblast Narcological Dispensary, Orenburg, January 2006–January 2007**  
(absolute numbers by month)



Similarly, the number of patients receiving VCT services at St. Petersburg TB Dispensary #5 almost doubled in 2006 compared to 2005.

Teams made several improvement changes that contributed to these results. The following are examples of how the collaborative is transforming HIV/AIDS care and support:

- The Saratov Oblast MOHSD and the Territorial Obligatory Medical Insurance Fund have agreed on funding and venues for regular medical check-ups for HIV-positive clients, allowing them to choose between primary care facilities and the AIDS center.
- The Saratov Oblast AIDS Center and the Oblast Chief Infectious Disease Specialist developed criteria to identify risk groups eligible for HIV testing using rapid tests.
- The head of the Engels City Health Administration has adopted an algorithm that regulates data transfer, patient referral, and outpatient record abstracts proposed by interdisciplinary teams. The new system allows for improved information exchange between specialists and improves patient confidentiality.
- The access and retention and care coordination teams developed an informational stand at four primary care facilities in Krasnogvardeisky District.
- St. Petersburg's District Chief Infectious Disease Specialist and the AIDS Center Infectious Disease Specialist have begun developing a unified system for registering HIV-positive

patients. Data transfer is built on the epidemiological record with a mandatory indication of the patient's consent to share information with all specialists involved in care delivery.

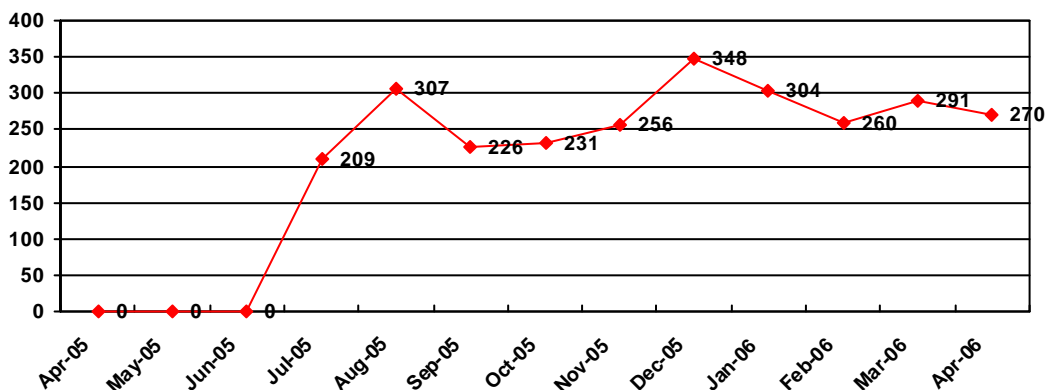
- The Krasnogvardeisky District access and retention team developed and is finalizing at this writing a leaflet with information on services available to those having a first HIV-positive test result.
- In Orenburg, the access and retention team developed a pre-test counseling survey to help assess people's knowledge of HIV and help them gauge their personal risk for HIV.
- The Togliatti patient management and adherence team has hypothesized that poor adherence may be caused by depression. To explore this idea, the team developed a flowchart of depression detection and correction and identified needed resources.
- Sites have reduced HIV test turnaround time. In less than a year, the turnaround time for HIV tests in Engels was reduced from eight–ten days to three–four. In Orenburg, this time lag at the Oblast Drug Rehabilitation Hospital also steadily declined: At least 50% of tests were returned within 48–96 hours as of the time of the evaluation.
- The role of primary care in the follow-up of HIV patients has also been further developed. In Engels, the collaborative team worked with AIDS Center staff to redesign the system to deploy a mobile team—an AIDS Center Infectious Disease Specialist and nurse—to receive patients at Polyclinics #1 and #2 monthly and provide consultations and collect blood samples for routine follow-up testing (e.g., CD4, viral load, and blood biochemistry). Blood samples for HIV follow-up testing are now drawn in all Engels polyclinics five days a week.

### ***Improvement of Services for HIV and TB Co-infection***

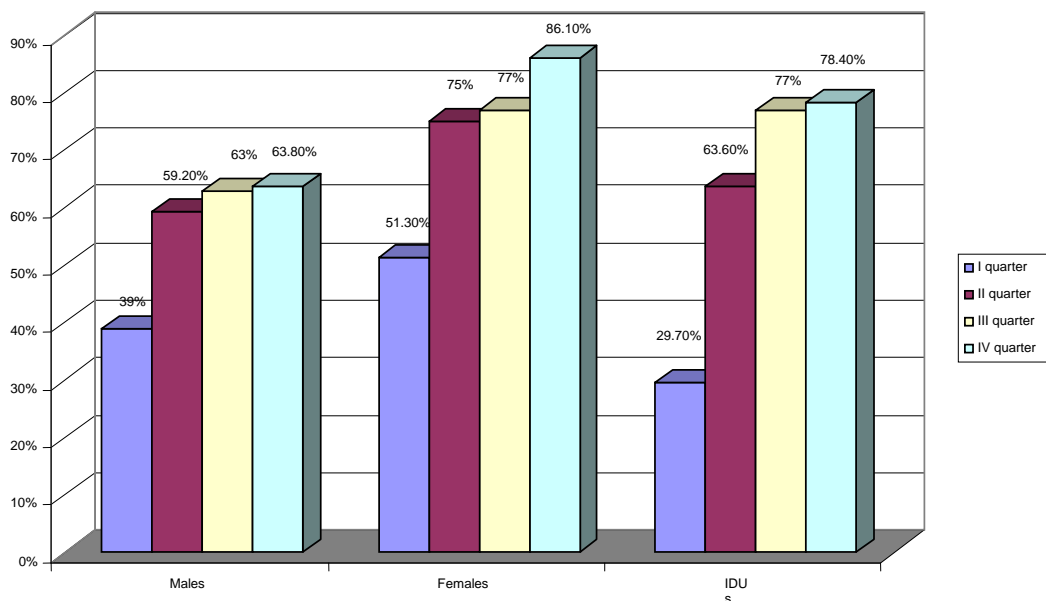
In view of Russia's growing TB-HIV co-infection problem and the opportunity to strengthen the functional integration of TB and HIV services as part of an improved model of HIV/AIDS care, QAP conducted a situational analysis of TB-HIV co-infection prevalence in Russia and in the collaborative regions. The assessment examined the federal and regional regulatory frameworks that affect the coordination of TB and HIV/AIDS services, existing TB and HIV/AIDS system practices in each region, and mechanisms of coordination between these services with regard to TB-HIV co-infection. The results were presented in a technical report (Boguslavsky 2005) and at the planning meeting of stakeholders held in St. Petersburg in early 2005. The report findings were also used to guide the improvement teams addressing TB-HIV co-infection in each.

