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An Assessment

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Table of Contents

Acknowledgment	i
Dictionary of Acronyms	ii
Assessment Methodology	iii
<i>EXECUTIVE SUMMARY</i>	vii
<i>Section I. Background</i>	1
<i>Section II. Program Description</i>	3
<i>Section III. Program Performance</i>	5
A. Establishing Partnerships	5
B. Program Substance	7
1. Clinical Training and Medical Education of Physicians	7
2. Nursing in the NIS	8
3. Hospital Management and Administration	9
4. Task Forces	10
5. Information Dissemination	14
C. Program Management	17
1. AIHA	17
2. USAID	18
<i>Section IV. Program Issues</i>	21
A. Activity Selection Criteria	21
1. Data Gathering/Program Planning/Information Systems Management/Evaluation	22
2. Financial Management and Planning/Cost-Accounting and Cost-Control/Budgeting	22
3. Development of Clinical Nursing Skills and Nursing Management Expertise	23
4. General Management and Administrative Skills, Particularly for Physician Managers	24
B. Measures of Success	25
1. Changes in Hospital Use	25
2. Improved Clinical Outcomes	25
3. Management/Administration Interventions	26
4. Educational Component	27
5. Impact on the National Health Policy	28
6. Impact on Perceptions of Partner Countries	28

b

7.	Benefits to U.S. Partners	29
C.	Graduation Criteria/Options for USAID Phase-out	31
1.	Options for Phase Out of USAID Assistance	31
V.	Strategy and Recommendations	37
A.	Some Assumptions, Findings and Conclusions	37
B.	Strategy Recommendations	39
1.	USAID Policy for the NIS	39
2.	AIHA Policy for Its Twenty-One Partnerships	40
3.	Ministry of Health and USAID Policy for Specific Countries	42
4.	Individual Partnerships Between U.S. and NIS Institutions	42
5.	Individual Projects of U.S./NIS Partnerships	43

ANNEXES

1. Extended Observations on Nursing in the NIS
2. List of Persons Interviewed
3. Bibliography
4. AIHA's Reply
5. Site Visit Memoranda*

*These memoranda concerning most of the site visits to partnership and other participant institutions are not included in this report but are available separately for distribution because of their possible utility to program participants. There are 21 active partnerships under the AIHA/USAID cooperative agreement. At least one partner for all but four was visited by one or more assessment team members, and for four partnerships both the U.S. and NIS partners were visited.

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Acknowledgment

We take this opportunity to thank all the people who helped us with the work of this assessment. Among those we particularly want to thank are the staff of the American International Health Alliance, Inc. (AIHA), both in the field and Washington, for their exceptional competence, forbearance and amiability in managing the challenging logistics of arranging transportation, accommodation and appointments for the four of us. Also our special thanks go to the staffs of the various participating partners, both in the United States and the NIS, who took the time out of their busy schedules, in often difficult circumstances, to extend us every courtesy along with the benefits of their experience.

Indeed we can claim no originality for any useful suggestion that may be found in this report. Invariably they reflect the thinking of program participants who had taken the time to reflect on the program and how it might be improved. For errors and misjudgments in the assessment, on the other hand, we take full responsibility.

Dictionary of Acronyms

AIHA	American International Health Alliance, Inc.
ARI	Acute respiratory infections
AUPHA	Association of University Programs in Health Administration
e-mail	Electronic mail
EMS	Emergency medical services
IMR	Infant mortality rate
KUH	Kansas University Hospital
MCV	Medical College of Virginia
MOH	Ministry of Health
NIS	Newly independent states (of the former USSR)
RFP	Request for proposals (as part of formal contracting process)
SABIT	Special American Business Internship Training Program
U.S.	United States
USAID	United States Agency for International Development
USSR	Union of Soviet Socialist Republics

Methodology

The purpose of the assessment was to review the performance of, and suggest future directions for, the program of partnerships between hospitals in the United States and hospitals in the NIS, administered by the American International Hospital Alliance and partially funded by a USAID grant to that organization. The assessment was carried out over a period of five weeks in June and early July of 1994. Either individually or together the team members visited AIHA headquarters in Washington, AIHA field offices in Moscow, Almaty and Kiev, and a majority of partnership institutions at their various locations in the United States and the NIS. The investigation included document examination, but was conducted primarily through interviews at the various institutional sites, with site visits usually not exceeding half a day. USAID and AIHA were provided opportunities to review and comment on preliminary drafts and the product has benefited substantially from their constructive comments. Also the final version has been revised from earlier drafts to respond to some changes in the field and more current information.

The four member assessment team consisted of a professional nurse with a Master's Degree in Public Administration and substantial international development experience, a doctor of public health with extensive experience in international development, a professor of health services at a leading university with a long career in health care management and policy following initial training and practice as a physician, and a lawyer/international development generalist experienced in project and program design, implementation and evaluation.

Executive Summary

In June 1992 the American International Health Alliance (AIHA), which represents numerous major U.S. hospital and health care organizations, entered into a cooperative agreement with the United States Agency for International Development (USAID) to help establish partnerships between U.S. and NIS¹ health care organizations. The purpose of the partnerships is to improve health care in the NIS by transferring U.S. medical knowledge and technology.

The situations in the NIS health sectors presented difficult challenges. Because of the long cold war estrangement between the United States and the USSR, there were many unknowns and few linkages upon which to build. The flaws of the former Soviet health care system were aggravated by demoralizing budget cuts of two thirds or more. Lack of funds for conferences and journals as well as for new equipment effectively denied access to technological advances. Lack of supplies and disposables impaired even the current level of practice and aggravated risks of infection during treatment. The one resource in abundance in some areas was trained physicians, but even this surplus tended to work to the further detriment of a poorly used nursing profession.

The Assessment Team found the Partnership Program to be well conceived for its time and place, and exceptionally aggressively implemented to achieve significant results rapidly. In less than two years 21 partnerships have been established. U.S. participants now include 47 hospitals and health systems and 18 medical schools in 18 cities and 15 states, and NIS participants include 42 hospitals and health systems and 12 medical universities in 17 cities and 10 countries.

Already, the partnerships with AIHA support have been able to achieve significant transfer of clinical skills among physicians, provide useful models for continuing education and hospital administration, and expand impact by dissemination through seminars, conferences, publications and electronic communication. While transferring needed knowledge and skills, the program has been highly successful in mobilizing private resources for the high foreign policy priority assistance to the NIS. The partnerships have built grass roots support for U.S. economic assistance programs and in the process have enhanced international understanding and goodwill by people-to-people contacts. The program has demonstrated potential for substantial development impact with some further modifications.

The Partnerships Program as designed two years ago was an appropriate way to start. There was need at the time for both AIHA and the U.S. partners (and USAID) to acquire knowledge of the situation in the NIS and to build working relationships there, thereby constructing a base for a more developmental program. In general, however, the program thus

¹Newly Independent States of the former Soviet Union.

far responds to the particular skills and interests of individuals and institutions at the local level in both the U.S. and NIS. Therefore its impact beyond the local level has been limited.

Now that a strong foundation has been laid there is opportunity, already being realized in some cases, for the program to achieve more developmental impact by extending beyond local communities to respond to regional and national priorities. Partnerships have the opportunity to gain support for their long-term sustainability through increased linkage with host country priorities and development assistance from USAID and other donors. At the same time the partnerships provide strong institutional implementation capability to facilitate development assistance.

The experience already acquired is helping AIHA, the U.S. institutions, and their NIS partners further to determine areas of greatest need where investment will yield the highest dividends. Priority must continue to be given to activities which will help the NIS institutions to do significantly more with the limited resources available during the period of severe financial stress consequent to transition from a planned to a market economy. Most partnerships are already sharpening their focus on such areas as institutional management, infection control, emergency medical services, and reproductive health. NIS and U.S. partners willing to work in such areas of highest impact and returns should receive continuing support for their work in those areas.

Another important requirement for institutions to receive continued USAID funding should be their willingness and capability for effective dissemination in the NIS of the knowledge and expertise gained through the collaboration between NIS and U.S. partners. For this it would be helpful that the NIS partners be recognized lead institutions within their respective regions or countries. But some smaller, lesser known NIS partners, such as the Dubna group, may be capable of comparable impact through their exceptional innovation and dynamism. Also important is ability and willingness of the U.S. partner to mobilize institutional and community resources in support of their partnership's program.

Partnerships unable or unwilling to meet these criteria should be phased out from USAID/AIHA funding, but would of course be free to continue with their own or other resources.

In making other suggestions and recommendations, we are mindful of the nature of the partnership program as a "volunteer-driven" activity. The volunteers in the partnerships are under no obligation to the U.S. or NIS governments. For certain types of activities their personal interests are strong enough to motivate their gift of time, energy and skill without any compensation. Their interests and capabilities may not conform to USAID's priorities and preferences, and those having the interests and capabilities most favored by USAID's priorities may not be motivated to work as volunteers. It may be that if USAID wanted professional

services more tightly focused on USAID priorities than USAID would have to pay full price for these services.

On the other hand, the purpose of our recommendations is to help the partners achieve maximum impact from their efforts. Apart from their personal interests, the U.S. volunteers are probably also concerned that the benefits of their labors be maximized. To the extent their efforts can be influenced toward increased impact without diminishing the strength of their motivation, so much the better for all concerned.

Further, there is enough competition among potential partners that the program need not be overly indulgent of partnerships which disregard USAID and NIS national priorities. Therefore we suggest that AIHA and the partners try to sharpen the focus of activities, while being careful not to choke volunteer motivation in the process. Factored into such process should be due recognition of the value of the program participants' efforts in terms of people-to-people understanding and good will, the supplemental resources mobilized, and the worth of the work itself, even though some may not be directed to the highest of USAID or NIS priorities.

In this context we suggest that AIHA, USAID, and the partners consider the following actions to enhance the development impact of the program:

- ▶ AIHA to continue, even strengthen its support for NIS efforts to improve efficiency through training in administration and management.
- ▶ AIHA through guidance to partners and through own conferences, seminars, etc. to encourage increased participation of nurses, administrators and other non-physician professionals and paraprofessionals of the U.S. and NIS health care systems.
- ▶ In order to eliminate inefficiencies resulting from misuse of personnel and at the same time improve patient care, AIHA and the partnerships to encourage and assist NIS partners' analysis of the division of labor and potential for better teamwork between physicians and nurses, in addressing unsatisfied needs in care of patients, and conforming level of professional preparation to the tasks to be performed. As a part of such effort, AIHA and the partnerships to continue exposing NIS physicians and nurses to the teamwork of physicians, nurses, paraprofessionals and other support staff as practiced in the United States.
- ▶ AIHA and the partners to reconsider the degree of emphasis on neonatal resuscitation within the program.
- ▶ AIHA and the partners to consider lengthening the stays of NIS visitors in the United States.

- ▶ **AIHA and the partners to continue their efforts to develop contacts with NIS Ministries of Health to gain a better sense of regional and national needs and priorities, in order that partnership activities may be more responsive to them. The Ministries may also be able to provide support for dissemination of the knowledge and expertise gained through the partnerships. The partnerships should, however, be wary of relationships that might subject their own activities to bureaucratic approvals or vetoes of Ministry officials.**
- ▶ **AIHA to continue, even expand, its support for the development of dissemination systems within the NIS countries through such means as conferences, E-mail, professional associations, perhaps even some support for medical journals during this current period of severe financial strain.**
- ▶ **For conferences and publications, AIHA to encourage increased NIS professional participation in program planning and presentations, even at the risk of slowing the process through the increased coordination requirement.**
- ▶ **AIHA, as funding permits, to fill in the geographic holes in the program. This applies both in the United States, where now there are not many partners in the western part of the country, and especially in Russia, for the vast region from the Ural mountains to the Pacific coast.**
- ▶ **AIHA to discontinue funding for American partner resident coordinators in the NIS. To qualify for consideration for a partnership, an NIS institution should have the capacity to implement programs without such continuous U.S. involvement, which can place the U.S. "partner" in a paternalistic role, undermining the partnership concept.**
- ▶ **AIHA to consider strengthening the medical technical competence of the AIHA home office in Washington. The purposes thereof would be to influence development strategy for the program, and to facilitate (1) access of new partnerships to experience of predecessors and (2) sharing of experience and expertise among existing partnerships. Ideally, such a technical person would combine both medical and international development experience and expertise, which in this case we would consider more important than Russian language competence.**
- ▶ **USAID and AIHA to consider the advisability, on a limited scale, of financing equipment essential to use technology, available through partnerships, which offered particularly high return on investment in medical efficiency, for example equipment for ultrasound examination, endoscopy or laparoscopy that would**

substantially reduce number or scope of intrusive procedures with corresponding reduction of risk of infection and length of hospital stays.

While this assessment includes recommendations for how AIHA and the partners might focus their activities more in subsequent years, such recommendations in large part apply more appropriately to a second than a first phase and often endorse initiatives already undertaken by AIHA and various partners. Therefore, the recommendations should not necessarily be considered to reflect negatively on the performance of AIHA during the initial stage of the program.

In closing, we emphasize that the partnership program is of a type particularly appropriate for the NIS countries. Because of the level of knowledge and skill already attained by NIS professionals and their consequent pride, they are able to work much more comfortably and effectively in an atmosphere in which they and the U.S. institutions involved are viewed as partners rather than supplicants and patrons respectively.

I. Background

Following the breakup of the Soviet Union, all the NIS countries have suffered severe economic problems which have deeply impinged upon an already flawed health care system. Theoretically the Soviet system provided universal coverage, but it was of highly variable quality. There were closed hospitals for the communist party elite that selected the best graduates from the medical schools and spared no expense on equipment and facilities for the best possible care. At the other extreme were dilapidated, under-equipped facilities in rural areas without even a doctor in attendance. The methods of treatment and the medical technology applied in the hinterlands was determined by a doctrine passed on from Moscow, and the equipment and supplies were allocated by Moscow.

In general, the NIS systems follow the Soviet model of receiving patients in a polyclinic where they are either treated and returned to their homes or, as necessary and appropriate, referred to more specialized hospitals. Specialized facilities include separate hospitals for heart, cancer, maternity, pediatrics (with the latter two usually separated and often by some distance). The patient is seen at the outset by a physician without any screening or treatment by nurses or other paramedical personnel. The nurse's role is generally limited to that of a doctor's assistant, with physicians performing many of the functions of professional nurses in Western health care models.

Nurses in the NIS have a minimum of a high school education and two years of training in a medical college. The vast majority of the nursing professors and administrators in these colleges are physicians. There seems to be an overall theoretical framework in nursing curricula; however, there apparently is little emphasis on clinical practicum in either nursing or medical education. NIS nurses relayed their frustration to the assessment team at their inability to put into practice the level of theory they had studied in school. As for continuing education, nurses are required to take a refresher course every five years if they expect to be promoted to a higher salary level.

In actual practice, nurses are given little option to exercise independence at any level. They appear to be functioning as nurses' aides, at best. They are given such tasks as cutting large sheets of gauze into four-inch squares to be prepared for sterilization, scrubbing the floors, washing windows, bathing patients, and cleaning soiled linen. The role of the professional nurse is carried out by physicians because in most of the NIS there is an overabundance of medical school graduates each year. Further, the NIS partners in general show lack of appreciation for the nurse role as a professional caregiver, distinct from the diagnosis and treatment roles of the physician. The investment in two years of higher education for nurses is largely wasted unless significant changes are made in their practice.

Although each hospital has a director of nursing and nurse managers for each department, they are not permitted to supervise themselves independently. Each nurse manager is supervised by her respective physician manager. Nurses are not included in the decision making or planning processes.

All hospitals and clinics are managed by doctors; there was and still is no place in the system for professional managers without medical degrees. There was not even management training for those medical personnel with managerial responsibilities. Hospital stays were and still are typically long, which especially in recent years has tended to increase exposure to higher rates of hospital-acquired infection. The physically and mentally handicapped, the mentally ill, and substance abusers, have been stigmatized and institutionalized with little outpatient treatment and assistance to lead normal lives. Indeed, with respect to substance abuse, there has been little, if any, recognition of alcoholism as an illness.

With the downfall of communism, the difficult transition to a free market economy substantially reduced public resources available for support of the Soviet public health and hospital systems. Now, with independence, the problems are compounded by disruption of normal supply channels, and, for the non-Russian NIS, by a virtual complete cutoff of any technology dissemination from Moscow. These factors have severely diminished the supply of medicines and disposables and substantially reduced the real earnings of doctors, nurses and staff, which in turn has materially impaired the ability of the health sector to attract and keep good people. Equipment is failing for lack of parts; diagnostic facilities and equipment are inoperable for the lack of necessary reagents; access to modern medical research and technology through Moscow has been cut off; and there is no money to gain access through periodicals and conferences to the results of pure and applied research, new developments in practice, etc. from the rest of the world. The working conditions are such as to demoralize even the most dedicated doctors and nurses in the system, which in turn further aggravates the general decline in quality of medical care.

II. Program Description

On June 1, 1992 USAID executed with AIHA a cooperative agreement whose purpose was "to provide support for the recipient's program of health care improvement in the former Soviet Union." AIHA in turn described the purpose of its program as "to improve health care in the New Independent States of the former Soviet Union by transferring modern U.S. medical knowledge and technology by means of establishing partnerships between U.S. hospitals, health institutions and comparable institutions in the NIS."

The AIHA program description went on to describe the activities contemplated in the project:

"(1) physician and nurse exchanges to improve clinical services and diagnostic and therapeutic programs; (2) training and continuing education programs to extend and expand the scope and effectiveness of nursing and physician practices; (3) training in the management and administration of health care facilities; (4) the provision of [basic] diagnostic equipment; (5) development of . . . standards for hygienic and infection control; (6) introduction of quality control for medical treatment and practices."

The cooperative agreement provided that the program would be managed by AIHA as:

"a consortium of major U.S. hospital related organizations, which includes, among others, the National Association of Public Hospitals, the American Hospitals Association, Voluntary Hospitals of America, Inc., the National Public Health and Hospital Institute and Association of Academic Health Centers."

This consortium was created to work with USAID to provide an institutional framework for the successful development of, and support for, partnerships between U.S. and NIS health care institutions.

In its initial program description AIHA undertook the following responsibilities and functions:

- "a. Conduct site visits to potential NIS partnerships sites with the purpose of confirming interest: identifying specific needs and key contacts: developing the program description, implementation schedule, evaluation criteria, and budget.
- b. Inform member hospitals of the nature of the project and request expression of interests in participating.
- c. Survey the membership of the participating associations to verify which hospitals have ongoing activities in the NIS.
- d. Establish primary partnerships between a U.S. hospital and its NIS counterpart by matching the interest and technical capability of the U.S. potential partner with the needs of the NIS partner. Primary partnerships may be strengthened by other resources and programs at the disposal of the consortium.
- e. Establish communications with other donors, AID contractors and donors working in the NIS on health related activities in order to gather information on health conditions, key contacts, nature of constants, and likely solutions that will improve the success of this program."

III. Program Performance

A. ESTABLISHING PARTNERSHIPS

A primary objective of the initial phase of the program, and the essential precursor for any substantial technology transfer, was establishment of partnerships between the U.S. and NIS health care institutions. Through aggressive and cost-conscious program implementation, AIHA was able to establish fifteen partnerships from funds and time allotted for nine, and to add seven more from a second grant increment for five. While some of the partnerships were based on existing relationships, including some sister cities, most were started from scratch and required substantial support from AIHA.

Beyond quantity, the partnerships formed by AIHA have generally shown a high level of commitment and quality of performance. Indicative of commitment are the total of U.S. partner contributions estimated at \$14.3 million of volunteer time, \$4.3 million of donated equipment, supplies and services, and \$5.3 million in foregone indirect costs. The average partnership donations of well over \$1 million compare to an average of about a quarter million dollars of USAID grant funding for each partnership, principally for reimbursement of travel costs. The ratio of partnership contribution to the USAID grant is thus about 4:1, and even including the USAID grant funds for AIHA program management costs, the overall program resource mobilization ratio is about 2:1, that is, for every USAID dollar there are two dollars in private source funds.

During the initial phase, by necessity, the location of partnerships has been largely determined by factors of comparative feasibility, influenced by some degree of political pressure. This has produced a relative concentration of partnerships in the eastern United States and the European nations and regions of the NIS, leaving some notable voids in the western United States and the Asian regions and nations of the NIS. In fairness to AIHA, we understand that the situation is more a product of USAID approvals than AIHA nominations. We suggest that there

NIS Medical Partnerships Program: An Assessment

is political advantage both to the U.S. and NIS and enhanced developmental impact in the NIS to be gained from broader distribution of partnerships.

B. PROGRAM SUBSTANCE

Introduction

While many of the well-trained, experienced physicians and physician administrators of the NIS tend to view their problem as being lack of money, and of the equipment, supplies, books and journals that can be purchased with money, many of the more thoughtful recognize that circumstances as well as lack of money have cut them off from advances in medical and management technology and practice. They look hungrily to the Partnership Program as a means to catch up with the rest of the world through transfer of technology among peers.

1. Clinical Training and Medical Education of Physicians

Clinical Training: In the post-graduate clinical training of physicians (i.e., training after graduation from medical schools, in residency or fellowship programs or in continuing education courses), a great deal of experience and expertise transfer has taken place with consequent impact on NIS clinical practice. Many NIS physicians have taken part in short-term training experiences in the United States, and many U.S. physicians have traveled to the NIS and conducted special training programs for NIS physicians at their own sites.

These exercises have heightened NIS respect for the technical knowledge and expertise of their American counterparts, and generated great interest in the methodology and process of post-graduate clinical training. Up to the present, the process of post-graduate clinical training in the NIS does not appear to have changed significantly, but the heightened interest in such process from the actual first-hand experience with it has enhanced the potential for such change.

Accustomed to operating with relatively abundant financial resources and facing the omnipresent specter of malpractice litigation, U.S. hospitals have developed technologies and practices which in some cases would be inappropriate for the budgets and unreliable supply chains prevailing among the NIS partners. Therefore, the assessment team was watchful for situations in which NIS partners might have been encouraged into technologies or practices which they would be incapable of sustaining without external support. Subject only to the concern stated below relative to neonatal resuscitation, we found no notable instance of inappropriate technology transferred within the program.

Despite the successful efforts by the partnership program in its clinical educational component, there is need for continuation and room for improvement, particularly in the training of trainers in order to ensure the long-term impact on the health system. More use should be made of the ability of the NIS personnel directly involved in the partnerships to transmit their newly acquired knowledge and skills to others. In particular, through the task forces in infection control, provision of emergency services, etc., the U.S. partners can demonstrate, and help NIS

partners to develop the teamwork among physicians, nurses, and other paraprofessionals and support staff for accomplishment of specific tasks.

Medical Education: Neither medical education reform nor strengthening of medical education process and expertise per se have been objectives of the program and, as might be expected from the limited scope of this volunteer program, thus far it appears that very little medical education expertise has been transferred. Nevertheless, the various partnerships have exposed their NIS partners to some of the best American universities and medical schools. There clearly has been great interest among the NIS partners in the process of American medical education; there has also been a growing respect for the efforts in American medical education to study and experiment with the process of undergraduate medical education.