Following the two QAP roundtables on TB-HIV co-infection in October 2005 and March 2006, collaborative teams made TB screening more accessible for HIV-positive clients, increased counseling on TB-HIV co-infection, developed and implemented algorithms for TB preventive treatment in HIV clients, and spread the improvements made in screening and preventive treatment of TB among HIV-positive individuals to additional facilities in St. Petersburg and Orenburg, Saratov, and Samara oblasts. The number of HIV-positive individuals who received counseling for TB-HIV co-infection or who were screened for TB increased significantly (Figures 8 and 9).

**Figure 8. Number of HIV-positive individuals who received counseling on TB-HIV co-infection, Togliatti, Samara Oblast, April 2005–April 2006**



**Figure 9. TB screening of HIV-positive patients in Engels, Saratov Oblast, 2005**



A number of system changes contributed to the improvement in the treatment and prevention of TB-HIV co-infection. In Togliatti, a TB specialist position was approved by the City Health Care Committee to provide services in the city AIDS center. TB-HIV services were also decentralized to improve access for patients. In Togliatti, the new model of TB-HIV care includes X-ray screening at the primary care level; on average, 200 HIV-positive patients are now screened for TB each month. In St. Petersburg, the TB-HIV team developed a scope of work for a TB specialist at the TB dispensary to work with HIV-positive clients and an algorithm of information exchange and

referrals; both were approved by an order of the Health Department of the Krasnogvardeisky District Administration in September 2005.

Similarly, the number of patients provided with VCT services and voluntary testing for HIV at TB Dispensary #5 in St. Petersburg almost doubled in 2006 compared to 2005. VCT coverage (percentage of TB patients registered at the TB clinic who received VCT once a year) increased from 13.9% in 2005 to 31.3% in 2006. The change was most notable after the TB specialist at the clinic was trained in VCT in August and September 2005.

### ***Other Improvement Changes***

In 2006, QAP supported a major technical intervention that involved a series of regional trainings to improve the quality of HIV counseling and testing. Following a training of trainers in VCT led by the Healthy Russia Foundation, collaborative teams in each region integrated schedules for VCT training into local health plans and budgets, including determining which specialists needed priority training. From May to September 2006 each region conducted four VCT trainings for local health providers. In total, 67 providers were trained in St. Petersburg, 57 in Engels, 34 in Togliatti, and 80 in Orenburg.

The case management model implemented in Engels, Saratov Oblast, was adapted to St. Petersburg and Orenburg, and case manager positions were created by local authorities and funded by municipal budgets. In Orenburg, this model was modified to create a social worker position at the AIDS Center beginning in January 2006. The new services have proven popular, with 370 patients signing up for the social worker's services by August 31. In St. Petersburg, two case managers started to receive patients in July 2006 at the Youth Drug Rehabilitation Center.

In summary, some of the most important accomplishments of the QI teams include:

- Reducing turnaround time for HIV test results;
- VCT training for key providers;
- Reorganization of referral systems and communication between facilities;
- Creation of case management positions;
- Creation of a TB specialist position at Orenburg AIDS Center;
- Increased role of primary care in HIV follow-up;
- Re-organization of TB and HIV screening processes;
- IPT (TB) started for HIV-positive clients; and
- Changes to directives, budgets, and job descriptions to support the work.

### ***Institutionalization of Improvements***

An important result of the work of teams in all four regions has been the creation of new official positions to support and spread the improvements generated through the collaborative and allocations from local budgets to support these positions.

- At the recommendation of the TB-HIV team, the head of the Orenburg Health Care Department approved an Order in November 2005 to create a position for a TB specialist in the AIDS Center and established a formal referral system among the AIDS Center, the

City TB Dispensary, and the Oblast TB Hospital. In December 2005, the TB specialist received only five patients, but by February was seeing over 100 patients per month.