This appraisal team has heard numerous statements from persons directly or indirectly connected with NIS medical school education that there is much to be learned from their American counterparts about the process of medical education. Although little actual transfer has taken place, the climate for learning new approaches has been created. In view of the medical education strength of various among the U.S. partners, we suggest that AIHA consider more deliberate and structured approaches to help NIS partner teaching institutions improve their medical education methodology.

On the NIS side the team was particularly impressed by the I.M. Sechenov Moscow Academy ("MMA"), with its obvious competence and zeal to support health sector reform. Especially notable was its interest in strengthening the role of nurses and nursing in the system. Although MMA is not technically a partner in the program, AIHA has made good use of their resources in strengthening the NIS contribution to AIHA-sponsored seminars. We strongly endorse AIHA's plans to further expand participation of this leading NIS institution in the partnership program.

2. Nursing in the NIS

Work with nurses and nursing presents a special challenge for AIHA and the Partnership Program, one quite different from work with physicians as clinicians and administrators. There is need to reexamine the whole institution and system of nursing and its appropriate role and function relative to those of the physicians and administrators within the total health care system. The need must be addressed by the NIS governments, education, and health care systems. The necessary sector examination and analysis are not activities which the Partnership Program can perform by itself. The NIS governments and USAID must draw on additional institutions and resources to address fully this need.

The AIHA Program has exposed the NIS partners to the profession of nursing as practiced in the United States. From program documentation and interviews, however, it appears

that few nurses participate in the exchange trips. AIHA reports that of the U.S. partner visitors to the NIS, 60% have been physicians, 30% administrators, and 10% nurses. Although nursing is a part of almost all partnership activities, and initial interviews in the United States indicated that a good deal of attention had been devoted to nursing, the NIS interviews evidenced little NIS nursing involvement thus far for most partnerships.

Among the exceptions are the Bishkek/Kansas City, Almaty/Tucson, and St. Petersburg/Louisville partnerships. Bishkek/Kansas City is providing a two-month management training program in the United States for nurse administrators from all over Kyrgyzstan; Almaty/Tucson is working with the nursing school in Almaty; and Hospital No. 122 in St. Petersburg has enlisted the support of the Dean of the School of Nursing to provide special training for nurses who will be part of an experimental unit for paying foreigners during the Goodwill Games.

We are mindful of the limited impact which should reasonably be expected of partnerships whose involvement has been from twelve to twenty-four months at most. Nevertheless, in some partnerships where there has been particular receptivity on the part of the NIS partner, there has already been significant progress, as mentioned above. These successful examples could lead to the establishment of tangibly productive models in nursing education and practice which may stimulate interest and appropriate examination and reform elsewhere among the NIS countries. (See Annex 1 for extended observations and suggestions concerning nursing in the NIS partners.)

Recommendations

- ▶ That AIHA and U.S. partners encourage and support initiatives of the NIS partners to examine and define the relationship between the roles of physicians and nurses within a continuum of levels of training related to needs for service.
- ▶ That the U.S. partners continue to expose the NIS partners to the physician/nurse relationship in the United States, focusing on management and education as well as transfer of clinical skills. U.S. nurses and physicians can function as role models of a team approach to health care delivery for their NIS partners.
- ▶ That AIHA and the partnerships increase emphasis on nurses as managers/directors of nursing, and as trainers of nurses, along with clinical skills transfer for nurses in areas which dovetail into areas being addressed by physicians, such as infection control, emergency medical systems, and reproductive health.

3. Hospital Management and Administration

Hospital management figures importantly in AIHA strategy; management reform could be a major factor in improving the efficiency of the NIS health care systems to accomplish as much as possible with severely limited resources.

Almost all of the partners underscored the importance of the health management workshops that were conducted by AIHA in collaboration with the Association of University Programs in Health Administration (AUPHA). Three regional management workshops were held in Lviv, Moscow and Almaty. Also, of course, the Health Alliance partnerships have brought the NIS partners together with some of the best managed hospitals in the United States; but thus far most of the technical knowledge transfer within each partnership has been clinical, not administrative. Whatever management expertise has been transferred in the limited time available has been principally through the special AUPHA courses.

What has clearly been conveyed already to the NIS partners, however, has been an important (indeed, essential) pre-conditioning phase for management change and that is a genuine appreciation for the necessity of expert management in modern health care programs and facilities. Repeatedly, this assessment team heard great respect from NIS partners for the management and administrative activities of their American partner hospitals. Again and again the clinical directors of the NIS partners stated to us that the major deficiency in their NIS institutions (and the one they think must be changed soon) is the lack of management skills and experience. Thus, although the partnerships have transferred little management expertise per se in the first phase of the partnership experience, they have created a great respect for the importance of management excellence and a significant desire for further training and experience. Thus the program has created a setting in which real learning and absorption of knowledge can now take place.

Recommendation

- ▶ That AIHA continue its emphasis on health care management, particularly the involvement of the AUPHA in addition to the individual partnerships.

4. Task Forces

There are three overlapping program activities shared among many partnership programs which have been coordinated into task forces. These are infection control, emergency medical services and neonatal resuscitation. Such task force type of intervention builds on common experiences, prevents duplication of effort and coalesces distant partners who otherwise may not have the opportunity to work together. While partners are sharing information about the task force, there is also the potential to be exposed to other technical activities their colleagues are involved in.

Hospital Infection Control: Hospital infection control is probably the most important of the three task forces because it encompasses every level of the hospital care system in addressing a serious problem for NIS hospitals, aggravated by current shortages of pharmaceuticals and supplies. The outcomes of the best technical procedures are diminished if the patient is infected in the process. Infection control is also a very cost effective measure. Many of the rudimentary

interventions in infection control require little cost for equipment and supplies and will significantly decrease the average length of patient stay in the hospital.

The Odessa Oblast Hospital, with the support of its Coney Island partner, is developing an infection control department and has designated a nurse with an additional degree in microbiology as the person to lead the team effort. This is an appropriate person to target. Some partnerships have assigned their infection control efforts to the director of nursing. This, however, impairs the director's role as a manager, especially in the larger hospitals where the nursing director must supervise several other department heads. Infection control warrants the attention of a full-time team member to meet the challenges of this pervasive problem.

The current state of national infection control policies in the various NIS countries is not clear. In countries where such policies do exist, they may be outdated. Some personnel reported adhering only to those sections since some sections of the policies are outdated. For example, individual hospitals in the Ukraine do not appear to have their own written policies because such decentralized policy-making is not permitted by the oblast administration. In Russia, on the other hand, AIHA and the partnerships prompted the Ministry of Health's Department of Infection Control to review its infection control policies and procedures, a collaborative process initiated by invitation to an AIHA-sponsored conference.

The Infection Control Task Force, which recently held an international conference, would be appropriate to develop guidelines for a standardized surveillance system. Hospital data could be computerized to generate statistics on hospital infection prevalence, and related morbidity and mortality. The results could facilitate development of standardized procedures focusing on the most critical sources of infection and the most effective means of controlling them.

Recommendations

- ▶ Infection control begins in individual hospitals with many of its components being universal. For this reason, we endorse continuance of the Infection Control Task Force, with future steps, inter alia:
 - to seek guidance and approval from the appropriate oblast administrative department
 - to form a hospital wide infection control management team
 - to develop a surveillance program looking toward computerizing the inputs
 - to institute the simpler, lower cost methods first
 - to disseminate information concerning hospital efforts through the Infection Control Task Force directly and broadly through E-mail, CommonHealth newsletter, and conferences.

Emergency Medical Services (EMS): Because of a large volume of injuries, accidents, emergency cardiac conditions, etc., which take an enormous toll in mortality, disability and health costs in the NIS, Emergency Medical Services are essential to any hospital and therefore warrant

attention. Recognizing this, AIHA has already coordinated the EMS activities of several partnerships and has designated four regional centers throughout the NIS.

The collaboration of EMS activities is supported for the following reasons:

- ▶ EMS has overarching implications which connect the community with the hospital.
- ▶ EMS provides an opportunity for the various hospital departments to collaborate.
- EMS provides an opportunity for nurses, physicians, paraprofessionals and ambulance drivers to function as a team and therefore, provides a role model for the team approach to patient care.
- ▶ EMS provides a forum for various partnerships to unite who have otherwise been isolated from each other.
- ▶ EMS activities have already been successful as components of a few of the partnerships, e.g., Yerevan/Boston, Vladivostok/Virginia and Almaty/Tucson, which reflects strong commitment from both the U.S. and the NIS partners.

The Armenian Emergency Medical School is a good model which can be adapted for use by the other partnerships. If the staff are being trained separately, we would suggest coordination of the training to support the team approach. Different instructional methodologies were employed such as role modeling a field situation. Diversifying the training strategies is important in relaying the information to a broader group of people.

There are, of course, limitations to the EMS model. For instance, care should be exercised that the model is not translated into an intensive care component. Although some patients from emergency rooms are transferred into intensive care units after they are stabilized, critical care is a very different activity and should be treated as such. We don't recommend partnership activities in critical care, because most of the hospitals visited were not in a position to develop and sustain expensive intensive care units. Other departments need to be functioning well before there is utility in amplifying the capacity of an intensive care unit. Not only will it make little difference on the overall morbidity and mortality of the patients, but with limited financial, professional, and technical resources it is not possible to address critical care appropriately. In fact, without the essential elements in place, more harm can be done and patients can actually be put at a higher risk for morbidity and mortality when subsequently admitted to an inadequate intensive care unit.

Neonatal Resuscitation: During the first few moments of a newborn's life when it is struggling to breathe and survive, simple interventions and supportive care can make a critical

difference, both to the immediate and long-term outcomes, such as disabilities. Partners have recognized that certain simple improvements in the NIS handling of high-risk newborns, e.g., keeping the infant warm, coordination of delivery and pediatrics, can make a major difference in the survival of infants.

Many partnerships have focused on improving techniques for care of the newborn as a means of helping to reduce high rates of infant morbidity and mortality. Various among the partners are emphasizing the resuscitation of newborns experiencing breathing distress. AIHA has supported the partnerships by making available a standard package of training materials and supplies and by coordinating and supporting a number of related training workshops. The key factors in the AIHA program focus on educating staff with respect to cleanliness, maintaining thermoregulation, prevention of sepsis, and oxygenation to ensure circulation. At least some of the NIS partners are carrying these concepts into elaborate systems for resuscitation and sustenance of severely premature babies.

We observed NIS partner hospitals where partnership-supported efforts in neonatal resuscitation were experiencing problems. In some situations there was lack of the scarce and costly surfactant essential to sustain the lung function of severely premature babies which were being resuscitated by rather heroic measures. In another situation there was no means for measuring ambient temperatures which must be precisely controlled to avoid death of the severely premature. The team's experience may be exceptional and we hesitate to generalize from our admittedly limited exposure, but we do feel obliged to express our concern as to whether neonatal resuscitation is appropriate for emphasis in the Partnership Program under present conditions.

We do not question the commendable efforts to update NIS practice in the care of newborns. Such interventions as loosening the swaddling clothes, keeping the newborn with the mother, bringing pediatrics closer to the delivery room, reducing the newborn's exposure to hospital infection, are clearly desirable and cost effective. Resuscitation of the severely prematurely born presents difficult challenges, however, with exacting and costly requirements of training, equipment and supplies where the slightest deficiency of any one will produce death or severe damage. If done it must be done well since the cost to society and distress to parents of the failures exceeds even that of the stillborn child.

In general the program appears to have avoided disproportionate investment in heroic measures to sustain low quality of life at the two extremes of the life span, the most prematurely born and most late in dying. Nevertheless we suggest that AIHA and the partners be watchful for such tendencies, which would be particularly harmful in the NIS countries which can least afford them and whose limited resources might better be directed to preventive than curative approaches to the problems involved. The most cost-effective measures toward healthy neonates and problem-free births are often in prenatal care and education to the mother to be.

Recommendation

- ▶ **The Neonatal Resuscitation Task Force is under the umbrella of Maternal Child Health. While recognizing that broad coverage family planning programs are generally beyond the role and capability of the hospital-based partnership programs, we suggest that partnership efforts in neonatal resuscitation should be balanced by USAID with broader programmatic emphasis on the larger picture of women's reproductive health. Further we suggest that AIHA and the partners reconsider the degree of emphasis on neonatal resuscitation within the program.**

Conclusion on Task Forces

Although the task forces provide a unifying force, caution should be exercised that these task forces do not substitute for an overall strategy for the partnership program as a whole. These task forces are composed of technical skills which are the nuts and bolts of a health system and not the machinery which runs it. The task forces should fit inside a common program strategy which applies to all of the twenty-one partnerships. As discussed in Chapter V below such strategy can now be further developed by AIHA on the basis of knowledge and experience gained during the first two years.

5. Information Dissemination

A major component of AIHA's strategy is developing communications among partners in order to disseminate the lessons learned and skills derived from the exchange program. AIHA communication strategy and products include newsletters, printed materials on a variety of clinical, policy and administrative issues, conferences, workshops, and an E-mail based bulletin board and shared information system.

Conferences and Workshops: Participant institutions in the partnership program meet every six months to discuss common problems, to share experiences, and to discuss approaches to a full range of administrative, clinical and educational issues encountered in the NIS. In addition, special workshops are held to educate NIS partners on specific subjects and/or disseminate the clinical and administrative changes brought about in the NIS partnership hospitals to a wider audience of NIS health care providers. These workshops and conferences are being conducted in a collaborative effort between AIHA and U.S. partner institutions. These workshops and conferences have dealt with several important issues such as infection control, emergency medical services, neonatal resuscitation, gynecology/obstetrics and hospital administration. The workshops, conferences and seminars are among the most effective methods of disseminating information and should be continued.

Some NIS partners expressed concern that these conferences and workshops tended, in general, to be one way channels of communication. They would like to see more NIS presenters, and more opportunity as participants to relate presentations to their own experience.

Recommendation

- ▶ That AIHA encourage increased participation of the staff of NIS partners in presenting new technology in an NIS context for their NIS colleagues.

CommonHealth Publication: *CommonHealth*, a bi-monthly, bilingual newsletter published by AIHA, is an important communication device relaying useful information about partnership activities as well as substantive clinical and administrative information to hospital administrators, physicians, researchers, policy makers both inside and outside the NIS. Due to the difficult economic situation in the NIS, scientific journals and publication have become a rare and much valued commodity. *CommonHealth* is responding, in a limited way, to the need of scientific publication. Moreover, *CommonHealth* serves as a device for information dissemination by publishing the experiences of different NIS partner institutes and synopses of the workshops and conferences. However, *CommonHealth* tends to be oriented much more toward the interests and needs of NIS physicians than of the nurses.

Recommendations

- ▶ That AIHA continue to produce and distribute *CommonHealth*.
- ▶ That AIHA include regular sections in *CommonHealth* targeting nurses in order to provide them with useful information to upgrade their skills.

Electronic Mail (e-mail): Electronic mail is becoming a major method of communication and information sharing. For the NIS partners, e-mail could play a significant role in filling the gap resulting from the lack of regular scientific journals and publications. AIHA considers e-mail and the related bulletin board to be an important information sharing and communication component. AIHA provides the NIS partners with the computer hardware, software and related training and if used properly, e-mail could be a highly efficient and useful means of communication and information sharing. However, most of the NIS partner institutes visited by the assessment team did not use the e-mail system much. Several NIS partners cited inadequacy of telephone lines as the main reason for not making more use of e-mail. Some of the NIS partners used e-mail to consult with their U.S. partners and to receive scientific articles, but e-mail was rarely used to exchange information between the NIS partners.

Recommendations

- ▶ That AIHA ascertain the causes for low usage of e-mail.
- ▶ That, as needed, AIHA train the NIS partners on the efficient use of e-mail and encourage them to use it more frequently to share and receive information.

Medical Journals: All of the NIS partners visited were starved for the sort of reporting on scientific advances, epidemiological studies and improvements in technology and practice which are found in the great number and variety of medical journals published world-wide. Under Soviet rule, Moscow had provided somewhat screened access to the outside world in addition to the results of research in the USSR. But now, with the virtual disappearance of funding for such research and publication in Moscow, and then, for the non-Russian NIS, the substantial cutoff from central sources in Moscow, and, for all, the absence of funds for subscriptions and conferences, the partners program has become their only "window on the world".

Recommendation

- ▶ That AIHA, in addition to its support for conferences, training, and joint research, consider program funding to help the NIS partners subscribe to some medical journals for a few years until they are better able to afford them from their own budgets.

C. PROGRAM MANAGEMENT

1. American International Health Alliance (AIHA)

Newly organized especially to carry out this partnership program in the NIS countries, AIHA has benefited from the dynamic leadership of a chief executive officer who previously had substantial experience with U.S. health care associations in various capacities. He is not a physician, nor are any other members of the Washington office staff. He has, however, hired one professional with international development experience in the health sector. For most of the Washington staff, as for all representatives in the field, there has been heavy emphasis on fluency in the language of the NIS countries served, predominantly Russian.

AIHA/Washington moved remarkably quickly in putting its team together after execution of the grant agreement, getting partners together, and then helping the partnerships promptly to get their programs underway.

The three AIHA field offices at Almaty in Kazakhstan, Moscow in Russia, and Kiev in Ukraine, are similarly lean organizations that have emphasized linguistic and logistic competence. Further, the three field offices now each include a local professional with outstanding medical credentials. In Moscow and Kiev these professionals now head the offices. The Kiev mission makes particularly good use of local contractors in Kiev and elsewhere for performance of logistic functions.

In addition to the AIHA/Washington and field offices, there are several roving staff members who visit each partnership at least once every six months to monitor and report on partnership progress in implementation of its program. Such monitoring includes a certain amount of assistance in solving implementation problems as they arise in addition to reporting to AIHA and the respective partners.

Our interviews both in the United States and in the NIS countries evidenced that AIHA had performed remarkably well in facilitating the formation of the partnerships and providing essential logistical support to partnership visitors traveling in both directions. On the other hand, during the early stage at least, neither the Washington nor the regional offices contributed substantially to the content of the individual partnership programs. More recently, as experience with the program has identified certain areas of high priority to many partners, AIHA has sponsored special programs on those subjects to which representatives of all partners are invited. In addition to their educational value, these conferences have helped establish highly useful linkages among the different partners in the NIS countries as well as in the United States.

Recommendation

- ▶ That AIHA consider strengthening the medical/development experience and expertise in its Washington staff to support the development of more strategically-oriented programs among the partnerships and in AIHA.

This suggestion should not be considered to imply criticism of AIHA for lack of emphasis on such input before. During the first phase of the program it was logical to place more emphasis on building the vitally important logistical support for the program. Without it the program could not have happened. Further, there was not that much knowledge of the NIS health sector, and little or no partnership experience to be shared.

As the program evolves, however, it is appropriate to consider change in the AIHA's support structure. The logistical network and systems have become established. At the same time there are rapidly increasing amounts of knowledge to be shared to enable new partnerships to benefit from the experience of the pioneers, and to enable existing partnerships to gain from each other's experience. AIHA sponsored communications and conferences are already serving this purpose along with that of technology transfer; but we believe this need could be further served by application of more AIHA medical/development experience and expertise both in the United States and the NIS.

2. United States Agency for International Development (USAID)

In USAID/Washington the NIS Partnerships Program has been administered with an exceptionally loose rein. It was preceded by a Health Care Partnership Program for the Eastern Europe countries under a more tightly administered program of multiple grants with a separate grant for each partnership and a separate RFP process for each grant. USAID defined what it wanted through the RFP process, and the U.S. partnership institutions responded in kind, with full payment for services rendered. But these partnerships were relatively slow in getting started, requiring nearly a year and a half just to complete the award of the grants.

When the NIS countries opened up relatively suddenly with a high U.S. foreign policy priority on responding quickly to urgent needs, USAID/Washington decided to shortcut the RFP process and executed a grant agreement with a consortium of American health care organizations formed specifically for the task and determined to be uniquely qualified for implementation of the program. Recognizing that neither USAID nor any other American organization had particular competence in dealing with the NIS health sector, USAID/Washington decided on an approach which would permit leading U.S. health care institutions to link up with leading NIS health care institutions and "learn by doing" for a while to determine what the needs were and where the priorities should be as the program evolved. Having had the good fortune to select a grantee which performed exceptionally well in implementing the program rapidly, efficiently and

effectively, USAID/Washington showed the good judgment to avoid imposition of excessive guidance and bureaucratic red tape on AIHA.

In the field also the partnerships have been largely left alone by USAID, and seemingly deliberately so. One reason is to give carefully selected partnerships the opportunity to prove their worth without bureaucratic interference. The second reason is USAID's lack of experience in the NIS. USAID was not in a position to provide strong substantive guidance even if it wanted to. Indeed, in most cases the partnerships preceded the establishment of USAID missions adequately staffed to provide useful guidance. Further field missions have looked upon the partnerships as a USAID/Washington program for which the missions are not directly responsible, and they have not had enough staff for proper oversight of the programs for which they are directly responsible.

Although we were informed at both USAID/Washington and USAID/Russia that any future USAID funding for the partnerships would have to be authorized by the missions, USAID/Central Asia expressed their understanding that funding would be controlled by USAID/W. The division of labor between USAID/W and the USAID field missions needs clarification.

USAID/Russia appears to be the farthest advanced in the development of a health sector program. It has had a highly regarded health sector officer during most of the two year implementation period for the partnership program. That officer has taken an active interest in the program.

At USAID/Central Asia also the partnership program has had the oversight of an experienced health sector development officer serving as General Development Officer, and within the past six months another health sector professional has arrived to assume responsibility for that sector and give more time to it. USAID/CA has now completed a draft strategy for assistance to the health sector, although it has not been formally approved, nor has it been shared with AIHA.

USAID/Ukraine has not had a health sector professional on its staff until the past six months and has barely started in development of a health sector assistance strategy.

Recommendations

- ▶ That USAID/Washington and USAID field missions continue the relatively free rein for the partnership program, while encouraging a more strategically oriented approach along the lines suggested in Chapter V. below.
- ▶ That USAID expedite formulation of its regional and subregional health sector development assistance strategies and consult with AIHA during the drafting process as well as sharing the final product.

IV. Program Issues

A. ACTIVITY SELECTION

A review of the various activities undertaken within the individual partnerships reveals a wide variety of projects and activities. There are certain generalized subjects that occur in many projects, such as emergency medical services, infection control, maternal and child health. But for the most part, the selection of specific project activities is a very individualized matter, reflecting the talents, resources and perceived needs of each partnership. The result is a somewhat random collection of locally-appropriate activities that have less national or regional impact than a collection of 21 powerful partnerships might have with more focus. The challenge for the overall AIHA project is to devise a method by which individual activity selection continues to reflect the unique talents and interests of each partnership, but at the same time reflects a set of overall themes, subjects, or skills that the AIHA, NIS and USAID leadership feels are universally important in all projects.