- In Orenburg, the care coordination team prepared documents justifying a social worker position at the AIDS Center to improve coordination between medical and social services and NGOs. In November 2005, the Oblast MOH signed Order #725 on improving medical and social services for PLWHA. In January 2006, the AIDS Center filled the position for a social worker with its own budget. Information on this new service has been widely advertised within both the medical and PLWHA communities.
- In June 2006, the head of the Krasnogvardeisky District Administration approved an Action Plan to combat HIV infection in the district. The plan was developed by the joint efforts of district medical and social services and is funded by the municipal budget. The team working on improving access to care and patient retention has produced and installed 15 informational stands on HIV/AIDS; they have information on expanded access to ART in all pilot health care facilities of Krasnogvardeisky District. The stands, coupled with mass media campaigns and the announcement by the Globus Project on the arrival of ART in the city, led to a steady increase in the number of patients making appointments with the AIDS Center Infectious Disease Specialist. The average number of patients more than doubled from six–eight per day to 18 per day by December 2005. Evaluation of these individuals has resulted in significant increases in the number of patients on ART in Krasnogvardeisky. As of June 2006, 680 patients were receiving ART in St. Petersburg.
- The ART organizational model developed and tested by the Saratov/Engels teams has been replicated in five cities of Saratov Oblast at the initiative of the Oblast MOH. Subsequent to the regional order, similar municipal orders to organize ART for PLWHA in Engels, Balakovo, Balashov, and Saratov were developed and approved. The orders stipulate rules and criteria for ART administration and ARV drug provision, list facilities authorized to provide ART, and outline the algorithm of ARV drug provision by authorized facilities.

In addition, the success of innovative changes resulted in the development of normative documents (*prikazy*) that mandate the spread of the practice to other institutions and organizations throughout the region.

- Following testing at pilot facilities, the Orenburg Oblast MOH institutionalized new practices for pre- and post-test counseling, algorithms of care delivery to PLWHA, and information exchange through Order #76, which regulates HIV/AIDS care provided at the AIDS center, oblast drug rehabilitation hospital, oblast TB hospital, city TB dispensary, Pirogov Clinical Hospital, City Clinical Hospital #4, city perinatology center, and city infectious disease hospital.
- The two teams working on improving patient management and adherence and access and patient retention identified improvement of the existing practice of recruiting patients for ART as a joint priority and developed an ART readiness plan for identifying 1,000 HIV-positive patients in need of ART, wherein a crucial role in recruiting patients for ART is given to primary care providers. All primary care specialists authorized to provide ART have been trained and given the unified ART guidelines. This organizational model developed and tested by Saratov/Engels teams served as the basis for regional order # 613

issued by the Saratov Oblast Ministry of Health and Social Support (MOHSS) on organizing ART delivery to patients with HIV throughout the oblast.

- The TB-HIV practice organized and tested by the project TB-HIV team in Engels was evaluated and finalized by Saratov Oblast officials to serve as a basis for Order #128 on improving TB care delivery to HIV clients; it was issued by Saratov Oblast MOHSS in February 2006. This practice extends the TB-HIV care delivery model developed by the Saratov/Engels project team to all oblast municipalities and is a good example of an intentional scale-up initiated by oblast authorities.
- On May 15, 2007, the Orenburg Oblast MOH issued Order #666 on TB screening and IPT among HIV patients. Results and agreements reached at the QAP-hosted roundtables on TB-HIV and IPT served as the basis for this order. The order stipulates the procedure for information exchange between the AIDS Center, TB services, and district polyclinics; organization of TB screening among HIV clients; criteria for selecting patients for IPT; and reporting systems to monitor the work. The order has seven appendices, including the algorithm of TB screening among HIV patients; the screening program, including those responsible for TB screening organization and implementation venue, methods, and information exchange; IPT guidance; TB screening and IPT trackers; and a register for patients with TB-HIV co-infection. At the June 2007 learning sessions on ART and TB-HIV in Orenburg and Eastern Zone cities (Novotroitsk, Orsk, and Gai), participants discussed the order and identified areas for improvement at their settings to ensure compliance.

Thus, decrees were a means of spreading improved practices beyond the facilities participating in the collaborative. For example, the new algorithms developed by the TB-HIV co-infection in Engels were spread to all of the districts of Saratov Oblast as the result of an oblast MOH decree.

Another example of how the work of a QAP team spread beyond its original area of authority was the patient management system developed in Krasnogvardeisky District. The St. Petersburg health authorities expanded the coverage of what was initially a district decree to the entire city. This system became mandatory with the issuance of a decree—a feat made easier by the fact that one team member was a district head infectious disease specialist vested with the authority of the district health administrator. As a polyclinic infectious disease specialist said, “There was no need to persuade the health administrators, because they already could see the results.”

## **12. Spread and Scale-Up**

The original design of the TCS Collaborative had a design phase and a scale-up phase; in the later, the model would be spread to the remaining sites in each oblast and to other oblasts as feasible. In the case of St. Petersburg, the scale up covers the entire city (18 districts) and three districts of the surrounding Leningrad Oblast. In Orenburg, the improvements are being expanded throughout Orenburg city and to three cities in the Eastern Zone of Orenburg Oblast. The projected time frame is from 2007 through 2008. The focus is on increasing the number of patients on ART and expanding the role of the health care system in the provision of HIV/AIDS services, improving services for patients with TB-HIV co-infection and coordination of care. It is estimated that at least 15,000 of PLWHA will benefit from the scale up by the end of 2008.

Before launching the scale-up activities, QAP took care to gain political support and carefully organize the management structure of the scale-up activities. Both St. Petersburg and Orenburg organized around two spread collaboratives: one on “improving the system of detection, referrals, and follow-up for PLWHA for increasing access to ART” and the other on “improving coordination for the detection, prevention, and treatment of TB in HIV-positive patients.” It appears that providers in Orenburg place more emphasis on the care coordination topic due to the active involvement of the social service organizations in the collaborative. In St. Petersburg, it was less emphasized since there is a separate collaborative for the development of social support services for HIV-positive families.