What might some of these universal themes be? A standard set might include the following:

- data-gathering, program planning, information systems management, and evaluation,
- financial management and planning, cost-accounting and cost control, and program budgeting,
- nursing development, including clinical nursing skills and nursing management, and
- general management and administrative techniques, particularly for physician managers.

1. Data Gathering/Program Planning/Information Systems Management/Evaluation

Increasingly around the world, the importance of objective, data-based management is being recognized as a central theme for effective management. Since this is the case, and because of the special concern for most effective use of severely limited resources, each partnership (and indeed, each project within each partnership) should be organized to teach or reenforce the data-based principles of modern management.

For example, before any individual project is begun, AIHA might require an attempt to gather and review existing data on the subject in question; if existing data is not adequate for project purposes, AIHA might assist in the development of appropriate data-gathering techniques, even if only rudimentary and informal in nature.

Each partnership (and each project within each partnership) should be required to learn and apply modern program planning techniques. Indeed, by describing a basic approach to be used in all projects taken on by a partnership, AIHA would not only be developing some uniformity in its own data, but also be providing the partnerships with a guide to what good program planning really is.

Once the partnerships and the projects are established, there might be some uniform requirements for information systems, so that the project can keep track of what is being done, the quality of services provided, and the impact the services are having on recipients. In the same fashion, a systematic methodology for evaluating each project should be required as a part of the initial project planning.

It can well be argued that these requirements are too cumbersome, costly, and sophisticated for the current state of health care in the NIS. On the other hand, if the NIS situation is to move into a more modern and efficient model, as all the NIS partners want, these projects could play an important part in the introduction and teaching of these most important skills and techniques. If the purpose of these projects is to provide the NIS partners with information and skills that they do not already have, and that they will need if they are to move ahead, then data-based management and planning, information system management, and evaluation skills should be emphasized in each partnership across the board.

2. Financial Management and Planning/Cost-Accounting and Cost-Control/Budgeting

A second standard set of activities that should be present in all AIHA partnerships and projects is an organized approach to improved financial management and an organized approach to learning financial management techniques and skills. Included in this approach should be

standardized processes and instruction in program budgeting, cost-accounting and cost-control, and general financial management.

In most of the present partnerships and projects, there has been little training in these techniques, although there are obviously financial matters that must be managed. Each NIS partner seems to manage itself differently and little intentional instruction and training seems to take place. Little if any use is made of cost-benefit and cost-effectiveness analyses, as well as their use in choosing specific projects from among a range of alternatives. If these individual partnerships are seen as the training grounds for the future management and planning leaders for health care in the NIS, more attention should be paid to these matters and more stringent guidelines and procedures used.

As with the suggestions in the previous section concerning the need for data-based management and planning, it could be said that the NIS situation and the NIS partners are not ready for this set of more rigorous processes. The view of this appraisal team is that the NIS partners are quite ready for this more advanced set of financial management skills and the general NIS health care situation is moving rapidly into a phase in which these skills will not only be useful, they will be essential.

The AIHA partnerships offer an opportunity to the American partners to provide important financial management skills that do not exist in the NIS at the present time and will be actively needed in the near future.

3. Development of Clinical Nursing Skills and Nursing Management Expertise

One of the major observations to be made in the general appraisal of the AIHA partnerships is the relative absence of nursing influence and leadership in shaping and conducting the NIS portion of the partnerships. At the same time, there is general agreement within the NIS partners that one of the top priority areas is the improvement of nursing leadership and practice, in both the clinical and the management areas. This general consensus on the importance of improved nursing leadership and practice suggests that the partnerships and projects, regardless of their specific technical focus, should include a set of activities organized to enhance NIS nursing leadership and practice.

What should these required components for enhanced nursing leadership and practice include at the NIS sites? At a minimum, they should include NIS nursing involvement in the project selection and design, NIS nursing involvement in project management, and nursing communication of newly learned skills and techniques to other NIS nurses in the partnership institutions and throughout the NIS.

In general there has been obvious absence of NIS nursing involvement in the selection and design of the individual projects undertaken by each NIS partner. In the future, AIHA should establish a program requirement that nursing personnel be actively involved in the selection and design of individual projects; if it is felt that there is need for external assistance to allow nurses to participate fully in project selection and design, AIHA should provide that assistance to individual NIS partnerships.

There also seems to be similar absence of nursing leadership involvement in the management of individual projects in the NIS partnerships. In the same fashion as was discussed for nurse involvement in project selection and design, AIHA should promote active nursing involvement in all aspects of the project and partnership management.

Finally, AIHA should devote more time and attention to the widespread dissemination of nursing activities, nursing achievements, and nursing leadership within the local NIS partnership site, across the 21 NIS partnership sites, and within the NIS in general. The nursing profession within the NIS is beginning to change and advance in significant ways, and the AIHA partnership program in the NIS should play a more active, supportive, and enabling role in that movement within the nursing profession.

4. General Management and Administrative Skills, Particularly for Physician Managers

One of the other major emphases that should be included in all the AIHA partnerships is the training and development of health care managers, particularly physician-managers, since they occupy such central and important positions at the present time. Since this is also one of the subjects most widely mentioned by the NIS partnership leaders themselves, this aspect of AIHA partnerships is doubly important to include in all projects.

There is at the present time the potential to conduct general management training seminars, thanks to the AUPHA involvement in the entire AIHA partnership effort. This is a very limited effort, however, requiring partnership and project leaders to leave their work sites and go off for short term training, with neither extensive preparation beforehand, nor extensive followup afterwards. A more productive approach would be to link the AUPHA training with continuing management development efforts at the partnership site, linked to activities and circumstances of the partnerships and using the individual projects as case studies for particular learning experiences. AIHA could contribute significantly to the health care management expertise in the NIS by building in a requirement for organized management assistance and support from AUPHA, from AIHA central office, and from the individual American partnership managers, according to a general management development outline and curriculum.

B. MEASURES OF SUCCESS

The partnerships between NIS and U.S. health care facilities all have the goal of improving health care services to the NIS population. Some of the partnerships focus on specific groups of patients such as women and children while others focus on specific services such as cardiology, toxicology and emergency services. Regardless of specific partnership focus, all partnerships emphasize the improvement of clinical services and patient care, both directly and indirectly, by offering information, support, technological expertise or management strategies.

Given the variation in needs, service availability, types of health care facilities and interests of participating institutions, the partnership programs vary in their scope and clinical emphases. Nonetheless, certain elements are common and could be used in the assessment of all the partnerships. These include utilization review, clinical outcomes assessment, assessment of the facility or system of care and information transfer/education.

Several indicators could be used to assess the partnerships. These indicators could measure changes in the following areas:

1. Changes in Hospital Use

The partnership program activities have contributed to significant reduction in average length of stay in some NIS partnership hospitals. Care must be exercised in determining significant trends over such a short period of program implementation in countries where statistics are not uniformly reliable; and there are significant factors external to the partnerships, both positive and negative, bearing on the results. Nevertheless we were impressed that Almaty First Aid City Hospital provided seemingly valid data substantiating reduction of average length of stay by a half, from 20 days to 10 days.

Reduction in length of stay in turn reduces the numbers of beds needed by patients. Here again we were impressed that seemingly valid data generated by several of the NIS partner institutions in Kazakhstan and Kyrgyzstan evidenced substantial reductions in number of beds. This reduction was reported to be 10 percent in 1993 in Bishkek, with an additional 15 percent reduction in the number of beds expected in 1994. Other partnership institutions reported reductions of up to 40 percent in the number of beds. However, some of these reductions could be attributed to previous disuse as well as reduction in average length of stay.

2. Improved Clinical Outcomes

Subject to similar caveats as to reliability, the data may indicate that improvement in health services and practices during the period of partnership program activities could have helped to

reduce the infant mortality rate (IMR). The caveats include the influence of other maternal and child health programs, but the effectiveness of such programs depends heavily on the availability of strong health care institutions to implement them. Examples include reported reduction in IMR (for newborns only) in Kyrgyzstan from 8.1/1000 live births in 1992 to 7.1/1000 live births in 1993. Data from Almaty suggest that IMR was reduced there from 21.7/1000 live births in 1992 to 19.1/1000 live births in 1993. Data from Almaty and Bishkek indicate that maternal mortality ratio also was reduced substantially, in part due to improvements in prenatal and obstetric care introduced by the partnerships.

A third of the Emergency Medical Services centers established under the partnership program are already systematically collecting data to determine their performance and impact. Similarly, some of the NIS partner Infection Control Programs already include an infection control nurse and/or an epidemiologist responsible for surveillance and obtaining statistical data to measure performance as reflected in results.

Successful patient education programs have been established in the cardiology department of Almaty First Aid City Hospital, and in diabetes treatment at Dubna. Dubna has also established an alcoholism counseling center.

Several NIS partner institutes are now using better diagnostic techniques and equipment. The Erebuni Hospital in Yerevan, Armenia even takes their diagnostic equipment, including ultrasound, to district satellites once a month.

3. Management/Administration Interventions

Knowledge acquired in the United States and in the AUPHA management training workshops has produced identifiable changes of management practices and administrative reorganization. Among them are reorganization of the Almaty City Health Administration, which will affect 82 medical institutions in Almaty. Such changes require time to produce measurable results. But it is not too soon for AIHA and the partnerships to start looking for data to substantiate significant reductions in cost per patient.

On the revenue side of the equation, we note that readily quantifiable, tangible results should be forthcoming from the introduction of a fee for service or service charges concept in Almaty First Aid City Hospital which will open a 20-bed ward for patients who are willing to pay for the services provided to them. Also, the director of the Oncology Institute in Bishkek had established hotel services for the patients' families who come from outside Bishkek for a nominal fee of \$8 a week per family. St. Petersburg Hospital No. 122, Erebuni Hospital in Yerevan, Armenia, and the Kiev Center for Maternal and Child Care have also instituted fee for service programs.

4. Educational Component

This major component of the partnership program involves exchange visits between the U.S. and NIS partners, the training of the NIS medical personnel and the transmission of information and techniques to the NIS medical personnel. Examples of successful educational activities that have been/will be carried out by the partnership program include the following:

- ▶ Training of medical doctors and nurses in a wide range of specialties both in the United States and in the NIS.
- ▶ The establishment of regional training centers such as those at the Institute for Obstetrics and Pediatrics in Bishkek, Almaty First Aid City Hospital, and both partnership hospitals in Armenia.
- ▶ The establishment of an Emergency Medical School in Yerevan, Armenia which offers basic courses for physicians, nurses and ambulance drivers.
- ▶ The establishment in St. Petersburg Hospital No. 122 of a special training program for nurses to work in an experimental unit for foreign paying patients.
- ▶ Assisting existing training institutions, such as Almaty Medical College, for nurses in organizing education system and developing necessary curricula.
- ▶ Assistance with drafting and publication of medical educational materials, such as those for the alcoholism prevention center in Dubna, and manuals for breastfeeding, caring for premature infants, prevention of acute respiratory infections (ARI) which are being used to train nurses and doctors all over Kyrgyzstan. Similarly, layperson-oriented maternal and child health educational materials have been produced by the Savior-Magee partnership in Moscow.
- ▶ Sponsoring regional workshops and seminars, such as the three regional workshops in management training, conducted by AUPHA.

Not yet included, but which should be, is training in processes and techniques for transmitting skills and knowledge. This is a basic step toward improving medical education expertise.

While numbers for participants in these educational activities are readily available, and questionnaires are useful to determine pedagogical quality and effectiveness, the ultimate measure of success for such educational activities is in the clinical outcomes of the activities they support (see IV.B.2 above).

5. Impact on the National Health Policy

The partnership program was not intended to have major impact on national health policy. However, in some of the smaller countries, where the health ministries and other public authorities have taken an active interest, some significant impact on policy has been achieved. For example, the partnership program activities in Kyrgyzstan have supported health sector reforms in the areas of management and administration, financing, training and role of nurses. In the Kyrgyzstan Ministry of Health the partnership program was a major factor in increasing emphasis on curative relative to preventive medicine.

6. Impact on Perceptions of Partner Countries

One of the benefits expected from people-to-people activities such as the Partnership Program is enhanced understanding of, and appreciation for, the countries and peoples to which the participants are introduced in the course of program activities. For participants generally, especially for people from continental interior communities like Bishkek and Kansas City, the experience should result in substantially increased international awareness as a basis for sound foreign policy debate and decision making within a democratic environment.

Invariably in the course of our interviews, both in the United States and in the NIS countries, participants commented on how pleasantly surprised they were at the friendliness and openness of their "foreign" counterparts. One factor in this, of course, is the low level of expectation created by nearly half a century of cold war between the United States and the former Soviet Union. Another factor, less true perhaps of large cosmopolitan cities like Moscow and New York City than of the more rural areas of the U.S. and the NIS, is that the people involved truly are exceptionally open and hospitable.

Another important factor, however, is that most of the partnerships, with the very able assistance of AIHA, did a remarkably good job with very difficult logistics. In the course of our travels we heard notably few complaints concerning arrangement failures for airline tickets, airport meetings, or living and eating accommodations. And when the inevitable incidents did occur, in most cases at least, they seem to have been handled with good spirit as well as with skill and some degree of anticipation.

We have no statistics to bear out our judgments, but our sense gained from a large number and variety of interviews including highly appreciative U.S. ambassadors, is that good feelings between the United States and the various NIS countries have been significantly advanced by this program. Such subjective perceptions are subject to verification by questionnaires and polling data. If baseline data have been established, the dynamic trends can and should be determined within a program evaluation, together with interim sampling as practically feasible.

7. Benefits to U.S. Partners

Since mutuality of benefit is essential to the viability of any partnership, the term would be a misnomer if there were not some benefit to the U.S. as well as the NIS partner. The benefits to NIS partners in terms of technology transfer, equipment and supplies are of course obvious. The benefits to the U.S. partners are less tangible but seem nonetheless real.

As noted above, the personal enrichment of foreign travel and gaining understanding of other countries, their people and their cultures, is of course a significant product of the program for all participants. Looking to institutional gain, some U.S. participants informed us of the team-building aspect of bringing together on a common task hospital departments and personnel who had been accustomed to being strangers. In the course of helping their NIS partners with institution and system-building problems, the U.S. partners are often motivated to rethink their own systems and procedures.

Of particular benefit to the U.S. partners during this period of intense pressures to reduce their costs has been the experience of their NIS colleagues in devising means to cope with budget cuts of two-thirds or more. Further, apart from cost considerations, some of the more thoughtful program participants were impressed by the potential for improving patient outcomes by striking a better balance in medical care between high technology and personal contact.

C. GRADUATION CRITERIA FOR PARTNERSHIPS

1. Options for Phase Out of USAID Assistance

Overview

Most partnerships have completed at least one year, none more than two, of professional exchanges. This has been an introductory phase whereby the partners have become acquainted with each other. Some partners have endured misunderstandings which have created impasses. Other partners have worked through their difficulties and now have a better appreciation for each other. For the most part, this initial phase has allowed partners to develop trust and lay the groundwork for a fruitful relationship. Whether planned or not, the partners have been assessing each other's motivations, expectations, and intentions, in addition to observing their respective working environments.

The program activities have been directed toward the apparent needs and opportunities available. A structured framework for conducting assessments was not embodied, but nonetheless, assessments were made to varying degrees albeit ad hoc. The phase into which the partnership can now progress is one of concrete, longer term planning. This can be accomplished by budgeting for one to two year periods and developing the implementation plans with input from both sides. A written plan of action would assist in the implementation of specific activities. A systematic approach to monitoring and evaluation should be included. Partnerships should be considered for phase out depending upon the goals and limitations of the participants. Possible scenarios indicating readiness for phase out include:

- the partners have reached their common goals and they are at a point where they can maintain their relations without the assistance of AIHA,
- the partners may have limited common goals or capabilities and, therefore, will reach a point whereby the marginal benefit of continuing the partnership no longer justifies the investment or opportunity cost, and
- the partners are unable to reach a point of agreement and the evaluation process reveals that they are not effectively working together.

Thus, the phasing out of partnerships could be for two reasons: 1) the partnership has proven to be insufficiently productive; or 2) the partnership has successfully matured.

Phase Out of Low-Performance Partnerships

The following criteria may be considered when determining whether a partnership should be phased out because of low performance level. The intention is not to create a "checklist" of absolutes but to reveal trends. Failure of a partnership to meet most of these criteria within two years of startup would be indicative of potential problems in the partnership.

Program Strategy

- ▶ The partnership activities address the health care priorities of the region, and are consistent with Ministry of Health and USAID strategies. The activities are not just contrived to fit with whatever the U.S. partners have available to offer at the time. If no such priorities or strategies have been established, the activities should be selected in relation to potential impact, including factors such as institutional efficiency, cost effectiveness, prevalence of the problem and size of population effected thereby.
- ▶ The Ministry of Health and USAID are informed of and supportive of partnership activities.
- ▶ Both partners have jointly developed a written plan of action encompassing their common goals and objectives; NIS counterparts are not merely approving one presented by the U.S. partners.
- ▶ Activities coincide with the written plan of action. Activities are not random or ad hoc but directly relate to the achievement of the stated goals and objectives of the partnership.

Management

- ▶ Specific activities relate to hospital management in both medicine and nursing. There is a written plan with stated goals and objectives which target medical and nursing administrators.
- ▶ Exchange trips are focused and relate directly to activities described in the work plan. Partners who join in an exchange visit perform a function related to the written goals and objectives of the program.
- ▶ A standardized system for monitoring and evaluation has been developed and adhered to.
- ▶ Quarterly progress reports are submitted by both partners.

NIS Medical Partnerships Program: An Assessment

- ▶ **Recommendations in partnership progress reports and AIHA monitoring reports are acted upon.**
- ▶ **To the extent feasible, partners and AIHA have identified measurable indicators of achievement for the various activities.**
- ▶ **Partners are able to solve problems creatively. Partners can devise alternative strategies to tackle problems; when one intervention does not solve the problem, a different approach is employed.**
- ▶ **Departments within the principal partnership hospital collaborate on program activities.**
- ▶ **The departments selected to carry out the activities are chosen in relation to NIS partner needs as well as U.S. partner interest and availability.**
- ▶ **Program activities include developing the professional role of nurses.**
- ▶ **Nurses from both the U.S. and the NIS are appropriately represented in the exchange visits.**

Multiplier-Effect via Education

- ▶ **NIS nursing and medical educators have been identified who will perform the function of training others to teach. These educators are versed in various instructional methodologies which enable them to transfer their teaching skills to new educators identified in other district satellites outside of the principal NIS partnership hospital.**
- ▶ **A plan of information dissemination has been developed and carried out. Program activities are communicated through *CommonHealth*, electronic mail, publications, seminars, and conferences.**
- **Program activities are shared with other institutions within the region. Efforts are made to create satellite centers which will multiply the activities of the principal partners.**

Technical Skills Transfer

- **Medical equipment is not donated by U.S. partners before a biomedical engineer has been identified and trained in repairing the equipment shipped. Replacement parts for the equipment are either included with the equipment or are otherwise readily available in the**

NIS . The costs of replacement parts have been ascertained and included in the NIS hospital budgets.

- **The NIS partners are not dependent on the donation of supplies and equipment in order to maintain progress with activities. Activities are not reliant on continuous supplies from the United States. The supplies needed to sustain the activity can be procured independently by the NIS hospital.**
- ▶ **Educators from the principal NIS partnership hospital have trained educators in satellites who are prepared to assist in the transfer of technical skills.**
- **Medical, nursing, and auxiliary personnel from satellites are invited to participate in partnership activities at the principal hospital. They are encouraged to participate in joint activities while U.S. colleagues are in-country. They present their work at conferences and seminars and contribute to information dissemination.**
- ▶ **To the extent practical equipment donated to the principal NIS partnership hospital is made available to personnel from the satellites.**
- ▶ **Efforts are made to develop cost recovery systems.**
- ▶ **A hospital accounting system has been developed.**
- ▶ **An Infection Control Department has been established and is responsible as a matter of routine for thorough surveillance of hospital acquired infections throughout the entire hospital.**

Phase-Out Criteria for Matured Partnerships

The U.S. partners frequently mentioned the humanistic aspect as being the most important aspect of the program. A common fear among the NIS partners is that the U.S. interest will fade and they will be deserted after U.S. partners lose interest or become frustrated. Before a partnership is phased out on grounds of maturity, it should have a means of continuing their relationship on a significant level. The altruistic component of the partnerships can continue long after the financial contributions cease. With the installation of telecommunications at each site, the partners can keep in contact by written correspondence, at the very least. One long term goal for each partnership should be to deemphasize the gifts-in-kind and monetary inputs but still to maintain frequent communication.

There are many considerations to phasing out one partnership so that another may commence. There is always the risk that the new partnership will not be effective and this may not be realized until a thorough assessment has been conducted which may take up to a year or longer. Thus would be lost the future benefits of continuing a partnership which already has proven to be effective. Another consideration should be the stability of the Oblast administrative units of proposed NIS partners. Similarly, AIHA should be wary of initiating new programs where the Ministry of Health is unstable or ineffective since this will effect indirectly the sustainability of the partnership outcomes. The partnership can be weaned from AIHA's financial support as one or more of the following criteria are met:

- ▶ Programmatic goals and objectives have been accomplished.
- ▶ The marginal cost of continuing with existing activities or beginning new ones is getting larger relative to the health benefits derived. In other words, the new partners to be chosen meet the criteria delineated in the "Activity Selection Criteria" section and the existing partnership has reached a point where incremental progress is beginning to level off or diminish. This is especially important if the existing partnership activities would require large financial contributions in relation to progress to be achieved.
- ▶ One or more alternative sources of support are available to the partnership after AIHA's support is withdrawn.

V. Strategy and Recommendations

A. SOME ASSUMPTIONS, FINDINGS AND CONCLUSIONS

In attempting to outline a strategy and a set of recommendations for the partnership program in the future, it is probably wise to first identify some of the assumptions upon which these recommendations are made and to include some general observations and conclusions that the assessment team developed during the course of its interviews.

- ▶ A great deal of energy and enthusiasm has been invested in the various partnerships and 21 affiliations or linkages have been established in a relatively short period of time.
- While there has been a great deal of activity around the partnerships, the program operates in a health sector context with many other factors, positive as well as negative. This situation combined with the relative newness of the programs themselves makes it difficult to document major effects on the health of the people served by the partnerships.
- ▶ While there have been at least some linkages established between institutions in the United States and the NIS, it is difficult to judge the actual strength of the linkages themselves, since in many instances the personnel most directly involved in the projects in the institutions may not have great authority to speak for or make official commitments for the whole institution.
- ▶ It is early and also difficult to determine the partnerships' linkages with, and effects upon, local, regional, or national health policy in the NIS. It is similarly early and difficult to tell how the partnership program fits into overall USAID policy in general or the specific USAID health policy and strategy in an individual region or country.
- ▶ It is clear that the overall potential for the projects and partnerships is great as pilot project sites for the future, as catalysts for change, and as learning centers for future efforts of various kinds.