Within each of the broad topic areas, the specific improvements to be scaled up were drawn from a list of improvement changes that had been tested and proven to be effective in the design phase within the local context. Table 6 summarizes the improvement changes that were *proposed* for scale-up in St. Petersburg and Orenburg.

**Table 6. Improvement changes proposed for scale-up**

St. Petersburg	Orenburg
<p><i>Screening for TB among HIV-positive clients in polyclinics</i></p> <ul style="list-style-type: none"> <li>Algorithm for screening process</li> <li>Reporting forms</li> <li>Information exchange system</li> </ul> <p><i>Detection of HIV among TB patients on post-treatment follow-up</i></p> <ul style="list-style-type: none"> <li>VCT training for TB specialists on HIV, VCT skills, and importance of testing</li> <li>Education on co-infection of TB-HIV and recommendations</li> </ul> <p><i>Informational exchange: development of a feedback mechanism</i></p> <ul style="list-style-type: none"> <li>Algorithm for the exchange of information between the district infectious disease specialist responsible for HIV testing and the AIDS center on: who was tested, who came to the AIDS center, and who did not. Feedback is sent to the testing facility to follow-up with those who did not go to AIDS center.</li> <li>Database of all detected HIV-positive patients in the district and when test results were confirmed</li> </ul> <p><i>ART scale-up plan for district plan for recruitment of patients for ART</i></p> <ul style="list-style-type: none"> <li>Algorithm for referrals (to whom, when, why), exchange of information between district</li> </ul>	<p><i>Social support for PLWHA</i></p> <ul style="list-style-type: none"> <li>System of patient referrals to other specialists and services</li> <li>Description of functions of social workers who serve PLWHA</li> <li>Experience in organizing care for patients through social services, medical services, psychological care, NGOs, etc.</li> <li>Examples of documents and reporting forms (agreements, prikazy, etc.) needed to implement the position</li> </ul> <p><i>ART scale-up plan</i></p> <ul style="list-style-type: none"> <li>Plan for recruiting patients for ART</li> <li>Program for building adherence, describing roles of social workers, infectious disease specialists, psychologists, and peer counselors</li> </ul> <p><i>Involving PLWHA in the system of care</i></p> <ul style="list-style-type: none"> <li>Reduction of turnaround time for test results</li> <li>Database of PLWHA at the polyclinic level</li> <li>Infectious disease specialists to keep track of newly detected and existing HIV patients to determine whether they have been appearing in the system for examinations</li> <li>Coordination between narcological services and city AIDS centers with an emphasis on motivating patients to visit the center if they are detected to</li> </ul>

St. Petersburg	Orenburg
<p>specialists and AIDS center</p> <p>Patient follow-up at AIDS center and at the level of district</p> <p><i>Case management</i></p> <p>Job description</p> <p>Algorithm (“how to work” job aid) and description of interaction with other specialists</p> <p>Examples of documents (agreements, prikazy, etc.) needed to implement the position</p> <p>Experienced case managers</p> <p><i>Voluntary counseling and testing</i></p> <p>Trainers</p> <p>Training course and material (Healthy Russia 2020)</p> <p>Experience in training plans: who to train, in what priority order, when</p> <p>Resources for preparing trainers and conducting trainings together with Healthy Russia 2020 and NGOs</p>	<p>be HIVpositive</p> <p><i>HIV screening among a) TB patients under active treatment and b) TB patients on post-treatment follow-up</i></p> <p>New system of screening for HIV among TB patients every six to 12 months</p> <p>System of referrals when HIV is detected</p> <p><i>Voluntary counseling and testing</i></p> <p>Trainers</p> <p>Training course and material (Healthy Russia 2020)</p> <p>Experience in training plans: who to train, in what priority order, when</p> <p>Integration of VCT in practice</p> <p>Resources for preparing trainers and conducting trainings together with Healthy Russia 2020 and NGOs</p>

As with the original sites, interdisciplinary and inter-facility teams were set up at the district level and include representatives from all government medical and social services and NGOs working on the given topic. Each team is responsible for adapting proven best practices from the original sites to their specific district systems of care for HIV-positives. Key stakeholders participating in the scale-up collaboratives include:

- The oblast or city AIDS center,
- The oblast or city infectious diseases hospital,
- The oblast or city TB hospitals,
- The Oblast or city narcological dispensaries,
- City dermatological dispensaries,
- Directors of district or municipal health departments,
- Leading specialists of the oblast MOH or city health care committee, and
- Medical academy for post-graduate education.

The number of facilities and teams participating in the scale-up reflects its magnitude (Table 7).