NIS Medical Partnerships Program: An Assessment

- ▶ **There is a great range in the organization of the partnerships and in their productivity, making it difficult to make broad generalizations for all the partnerships.**
- ▶ **There does not seem to be a good system in place yet for monitoring real success, nor are there objective criteria for success. In some ways, the descriptions of what "works" and what doesn't, and to what degree things work or not has been left to the individual partnerships.**
- ▶ **AIHA has been careful not to impose too rigid or centralized a set of strategies or requirements on the individual projects and partnerships, but at the same time, it has not articulated an overall strategy or plan in which all partnerships or projects must fit in some fashion.**

B. STRATEGY RECOMMENDATIONS

Strategies and recommendations can be suggested on a number of levels and are probably best expressed in that fashion. These levels or spheres of strategy are:

1. USAID policy for the NIS
2. AIHA policy and plans for its 21 partnerships
3. USAID and Ministry of Health strategy country by country
4. Individual partnerships, including both US and NIS institutional participants
5. Specific projects within an individual partnership

1. USAID Policy for the NIS

The AIHA partnerships project was started rapidly and as the result of a desire to provide some form of assistance as quickly as possible. It has been remarkably successful in setting up linkages between individual institutions in the United States and in the NIS. It has not had the luxury of time to think clearly how the project fits into evolving overall USAID health policy in the NIS and as a result, the health partnerships projects operate somewhat outside the overall USAID efforts in the various NIS countries.

For the future, it will be important for USAID to articulate clearly what its long range health policy is for the NIS and, as much as possible, describe clearly how the entire health partnership project fits within that overall health policy. This will have the dual effect of giving the health partnerships project a stronger sense of direction and at the same time will integrate it more closely into the other USAID efforts in the NIS, to the mutual advantage of the health partnerships project and the other USAID efforts. As was mentioned previously, the partnerships could provide excellent pilot sites and learning sites for other USAID efforts in the NIS, such as the health financing project, and for the NIS projects of other donors as well.

Also the longer term financing of the health partnership program and the individual partnerships themselves must be placed on firmer footing as soon as possible. It is impossible for individual institutions to make long range plans of any kind without any assurance of long range funding. It is impossible for AIHA to require a long range strategy without similar assurance of long range funding. It is obvious that both U.S. and NIS governmental funding problems will make the creation of longer term budgets very difficult, but longer term budgeting and planning is vital to enhance the effectiveness of the health partnerships project.

2. AIHA Policy for Its Twenty-One Partnerships

AIHA has worked very hard to attract an excellent set of U.S. partners and to quickly establish linkages between these institutions and similar types of institutions in the NIS. Whether intentionally or just by pressure of so many other things to accomplish, AIHA has not projected a specific set of strategies or objectives that each partnership must follow, and has imposed only a very limited set of rules or regulations. As a result, each partnership has developed in its own way, on its own, and with its own specific objectives guiding it.

It seems clear that, if the health partnerships are to continue or to expand, a set of central themes and strategies needs to be more precisely formulated by AIHA and promulgated to the individual partnerships. These overall AIHA strategies should probably include the following:

- ▶ Each partnership to fit into the general overall USAID goals and strategies for the country and the region.
- ▶ Each partnership to fit into a rationalized health care delivery system consistent with the NIS Ministry of Health and Oblast goals and strategies, to the extent they exist, for the individual NIS country or region.
- ▶ Whatever individual clinic projects and subprojects an individual partnership may wish to develop, each project in each partnership and each partnership in total to pay specific attention to four major areas or themes:
 - Improvement of nursing services and organization
 - Improvement of general management and administration of the institutions
 - Creation of interest in, and the actual implementation of, quality assessment and improvement techniques
 - Integration of the individual institution's health care efforts into whatever national health care reform efforts may be taking place in the country.

This means that as each individual clinical project is developed, it should include efforts to improve nursing services, improve general management skills, create interest in quality assessment and improvement, and seek ways to integrate the specific clinical project into national health reform.

AIHA should also look at its present selection of specific clinical projects within each partnership and decide whether it wishes all future projects to focus only on a few carefully chosen clinical subjects. This would mean that AIHA and the partners might formally say that each partnership in the future must include efforts in emergency medicine, in infection control, in family planning, and some other specific subjects before any other projects might be considered.

There is some consolidation of efforts along these lines now, but there is by no means universal involvement in any set of specific efforts, and perhaps there should be.

In order to carry out these centrally-required general themes (such as nursing improvement, management and administrative training) and these centrally required clinical topics (such as infection control, emergency medicine), AIHA may have to provide much more technical expertise and assistance to guide the individual partnerships than it does now. AIHA has been careful to keep its central budget and central staff as small as possible, but now may be the time to review this policy and consider whether and how the central staff should be augmented to assist the individual partnerships with some form of central technical expertise in public health.

Further, AIHA should consider increasing its sponsorship of area-wide meetings and of conferences and seminars on specific subjects such as management and administration, improvement of nursing services and organization, and the like. There seems to be universal agreement by the NIS partners that these formal courses, seminars, and meetings, whether in the NIS or the United States have been one of the best aspects of the partnership program in general.

One matter that AIHA must consider seriously is a process for phasing out existing partnerships, either because they have been successful and have achieved the goals they set out to reach, or because they have been unsuccessful and seem unlikely to make much more progress. It was not clear to the assessment team that AIHA has established guidelines for the "graduation" of its programs, and it must begin to do so with some urgency, since action will have to be taken rather soon in this regard.

In a different area, AIHA should determine what its measures of real "success" are and should require much more rigorous monitoring to determine that the partnerships are moving towards those measures of "success". At the present time, it is difficult to determine how "successful" the individual projects and partnerships are and it is therefore difficult to determine how "successful" AIHA has been in managing the effort. There are considerable efforts to gather data about activities and movements (i.e., numbers of people who have travelled in one direction or another, numbers of people attending conferences, etc.) but these are not real measures of success.

In this same general area (i.e., measures of success), AIHA should use care in ascribing monetary value to in-kind contributions. There are impressive sums of money being credited as contributions by the U.S. partners, which amounts are really only estimates by the partners themselves of the amount and value of their volunteer's time, of used equipment that has been taken out of service and sent to the NIS institutions, and of other items that do not usually represent actual financial expenditures by the U.S. partner. It is probably as dangerous to overstate the amount of the U.S. partner's contribution as it is to understate it. Comparison of the amount allegedly invested with the actual accomplishments on the ground could impair the credibility of AIHA and its program. This is not to say that the partners have not contributed

anything, but rather to suggest that it is important to document this amount in a more rigorous fashion, and to exercise care in the ways the numbers are used.

3. Ministry of Health and USAID Policy for Specific Countries

The general suggestion here is that no partnership should be undertaken unless it is clear that it is consistent with the USAID country development assistance strategy. The extent to which it should conform to host country strategy would depend on the situation. Some NIS health ministries have no strategies worthy of the name. Some strategies may not be sound. The assessment team found a number of instances in which the individual Ministry of Health or local health authority knew little about an individual partnership except that it existed, and had no idea what its relevance might be for the country, region or city. This may be appropriate in some cases, but not where the health ministry or a reform element within the ministry has a sound strategy or wants to develop one. In such situations, new partnerships, and old ones as well, should be encouraged to build linkages to, and support reform-oriented individuals/groups in health ministries, as has already occurred with the Kyrgystan MOH and preventive medicine, the Kazakhstan MOH and prenatal care, and the Russian MOH and hospital infection control, just to name a few examples.

For their parts, the individual Ministries of Health and the individual USAID offices should consider their expectations of a partnership. Although USAID approval is required, whether prior Ministry approval of each partnership should be required is a matter for careful consideration and would vary among different countries depending on the ministry agendas and the celerity of ministry bureaucracies. While such requirement of Ministry of Health clearance might help ensure a better integration of the individual partnerships into each country's national health care reform efforts, it would carry a high risk of vitiating one of the distinct advantages of the partnership program thus far: the ability of AIHA and of individual partnerships to respond quickly and flexibly to changing circumstances and new problems and opportunities. We suspect that in most cases, the benefit would not outweigh the likely cost.

4. Individual Partnerships Between U.S. and NIS Institutions

There should be clearer communication of expectations, roles, and productivity between the U.S. and NIS partners. In a number of instances, it was clear that the partners were not sure exactly what they could expect of the other partner, did not know how free they could be in seeking clarification and/or actually demanding greater effort or results, and did not have a clear idea of what resources they both had to work with. As a result, what should have been clear and direct communications became weak and indecisive, and what should have been action resulted in delay. There is almost certainly general good faith on both sides of the 21 partnerships, but there

is some lack of clarity of decision-making, control, and evaluation, which needs to be remedied soon.

One element of each partnership that needs to be emphasized, both by AIHA in general for all its partnerships and by each of the individual linkages, is the full participation by the NIS partner in all aspects of the partnership. This should include active participation in project planning, presentations and seminars, evaluations, and the like. At present, the partnerships tend to be dominated by the U.S. partners, usually without knowing that such dominance is taking place. Such overly strong U.S. partner "presence" has tended to discourage the NIS partners from taking a more active part and learning how to participate more effectively. It has also resulted in some quiet, understated, but nonetheless real resentment on the part of some NIS partners that their U.S. counterparts feel the NIS partners are less skilled or less capable. A clear policy of genuine "partnership" and equal participation in all matters, especially the highly visible formal program presentations, will go a long way toward improving this important aspect of bilateral relations.

For the individual partnerships, as for AIHA, the uncertainty of financial and other resources makes it very difficult to plan any strategy longer than a single trip or short-term project. While the USAID budgetary uncertainties are understandable, the unavoidable consequence is that the lack of long-range budget security make it impossible to develop the necessary long-range plans and objectives that are important to success and essential for efficient use of limited resources. If the overall AIHA program and the individual partnerships are to take a stronger, more effective posture, they must be able to project their financial needs and resources in terms of an annual budget, possibly stretching over several years, something that they are unable to do now.

5. Individual Projects of U.S./NIS Partnerships

In the future, individual U.S./NIS partnerships might be selected to fulfill specific purposes or cover specific areas or functions that are not covered now. This might include geographic areas in the NIS and the United States that are not represented now; it might also include subject areas and types of issues that are not covered or represented now. This might well mean that AIHA would have to be more proactive in seeking out certain partners, both in the NIS and in the United States, than it has been in the past.

This might also mean that AIHA would have to become more directive and even more controlling of the selection of individual projects that a particular partnership might wish to take on. In an earlier section, it was mentioned that every project should probably reinforce four main themes, (nursing improvement, management and administrative improvement, quality assessment and improvement, national health care reform), and that it might want to require participation by every partnership in at least one of the "core" clinical subjects, such as emergency medicine or

infection control. In its most proactive posture, AIHA might want to be even more controlling of a specific partnership's efforts, in order to ensure that one or more particularly important activities are carried out in a particular region or area. This policy has obvious disadvantages as well as advantages, and each must be weighed carefully before determining the general policy.

Annex 1

45

Annex I. Extended Observations on Nursing in the NIS

Assessment

In general, nurses were not invited to participate in the NIS interviews and were present only when the assessment team specifically requested nurse representation. The few nurses who did attend the meetings usually sat quietly and did not offer any commentary unless directly questioned. It was not unusual for a physician to answer for her. Often, the nurse would not stay for the duration of the meeting. The one Russian exception occurred at Hospital No. 122 in St. Petersburg; the director of nursing was not initially invited, but once she was present it was clear that she was indeed an active partner. It was also clear the hospital director held her in high regard, despite saying her presence was not necessary since she was "only a participant" in the program.

A common sentiment expressed by U.S. physicians throughout the partnerships was that the role of the nurse needs to be developed and that this can only be accomplished by redefining their role and providing them with a better education. The message through most of the NIS hospitals was that nurses are uneducated, unskilled, and incapable of functioning like an American nurse. The reason the NIS physicians gave for not sending their nurses to the United States was that they had no power to effect change in their institutions. The physicians see it as their role to observe the nurses in the United States, and for the physicians to make the appropriate nursing curriculum changes. Yet, when physicians are asked what is the most important aspect of the partnership program, they often say it is the ability to see for themselves first hand how health care is given in the United States. NIS nurses are described as being too inept to be able to absorb what they would see in the United States.

This line of thinking is somewhat convoluted. While those NIS physicians clearly state the need to expand nursing responsibilities, at the same time they believe that the physicians are the only ones capable of doing this for the nurses by providing them with more education. If they are not able to put into practice the education they are already receiving, the answer does not seem to be to provide them with even more education. In many countries, a solid two-year college degree is sufficient to produce a nurse with basic skills. Moreover, nursing curricula in medical colleges are formulated by Ministries of Education; therefore, clinical physicians have little impact on promoting change unless they happen also to be at a parliamentary level or, perhaps, if they are professors of nursing.

If the role of nurses is to be developed, nurses themselves need to participate in defining their profession as one distinct from that of the physician, while still working as part of a team who can care for the patient. Nurses throughout the developing world with much less formal education are functioning at a much higher level than most NIS nurses are allowed. The commentaries about nurses may be similar to those heard in other countries, but at the very least they are allowed to train and supervise themselves.

Although some nursing activities are occurring in the partnership program, they are, with few

exceptions, ad hoc and, as with many other clinical activities, depend on what the U.S. volunteers are willing and able to offer at the time, rather than part of an overall strategy. A common activity described for nurses is infection control. Directors of nurses are sometimes targeted by the NIS institution as the appropriate person to take on this responsibility. This is contrary to common practice in the United States, where a director of nurses would not be expected to acquire the clinical and technical expertise needed to address something as specific as infection control. The Coney Island/Odessa Oblast partnership appears to have described a more appropriate approach to infection control by planning to create an infection control department (see Section III.A.3).

The concept of nurse administrators providing supervision and management has not been addressed by most of the U.S. partners. The only NIS partnerships interviewed where the role of nurse as administrator has been successful are the Central Asian partnerships and, to a lesser extent, Hospital No. 122 in St. Petersburg. The Kansas University School of Nursing has developed an excellent strategy which introduces the concept of a nursing philosophy to provide the foundation for the clinical skills transferred. Also, they are allowing a more realistic time period (2 months) to accomplish this focused activity. Further, all Krygystan oblasts are represented so as to create a cadre of nurse leaders for the whole country, which should significantly influence general perception of the nurse's role.

For the nurses, as largely for the physicians, technology and skills have been transferred on an individual basis. Physicians, however, have enjoyed participation in conferences to a far greater extent than nurses. The director of nursing from Hospital No. 122 in St. Petersburg expressed her dismay at finding she was the only nurse from any of the partnerships attending a conference. The few nurses who we had a chance to interview did not attend conferences or use e-mail, although they did avail themselves of the *CommonHealth* newsletter. Thus the primary means available to nurses for gaining new knowledge is the individual attention given them by U.S. nurses.

Preparation of NIS nurses to become educators was not evident during the interviews in the United States or the NIS. The Medical College of Virginia (MCV) seemed to have the potential to address this issue. The MCV Director of Nursing Research and Development is an active participant in the partnership. As an educator she understands instructional methodology and can teach nurses how to teach better than a staff nurse who is clinically oriented. The discipline of education is often underestimated, and proficiency as a nurse or doctor does not necessarily include proficiency in teaching the technical skills in which that professional is proficient. In general, the partners do not have clear plans of action which describe how they are preparing NIS program participants to educate others in the skills which they are being taught. This program aspect is especially critical in view of the hesitancy of some NIS partners to share information.

Despite the aforementioned deficiencies, the partnership program has made one very crucial contribution which is the starting point not only in health but for our relationships overall with the NIS countries. The program has introduced its participants to each other in a milieu whereby they share a common goal. The NIS nurses and physicians have been exposed to a different nurse role. The U.S. nurses and physicians have been exposed to clinicians who can provide adequate care

with a minimum of resources. Given the U.S. need to reexamine the costs of our own health care system, the partnerships provide the U.S. partners an opportunity to sharpen their own assessment skills and to step back and *look* at their patients rather than relying so much on the costly equipment to which they may have become unduly attached.

Impression

The partnership program has not yet been able to provide for the nurse as a professional to participate at a level comparable to the physician. Since only one out of every ten partner exchanges thus far has included a nurse, it is not surprising that the impact on nursing has been minimal. If more substantial impact is to be achieved, AIHA must continue to encourage more appropriate representation and participation of nurses in the program. U.S. partners may be delivering a hypocritical message by attempting to portray nurses as equal team members and at the same time failing to provide nurses more than 10% input in the partnership program.

Recommendations

The following three areas are suggested as foci for each partnership in relation to the nursing program:

1. Management

Increased participation by U.S. directors of nurses comparable to that of the hospital directors would be helpful. Since the U.S. partners are generally less able to spend extended periods of time in their host countries, it seems more feasible to have NIS nurses study for extended periods of time (2-6 months) in the United States. SABIT fellowships may be one avenue which can provide the needed support. The Kansas City University School of Nursing provides one role model which has a broad-reaching effect beyond the walls of an individual hospital.

However, if the Kansas City methodology is not feasible, individual nurses can be selected to work side by side with a U.S. director of nursing, thereby gaining an appreciation of the intricacies involved in managing a health care institution and in the relationship between nurse and physician managers. The commitment of the U.S. director is critically important. Also, the nursing director's position of power within the hospital should be closely evaluated before being used as a role model for others. Some NIS directors of nursing have been described as too inflexible to warrant investment in the U.S. training experience. Care must be taken to select a nurse who, after training, will be able to return to a position of sufficient power and influence to be an effective agent of change.

The AUPHA management conferences could include more participation by the Moscow Medical Institute and other sources of qualified NIS nurse/managers in instructional roles. The conferences should include nurses along with doctors as opposed to separate conferences for nurses, since the issues addressed are appropriate to both professions. Thus, nurses might be empowered and physicians enlightened so that they can work together on common problems.

2. Training of Trainers

Particularly useful from the U.S. partners would be clinical nurse specialists and nurse educators adept at transferring instructional methodologies. Along with the NIS nurse managers, NIS nurses who either are teachers or are capable of becoming teachers should be identified. An obvious place to look for such a person is in the medical college; however, the search should not be limited to there. Once selected, these nurses first must feel confident about their own clinical skills before beginning to teach others. If possible, job descriptions should be created for these new clinical educators and they should no longer be expected to give bedside care but rather to work at the bedside as teachers of nurses.

The nurses should work together in developing protocols for specific clinical foci. Honing in on one discipline is advised so as to avoid overloading the nurse in her new role. Careful consideration should be taken so as to work within the realm of the hospital's limitations. For instance, before developing written protocols, the appropriate ministry and/or oblast officials should be consulted since it may not be possible to develop individual hospital protocols without their approval.

For nursing school education, curricula changes may be difficult to change initially without the support of the dean and ministry involvement. Almaty and Hospital No. 122 in St. Petersburg are two examples where the schools of nursing are actively involved in changing curricula. At the very least, the U.S. partners can provide examples of nurses teaching themselves. Also, although the Moscow Medical Institution has no U.S. partner, AIHA is in a position to tap directly into its strong capability and keen interest in nursing reform in support of interested NIS partners.

3. Clinical Skills Transfer

Once the roles of nurse managers and nurse educators are developed, the groundwork will have been laid to allow for the transfer of technical skills. When feasible and appropriate, the clinical areas chosen should dovetail into the areas being addressed by physicians. This will entail some long term planning and collaboration with physicians so that their efforts are parallel and merging rather than being independent of each other.

The initial clinical skills selected should be those, such as infection control, which reach across departments. Other areas which may be of high priority are women's reproductive health which extends from pre-natal clinics to obstetrics and gynecology to well baby nurseries to family planning centers. Emergency care is particularly important in countries such as Georgia and Armenia and may take precedence over other problems. In these countries, the Emergency Medical System activities cross through several levels of care and have an effect on the recovery of the patient in the field, stabilization in the emergency room, and transfer into the hospital. The Dubna/La Crosse partnership is unique in the activities chosen and the size of their catchment populations. This partnership also provides us with an excellent example of how much can be done with very few resources (see Annex 5 for a detailed description of the program).

The above clinical areas are highlighted because they are areas focused upon already in many of the partnership programs. Moreover, unlike most of the other clinical activities which have had transient attention, these programs have survived the test of time. Every hospital has an outpatient clinic which would be an excellent place to start activities if reaching a broader patient population is deemed important. Moreover, by focusing on preventive public health activities, the need for high tech care will be placed into a more appropriate context.

Women's reproductive health is a field in which nurses play an important role in the United States. The partnerships which have such programs could be utilizing nurses more actively.

Annex 2

ANNEX 2

U.S./N.I.S. PARTNERSHIP PROGRAM ASSESSMENT

PARTIAL LIST OF PERSONS INTERVIEWED

(Listed alphabetically by country, by state and city within country, and by name of institution within city)

ARMENIA

Yerevan

Emergency Medical Scientific Center

Ara Minassian, Director

Anushavan Virabian, Chief of the Substation

Gaghik Manookian, Chief of the Reanimation Department

Morhaness Szakvagian, Chief of Thoracic Surgery Department

Suren Mazganian, Anesthesiologist

Voskan Pahlavian, Chief of Cardiology Department

Yuri Hovakimian, Chief of General and Vascular Surgery

Robert Ozgusian, Chief of Emergency Department

Anna Boshian, Assistant Director of Emergency School

Hripsime Nazasian, Deputy Director of Nursing

Erebuni Medical Center

Haroutioun M. Koushkian, Director

Frunz Tumanian, Head of Maternity Hospital

Karina Sarkissian, Admin. Director of Center for Women's Reproductive Health

Marina Sahakian, Medical Education Director of CWRH

Aram Gevondian, Head of Delivery Department

Larisa Eritsian, Head of Neonatology Department

Emma Harutunian, Physician, CWRH

Sona Khachaturian, Physician, CWRH

Nana Danielbek, Physician, Maternity Hospital

Arpine Harkobian, Head Nurse, CWRH

Cakhtsrik Khathatrian, Head Nurse, Maternity Hospital

U.S. Agency for International Development, United States Embassy

Bella L. Markaryan, Project Development Assistant

KAZAKHSTAN

Almaty

Ministry of Health

Aman Dusekeev, Deputy Minister

AIHA/Eastern NIS

Matthew E. Leafstedt, Regional Director

Zhamilya S. Nugmanova, Scientific Advisor

Sultanat Abdrakhmanova, Office Administrator/Interpreter

Almaty City Health Administration

Gulshara Gazizovna Urmurzina, Head

Askhan Smailovich Smailov, First Deputy

Aleksandr Idorovich Kim, Deputy

Orunkul Akhmetovna Alimbekova, Chief Ob/Gyn.