**Table 7. Scale-up of QAP activities in Russia, June 2007**

<b>Clinical Focus: (Type of Collaborative)</b>	<b>Scope of Initial Improvement Activities (Start Date)</b>	<b>Extent of Scale-up of Activities</b>	<b>Percentage of Facilities or Areas Covered</b>
HIV/AIDS treatment, care, and support (Demonstration)	4 of the country's 89 territories (November 2004)	19 facilities in 1 out of 18 districts in St. Petersburg; 17 facilities in Samara Oblast; 11 facilities in Orenburg Oblast, including Oblast AIDS Center; 23 facilities in Saratov Oblast, including Oblast AIDS Center	QAP-assisted facilities serve 1.8 million population.  During 2006–2007, QAP provided support to teams in Togliatti and Saratov mainly on TB-HIV aspects. The work was done through the use of non-PEPFAR infectious disease funds. In early 2007, QAP nominated TB-HIV teams from Saratov and Togliatti to the MSH TB-HIV Virtual Leadership Development Program.
ART (Spread)	All 18 districts of St. Petersburg City and 3 districts of Leningrad Oblast (March 2007)	123 health and social service facilities work on improving access to HIV/AIDS care and retention of patients. The number includes 6 clinical sites that provide ART.	40% of general health care facilities (polyclinics) and 100% of specialized clinics in St Petersburg city participate in the collaborative.
ART (Spread)	The capital and 3 other main cities in Orenburg Oblast (May 2007)	45 health and social service facilities work on improving access to HIV/AIDS care and retention of patients. The number includes 9 clinical sites that provide ART.	100% of general health care facilities (polyclinics) and 100% of specialized clinics in Orenburg, Orsk, Novotroitsk, and Gai participate in the collaborative.
Social services for HIV-positive women (Demonstration)	St. Petersburg city (March 2007)	Teams in 9 of St. Petersburg's 18 districts: 45 facilities are involved in the collaborative and include women's consultations, pediatric polyclinics, and centers for social service.	50% (9 of 18 city administrative districts)
Increasing access to ART for IDU (Demonstration)	St. Petersburg city (May 2007)	Teams in 3 of St. Petersburg's 18 districts are involved in the collaborative: 26 facilities, including polyclinics, ambulatory narcological clinics, STI clinics, TB dispensaries, and drug rehabilitation centers	17% (3 of 18 city administrative districts)

The management of such a large number of new sites and teams presented a major challenge. One of the key elements in the scale-up is that the process was to be administered or supervised by the City Health Care Committee in St. Petersburg and the Orenburg Oblast Health Administration and local city health administrators. In this way, the scale-up is seen as part of the local health administration's activities and not as a separate project. The successful implementation of the strategy relies heavily on buy-in and stakeholders' commitment to participate, including their inputs of personnel time, budget resources, and other contributions on behalf of all district health authorities.

QAP also sees improving VCT among health care providers as a key component of improving access and retention of patients in the system of care. Therefore, as part of the scale-up efforts, QAP decided to expand coverage of VCT training and contracted with a USAID-funded NGO to train VCT trainers in the project regions. QAP assisted the city health departments in selecting appropriate candidates to become the city VCT trainers. QAP also organized master classes for the local trainers to enhance their skills in training others.

### ***Rapid Successes in Scale-up***

Even in this short time since the start of the scale-up, several improvements in outcome are evident:

- The number of patients on ART increased four-fold in the six months ending in March 2007 in Tosnensky District, St. Petersburg, due to better detection of eligible patients and counseling at primary care facilities.
- The team in Tsentralny District, St. Petersburg, developed and tested a patient referral form that includes a report on a patient's regular check-ups, ART administration and referral to other medical services at TB dispensaries, STI clinics, women's consultations, and to social services.
- The percentage of people diagnosed with HIV who registered at the City AIDS Center rose from 55% in 2006 to 77% by June 2007. When data are disaggregated by district and compared with quality improvement team performance, better team performance demonstrated correlation with greater registration of HIV-detected patients.
- The number of patients on ART in Krasnogvardeisky District more than doubled between January 2006 and March 2007. The change resulted from systemic team efforts of infectious disease specialists from Krasnogvardeisky polyclinics and the City AIDS Center to develop and implement a plan for patient enrollment on ART and follow-up.
- Based on improvements made in the collaborative, the Orenburg Oblast MOH issued Order #666 in May 2007, stipulating the involvement of primary care facilities in care delivery to patients with HIV. The order has seven appendixes, including an algorithm of TB screening among HIV patients; a screening program, including those responsible for TB screening organization and implementation, venue, methods and information exchange; IPT guidance; TB screening and IPT trackers; and a register for patients with TB-HIV co-infection.

In summary, a number of factors are thought to be important for the success of the scale-up:

- The scale-up was part of the original concept for the collaboratives.
- A participatory process was used in planning the scale-up.
- The scale-up was to build on the achievements/successes of the original sites.
- The scale-up focused on a select number of topics of highest priority.
- Local ownership was promoted by integrating the new sites into existing administrative structures and making that explicit through memoranda of understanding.

### **13. Challenges and Future Directions**

Even as the initial treatment gaps have been addressed, the collaborative process has uncovered new problems. In the words of a Krasnogvardeisky health administrator, “We have identified loads of problems, and we have to keep the ball rolling to keep up. As HIV cases turn into AIDS cases, there will be many medical needs.” Among the new issues doctors and administrators cited are: the lower-than-expected demand for ARVs in St. Petersburg and Orenburg; the need to dispense ARVs to the larger number of individuals who should, and probably soon will, be coming for treatment; links between HIV and other STIs; stigmatization of children of PLWHA; cost of replicating collaboratives; and sustaining current and future improvements without external support.

The recently expanded availability of ARVs has made possible the treatment of a much larger number of PLWHA. Yet, until recently, demand for ARVs among this group was less than expected. QAP subcontracted with the Russian NGO Stellit to conduct a research study on barriers to ART access and causes for the low demand for ART among PLWHA in St. Petersburg and Orenburg. The study found low levels of knowledge and awareness of ART. In St. Petersburg, only 64% and in Orenburg, only 70% of PLWHA were aware of the existence of ART. On average, respondents only answered three out of 10 questions on ART correctly.