Almaty Medical College

Kalkaman Ayapov, Director

Galina Sultanovna Beisenova, Vice Director

First Aid Hospital

Amantai Birtanovich Birtanov, Head Physician

Vladimir Ivanovich Lapin, Head of Intensive Cardiology

Elenora Beisenova, Head of Toxicology Center

Naila Almagambetova, Cardiologist

Galina Poddubnaya, Toxicologist

Institute Of Pediatrics

Kamal Saruarovich Ormantaev, Director

Kulyan Omarovna Omarnova, Deputy

Zhana Kakeshevna Sekenova, Deputy

U.S. Embassy

Ambassador William Courtney

USAID/Almaty

Paula Feeney, General Development Officer

Marilynn Schmidt, General Development Officer

Jonathan Addleton, Program Officer

Murat E. Kuzhukeev, General Development Officer

KRYGYZSTAN

Bishkek

Ministry of Health

Kafan Subanbayev, Vice Minister

Institute of Obstetrics and Pediatrics:

Duyshe Kudayrov, Director

Orazaly Uzakov, Deputy Director

Institute of Oncology and Radiology

Zakir Kamarli, Director

U.S. Embassy

Ambassador Hurwitz

Michael Scanlon, Economic Counselor

RUSSIA

Dubna

Oblast Administration

Arslan A. Mavlyanov

Gennady Smirnov, Deputy Major of Dubna

Svetlana Alekseevna Bertash, First Deputy, Main Moscow Health Oblast
Administration

Irina Makarova, Oblast program administrator

City Hospital

Victor Demetiev, Director

Galina Kamkina, Chief of Obstetrics/Gynecology Department

Alexander Hodak, Administrative Director

Lidiy Maslennikova, Director of Nursing

Alcoholism and Diabetes Clinic

Yefgeny Alexander, Director, Alcoholism Program

Kunseva

Government Medical Center of the Russian Federation

Yuri L. Perov, Director, Postgraduate and Research Center

Fedor Tumanov, Chief doctor, Central Clinical Hospital

Vladimir Makarovskiy, Deputy chief doctor

Gennady N. Ushakov, Chief of polyclinic

Moscow

AIHA/Russian Federation

Elena A. Bourgangskaia, Deputy Regional Director

Gennady Konovalov, Senior Medical Advisor

Phoebe Yager, Regional Director/Moscow

Ms. Sharon Weinstein, Program Monitor

Ministry of Health

Dr. Fyodorov, Deputy Chief

Inna Martinovna Timchakovskaya, Infection control department

Moscow Medical Academy

Igor N. Denisov, MD, Vice Rector for Postgraduate Training

Galina M. Perfiljeva, MD, Dean of Faculty of Higher Nursing Education
Pavel I. Salmanov, MD, Chief of Department of Management

Savior's Hospital of Peace and Charity

Alexander Goldberg, Chief physician

Vadim O. Lopukhin, Head physician of maternity hospital

Olga L. Trianina, Instructor/neonatologist

Rachel Mays, Magee-Womens Hospital Field Representative

Melissa R. Zahniser, Magee-Womens Hospital/Program assistant

U.S. Embassy/Moscow

Jason Hurwitz, Economic Section

USAID/Russia

Jack LeSar, Public Health Adviser

St. Petersburg

Hospital No. 122

Jakov. A. Nakatis, President, Hospital No. 122

Irena S. Bakhtina, Dean Post-Graduate School of Nursing

Galina Orlova, Director of Nursing, Hospital No. 122

Jane Younger, Vice President, Jewish Hospital of Louisville, Ky.

Linda Porteat, Program Director, AIHA Moscow Office

Pavlov Medical Institute (aka St. Petersburg Medical Institute)

Nicolai A. Yaitsky, Rector

Slaman H. Al-Shukri, Vice Rector for International Affairs

Larisa Kochororova, Chief Course Coordinator

Michael Herndon, Georgia Baptist Medical Center

Mark Perloe, Gynecologist, Georgia Baptist Medical Center

Linda Porteat, Program Director, AIHA Moscow Office

UKRAINE

Kiev

Ministry of Health

. Vice Minister

AIHA/Western NIS

Miron Fedoriw, Regional Director

Wasył Fedoryshin, Administrative Assistant/Interpreter

Children's Hospitals, Obstetric and Gynecological Hospital

Dr. Victor Didychenko, Director

USAID/Ukraine

Anne Arnes, General Development Officer

Victor Boguslavsky, Health Program Adviser

Lviv

Lviv Oblast Hospital/Lviv Medical Institute

Boris Uspensky, Director, School for First Aid and Postgraduate Medical and
Paramedical Education

. Acting Medical Director

Lviv Perinatal Hospital

Roman Matzura, Director

Ludmila Mikolichuk, Director of Perinatology

Western Ukraine Regional Hospital of Railways

Severy Dybu, Chief Doctor

Odessa

Odessa Oblast Hospital

Vasily Gogulenko, M.D., Director

Svietlana Strelkova, Clinical Director of Hospital and Chief of Internal Medicine

Liana Didenko, Chief, Obstetrics and Gynecology

Nelly Gozhenko, Director of Polyclinic

Dr. Grubnick, Chief of Surgical Department

UNITED STATES

Tucson, Arizona

Tucson Medical Center

Emily Jenkins, Project Director

Washington, DC

American International Hospital Alliance, Inc.

James P. Smith, Executive Director

S. Anthony McCann, Deputy Director

F. Curtiss Swezy, NIS Program Director

Paul M. Stronski, Program Analyst

USAID/Washington

Julie Klement, Chief, Health Office for Eastern Europe and NIS

Petra Reyes, Project Officer, NIS Partnerships

Jacksonville, Florida

Memorial Medical Center of Jacksonville

Debra Bachman, Project Coordinator

Drew A. Snyder, Executive Vice President/Chief Operating Officer

Liz Morrow Ratchford, Director of Special Programs/Coordinator for St. Vincent's Center

Kansas City, Kansas

The University of Kansas Medical Center

Louise Redford, Program Coordinator

Kimberly A. Russel, Chief Operating Officer

Judith E. Reagan, Associate Director International Studies

Fred Holmes, Chief of Outpatient Clinic

Detroit, Michigan

Henry Ford Health System

Michael Lesch, Chair Internal Medicine Department

Brooklyn, New York

Coney Island Hospital

Howard C. Cohen, Executive Director

Nancy Walter, Director of Nursing
Regina Napolitano, Director Infection Control
Ellen Kaplan, Program Coordinator
Alex Sinobicher, Administrator for Primary Care
Dr. Kagen, Medical Director

Pittsburgh, Pennsylvania

Magee-Women's Hospital/Woman-Care International

Tanya M. Kotys, Program Coordinator
Irma Goertzen, President and Chief Executive Officer
Mary Zubrow, Vice President Community and Government Affairs
Michele Ondeck, Consumer Education
Elaine Kitchen, Nurse Manager Labor and Delivery Suite
Francine McCants, Nurse Clinician
Pam Golden, Director of Communications
Linda Thiebald, Director of General Accounting
Sandra Jackson, Infection Control Manager

Children's Hospital of Pittsburgh

Thomas Foley, MD, Endocrinology and Program Coordinator
Susan Reynolds, Assistant Vice President
Basil J. Zitelli, MD, Pediatrics
Miriam Bloan, MD, Pediatrics
Pat Schneider, Nurse Administrator
Mark Sperling, MD Chairman of Pediatrics
Sergi Melinov, PhD, Visiting Fellow in Medical Genetics

Richmond, Virginia

Medical College of Virginia

Carl R. Fischer, Executive Director
Barbara A. Farley, Executive Director, Nursing Services
Bill Bush, Administrator
Ed Racht, Medical Emergency Room
Doug Neely, Administrative Assistant
Eugene Trani, President of VC University
Gwen Burley, Director Emergency Services
Lauren Goodlor, Director, Research & Development
Nataha Olehansky, Interpreter

Members of Russian delegation

Yelena Volkova, Senior Economist

Ludmila Nefedkova, Facilities Designer
Elena Voronukhe, Computer Programmer
Vere Guseva, Reanimation Nurse
Natalia Lada, Nurse Director of Toxicology
Vladimir Pavluk, Reanimation Physician

Annex 3

**ANNEX 3
BIBLIOGRAPHY**

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Annex 4

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October 24, 1994

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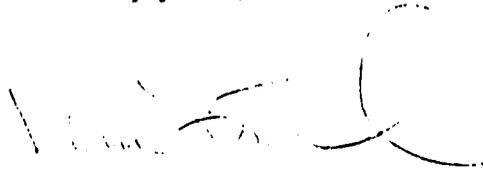
VIA HAND DELIVERY

Dear Linda:

Enclosed is AIHA's formal response to the assessment team's October 5 draft report. We understand from Petra Reyes, Project Officer for the Medical Partnership Program, that this response will be included with the final Program Assessment Report (following Section V: Strategy and Recommendations and prior to the Annexes).

We appreciate the opportunity to offer our comments to the draft report. We look forward to receiving the final version.

Sincerely yours,



James P. Smith
Executive Director

Enclosure

64

AIHA Response to October 5 Draft NIS Medical Partnerships Program Assessment Report

INTRODUCTION

We appreciate the opportunity to respond to the USAID-sponsored assessment of the NIS Healthcare Partnership Program. We would like to acknowledge the assessment team's conscientious effort to get its hands around a program which, since the outset, has been non-traditional, highly organic and decentralized in its development, and consistently flexible in response to a rapidly changing environment. As USAID indicated in launching the assessment, the assessment effort was undertaken in the spirit of further refining the partnership program so that it might best contribute to fulfilling USAID health care "developmental" objectives for the NIS now and in the future as those objectives are fully developed and articulated. We offer the following response to the October 5 draft of the Assessment Report in a similar spirit of furthering this process of program refinement to meet these developmental objectives while preserving the features of the program which make it successful.

Our response to the assessment is divided into three sections: Section I addresses the specific Executive Summary recommendations and summary conclusions highlighted as recommendations in the text of the larger assessment document. Section II addresses the concerns expressed by the assessment team with respect to the vertical task forces, or what AIHA describes as "synthesis areas," of hospital infection control, emergency medical services and neonatal resuscitation. While these concerns did not trigger any specific recommendations, they nevertheless raise issues which deserve a careful response. Section III addresses the overall conclusions of the assessment team with respect to future program direction, and presents an alternative approach which takes greater advantage of the special strengths of the partnership methodology while maintaining flexibility for USAID regional offices.

Overall, the assessment gives high marks to the program, noting that it was well conceived and exceptionally well implemented to achieve significant results rapidly. The assessment goes on to validate virtually all of the programmatic elements which have been implemented, and in many instances, strongly urging their expansion.

The assessment's main purpose, however, is to suggest future direction for the program. In the main, these suggestions relate to focusing the partnerships on specific USAID and MOH priorities, establishing criteria to judge winners and losers, eliminating "low performance" partnerships which do not conform to these priorities (and establishing new partnerships which will conform), and AIHA increasing its focus on overarching programs which meet specific USAID developmental goals.

We believe that there is a danger in overemphasizing USAID developmental goals, which may only now be in the process of formulation. The fact is that the partnerships pursued a rigorous objective setting process in which partnership activity was agreed upon by

65

institutional leadership, often with the input and active participation of regional and national health officials. As we note in our response, we recognize that USAID may have developmental objectives which could be better pursued through traditional grant programs, consultancies and other means. Forcing partnerships, however, to fit the mold of other programs by eliminating the local, demand-driven aspects of the objective-setting process or abandoning the voluntary component of the program is not warranted, especially in light of the fact that the partnerships seem to be effectively addressing critical overarching objectives such as the establishment of a management culture and the values and concepts related to democratic decisionmaking, concern for quality, team building, patient centered care, and so on. As we have seen time and again, once these values and concepts find fertile ground, the results are quite often extraordinary and, more often than not, unplanned.

The assessment may also leave an erroneous impression that some current partnerships are not achieving their objectives or otherwise might not meet criteria for continued support, thus presenting a need, and even perhaps an opportunity, to phase them out and start new partnerships better directed at USAID objectives. The partnerships are, in fact, largely meeting the criteria suggested by the assessment (most of this criteria is already part of AIHA's management process) and producing significant results, as acknowledged by the assessment. In those few instances where the partnership's success in terms of programmatic outcome is somewhat more modest, we are not persuaded that it represents, or should be characterized as, a "failure" on the part of the partners or the partnership methodology or that US interests would be served by abandoning the current project and starting another.

In our opinion, the programmatic elements and documented successes taken together with the significant people-to-people and democratization objectives that the program is responding to, and the continued uncertainty of long-term funding in the NIS, dictate a program direction which is consistent with, but nevertheless slightly different than that suggested by the assessment. This approach is fully described in Section III of this response.

SECTION I: RESPONSE TO SPECIFIC RECOMMENDATIONS AND SUMMARY CONCLUSIONS

RECOMMENDATION 1

AIHA to continue, even strengthen, its support for NIS efforts to improve efficiency through training in administration and management (Executive Summary p. 4); AIHA to continue its emphasis on health care management, particularly the involvement of the AUPHA in addition to the individual partnerships (Assessment p. 17).

Although we strongly agree with the Assessment's validation of AIHA's support for administration and management training, we take some issue with the accompanying observation that "...thus far most of the technical knowledge transfer within each partnership has been clinical, not administrative. Whatever management expertise has been transferred

in the limited time available has been principally through the special AUPHA courses," (p. 16). The lack of a 'management culture' has been cited time and again as one of the greatest weaknesses of every productive sector of the Soviet system, including health care. During the early partnership development stages of the program, AIHA was continually advised by prospective NIS participants that "a change in mentality" was their greatest need and should be the program's most important goal. AIHA and its partners have fully incorporated the philosophy that the development of a management culture must extend to every facet of the delivery of health care including clinical and nursing approaches and organization, and must be much more extensive than simply training key personnel in administration and management. The concept of managing health care and such related ideas as assuring quality, planning strategically, and deploying resources effectively and most cost efficiently must be firmly ingrained in every aspect of health care delivery and most especially in clinical approaches which, after all, are the 'product' of the health care provider. This integrated approach is consistent with the predominant role currently played by clinicians in the NIS and recognizes that the separation of clinical and administrative spheres may represent a deficiency in our own system (note increased emphasis on clinical management in the US by group practices and capitated providers). Viewed from this larger perspective, we believe that the partnerships have transferred considerable management expertise over the past two years, evidenced by numerous examples of reductions in length of stay and increases in patients treated.

The AUPHA/AIHA approach to management training was specifically developed in support of this larger interest in management culture and in recognition that a specialized cadre of administrators was largely nonexistent. These two-week courses and various follow-up workshops have consistently focused on the development and application of basic management skills such as problem definition, strategic planning, and team building through a highly participatory, small group, case-study methodology. As often as not, the participants have focused on high priority clinical-organizational issues in their individual projects, reflecting the inseparability of clinical and administrative issues in the delivery of care.

Although we have focused on the development of the larger management culture, administrative specialization is inevitable and desirable. In addition to supporting follow-up workshops for course alumni in leadership skills and institutional productivity during AIHA's recent Annual Conference and an additional basic management course for Armenia and Georgia (November 1994), AIHA and AUPHA will develop and introduce more specialized workshops in Spring 1995 to address specific needs in institutional budgeting/financial management, asset acquisition/purchasing and resource allocation. As the Assessment correctly points out, important preconditioning for such specialized training has taken place; equally important, the larger health care delivery and political/economic environments in which the partnerships operate are stabilizing and directions for health financing and system control are more predictable in 1994/95 than they were in the first two years of program operation. AIHA will also identify institutions which might benefit from the Abt health financing reform project funded by USAID.

In response to the Assessment's observations, AIHA is also taking steps to assure that individual partnerships clearly identify and specifically focus on administrative and

management issues by requiring that individual partnership workplan objectives include a description of the administrative/management elements of each partnership objective, including those predominantly associated with clinical and nursing issues.

RECOMMENDATIONS 2 AND 3

AIHA, through guidance to partners and through own conferences, seminars, etc., to encourage increased participation of nurses, administrators and other non-physician professionals and paraprofessionals of the US and NIS health care systems (Executive Summary p. 4).

In order to eliminate inefficiencies resulting from misuse of personnel and at the same time improve patient care, AIHA and the partnerships to encourage and assist NIS partners' analysis of the division of labor and potential for better teamwork between physicians and nurses, in addressing unsatisfied needs in the care of patients, and conforming level of professional preparation to the tasks to be performed. As part of such effort, AIHA and the partnerships to continue exposing NIS physicians and nurses to the teamwork of physicians, nurses, paraprofessionals and other support staff as practiced in the US (Executive Summary p. 4).

AIHA strongly supports the increased participation of non-physician professionals in both partnership and inter-partnership activities of the program. We have been strong proponents of the view that enhancing the role of nurses, in particular, is essential to improving health system productivity and quality of patient care in the NIS. While we concur with the recommendations of the Assessment to further strengthen the role of nursing in the partnership program, we do not believe that the Assessment's commentary in Annex I (that AIHA and its US partners have been hypocritical in their approach to nursing involvement or that the partnerships should be faulted for not having been able to leapfrog across the significant cultural and social barriers to allow nurses in the NIS to operate at a comparable decisionmaking level to that in the US) is warranted. The exchange participation numbers used as the premise for the contention that nurses are not active participants in the program was based on early data from the program. While nurses constituted only 10 percent of participants in the first year of the program, they constituted almost 30 percent of all exchanges in the second year of the program. This trend, which we expect to continue, more accurately represents the very real efforts of the partnerships to overcome strong cultural and social resistance to a significant change in the relative roles of physicians and nurses. Nor do we believe that the absence of nurses in the top leadership councils of the NIS hospitals -- the leadership level at which the assessment team met briefly during their site visits -- indicate that there is not an increased willingness and effort to enhance the role of nurses within the hospital.

Changing the role of NIS nurses will be contentious at best and, in the absence of the significant economic factors which have driven much of the change in roles in the US (e.g., high-cost physician and bedside technology inputs), a potentially more difficult proposition than our own experience in the US suggests. While we have reason to believe that change

will occur, it is unreasonable of the assessment team to expect conclusive change over a 12-18 month period or change that necessarily mirrors the US experience.

We are concerned that the Assessment not only sets an unrealistic goal but that it fails to sufficiently credit the program's efforts to date as well. There is compelling evidence that most NIS partner hospitals and many of their related MOH now recognize that their institutional success over the intermediate and longer terms depends to a great degree on their ability to make changes which will result in better utilization of nurses and other non-physician personnel. Since nurses play such a significant role in patient care in the US partner hospitals, it is not surprising that all partnerships have focused to some degree on an enhanced role for nurses in the NIS. This focus has been reflected in the steady increase in the proportion of nurse participants in the exchanges cited above.

Moreover, several of the partnerships have gone so far as to make nursing administration and leadership their primary partnership objective. Four partnerships specifically focused on their efforts in this regard during AIHA's recent Annual Conference in St. Petersburg. Although the Assessment acknowledges the directions taken by several of the partnerships, it fails to give adequate credit for the significant clinical and physician related tradeoffs which these decisions imply on the part of the NIS partner or the persuasive efforts of the US partners.

The Assessment also fails to acknowledge the numerous efforts that AIHA and its partners have made to specifically focus on nursing related education and issues as part of the AIHA and partnership-sponsored conferences, workshops, and training centers. Virtually all such conferences have approached the provision of clinical care through a team approach; US nurses have been key faculty members in the conferences and workshops and, in many instances, have been the predominant faculty. At each conference, clinical workshops or sections have been addressed to NIS nurses and designed to improve their participation in clinical decisionmaking. This approach to changing the role of nurses at a very practical level will be more effective, in our view, than the ideological approach taken by the assessment team.

In addition to increasing participation overall and urging a more direct focus on nursing leadership in a number of additional partnerships, AIHA has established a Nursing Task Force of US and NIS nurse leaders to develop and implement a coordinated partnership strategy. The task force is examining regional differences in nursing practice, developing standards of practice for professional nurses and nurse administrators, and is establishing a nursing leadership support group within the NIS. The task force has already reached out beyond the partnership institutions to include other key nurse educators and leaders in the NIS and is seeking to integrate the efforts of other USAID-supported efforts in nurse training through the NET and other programs.

As with the administration/management initiatives discussed in Recommendation 1, AIHA has also taken steps to assure that individual partnerships clearly identify and specifically focus on nursing issues by requiring that individual partnership workplan objectives include a

description of the specific nursing related elements of each partnership objective, including those predominantly associated with clinical and administrative issues.

RECOMMENDATION 4

AIHA and the partners to continue their efforts to develop contacts with NIS Ministries of Health to gain a better sense of regional and national needs and priorities, in order that partnership activities may be more responsive to them. The Ministries may also be able to provide support for dissemination of the knowledge and expertise gained through the partnerships. The partnerships should, however, be wary of relationships that might subject their own activities to bureaucratic approvals or vetoes of Ministry officials (Executive Summary p. 4).

AIHA and its partners have always sought the active support and involvement of the respective NIS Ministries of Health (MOH) in the partnership program, enjoying in many instances, a very special relationship with the MOH. While a second generation of partnerships would be likely to involve the various MOH more directly (as has been the case in AIHA's Central and Eastern European partnerships), the Assessment acknowledges the difficulties of targeting partnership objectives on MOH strategies which may be either non-existent or in the process of significant reform or debate.

Like other governmental institutions, NIS MOHs are still defining their role in the aftermath of the breakup of the Soviet Union. AIHA and USAID sought the involvement of MOHs during the partnership establishment phase; in some instances (in the newer and smaller countries of Georgia, Moldova, Kyrgyzstan, Turkmenistan, for example) the MOHs were deeply involved in the identification of the NIS institutions and in the development of the partnership. In the case of Moldova and Turkmenistan, the MOHs even participated in the US partner selection process. In other instances where the MOH was relatively headless or passive at the time (such as the larger countries of Russia and Ukraine), Ministry personnel were less involved. In these instances, the Ministry was, more often than not, simply eager to assure that some needed assistance would flow to hospitals under serious economic duress. In these cases, however, city or oblast health administrations to which power was effectively decentralized, were more heavily involved (Kiev, Moscow, Vladivostok, Murmansk, Stavropol, Almaty).

During the course of the program, the attitude of MOHs toward the program has changed, often as a reflection of the Minister's personal interests, but always toward more involvement, not less. Those that were heavily involved from the beginning (Georgia and Kyrgyzstan, for example) have increasingly drawn directly on the partnerships for expertise in specific areas of health reform: the Atlanta-Tblisi partnership has provided many of the consultants and outside expertise in support of the MOH recent health care reform proposal to the Georgian Parliament; the University of Kansas training program for senior Kyrgyz nurse administrators is part of the Kyrgyz MOH strategy to convert excess acute care hospitals to needed nursing facilities and hospices. Some, like the Russian Federation MOH, that were less involved in the beginning, have increasingly begun to see the partnerships as potential models and

10

sources of expertise in infection control and pre-hospital emergency services and have joined AIHA in the development of collaborative efforts.