Many clinics lack the capacity or will to administer ARVs to the number of patients who could be treated. According to QAP staff, some directors of specialty clinics and AIDS centers still insist on rationing ARVs to “deserving” patients, which usually means excluding IDUs. In response to the desirability of making ARV treatment more convenient, both the St. Petersburg and Orenburg AIDS centers proposed equipping polyclinics to provide ARVs. St. Petersburg stakeholders are considering having the polyclinic infectious disease specialist hand out medications and help with monitoring the patient while the AIDS center continues prescribing. This follows a year when infectious disease specialists began to take a greater role in regular follow-up of HIV-positive patients not yet needing ART. In Orenburg, teams are discussing increasing the role of polyclinics in regular medical follow-up. Striking a balance between patient demand for responsive, convenient treatment, and clinic preparedness will, no doubt, preoccupy the collaborative team members in the scale-up sites.

One of the limiting factors for addressing these challenges is the high cost of spreading the solution strategies in a country with such a widely dispersed population. According to a USAID officer, the cost of replicating authentic QI collaboratives would be prohibitive. Yet, the evident benefits of medical and social service staff working cooperatively on a major medical-social problem like

HIV/AIDS does justify finding a way to graft the collaborative process onto a training mechanism to spread innovations.

Finally, there is still a question whether the improved clinical *practices* and the quality improvement *processes* applied by the collaboratives can be sustained. To address this issue, we need a much better understanding of the factors that would promote sustainability of improvements and processes to generate new improvements in Russia. Some of the questions that could be addressed in future work include:

- How can local ownership of collaboratives be enhanced?
- How can the collaborative structure be made complementary to or better integrated into existing organizational structures and systems?
- Who are the local and national leaders who can play a pivotal role in sustaining the collaborative approach, and how can they be encouraged to take a leadership role with collaboratives?
- What additional strategies (in addition to learning sessions and coaching) can be used to strengthen human capacity building for supporting QI and the collaboratives process?
- What variations in the collaborative model have proven effective in the Russian context, and what additional changes or innovations might be needed to promote sustainability?
- Given the challenges of size and scope in Russia, what strategies can be used to accelerate spread and scale-up of collaboratives there?

## IV. CONCLUSIONS

The collaborative methodology was particularly appropriate in addressing HIV/AIDS in Russia, where services are fragmented and systems are vertical. Using a collaborative to create a new model of integrated HIV/AIDS care provided an innovative approach for interdisciplinary collaboration between various sectors such as health, social services, and education. Traditionally in Russia (and other former Soviet republics), all these sectors were separated from each other due to separate budgeting and control by the national government. As a result, solutions for the complex issues of HIV/AIDS were often ineffective.

The collaborative work has enhanced system coordination through committees made up of local institutions and interdisciplinary teams of providers, outreach workers, and clients who are focused on specific problem areas. The TCS Collaborative built a shared vision, generated ownership for the successes and commitment for improvement, and thus facilitated the long-term sustainability of new practices. While the concept of interdisciplinary collaboration is not new in Russia, the collaborative methodology operationalized the concept in a structured and purpose-oriented way.

QAP and the HIV/AIDS Treatment, Care, and Support Collaborative contributed to the improvement of HIV/AIDS care in Russia in the following important ways:

- Garnered the support of regional and federal Ministries of Health in the fight against HIV/AIDS;

- Provided a framework and management structure to address the interdisciplinary nature of HIV/AIDS care and established regional coordinating committees that serve as a forum for collaboration and decision making;
- Engaged key stakeholders in a well-organized planning meeting in St. Petersburg in January 2005, setting the stage for the development of a common vision and agreement on the priority areas for improvement;
- Provided training and capacity building to interdisciplinary teams on both clinical practice and QI methods through a variety of means, including learning sessions, coaching, technical roundtables, and use of experts;
- Provided training on VCT (including training of trainers) to medical practitioners;
- Provided ongoing support to the concept and function of interdisciplinary teams, which are the true “change agents” in improving HIV/AIDS care;
- Promoted an evidence-based approach to establishing standards of care and provided the tools for monitoring both the outcomes and impact of improved standards of care; and
- Most importantly, provided the opportunity and means for sharing experiences, best practices, and lessons learned to accelerate learning and contribute to the spread of changes and new practices that have been tested and proven to be effective in the local context.

Each of these key elements not only contributed to better care and prevention of HIV/AIDS, but also enabled the individuals, teams, and institutions that participated to make concrete changes that improved the quality of care for communities affected by the HIV/AIDS epidemic.

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# APPENDICES

## Appendix 1: People Interviewed during the Evaluation Site Visit

### March 13, Moscow

Mrs. Elena Gurvich, Senior Advisor, Office of Health, USAID

### March 13–16, Orenburg

Dr. Sergei Mikhailov, Deputy Head Physician, City AIDS Center (HIV/TB team)

Dr. Yaroslava Mass, TB Specialist, City AIDS Center (HIV/TB team)

Mr. Sergei Churkin, Deputy Head Physician, Oblast TB Dispensary (HIV/TB team)

Dr. Galina Lazareva, Deputy Head Physician for Care organization and Methodological Support, City TB Dispensary (HIV/TB team)

Dr. Vladimir Gerasimov, Head Physician, City AIDS Center

Dr. Tatiana Patutina, Deputy Head Physician, City Drug Rehabilitation Clinic (access and retention team leader, VCT trainer)

Dr. Alla Shishkina, Head of the hot line service under Center for Social Support for Children and Families (access and retention team, VCT trainer)

Dr. Nikolay Komarov, Minister of Health, Orenburg Oblast

Dr. Vladislav Golikov, Deputy Minister of Health (former chair of coordinating committee under the Treatment, Care, and Support Project in 2005)

Dr. Andrei Ilchenko, QA Senior Advisor, URC

Dr. Olga Marinets, Psychotherapist, City AIDS Center, Head, New Life NGO (care coordination team)

### March 17–19, Moscow

Ms. Anna Korotkova, Deputy Director, Federal CPHRI (former director of QAP in Russia)

### March 19–22, St. Petersburg

Dr. Elena Vinogradova, Head Physician, City AIDS Center

Dr. Olga Shernobrovkina, QA Senior Advisor, URC

Dr. Anatoly Lavrov, Head Physician, Interdistrict TB Dispensary (HIV/TB team leader)

Ms. Natalya Zaitseva, Head nurse, Interdistrict TB Dispensary (HIV/TB team)

Dr. Natalya Lokshina, Krasnogvardeiski District Infectious Disease Specialist, Head for Therapy, City Polyclinic #107, VCT trainer (care coordination team leader)

Dr. Tatiana Trubetskaya, Head, Youth Consultation “Rzhevka” (access and retention team)

Mr. Sergei Dubovsky, Head, SANAM Clinic, VCT Main trainer (SANAM is providing VCT training of trainers for URC)

Dr. Olga Frolova, Director, Federal Center for TB Care Delivery to HIV Clients (Project clinical expert in HIV/TB)

Dr. Tatiana Popova, Head, Health Department, Krasnogvardeiski District Administration

Dr. Larisa Solovieva, Deputy Head, Health Department, Krasnogvardeiski District Administration (patient management and adherence team leader)

Dr. Alla Tarasova, Deputy Head Physician, City Polyclinic #107 (patient management and adherence)

Dr. Olga Butko, STI Specialist, District STI Clinic (patient management and adherence)

Dr. Svetlana Sincha, OB/GYN, Head, Youth Consultation “Okhta”

## Appendix 2: PEPFAR Indicators Summary

Summary of data collected according to indicators developed under the HIV/AIDS treatment, care and support activity and PEPFAR, FY 2005 and 2006

Category: Indicator	Site	FY 2005 (by Quarters)				FY 2006 (by Quarters)				Comments
		I	II	III	IV	I	II	III	IV	
Former SO 3.2: % of HIV-positive individuals accessing quality HIV/AIDS treatment, care, and support programs	St. Petersburg				44	42			51	This indicator was not measured in Saratov and Togliatti during FY06 (Mission indicator)
	Orenburg				56				92	
	Saratov				81	92				
	Togliatti				63					
Former IR 2.3: Number of HIV/AIDS and TB counselors trained in implementing quality HIV-TB co-infection services	St. Petersburg					4	6			(Mission indicator)
	Orenburg					4	5			
	Saratov					4	5			
	Togliatti					4	5			
	GFATM						6			GFATM-assisted regions
Former IR 2.3: Average number of visits for appropriate non-ARV clinical care per registered HIV patient	St. Petersburg									(Mission indicator)
	Orenburg						2.27	2.5	2.8	
	Saratov									
	Togliatti									
PEPFAR 6.1: Number of service outlets providing VCT according to national and international standards	St. Petersburg			12	12	19	19	19	19	
	Orenburg			11	11	15	15	15	15	
	Saratov			14	14	19	19	19	19	
	Togliatti			12	12	20	20	20	20	
PEPFAR 6.2: Number of individuals who received VCT for HIV and received their test results	St. Petersburg			610			2897		6791	The columns in FY06 represent cumulative numbers for 6 and 12 months, respectively (number of HIV tests done).
	Orenburg			36967			1118		1339	
	Saratov			3920	2081		9226		21708	
	Togliatti			1190	8802		73056		114164	
Project: Number of patients receiving pre-test counseling and testing for HIV	St. Petersburg		709	974	635	710	948	956	986	
	Orenburg		1269	1452			975	1489	4468	
	Saratov		5474	3920	2081	2154	2969	2080	1925	
	Togliatti			1675	2183	1977	1844	1286		

Category: Indicator	Site	FY 2005 (by Quarters)				FY 2006 (by Quarters)				Comments
		I	II	III	IV	I	II	III	IV	
Project: Number of patients receiving post-test counseling and results	St. Petersburg			974	635	710	948	956	986	The numbers of St. Petersburg and Saratov are available but need to be checked for correctness.
	Orenburg								3152	
	Saratov			3920	2081	2154	2969	2080	1925	
	Togliatti			1612	2122	1230		1269		
Project: Percent of HIV test results returned within 48 hours after sample collection	St. Petersburg									Adjusted indicators based on what was realistic (i.e., 48 or 96 hours).
	Orenburg						12	10	25	
	Saratov		86	71	73	82	79			
	Togliatti									
PEPFAR 6.3: Number of individuals trained in VCT according to national and international standards	St. Petersburg				3	0	17	24	28	The numbers represent trainers and trainings supported by funds from QAP.
	Orenburg				1	16	0	16	46	
	Saratov					15	0	14	43	
	Togliatti					15	0	38	0	
PEPFAR 7.1: Number of service outlets providing ART (includes PMTCT sites)	St. Petersburg				3				4	
	Orenburg				4				4	
	Saratov				3				5	
	Togliatti				3				3	
Project: Percent of HIV patients receiving ART who are treated in compliance with treatment guidelines										Although developed, this indicator was not measured by QAP in 2005 due to the lack of ART; also, compliance with treatment was not a project goal.
PEPFAR 7.4: Number of individuals receiving ART at the end of the reporting period, disaggregated by sex and age and pregnancy status	St. Petersburg					45	57	75	79	The St. Petersburg figures are represented by the numbers for Krasnogvardeisky District. The total number of patients on ART in the entire city during the 2 <sup>nd</sup> quarter of 2006 was 502.
	Orenburg					59	116	162	222	
	Saratov									
	Togliatti									
PEPFAR 7.5: Total number of health workers trained to deliver ART services according to national and/or international standards	St. Petersburg					4	6	0	0	
	Orenburg					4	5	0	0	
	Saratov					4	5	0	0	
	Togliatti					4	5	0	0	
	GFATM					16	27	0	0	