In the interest of seeking maximum impact, AIHA, through its regional offices, has encouraged the involvement of all of the appropriate levels of health care administration in widely disseminating partnership success. Related conferences and workshops are increasingly co-sponsored by these higher levels of government. In this same vein, the regional EMS training centers are each co-sponsored by their respective regional or national governments. As the dissemination activities of each partnership increase in the latter part of the partnership period, these efforts will receive additional priority on the part of the partnerships and AIHA's regional office. In order to guarantee this focus, AIHA has also taken steps to assure that individual partnerships clearly identify how partnership workplan objectives are related to MOH reform initiatives and AIHA regional offices are developing dissemination workplans with the MOHs.

RECOMMENDATIONS 5 and 6

AIHA to continue, even expand, its support for the development of dissemination systems within the NIS countries through such means as conferences, E-mail, professional associations, perhaps even some support for medical journals during this current period of severe financial strain (Executive Summary p. 4); For conferences and publications, AIHA to encourage increased NIS professional participation in program planning and presentations, even at the risk of slowing the process through the increased coordination requirement (Executive Summary p. 5); AIHA to include regular sections in CommonHealth targeting nurses in order to provide them with useful information to upgrade their skills (Assessment p. 23); AIHA to ascertain the causes for low usage of E-mail and train the NIS partners on the efficient use of E-mail and encourage them to use it more frequently to share and receive information (Assessment p. 23).

While AIHA's partnerships are distinguished by their highly voluntary nature and decentralized, peer-based objective setting and decisionmaking processes, AIHA's overall program is distinguished by the extent and quality of its inter-partnership communications. Over the course of the past two years, over 40 conferences and workshops have been held involving thousands of participants, including many from non-partnership institutions. As the Assessment acknowledges, in the absence of other sources of information, the partnership program and AIHA's sponsored activities have become a principal "window on the world" for many NIS countries.

AIHA is very much aware of the concerns expressed by some of its NIS partners that they have a greater opportunity to serve as faculty of various conferences and workshops. In conferences and workshops that it primarily sponsors, AIHA has shifted most of the burden to NIS participants and faculty; in the recent Annual Conference, for example, all partnership presentations and the majority of workshop presentations were made by NIS participants and co-sponsoring MOH staff. Similarly, the EMS training centers will rely almost exclusively upon NIS trainers. During the initial period of partnership activity, we believe that the balance in favor of US faculty was more often than not appropriate. In a few instances of

contention between partners, US partners argued persuasively that NIS participants were not yet sufficiently trained to assume dissemination responsibilities and that there was some danger in misinformation being directed at a larger audience. At this later stage, however, sufficient train-the-trainer activities have been undertaken so as to allow the majority of dissemination to be undertaken by NIS faculty in the future. AIHA will carefully monitor all future dissemination activities to ensure that NIS participants are primarily responsible for organization and instruction.

CommonHealth articles and coverage reflect partnership and programmatic emphasis. As nursing issues become increasingly important in the partnerships, CommonHealth has seen a similar shift in emphasis. A considerable portion of the August/September 1994 issue, for example, was devoted to the Bishkek and St. Petersburg partnerships' activities addressing nursing education and administration, and we expect to see considerable coverage in forthcoming issues of the upcoming NIS nursing conferences on infection control and nursing administration/leadership. While a separate CommonHealth section devoted to nursing is under active consideration, we are concerned that this action might only serve to further isolate nursing. As an alternative, we are considering a requirement that all articles address the nursing relationship, thus ensuring a more mainstream approach. Although CommonHealth can provide models and success stories and direct readers to sources, its purpose is not to provide a vehicle for upgrading skills. AIHA has asked the Nursing Task Force to recommend other communications vehicles and approaches for meeting this need.

AIHA has been active in applying state-of-the-art communications strategies to partnership activities. While the AIHA Internet Clearinghouse and E-mail network was developed to meet partnership communications needs, we share the concerns of the assessment team that the NIS partners are not utilizing E-mail to its fullest potential -- particularly in NIS-to-NIS communication. While we are mindful that the barriers to NIS-to-NIS communication may not be solely technical, a series of E-mail workshops were held during the recent Annual Conference and a follow-up strategy is currently under development to increase use at each individual partnership. In the meantime, an E-mail workshop targeted at participants in the upcoming Georgia/Armenia management course will be held during the first week of November in Tblisi, Georgia. As part of its overall information strategy, AIHA will also be meeting with the National Library of Medicine to determine whether Med-line and similar on-line services may now be feasible given recent changes in the Internet.

AIHA has considered supporting the funding of subscriptions to key medical journals and has also considered seeking funds for the development of "health services libraries" in key NIS cities. To date the partnerships have relied upon the US partner providing back issues of subscriptions as part of their in-kind contribution. In view of the assessment team's recommendation, AIHA has instructed its regional offices to survey the basic requirements of each NIS partner with respect to medical, nursing, and administration journals. This information will be used to develop a strategy to be funded under the Partnership Program's extension proposal.

RECOMMENDATION 7

AIHA, as funding permits, to fill in the geographic holes in the program. This applies both in the United States, where there are not now many partners in the western part of the country, and especially in Russia, for the vast region from the Urals to the Pacific Coast (Executive Summary p. 5).

Based upon the recent response to partnership solicitation in Central and Eastern Europe, AIHA believes that US health care providers continue to be prepared to engage in partnerships if and when additional USAID funding becomes available. While the recommendation should more properly be directed toward USAID, it is important to clarify that the current geographic distribution of partnerships is not a function of AIHA's partnership identification or development process, which is open to all interested US health care providers. With respect to distribution in Russia, AIHA proposed additional partnerships in Southern Russia, the Urals and the Russian Far-East in late 1992, several of which involved US institutions in Texas and California; faced with insufficient funds to make awards to all partnerships, USAID chose partnerships elsewhere in Russia and the NIS. In an unfortunate coincidence, hospitals in Utah and Washington were involved in two partnerships which were terminated or curtailed in 1993 because of lack of commitment of the NIS partner institutions.

RECOMMENDATION 8

AIHA to discontinue funding for American partner resident coordinators in the NIS. To qualify for consideration for a partnership, an NIS institution should have the capacity to implement programs without such continuous US involvement, which can tend to undermine the partnership concept and put the US partner in a paternalistic relationship (Executive Summary p. 5).

We agree with the recommendation in principle and have advised the two partnerships involved that AIHA funding will not be used to contribute toward onsite US personnel effective with the new workplan cycle beginning on December 1, 1994. Notwithstanding our decision, it is important to note that the Magee-Savior and Atlanta-Tblisi partnerships are among the most successful partnerships programmatically and have evidenced some of the highest ratios of in-kind contribution to US funds. The onsite resources provided under their agreements with AIHA have been instrumental in both partnerships achieving their significant progress and the personnel involved have been highly praised by the First Lady of Russia and the President of Georgia, respectively.

RECOMMENDATION 9

AIHA to strengthen the AIHA regional coordination office in Moscow, and, in this connection, AIHA to consider consolidating the Kiev and Moscow offices in Moscow. Such consolidation could permit employment of more mature leadership for the Moscow regional office, including some medical/developmental experience and expertise to facilitate (1) access of new partnerships to experience of predecessors and (2) sharing of experience and expertise among existing partnerships (Executive Summary p. 5).

While we are mindful that additional resources in the Regional offices would be extremely helpful in further coordinating a number of intra-partnership initiatives and relieve some of the burden on an overworked staff, we object to the recommendation because it rests on a presumption that the partnership program should more closely approximate a traditional USAID developmental assistance program, where expert resources advise governments and institutions on programs and strategies. Our own view is that the AIHA regional offices -- within their current role as managers of the partnership program -- should be facilitator, enabling the partners and especially the NIS participants (including MOH and other levels of government) to effectively tap the resources that AIHA and its US partners can offer. We believe, moreover, that the assessment team has significantly understated the complexity and significance to program success of this facilitation and what they refer to as "logistical services," apparently failing to understand that the thousands of person exchanges and dozens of high quality conferences and workshops represent extraordinary management and substantive achievements in their own right.

In recommending that AIHA hire someone with "developmental as well as medical qualifications" -- presumably an American -- the team has failed to appreciate the fact that the regional offices have been carefully staffed with NIS personnel with medical qualifications who understand both NIS and US health care issues and thus can fulfill the enabling role without being perceived as being paternalistic. The assessment team has especially underestimated in this regard, for whatever reason, the capability of AIHA's Regional Director and other staff in Moscow. The Regional Director, in fact, was specifically excluded from the team's meetings with several of the Russian partners out of some inexplicable concern that her presence would distort their interview. Over the course of the past eighteen months, AIHA has made a significant investment in carefully developing a small group of NIS physicians who have completed graduate degrees in health administration in the US; the Regional Directors in Moscow -- and now, Kiev -- have such unique backgrounds and, although young, are extremely well respected by senior MOH personnel and both US and NIS partners. In addition, the Moscow and Almaty offices have NIS physician advisors who have significant academic stature and are highly respected among their peers. The AIHA regional offices are meant to facilitate partnership activities at three levels: within partnerships, between partnerships and between partnerships and the MOH. Like its counterpart offices in Almaty and Kiev, the Moscow office has distinguished itself in each of these activities and clearly enjoys both the confidence of the USAID/Moscow office, the Russian Federation MOH, and the partnerships themselves.

The assessment team has also underestimated the importance of AIHA's Kiev office. Closure of this office in favor of a larger consolidated office in Moscow flies in the face of important geopolitical realities and would compromise the level of support provided to the partnerships in the area. It also understates the amount of supervision and effort to assure logistical services in Ukraine, Moldova and Belarus and fails to appreciate the administrative and program management relationships required by the USAID/West NIS office in Kiev.

RECOMMENDATION 10

Further, in this connection and to influence development strategy for the program, AIHA to consider strengthening the medical technical competence of the AIHA home office in Washington. Ideally, such a technical person would combine both medical and international development experience and expertise, which in this case we would consider more important than Russian language competence (Executive Summary p. 5).

As in the case of its regional offices, AIHA recognizes that additional resources would be helpful in furthering certain aspects of its program and would provide some relief for a staff which is often overworked and thinly stretched. As in the case of the regional offices, we strongly disagree, however, with the apparent basis and thrust of the recommendation as it applies to management of the partnership program. The recommendation is better suited to a more traditional consultant/grantee role, a role which AIHA may elect to pursue under other programmatic initiatives but which are not the subject of the assessment.

The assessment team has similarly understated and under-appreciated the staffing pattern and personnel qualifications in AIHA's Washington office. The assessment is correct in pointing out that only one senior staff member has a development background and that none are physicians. It fails to point out, however, that the Executive Director and Deputy Director have extensive backgrounds in health policy formulation and implementation at very senior levels in both the US public and private sectors. The assessment team also failed to note that the three "roving" staff members who are heavily involved in partnership coordination and intra-partnership activities have extensive and very senior backgrounds in nursing leadership and administration, managed care and health promotion, and hospital and health system strategic planning, respectively. We believe that the backgrounds of these senior staff, coupled with a strong language and NIS living experience of the more junior staff, have proven to be precisely the right mix for program success.

RECOMMENDATION 11

USAID and AIHA to consider the advisability, on a limited scale, of financing equipment essential to use technology, available through partnerships, which offered particularly high return on investment in medical efficiency, for example equipment for ultrasound examination, endoscopy or laparoscopy, that would substantially reduce number or scope of intrusive procedures with corresponding reduction of risk of infection and length of hospital stays (Executive Summary p. 5).

While AIHA has supported the partnership's application of essential productivity-enhancing technologies, we have sought to minimize the direct expenditure of funds for such equipment, believing that the partnership program should not become an equipment and supply effort, but rather should use limited funds for the support of exchanges. Recognizing that many of the partnership efforts would be limited without certain key supplies and equipment, limited funds have been focused on enabling the partners to provide such equipment and supplies, thus targeting AIHA/USAID funds on shipping and packing and occasional key spare parts. AIHA's US partners and related US manufacturers and suppliers

have contributed to the program almost \$10 million in equipment, supplies, and pharmaceuticals over the past two years. (Note: contrary to the assessment team's perception, the values of such contributions are not overstated, and we have been careful to assure that the NIS partner hospitals do not become dumping grounds. Much of these contributions are of new supplies, pharmaceuticals and equipment; used equipment has been valued at fair market values and has been fully refurbished, with training and spare parts provided for.)

Recognizing that the partnerships have a solid track record, carefully identifying needs and helping to assure appropriate utilization of technology inputs, the State Department's NIS Coordinator and DOD have extensively involved AIHA and the partnerships in their significant supply and equipment efforts in Russia, Belarus, Ukraine, Kyrgyzstan, Uzbekistan, Georgia, Moldova, and most recently, Kazakhstan.

SECTION II: DISCUSSION OF AIHA PARTNERSHIP SYNTHESIS PROGRAMS

AIHA has encouraged the development of regional and system-wide approaches in instances where many individual partnerships have recognized a similar problem/need and where developmental activities might otherwise have led to unnecessary duplication of effort or loss of valuable time. Over the past year, three such areas have been addressed: hospital infection control, emergency medical services, and neonatal resuscitation. In the course of their assessment, the team formed impressions about the activities in each of these areas. Although the team's views are not part of a formal recommendation, we believe sufficient misunderstanding exists in the assessment report regarding AIHA's approaches in at least two of these areas, emergency medical services and neonatal resuscitation, that a response is required.

Emergency Medical Services

Nine AIHA partnerships are addressing issues related to pre-hospital emergency care. This focus is especially appropriate because it addresses an area of rapidly rising morbidity and mortality in the NIS and has the potential of improving overall health care delivery system productivity. The focus of the AIHA synthesis activities has been on the development of a common basic training curriculum for physicians, nurses, and drivers traveling as part of ambulance/home call teams and funding the development and equipping of four regional training centers in Almaty, Vladivostok, Chisenau and Yerevan. These centers, utilizing NIS faculty, will train thousands of pre-hospital personnel each year. The program has the potential of touching communities throughout the NIS and is being actively considered by the World Bank and several MOH's for replication.

While the assessment generally supported AIHA's efforts in this area, the team evidenced concern that NIS hospitals may be drawn into hospital based critical and intensive care activities as a result of the program. We believe that the assessment team has seriously misunderstood the AIHA EMS efforts in this regard. Contrary to the team's perception, the

EMS program is focused almost exclusively outside of the hospital and aimed at on-site first-aid, patient stabilization and transfer. At the hospital, the program focuses on effective coordination with the hospital intake unit so that pre-hospital gains are carried forward.

Neonatal Resuscitation

Virtually all partnerships have focused on improving techniques related to newborn resuscitation as a means of helping to reduce high rates of infant morbidity and mortality. In doing so, the partnerships are responding directly to MOH descriptions of reducing newborn asphyxia and epoxia as one of their highest health care priorities. AIHA has supported the partnerships by making available a standard package of training materials and supplies and by coordinating supporting a number of related training workshops.

The assessment seriously questioned the priority given to newborn resuscitation and suggested de-emphasizing neonatal resuscitation in favor of a greater emphasis on women's reproductive health. We believe that this recommendation is based upon a basic misunderstanding of the nature of the population at risk in the NIS and what newborn resuscitation means as it is applied in the NIS context.

In discussing the assessment's critique with AIHA's Resuscitation Task Force Chairman, Dharmapuri Vidyasagar, MD, Director of Neonatology at the University of Illinois, Chicago, and director of the WHO Collaborating Center in Neonatology, he concurred with the assessment observation that NIS professionals cite newborn asphyxia as the predominant disorder in their intensive care units. As Dr. Vidyasagar points out, however, in order to appreciate the context of the statement made by those in the NIS one must first recognize that when we teach resuscitation, we are teaching it not as we know it in the US, but rather as a concept of "preventive neonatology". Under this program, NIS partners are taught to recognize infants at risk of asphyxia and attend to these neonates in the delivery room, thus decreasing the number of neonates requiring admission to a Neonatal Intensive Care Unit (NICU). Dr. Vidyasagar and his US colleagues at other partnerships believe that given current practice in the NIS and under present conditions, 30-40 percent of babies at birth will suffer birth asphyxia, possibly leading to death. Non-fatal cases will require significant health care and long-term social services and contribute to the cerebral palsy rate in-country. The model program being pursued by the partnerships should bring the rate of birth asphyxia within normal limits and eliminate the need for additional services for afflicted children. The end result will be an increase in healthy babies and a decrease in those requiring NICU services. The impact on infant mortality and morbidity can be relatively immediate and at very low cost to the NIS health care systems.

The WHO has addressed this issue, teaching birth resuscitation in Africa and India to residents. The WHO program, from which the AIHA partnership program is derived, is aimed at significantly reducing hypothermia and birth asphyxia by helping the neonate to establish neonatal circulation. Such a program is capable of "breaking the chain" which if one does not do, leads to brain damaged infants. The assessment team is reminded that intensive care is not always the next step; on the contrary, Dr. Vidyasagar and other experts believe

that the number of neonates requiring intensive care can be reduced by 50 percent through implementation of a neonatal resuscitation program.

In the program, NIS trainers (physicians and nurses) teach mothers to look at risk factors in their own maternal condition, such as pedal edema, abdominal girth, and color of eyes and tongue, that could indicate high risk pregnancy and resultant neonatal asphyxia. Physicians are taught to determine which mothers have a high potential to deliver such infants, and these mothers are directed to hospitals capable of providing high-risk care. The key factors in the AIHA program in the NIS focus on educating staff with respect to cleanliness, maintaining thermoregulation, prevention of sepsis, and oxygenation to ensure circulation; neonatology is thus taught in a very basic manner, encompassing a total of five-six competencies.

Finally, we believe that while the extreme outcomes predicted by the assessment team with regard to increasing marginal investments in ever decreasing birth weight babies represents a long-term possibility, we should note the fact that NIS countries do not have the same standards for medical ethics that we in the US support. Hence, aggressive approaches to resuscitation in marginal cases are not enforced, and if the baby cannot breathe beyond a predetermined number of minutes, resuscitative efforts are generally withdrawn.

Our support for basic resuscitation programs does not in any way reflect a decision on our part that women's reproductive health is not a significant priority in the NIS. On the contrary, AIHA's partnerships have been in the forefront of recognizing the impact of a reliance on abortion as a means of contraception and a number of AIHA partnerships have focused on establishing model programs in women's reproductive health. We have urged and continue to urge USAID to allow partnerships to play a stronger role in the development of such programs in the NIS.

SECTION III: FUTURE PROGRAM DIRECTION

As noted in the introduction, the assessment was undertaken with a view toward refining the partnership program so that it might better fulfill USAID health care developmental objectives. Overall, the assessment gives high marks to the program, noting that it was well conceived and exceptionally well implemented to achieve significant results rapidly. The assessment goes on to validate virtually all of the programmatic elements which have been implemented, and in many instances, strongly urging their expansion.

The assessment's main purpose, however, is to suggest future direction for the program. In the main, these suggestions relate to focusing the partnerships on specific USAID and MOH priorities, establishing criteria to judge winners and losers, eliminating "low performance" partnerships which do not conform to these priorities (and establishing new partnerships which will conform), and AIHA increasing its focus on overarching programs which meet specific USAID developmental goals.

It would be easy for AIHA to simply agree with the assessment team's views in this regard. The result would clearly be a program which fits more easily into the traditional development paradigm and would enhance AIHA's role as a mainstream development agency. We believe, however, that the partnership program embraces a number of non-traditional elements which, although challenging conventional developmental strategy, have proven to be valid in the NIS and elsewhere and have resulted in considerable programmatic success. In our opinion, these programmatic elements and documented successes taken together with (1) other important US government objectives that the program is responding to, and (2) the continued uncertainty of long-term funding in the NIS, dictate a program direction which is somewhat different than that suggested by the assessment.

PROGRAMMATIC ELEMENTS

Although not always fulfilled in practice, the partnership program embraces and strives to implement the concept that development activities should be driven by local demand and be peer-based, involving real-world practitioners -- volunteer counterparts rather than professional development consultants. While the assessment team voiced support for this concept in the NIS and validated its successful results, it nevertheless often reverts back to a more traditional approach as it focuses on future directions for the program. This approach is especially evident in discussion of: (1) the development of program objectives; (2) criteria for "success"; and (3) increasing the role of "development" professionals.

- In remarking that the program responds to "the particular skills and interests of individuals at the local level on both US and NIS" (Executive Summary p. 2) and that the partners have pursued their "personal interests" to fit whatever the US partners have available to offer, the assessment implies that the partnership activities bear little relationship to health care priorities in the NIS. Moreover, it fails to acknowledge that the partnerships pursued a rigorous objective setting process in which partnership activity was agreed upon by institutional leadership, often with the input and active participation of regional and national health officials. The assessment goes so far as to suggest that USAID might consider abandoning the voluntary component of the partnership methodology in exchange for pursuing USAID objectives which the partners might not otherwise pursue.

We recognize that USAID may have developmental objectives which could be better pursued through traditional grant programs, consultancies and other means. Forcing partnerships, however, to fit the mold of other programs by eliminating the local, demand-driven aspects of the objective-setting process or abandoning the voluntary component of the program is neither necessary, nor prudent for several reasons.

First, we believe that a persuasive case can be made that the most important objectives addressed and technology transferred underlie and transcend all of the specific health care objectives of the partnerships, no matter what they are. These objectives include the establishment of a management culture and the values and concepts related to democratic decisionmaking, concern for quality, team building, patient centered care, and so on. AIHA emphasizes exchanges to the United States

because we strongly believe that these values and concepts are best shared and acquired firsthand and through experience. As we have seen time and again, once these values and concepts find fertile ground, the results are quite often extraordinary and, more often than not, unplanned.

Second, a review of specific partnership objectives and successes clearly indicates that the local interests which the assessment refers to, for the most part do, in fact, coincide with MOH and USAID strategies and priorities to the extent that the latter are formulated and articulated. This should not be surprising in view of the encompassing role and extensive membership of most of the partnerships and the fact that the NIS, like most countries, face multiple challenges in providing health care to their populations. Although USAID regional offices were not established in the field at the time of program initiation, as part of the AIHA/USAID Cooperative Agreement, implementation plans and partnership priorities were shared with, and concurred in, by USAID and have since been largely endorsed by USAID missions. In almost all instances, local and regional health administrations were part of the partnership priority setting process as well, and these same priorities were endorsed by the MOH. Just as AIHA encourages the partnerships to constantly review and, if necessary, amend their workplans, we agree that USAID and MOH input should be regularly sought. AIHA has taken steps to ensure that this happens again over the next several months.

Third, in those instances where USAID has more narrowly defined objectives, and partnerships may not be the most appropriate vehicle for mobilizing resources to that end, AIHA and the participating US institutions have demonstrated their capacity to perform under other USAID funding options. AIHA, for example, has transferred its expertise into support for special study tours and other directed programs. Similarly, several partnerships have developed model programs in Russia whose replication USAID has supported under more traditional grant programs; similarly, several projects in Central Asia are receiving consideration for grants under USAID's health financing project. In fact, one of the central tenets of the AIHA program is that partnerships can be effective platforms and models for other development activities. We are mindful that these other developmental activities, however, should be carefully separated from the partnership program so as not to undercut the unique elements of the program which have contributed to its success.