Category: Indicator	Site	FY 2005 (by Quarters)				FY 2006 (by Quarters)				Comments
		I	II	III	IV	I	II	III	IV	
Project: Percent of HIV patients on ART who are monitored for adherence at every visit	St. Petersburg					17	48	65	67	Data are available for St. Petersburg only.
PEPFAR 7.2: Number of individuals newly initiating ART during the reporting period	St. Petersburg						18	18	7	Although this indicator is not on our reporting list, the St. Petersburg team initiated this indicator and monitored it in 2006.
PEPFAR 8.1: Total number of service outlets providing HIV-related palliative care (including TB-HIV)	St. Petersburg				14		22		22	
	Orenburg				11		15		15	
	Saratov				19		20		20	
	Togliatti				12		20		20	
PEPFAR 8.1A: Number of service outlets providing clinical prophylaxis and/or treatment for TB to HIV-infected individuals (diagnosed or presumed) in a palliative care setting	St. Petersburg				2		4		4	
	Orenburg				2		3		3	
	Saratov				1		4		4	
	Togliatti				1		3		3	
PEPFAR 8.2: Total number of individuals provided with HIV-related palliative care (including TB-HIV)	St. Petersburg		311	341			418		736	
	Orenburg		510	459			3649		2610	
	Saratov		351	415			103		326	
	Togliatti		3157	3445			4076		6165	
PEPFAR 8.2A: Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease (a subset of all served with palliative care)	St. Petersburg		42	37			40		76	
	Orenburg		4	4	9		194		58	
	Saratov		44	43	45		23		29	
	Togliatti		224	193	189		135		252	
PEPFAR 8.2B: Number of HIV-infected clients given TB preventive therapy (a subset of all serviced with palliative care)	St. Petersburg		17	19	14		9		18	
	Orenburg						0		6	
	Saratov		9	3	5		25		31	
	Togliatti						0		3	
PEPFAR 8.3: Number of individuals trained to provide HIV palliative care (including TB-HIV)	St. Petersburg								7	
	Orenburg								8	
	Saratov								7	
	Togliatti								9	

Category: Indicator	Site	FY 2005 (by Quarters)				FY 2006 (by Quarters)				Comments
		I	II	III	IV	I	II	III	IV	
	GFATM								6	GFATM-assisted regions
Project: Percent of patients registered at TB dispensaries who were tested for HIV	St. Petersburg		69	44	52	86	139	129	112	Figures represent absolute numbers.
	Orenburg								1476	
	Saratov		168	168	162	330	198	217	174	
	Togliatti						149	134		
Project: Percent of registered HIV patients tested for TB	St. Petersburg		24	9	36	24	30	17	49	Figures represent absolute numbers of HIV-positive clients tested for TB
	Orenburg								190	
	Saratov		147	81	23	22	146		104	
	Togliatti			123	613	616	554	603	532	
Project: Percent of TB patients with HIV who received counseling on HIV/TB co-infection	St. Petersburg									Data on St. Petersburg, Orenburg, and Togliatti are available but require verification.
	Orenburg									
	Saratov		26.5	15.6	57.1	65		66.7	57.1	
	Togliatti									
Project: Number of TB-HIV patients with complete records per Ministry of Health and Social Development requirements (according to the recording form N263)	St. Petersburg				330				522	Data are presented at the end of each year.
	Orenburg				313				499	
	Saratov				281				326	
	Togliatti				443				717	
Project: Percent of HIV patients who receive referrals to social other clinical care services	St. Petersburg									Figures represent absolute numbers of clients served. Data for Orenburg are available for July–Sept. During October 2006, 19 clients were served by social workers at the Orenburg AIDS Center. By the end of the second quarter of FY2007, the number of clients served by social workers reached 175.
	Orenburg								85	
	Saratov				49	57	43	53	46	
	Togliatti									
Project: Number of HIV patients managed by case managers	St. Petersburg								7	The case manager positions were opened in Engels in 2005 and in St. Petersburg in 2006.
	Orenburg									
	Saratov				18	20	14	20	17	
	Togliatti									

Category: Indicator	Site	FY 2005 (by Quarters)				FY 2006 (by Quarters)				Comments
		I	II	III	IV	I	II	III	IV	
PEPFAR 11.1: Number of local organizations provided with technical assistance for strategic information activities	St. Petersburg				18		27		27	
	Orenburg				17		18		18	
	Saratov				23		23		23	
	Togliatti				17		18		18	
PEPFAR 11.2: Number of individuals trained in strategic information (includes monitoring and evaluation, surveillance, and/or health management information system)	St. Petersburg				66		0		0	
	Orenburg				64		0		0	
	Saratov				48		0		0	
	Togliatti				38		0		0	
PEPFAR 12.1: Number of local organizations provided with technical assistance for HIV-related policy development	St. Petersburg				11		11		11	
	Orenburg				9		7		12	
	Saratov				29		29		29	
	Togliatti				10		9		11	



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