- The assessment describes a list of criteria to consider in determining whether a partnership should be "phased out" because of low performance at the end of 24 months of activity. The partnerships are, in fact, largely meeting the criteria suggested by the assessment (most of this criteria is already part of AIHA's management process) and producing significant results, as acknowledged by the assessment. In those few instances where the partnership's success in terms of programmatic outcome is somewhat more modest, we are not persuaded that it represents, or should be characterized as, a "failure" on the part of the partners or the partnership methodology. Often, the transcendent values and concepts have taken root but the environment may be simply more limiting or more challenging.

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18-24 months of activity, we are equally concerned with a concept of partnership success which results in continued long-term funding (e.g., beyond 36-42 months). We believe, instead, that the essential goals and objectives of a "partnership" are essentially achievable within this period and a much more limited program of support is required to nurture and maintain them in the future. Limited funds can thus be mobilized to enable other US health care providers to initiate new partnerships with NIS institutions in areas which have not been addressed by the program.

- As described more fully in Section I, the assessment makes a number of recommendations regarding strengthening AIHA's staff with individuals with medical/developmental experience and expertise. In our response, we describe our success in developing and staffing our regional offices with a unique cadre of NIS physicians with US university graduate degrees in health administration. We note that this staffing pattern and a blend of senior Washington-based staff with extensive US health policy backgrounds and younger staff with Russian language skills and previous NIS living experiences provide exactly the right mix to perform the "enabling" function required of AIHA in the partnership program.

The strength of the partnership program (as distinguished from other applications of expertise described above) fundamentally depends upon the substantive interaction of the partners themselves. We believe that AIHA's role should be confined to an enabling function for the partners, on the one hand, and an interface and management function for the partnership-USAID-MOH relationships, on the other. An admittedly fine line exists between this latter function and a more traditional development/consultant role. We believe, however, that tilting the staffing pattern toward medical/developmental specialists could erode many of the basic premises of the partnership program. The use of such specialists should be carefully confined to non-partnership activities of AIHA.

RELATIONSHIP TO OTHER US GOVERNMENT OBJECTIVES

In approaching the assessment's recommendations with respect to future programmatic direction, it should be emphasized that the Medical Partnership Program was intended to -- and does -- fulfill a number of other critical US government objectives as well.

- In establishing the partnership program quickly and efficiently, AIHA and the US health care sector responded aggressively to the urgent call of the US Department of State and USAID in 1992 and despite lack of funding certainty and shifting priorities in Washington and in the regions, continues to respond in an urgent fashion.
- Over 28,000 exchange days involving over 1,600 US and NIS participants have taken place under program auspices, making the partnership program one of the most significant people-to-people and grassroots democratization efforts undertaken by the United States in the NIS.

81

- The program also represents an extraordinary public-private partnership in its own right having already mobilized and directed over \$35 million in private sector assistance, including almost \$10 million in critically needed medical equipment, supplies, and pharmaceuticals; this compact between health care providers and communities across the United States and its government represents a manyfold increase over traditional USAID private sector "matches" of 25-50 percent.
- Finally, the program continues to be a key component in the success of other US government and multilateral funded programs, providing assistance, for example, in the development of Russian Federation, Georgia, and Ukraine MOH proposals for the World Bank and support for the distribution and related training and utilization of US/DOD excess equipment and supply contributions in Georgia, Russia, Kyrgyzstan, Moldova, Belarus and currently, Kazakhstan.

Fulfillment of these other objectives was not the subject of the assessment, nor was it intended to be. The assessment's recommendations, however, regarding future directions, must be carefully considered to assure they are not inconsistent with other desired outcomes. USAID should carefully consider, for example, the trade-offs between partnerships addressing somewhat broader objectives than are contained in USAID country strategies and the private sector match and community involvement which AIHA's US partners are contributing in support of these broader objectives and/or their flexibility to respond to other US government initiatives which are occurring in response to a rapidly changing geopolitical environment.

FUNDING REALITIES

The assessment's recommendations must be considered carefully in light of USAID budgetary realities and competing priorities. As the assessment team points out, the short-term, brinkmanship-like funding that the partnerships have labored under since the program's inception has been a serious deterrent to the development of a long-term strategy. Notwithstanding this uncertainty and the anxiety which it has entailed (especially for our NIS partners), AIHA and its partners have invested in their programs as if funding for a minimally appropriate time (36 months) for such projects would be forthcoming. While we are hopeful that USAID will continue to affirm its commitment to the partnership program as a key, cost-effective means of carrying out US government objectives in the NIS and elsewhere in the world, we are also realistic about shifting US priorities and tight federal budgets. The program has demonstrated an exceptional ability to mobilize private sector resources. While we are fully prepared to fine-tune the partnership program and work closely with USAID's regional offices to ensure that individual partnerships are supportive of US government objectives, we believe that changes in programmatic strategies should be carefully considered to assure that they do not put at risk private sector commitment on the one hand, or assume unreasonable funding expectations, on the other.

AIHA'S PROPOSAL FOR FUTURE DIRECTIONS

We believe that the following approach provides a framework which incorporates the findings of the assessment team while taking into consideration the acknowledged strengths of the partnership program and a likely USAID no-growth budget scenario.

- AIHA proposes to "graduate" all partnerships after 36 months of primary program funding. Graduated partnerships would receive 24 months of additional, but more modest, support which would enable them to continue to participate in, and provide leadership for, inter-partnership activities. During the last half of the "transitional" third year, AIHA would initiate new partnerships under the direction of USAID regional offices and consistent with regional budget allocations. For those regions which are reluctant to start new partnerships because of funding uncertainty over the intermediate term but seek to replicate specific programs developed under the partnerships, AIHA will develop and manage a partnership grant program on a more short-term basis. These grants will be clearly distinct from support provided under the graduation program in order to preserve the integrity of the basic partnership program.

The premise of the graduation phase is that continued US-NIS interaction is essential to maintain the momentum of interventions initiated and to assist in the dissemination of these interventions to a broader audience; graduate partnerships will all be change agents in their own way. If handled properly, the "graduates" will not see themselves as being lessened in this phase but rather as the first "graduating" class. This presumes, however, that we indeed phase out all partnerships and do not pick and choose. Otherwise graduation will signify failure or at least, lack of success and could represent a breach of hard-earned trust on the part of the United States in an area of continuing priority. The graduation phase will allow AIHA/USAID to continue to maintain an investment in institutional leadership and ensure that NIS partnership institutions and their related health professionals have an opportunity for mutual support and to share what they have learned with new partnership members.

- In addition to providing each graduating partnership with two years of basic support, AIHA will work with each partnership to develop sources of funding for programmatic initiatives which have been started under the 36-month partnership. These sources of funding could be in the form of grants funded by USAID under other programs or under AIHA's auspices. Funding could also come from World Bank or other NIS country-based loan related programs. Several partnerships have demonstrated their ability to attract private sector investment capital as well. Recent awards of World Learning grants to Magee-Savior and LaCrosse-Dubna and the interest of the World Bank in partnership initiatives in Russia, Ukraine and Georgia validate this approach
- AIHA would initiate a new round of partnership beginning in late 1995, as current partnerships were being graduated. This new round of partnerships would build upon the lessons learned by USAID and AIHA and the MOH's and incorporate many of the recommendations of the assessment. We believe that the success of the current

program will continue to generate the necessary financial support of the US health care providers and their communities.

- In addition to the health care institutional partnerships which focus primarily on improving the delivery of health care, AIHA proposes to broaden the partnership format to include several key "association" partnerships. These partnerships will be designed to foster the development of new, essential non-governmental institutions at the CIS, national or regional level where successful initiatives must be multi-institutional and critical mass must be concentrated in order to be cost effective and successful. In the area of health administration education, for example, there is an important opportunity to encourage and assist a number of fledgling efforts to develop programs and schools in the NIS through a common, cost-effective approach. Such "mutual support/trade" associations can fill a significant gap in the NIS and are key to the success of independent institutions operating in a decentralized, market economy rather than under centralized government. We believe that key partner "trade" associations in the United States can be persuaded to participate in the program under the essentially voluntary format used to date. Partnerships would focus on organizational development, membership services such as group purchasing, standards and certification, and educational/training programs.
- AIHA proposes to continue to support the "synthesis" programs developed collaboratively under the partnership program and the intra-partnership conference activity. The synthesis programs in pre-hospital emergency medicine, infection control, and birth resuscitation not only reduce morbidity and mortality but are also extremely cost effective. Support will continue to be directed toward additional train-the-trainer programs and the provision of educational/training materials and related equipment.

84

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**NIS Medical
Partnerships Program
An Assessment**

Annex V - Site Visit Memoranda

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85

Annex 5

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ANNEX 5 SITE VISIT MEMORANDA ¹

There are 21 active partnerships under the AIHA/USAID cooperative agreement. Of the 21 partnerships, at least one partner for all but four was visited by one or more assessment team members, and for four partnerships both the U.S. and NIS partners were visited.

These memoranda concerning most of the site visits to partnership and other participant institutions are included because of their possible utility to program participants. They were written by different team members under differing circumstances, in order to inform the team as to visits in which not all team members could participate. There is no team concurrence in their content. There has been no effort to conform them to a common format or style. There is no correlation between length of memorandum and relative importance of subject matter.

ARMENIA

Yerevan

**Emergency Medical Scientific Center, Yerevan
Boston University Medical Center and Boston City Hospital, Boston, Massachusetts**

Yerevan Site Visit

Background Description

The Emergency Medical Scientific Center (EMSC) was selected to form a partnership by the AIHA assessment team which included the Dean of Boston University Medical School. The Memorandum of Understanding (MOU) was prepared and presented to EMSC several months later for their approval. The Memorandum of Intent (MOI) (which perhaps is the same document as the MOU) appeared to be prepared from a USAID public health perspective. In any event, the MOI has unrealistic expectations of an efficient use of a city hospital's emergency department. The MOI is more appropriate for a public health clinic and seems contrived to fit within the realm of this particular partnership. For instance, emergency departments should not have to address breastfeeding and pediatric nutrition. Nonetheless, the EMSC is addressing activities appropriate to the definition of emergency care.

Dr. Ara Minassian, Director of EMSC, is a close colleague and former schoolmate of the director of Erebuni Hospital and the two men compliment each other's efforts with their partnerships. Dr. Minassian is also quite positive and optimistic and seems to possess the administrative capacity

¹ For the reasons given in the second paragraph below, this annex should be provided only to AIHA and USAID staff directly involved in project implementation. It is not a part of the assessment report.

87

to progress forward. Ironically, he lacks an appreciation for management as a discipline in its own right. He feels that there needs to be a cadre of technically trained personnel before they can address management per se. He and his colleagues feel that they are the ones best equipped not only to manage themselves, but especially to manage the nurses who are supposedly incapable of supervising themselves. He feels that a good manager must be a good technician first.

Description of Activities

The hospital director refers to his two big "elephants" which comprise the direction of his program: the Pre-Hospital Stage and the Hospital Stage. In the Pre-Hospital Stage the emphasis has been on educational development and the inception of the Emergency Medical School one year ago. Teams of nurses, physicians, and drivers attended 100-hour basic courses and will soon be attending 400-hour advanced courses. It was unclear whether there are separate courses for each type of student or if they attend as a team. There are seven permanent teachers in the school who are also hospital department chairs.

The Hospital Stage has involved the redesign of the emergency room into a "Trauma Center" adopted from the American model. Presumably, the nurses who are working in the Trauma Center have attended courses in the Emergency School. The intensive care unit has been relocated and is now an extension of the emergency room. The rationale for this move was unclear. Perhaps it was based on the assumption that most patients coming through an emergency room will be intensive care candidates which is not usually the case. However, the majority of the patient population which presents in Yerevan may, indeed, be more likely needing critical care than is the case in the U.S. because of their war casualties. When we visited the emergency room there were no patients present and there was one soldier in the intensive care unit.

The Director of Nursing has been designated as responsible for the new infection control program. She is the director of several head nurses from throughout this 800-bed hospital. Nursing management is not being addressed with her other than incidental opportunities for knowledge transfer.

Strengths

The Emergency Medical School's greatest asset, outside of providing a formal milieu for training, is that it provides a forum for the nurses and physicians to work together as a team. The responsibilities of the nurse have been augmented as a result of the partnership according to the medical directors. However, only the Director of Nursing was represented during the interview and she was complacent for the most part so it was unclear as to whether the nursing staff appreciated any change in their status. She did note that the nurses who completed the courses in the Emergency Medical School were more theoretically oriented, which helped them in their overall practice.

The U.S. counterparts have introduced a computer software package which is used to document the function of the emergency department. It allows them to track the time it takes to answer a call in the field and to identify patients by types of injuries and diagnoses which can assist them in long-term planning. The software program is in English and is operated by the office manager, who is fluent in English. She is also responsible for compiling the monthly reports and functions as the hospital translator.

When U.S. delegations are in Yerevan, the EMSC hospital director telephones directors of all the other Armenian district hospitals to invite their participation. Unlike some of the other NIS countries, Armenians historically seem to be more willing to share information with each other.

Assessment/Impression

Although there was much discussion of the nursing activities by the physicians, it was interspersed with a very low regard for their capacity, and therefore it dampened any improvements which may have occurred.

From an outside perspective, the Trauma Center performance does not seem to match the claimed standards. It was difficult to ascertain this in one brief visit, however. The possible misperception is not detrimental but rather productive since it may be the motivating force which provides them optimism. This is a very different attitude from that of some of the physicians from the larger, well known institutes in Russia and Ukraine, who feel they have little to learn since they are at par with the U.S. and only lack the proper funding which will allow them to compete with U.S. standards.

The Emergency Medical School was an excellent means to formulate a basis for professional standards. The School is also a great medium to filter the teaching activities of the U.S. partners because it provides an organized structure to place them in.

Recommendations

On the surface, management did not seem to be a real issue with this partnership program; however, after extensive discussions, a different perception was derived. It would behoove the Armenians to explore the U.S. philosophy for management in medicine and especially nursing.

There was some disagreement about the methodology which should be employed for the professional exchanges. Some physicians felt that there should be a concrete group selected who have more clearly defined goals and they should be able to train in the U.S. for several months. The hospital director disagrees and prefers to have more of his staff exposed in 2-3 week intervals. He does not appreciate the justification for staying extended periods of time since the Armenians are not allowed to give direct patient care in the U.S. There are pros and cons to both sides of these arguments and it should be up to the Armenians to make these decisions.

Dr. Minassian suggests that ideas for program activities should originate from the Armenians and the most useful contribution from the U.S. is the transfer of strategies and methodologies for accomplishing their ideas. The Director suggests placing an AIHA regional office in Yerevan for the Caucasus. He said it is not important if it included an American representative since they have the capacity to staff the office themselves with their Office Manager, who is fluent in English and functioning in the role of a coordinator now. This idea seems viable and should be explored further.

Erebuni Hospital, Yerevan
Beth Israel Hospital, Boston, Massachusetts

Yerevan Site Visit

Background Description

The Center for Women's Reproductive Health (CWRH) was created before the partnership program began with the assistance of Nora Nercessian. Ms. Nercessian is a Harvard psychologist and is married to an American Armenian diplomat who is working for the Armenian government. The initial support for the CWRH came through Harvard-affiliated foundations, the American International Women's Association, and private supporters at Beth Israel Hospital.

Dr. Koushkian, Director of Erebuni Hospital, is a charismatic and optimistic leader. He works long, hard hours and has seemingly adopted an American style of management. He invited all of the physicians from the CWRH and the Maternity Hospital. Two nurses attended the meeting upon request. The group dynamics during the meeting made it evident that the Director has a democratic style of leadership rather than the traditional autocratic style.

Dr. Koushkian has a long history working and studying with Americans and Europeans. A few years ago, he studied at U.C.L.A. for four months. Beth Israel Hospital is only one of many foreign donors to his hospital. His wife is also a physician and is actively involved in computerizing the management of this 900 bed hospital.

The Armenian physicians planned to have more visits from the U.S. to Yerevan in the beginning because they thought this would provide them with a better basis for their trips to the U.S. The Armenians did not want to be overwhelmed by the various technologies and risk losing a focus for their trips. They felt they could make better use of their U.S. visits if they had already established a workplan so they could focus only on what pertained to their goals.

Description of Activities

The Erebuni Hospital activities relate to two departments: the Center for Women's Reproductive

Health (CWRH) and the Maternity Hospital. The former seems to more successful, yet it also started before the partnership program. Moreover, the CWRH hired a new staff upon its inception, whereas the Maternity Hospital project is working with pre-existing personnel.

The emphasis on the CWRH activities are prevention-oriented. The staff screens patients for sexually transmitted diseases and cervical cancer and are beginning to teach self-breast examination. In fact, one woman arrived at the clinic after having discovered a lump while performing a self-examination. Family planning is a significant component, with 160 women who make monthly follow-up visits.

The connection between women's care and pre-natal care was initiated by the CWRH staff. They incorporated the pre-natal clinic from another building into the CWRH building. Pre-natal care to prevent complications with labor and delivery and well-baby care (including breastfeeding) are now being taught in the CWRH.

Other than an international conference devoted to nursing education, there did not seem to be an activity specifically directed toward developing the role of the nurse.

Recently, there was a conference on neonatal resuscitation which led to some controversy between USAID and Beth Israel personnel. The topic of neonatal resuscitation was not viewed as a national health priority by USAID. USAID did not feel due respect was given to them for their critique. Although the Armenian physicians welcomed this subject matter, some of them felt that the U.S. team did not do an accurate assessment of their learning needs before organizing the conference because parts of the material covered was redundant for them.

Strengths

Patient Care Outcomes: The Chief of the Maternity Hospital observed a decrease in post-partum hemorrhaging, which he attributes to decreased patient anxiety, especially in very young or older women. The patients are less anxious because he and his colleagues learned that U.S. counterparts ask patients for permission before treating them and explain procedures before they begin. Despite the lack of scientific data substantiating his theory, the important issue is that through the partnership the Armenians have learned a different way to care for their patients which has lead to the emotional well-being of their patients. The CWRH staff also mentioned that their patients were more satisfied with the care they received, which has been exemplified by the increased compliance with follow-up visits since the program began. Also, they are attracting a patient population from the entire country even though these women could attend hospitals in their own districts.

The physicians also are using less invasive treatments than they did previously, which has reduced the number of hospital admissions and the length of stay for their in-patients. They attribute this to their enhanced ability to interpret data and observe patients rather than to immediately resort to an invasive procedure. They have been presented with more alternatives to

treat patients than they had known previously. Also, in the past each physician had a particular sub-specialty, whereas now all the physicians are sharing their expertise. Now each physician is capable of performing various procedures.

Cost Recovery: Patients at the CWRH are charged a nominal fee for all treatments and medications but not for physician services. There was a recent 100% increase in the fees because government salaries were also increased. Regardless of the fact that the fees do not recover the Center's costs, it is important that the concept of paying for service has been introduced as one means of sustaining their activities. These fees are waived if the patient cannot afford to pay so that no one is denied access to care.

A business manager has been hired to manage the logistics of the program. This is an important position since it is often assumed by the technical staff, which is not their expertise; nor can they devote the appropriate time needed to administer a program of this magnitude.

Information Dissemination: Starting three months ago, staff from the CWRH take their equipment and supplies and travel to two satellite districts to perform diagnostic procedures by ultrasound and to train the local staff. They provide them with Erebuni's written protocols to be distributed to the district hospitals.

Conferences are announced on television, radio and in newspapers. The MOH is also kept abreast but they are not as actively involved as they could be. However, the MOH does assist by sending buses to collect nurses and physicians from all over the country to bring them to conferences. On occasion, NIS faculty members have been invited to present at their work at the conferences which generated much enthusiasm.

Three articles are ready for publication in addition to a pre-natal care booklet written in Armenian.

Assessment/Impression

The CWRH activities are of high priority throughout the NIS, but no where else have such great strides been made as in Armenia. This may be due to the additional support from the Armenian Diaspora which allows them to place attention on women's reproductive health without the concern of competing with other USAID cooperating agencies. The success is also due to the foresight and open management style of the hospital director.

The Maternity Hospital has individual accomplishments but lacks the overall program strategy found in the CWRH. One area of focus could be to evaluate their infection control protocol, since some of their interventions do not have scientific basis. However, rather than addressing specific topics such as infection control, they may wish to explore the possibility of placing their activities into a more structured strategy and a good beginning could be with patient management. Since nursing is not being formally addressed, the maternity personnel could take

this initiative to begin an activity devoted nursing. The Head Nurse in the Maternity Hospital did not appear to be a strong leader, so another nurse may need to be delegated in order to facilitate a nursing program.

The Armenians maintain close contact with their Boston colleagues by faxing them their written reports every month. This frequent communication, augmented by the support of American Armenians in Boston, cannot be underestimated in leveraging the personal support needed to sustain the program. This support is especially appreciated by the Armenians themselves, who are literally blockaded from the outside world.

Recommendations

The Armenian staff is in a position to initiate their own workplans. After the Armenians prepare them, they can present them to the U.S. counterparts for input rather than the other way around, which is apparently the case now.

The Armenians would like to continue with a fellowship program with the intention of inviting professionals from outside the NIS to study at their hospital. They feel they could attract a larger audience if they were able to provide a certificate to the fellows which included American accreditation. Something as simple as including the U.S. institutions' names and emblems may suffice to boost the interest in the program from abroad. Incidentally, this fellowship program will be another method for the hospital to recover costs.

The CWRH is functioning well and has enough activities to focus on at the present time; there is no need to add any new ones. The monthly visits to the satellite areas is strongly encouraged to continue, and they can broaden the number of sites as resources permit. They should identify key individuals at each of these satellites who will be responsible for training other personnel in their districts. The satellite counterparts should also be invited to visit Yerevan when the U.S. delegations are present.

The Maternity Hospital should de-emphasize their efforts in neonatal resuscitation until they have sufficiently prepared the medical and nursing staff who can care for these patients. In addition to having a well-trained cadre of professionals, the hospital needs to be able to secure the appropriate supplies and equipment necessary to care for such critically ill children. They have other priorities to focus on, such as an appropriate infection control protocol and the development of standardized record keeping, before they can embark on such a high-tech activity which has a very low impact on infant mortality and morbidity. Another activity which would have a broad-reaching effect is administration. The management within the Maternity Hospital seems to be more traditional and they may wish to study the U.S. model and adopt some their strategies.

There may be a need for the Boston colleagues to demonstrate a better appreciation of the role of USAID mission personnel and to seek their approval rather than diminish the relevance of their

input. The Boston colleagues may want to do a more thorough needs assessment before presenting conferences, since some of the topics selected were perceived to be sophomoric by some of the Armenians. The U.S. partners need to be cautioned to address topics which incorporate the capacity of the hospital and which relate to regional health priorities that will have a significant health impact on a sizable population.

BELARUS

Minsk

**Hospital No. 4, Minsk
Children's Hospital at Pittsburgh, Pennsylvania**

Pittsburg Site Visit

Background Description

Dr. Thomas Foley, Program Coordinator, has been working with Project HOPE in Poland for ten years. After the Chernobyl accident, four physicians from the Belarus Radiology Institute approached him because Children's Hospital is renowned for their work in pediatric thyroid carcinomas. Shortly thereafter, Dr. Foley was alerted to the AIHA partnership program.

There were some misunderstandings between Dr. Foley and AIHA and he has since relinquished his position as the Program Coordinator.

Description of Activities

Program activities have been demand-driven and apparently not part of an overall plan of action to implement a set of objectives. One outcome has been the establishment of a Poison Control Center which has had a purported immediate impact on health and resulted in a large database. Other activities have included a pediatric radiation treatment for cancer, a CPR course, teaching physicians the use of an otoscope, and an activity in gastroenterology. The U.S. staff plans to present a post-graduate course which will include all the program activities. Research studies are in progress in relation to some of the activities and plans to do future investigations are being considered. Recently, the Director of Nursing has become involved in the partnership program and she has clearly delineated her plans to develop the role of nursing which she will be presenting to her Belarussian counterparts.

GEORGIA

Tbilisi

City Hospital No. 2, Tbilisi
Tbilisi State Medical University, Tbilisi
Emory University, Atlanta, Georgia
Grady Health Systems, Atlanta, Georgia
Morehouse School of Medicine, Atlanta Georgia

Tbilisi Site Visit

The Tbilisi portion of the Atlanta-Tbilisi partnership was visited by Paul Torrens on June 21-24, 1994. The visit consisted of a series of interviews (including two with the Minister of Health), site visits, and general observation of program activities as selected by the local partnership management. The site visitor was given general access to people and background materials as desired and the general atmosphere was one of warm welcome and cooperation.

History and Background

The memorandum of agreement was signed in August, 1992 and an implementation plan was submitted about a year later in July 1992. The Georgian partners are the City Hospital No. 2 in Tbilisi, the Medical Institute of Georgia (later the Tbilisi State Medical University), and the Ministry of Health of the Republic of Georgia. It is interesting to note in the Memorandum of Agreement that the overall purpose of the cooperative relationship was stated as improving the "quality of health care in the Republic of Georgia, with health care defined broadly to include not only the quality and character of health care, but also the administration of health institutions, health care delivery systems, and the medical education system." This seems to be standard wording in all the AIHA memoranda of understanding, but in the case of Georgia it seems to be particularly central to the purposes of the partnership.

The situation for the partnership has been made extremely difficult by reason of the civil unrest and violence that has torn Georgia in the last few years and by the economic difficulties that have resulted from the other social problems. Georgia has probably had one of the most difficult transitions of all the NIS countries, having to deal with much more than the simple transition from one form of government and economy to another.

In spite of these difficulties, the degree of cooperation that the partnership has had from the top levels of government (including the Ministers of Health themselves) is probably unequalled in any other partnership.

Objectives and Activities

The objectives of the Tbilisi-Atlanta partnership have been three-fold in nature and have focused on: (a) improvements at

City Hospital No. 2, (b) improvements in medical education, and (c) national health care reform.

At City Hospital No. 2, the improvements were supposed to focus on improvements in the clinical laboratories, the imaging and radiology services, the outpatient and diagnostic clinic services, cardiology (in general), gastroenterology (in general), nursing services, and administration. Many of these improvements were timed to coincide with the completion of a new hospital facility so that the organizational and clinical improvements would be implemented as the new facility was being opened and put into operation.

At the Tbilisi State Medical University, the objectives focused on changes in the medical curriculum, opportunities for Georgian students and residents to spend time in education and training at Emory University in Atlanta, improvements in medical library services, and the development of a new Georgian Medical Journal.

At the Ministry of Health, the objectives focused on public health policy and health system reform. More specifically, the objectives focused on health promotion and disease prevention in the area of preventive cardiology, on improvement of neonatal and women's reproductive services, and on initiation of national reform in the area of health policy and health care delivery systems.

To achieve these results, the Atlanta partners (Emory University, Grady Health Systems, and Moorehouse School of Medicine) agreed to provide technical assistance, opportunities for participation in activities in Atlanta, logistical support in the form of some supplies and equipment as feasible, and other forms of cooperation and support.

In the year since the implementation plan was completed, a number of the objectives have been achieved and a number remain to be accomplished. A partnership office has been established in Tbilisi and a project coordinator from the US has been in place. A number of exchange visits have taken place, in both directions, and have been generally successful. A good spirit of cooperation has been established and an increased understanding of the possibilities and the limitations of the partnership have been gradually developed. A number of specific project objectives, such as the medical library improvement, have been taken on and completed.

It must be said that the objectives of the City Hospital No. 2 remain largely unmet, as do the objectives with regards to national health policy and reform, for somewhat different reasons. With regards to City Hospital No. 2, the economic and other difficulties in the country have made it impossible to complete the new hospital building as proposed and this, in turn, has made it impossible to implement the organizational and clinical reforms that were originally planned. There seems to be a major difference of opinion between the administration and medical staff of City Hospital No. 2 and the Tbilisi Atlanta project staff, centering around the delivery of new equipment for the hospital. This difference of opinion may have made it more difficult to get things accomplished at City Hospital No. 2.

With regards to the Ministry of Health and national health reform, the problems in the country have created an overwhelming administrative burden for the Ministry staff and they have not had the time or the energy to consider preventive cardiology or reform of the national health care delivery system, in face of other more immediate threats to health in the country.

With regards to the Tbilisi State Medical University and the exchange of academic, professional, and student personnel, these activities seem to be progressing well and form the strongest part of the program just now. The "people-to-people" aspect of the partnership seems to have the full support of the various people involved, and when the organizational and economic difficulties can be overcome the results for individual participants seems quite positive.

Issues to Be Considered

- (1) The major issue for this partnership has little to do with the partnership itself and has everything to do with the events taking place in the country at this time. The partnership has very able people involved in Tbilisi, has support at the highest level of government, and has a clear set of objectives to be accomplished. The emergency needs of the country, however, are probably too pressing to make achievement of many of these objectives very likely. Perhaps USAID, AIHA, and the partnership needs to reprogram some of its current objectives in light of current events.
- (2) The completion of construction of the new City Hospital No. 2 building seems to be essential before many of the hospital-related objectives can be achieved. If this is the case, perhaps a task force needs to be formed to consider the issue of completion of the new facility (or at least parts of it that can be completed) as soon as possible.
- (3) There is an unusual opportunity to help this country carry out a major reform of its entire health care structure. The country's administration wants to do it, but currently has neither the technical expertise nor the time and energy to do it. Although the challenge is probably much broader in scope than the Atlanta partnership can take on solely by itself, there is a very significant role for the Atlanta partnership to serve in helping the Ministry of Health carry out its desired reforms. Perhaps the most important thing that the Atlanta partnership can do is to serve as the advocate for the Ministry in bringing in other resources from the associations sponsoring AIHA, from other USAID-funded projects (such as the recent Health Care Financing Project assigned to Abt Associates in Boston), and the like. The Atlanta-Tbilisi partnership has opened a number of important doors in the national health policy arena in Georgia and it would be unfortunate if that opportunity were not fully realized because of the structural limitations of the initial partnership project.

KAZAKHSTAN

Almaty

**Kazakh Science Research Institute of Pediatrics, Almaty
Almaty First Aid Hospital, Almaty
Tucson Medical Center, Tucson, Arizona**

Almaty Site Visit

This a partnership between Tucson Medical Center and two Kazakh hospitals in Almaty, the Kazakh Science Research Institute of Pediatrics, and the Almaty First Aid Hospital. This partnership was built upon a previously existent Sister City Agreement with Tucson. This partnership focuses on the following areas: 1) Infection Control, 2) Hospital Administration, 3) Epidemiology, 4) Laboratory Services, 5) Hematology, 6) Medical/Nursing Education, 7) Toxicology, 8) Equipment Repair and Maintenance, 9) Cardiology, and 10) Obstetrics.

Dr. A. Douisskeev, Deputy Minister of Health Services in Kazakhstan, expressed great satisfaction with the partnership's intensive activities which, according to the Deputy Minister, have accomplished a lot since their inception, particularly in the areas of training, hospital administration and humanitarian help. Dr. Douisskeev pointed to the partnership training activities in the areas of cardiology, toxicology, management, nurse retraining, and obstetrics as the most outstanding accomplishments by the partnership program. However, he would like to see more emphasis on maternal and child health services and other major health problems that face Kazakhstan: TB, HIV/AIDS, and vaccinations. Dr. Douisskeev would like to see the partnership program involved in health care reform by providing more training courses on health management and financing. In addition, he underscored the impact of the partnership program in portraying a very positive impact on the relationship between Kazakhstan and the US.

In two meetings with Dr. Urmurzina (the Head of Almaty City Health Administration) and her deputies, they emphasized the importance of the partnership program to their health reform plans. The Almaty Health administration is currently being reorganized using the management skills acquired both in the US and NIS through the partnership program. These reorganization plans will apply to 82 medical institutions throughout Almaty. The health officials noted that they need some help from their partners in Tucson in preparing job descriptions and in defining the roles and responsibilities of their staff.

Dr. Urmurzina and her deputies reported that the partnership activities in the maternity hospital were instrumental in reducing maternal mortality, infant mortality, and hospital-acquired infections. The Almaty/Tucson Partnership program helped in establishing the use of surgical sterilization as a method of family planning, which resulted in the reduction of abortion rates. As a result of the increased awareness of the infection control programs in the US hospitals, Almaty City Hospital Administration established the position of infection control nurse in every hospital in Almaty as part of a new infection control program; this strategy resulted in the reduction of nosocomial infection.

The Tucson/Almaty partnership is also involved in an emergency medical services (EMS)

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initiative. The Almaty City Health Administration is planning on finishing the renovation of the EMS center in September, 1994 and has already trained three trainers to start training other medical and non-medical personnel (e.g. firemen, ambulance drivers) in emergency medical services.

In our visit to Almaty First Aid City Hospital we met with the director of the hospital, Dr. Birtanov, and several physicians, including the heads of the cardiology and toxicology departments. This hospital serves as the training base for Almaty's medical college for nurses. According to Dr. Birtanov, the implementation of the knowledge and information acquired through the partnership program resulted in the reduction of the average length of stay (ALOS) in the hospital from 20 days to 10 days. Moreover, as a result of the partnership initiatives, the hospital has established an infection control program headed by the chief nurse and a patient education program in the cardiology department. A code blue emergency team similar to that in US hospitals was organized in the hospital.

The transfer of knowledge and technology was very helpful in the reorganization of the cardiology department. The newly-acquired equipment and continuing education techniques were used to establish a continuing education program for nurses in cardiac resuscitation, which was until recently performed by physicians only.

With the help of their US partners, Almaty First Aid City Hospital established the first toxicology center in Kazakhstan. The center is equipped with a computer and has a telephone hotline accessible to the public. The center receives about 20 calls daily since its inception in late May 1994.

The hospital is planning to open a 20-bed ward in July 1994 for patients who are willing to pay for the services. This can be broadened in the future with the implementation of the new insurance law.

As an NIS partner, the Institute of Pediatrics in Almaty serves as the referral center for the critical cases from six maternity hospitals in Almaty. The partnership program is assisting the Institute in its infection control program (which is headed by an epidemiologist), training of nurses, and management training. The director of the institute reported that treatment of leukaemia in children is of a high priority to the Institute. The Institute is also involved in efforts to implement a breastfeeding program in Almaty and other parts of Kazakhstan.

Almaty Medical College for nurses is also an NIS partner. In our meeting with Dr. Ayapov, the Director of the Medical College, he emphasized the important role of the partnership in the development of curricula and educational materials and in the restructuring of their nurses education and training programs.

In general, The NIS participants in the partnerships listed the following gains as the most important outcomes of their partnership:

- Training and exchange of information
- Introduction of new prevention and treatment techniques
- The contact with specialists in the US
- The improvement and upgrading of the nurses education system
- The transfer of technology in the form of equipment and educational materials
- The positive impact on the US image in Kazakhstan

Some of the future expectations from the partnership program, as listed by the Kazakh partners are as follows:

- Develop a family practitioner program
- Focus on maternal and child health services (MCH)
- Long term training in the US (three months minimum)
- Develop patient rehabilitation programs
- Train staff from Kazakhstan in equipment maintenance
- Continue the development and upgrading of nurses' training.

Tucson Site Visit

The Tucson portion of the Tucson-Almaty partnership was visited by Dr. Paul Torrens on June 13-15, 1994. The visit consisted of a series of interviews, site visits, and attendances at conferences, seminars, and other program activities as arranged by the Tucson partnership managers. The site visitor had complete freedom of access to people and materials as desired, and the atmosphere was one of complete host cooperation with the purposes and intents of the site visit.

History and Background

The Tucson-Almaty partnership grew out of a previous (and continuing) Sister City program between Tucson and Almaty. When the Health Partnership program was announced, various participants in the Sister City program saw it as an opportunity to strengthen the ties between the two cities and encouraged health care leaders to consider it.

The leadership in Tucson has been provided by the Tucson Medical Center, but from the beginning, it has been seen as a community-wide effort. A broad Steering Committee was created (see attached list) with wide participation from health care providers, educational institutions, and public health authorities in Tucson. From the beginning, the Steering Committee has served as the central decision-making and supervisory body (see attached table of organization), creating individual project teams to carry out the details of individual, approved projects. There seems to be a good balance between the need for some type of central organizational control and supervision, and at the same time, support for individual initiative and participant enthusiasm and support for specific projects. The atmosphere of the project seems to be genuinely cooperative and collegial, with a great sense of shared responsibility and enthusiasm.

100

Objectives and Activities

The memorandum of understanding was signed in May 1993, and in July 1993 an initial implementation plan was presented (see attached material on implementation plan). In general, the original implementation plan has been followed quite well and the initial objectives seem well on their way to being achieved (see one-year summary of progress and proposed trip schedule for Spring-Fall 1994, both attached).

In general, the Tucson-Almaty partnership is focused on the following specific sub-projects:

- (a) development of a poison-control center for the Almaty region,
- (b) emergency medical system development and training of EMS personnel,
- (c) development of a model maternity hospital and a model program of total maternal care,
- (d) development and improvement of hospital infection control methods and programs,
- (e) assistance in the reform of education and training for physicians, to include development of training in family practice,
- (f) assistance in the reform and improvement of education and training of nurses,
- (g) assistance in the development of a safe and efficient regional blood banking system,
- (h) assistance in hospital administrative reorganization and the training and development of improved management personnel.

A detailed schedule for travel (in both directions) between Tucson and Almaty has been developed and tentative budgets proposed for each trip (see attached materials). This proposed schedule seems to be progressing according to plan and budget, with satisfaction on both sides.

Results

As far as activities are concerned, the Tucson-Almaty partnership seems to be active and enthusiastic, well-planned and well-managed, and carrying out its stated activities. Given the relatively short-term existence and the multiple project approach that has been taken, it is not clear what long-term, structural results have been achieved. In the short-term, a great deal of technical support and information has been provided, the seeds for major social and technical change have been planted, and a strong bridge for collaboration and cooperation has been established between the two professional communities. The impact on individual participants, both in Tucson and Almaty, seems to be major and probably life-changing in many instances, at least in early appraisal.

Issues for the Future

(1) The key question remains: what is the best long-term strategy and use of resources: the short-term, multiple-project approach with quick start-up and broad community involvement, or the single, in-depth, long-term project focused on structural reform. There can be no answer given to this question now and perhaps ever. Indeed, the best answer may be that a mixture of approaches

is advisable.

(2) A second key question is the long-term sustainability of the program once USAID funding is withdrawn. It is clear that the majority of the partnership efforts are actually funded by non-USAID contributions, but it is also clear that USAID funds provide the "glue" that holds these voluntary contributions together. The USAID funds provide the organizational impetus and base around which other voluntary efforts can be gathered.

(3) A third major question is the integration of the partnership efforts into other USAID initiatives in Kazakhstan in general, as well as the integration of the partnership into the efforts of the other partnerships in the NIS. Some aspects of the Tucson-Almaty partnership are becoming integrated into the other larger efforts, while many remain in a somewhat stand-alone status.

Summary

The Tucson-Almaty partnership seems to be well-planned, well-managed, and well-supported by the Tucson community. It seems to be enthusiastically and ably attempting to carry out the objectives for which it was established.

KYRGYZSTAN

Bishkek

Institute of Oncology and Radiology, Bishkek
Institute of Obstetrics and Pediatrics, Bishkek
University of Kansas Medical Center, Kansas

Bishkek Site Visit

This is a partnership between The University of Kansas Medical Center and two Kyrgyz institutions in Bishkek, the Institute of Oncology and Radiology and the Institute of Obstetrics and Pediatrics. The memorandum of understanding for this partnership was signed in Washington in October 1992. This partnership focuses on the following areas: 1) hospital administration, 2) neonatology, 3) infant rehabilitation, 4) labor and delivery, 5) diagnostic radiology, 6) pediatric oncology, 7) adult medical oncology, and 8) pain control.

Dr. K. Sbanbayev, Deputy Minister of Health in Kyrgyzstan, expressed great satisfaction with the partnership intensive activities which, according to the Deputy Minister, contributed to health care reform in Kyrgyzstan, particularly in the areas of training, management, financing policies and administration reorganization. Dr. Sbanbayev emphasized that one of his objectives for the partnership is to establish a model for clinical education to train medical staff from different parts

of Kyrgyzstan.

Dr. D. Kudayarov, the Director of Institute of Obstetrics and Pediatrics, stated that a new maternity hospital (100 beds) will be opened in July 1994. This new hospital, which is established during the course of the partnership, will help in the reduction of maternal mortality rates.

The Institute serves as an educational center for the whole republic. It holds conferences, workshops and seminars for the medical staff in different specialties. The Institute staff, with the help of their U.S. partners, have developed manuals for breastfeeding, caring for premature babies, and prevention of acute respiratory infections among several others. These manuals have been distributed all over Kyrgyzstan. The Institute is also involved in research activities with its U.S. partners.

The obstetricians and gynecologist, in the Institute were trained in the surgical sterilization and the use of laparoscopes in the United States. Upon returning to Kyrgyzstan, they have started providing these services in the institute.

Dr. Kudayarov cited the following accomplishments resulting from the partnership activities:

- Training of the medical staff (doctors and nurses)
- Reduction of ALOS
- Reduction of hospital-acquired infection
- Reduction of new born (first 4 weeks of life) mortality
- The use of surgical contraceptives
- The provision of equipment and supplies

The institute of oncology in Bishkek is the second Kyrgyz partner in this partnership. Dr. Z. Kamarli, Director on the Institute, reiterated the importance of training the medical staff and the acquisition of diagnostic equipment in upgrading and improving the health services in Kyrgyzstan. Some members of the staff of the oncology institute were trained in the new techniques for diagnosis and treatment of pediatric oncology. The institute has received 30% of the components of the military hospital donated to Kyrgyzstan by the US. The institute is planning several research studies with the University of Kansas Medical Center. Dr. Kamarli reported a 40% reduction in the number of beds in the institute and he attributed half of this reduction to the partnership activities and the other half to economic difficulties.

The institute of oncology runs a hotel service for the families of the patients for a nominal fee of \$8 a week per family.

There is a general agreement among the Kyrgyz partners that the most successful aspects of the partnership are:

- Training and exchange of information
- Transfer of technology and educational materials

- Equipment and supplies
- Nurse education
- Positive impact on the US image in Kyrgyzstan.

The Kyrgyz partners enumerated the following areas for improving the future activities of the partnerships:

- Long term training in the US (3 months or more)
- Supplies (e.g., reagents, pharmaceuticals) and equipment
- Supplies of contraceptives

Kansas University Hospital Site Visit

Background Description

Dr. Fred Holmes, Director of Kansas University Hospital (KUH), was a Lutheran missionary and has worked for several years in developing countries. KUH also has another partnership in Hungary through the Europe/NIS (ENI) Bureau; however, USAID administers this program much differently than their partnership with Bishkek. Dr. Holmes had a particular interest in working in Krygystan and eventually discovered an avenue to do so through AIHA.

The program coordinator is Louise Redford, who is a nurse and a native Ukrainian who left the former Soviet Union when she was a young woman. She is an active supporter of the program and has enlisted the support of a local private foundation called "Heart to Heart". A doctor from this foundation persuaded the university chancellor to support the partnership program which, in turn, gave KUH public notoriety and community backing.

Description of Activities

The original objective was to assess the state of healthcare in Krygystan. The KUH staff feels they have accomplished this objective and are now moving toward substantive interventions to address the identified needs. Six months ago they started working in oncology and introduced chemotherapy; however, in order to continue this activity they must find outside funding since there is no money in their AIHA budget. They taught laparoscopic techniques to the physicians at the Institute of Oncology. The main thrust has been nursing management and administration. Currently, there is a group of Krygystan nurse administrators representing ten oblasts from across the county who are studying for two months at KUH. This management course is being taught by the Kansas City State School of Nursing faculty who are attempting to introduce a philosophy of nursing as a profession.

RUSSIA

Dubna

**Dubna, Moscow Oblast
LaCrosse, Wisconsin**

Dubna Site Visit

The Dubna portion of the LaCrosse (Wisconsin)/Dubna partnership was visited by Ms. Annette Bongiovanni (RN, MPA) and Dr. Paul Torrens on June 30, 1994; the day before, there had been an oral briefing in Moscow by the Russian project coordinator from Dubna, by the Deputy Mayor of Dubna, and by a physician official of the Moscow oblast public health authority. The visit to Dubna itself consisted of a series of interviews and site visits, and was characterized by an atmosphere of complete openness and access to people and programs as desired.

History and Background

The LaCrosse-Dubna partnership grew out of a previously-existing Sister City relationship between the two cities. This sister city relationship, in turn, was at least partially the results of the efforts of an American, David Bell, married to a citizen of Dubna and living in the area for some years. The partners in the project include almost all the health care providers in LaCrosse, Wisconsin (a city of almost 60,000 people) with the help of their USA partners and almost all the health care providers in Dubna (a city of almost 70,000 people). The original memorandum of understanding was signed in December 1992 and the implementation plan was completed in April 1993. Since October 1992, there have been more than a dozen separate delegations and groups exchanged between the two cities, with a high level of enthusiasm for the partnership being exhibited on the Dubna side (the only side with which this appraisal team had an opportunity to visit.) The partnership itself is also noteworthy in that it is the only AIHA program that involves two smaller cities (60,000-70,000 people each), is not focused around major tertiary teaching hospitals, and is embedded in a total community effort.

Objectives and Activities

In the beginning, the LaCrosse-Dubna partnership decided to focus on five areas of concentration: (1) rehabilitation; (2) home care; (3) infection control; (4) women's health; and (5) alcoholism. There has been substantial activity in the area of rehabilitation, home care, and alcoholism; there has been somewhat less activity in infection control and hardly any activity in women's health. An additional area (diabetes education and control) has been added, and a good deal of activity has taken place around this subject.

With regards to rehabilitation, the focus has seemed to be more on children than adults and more on children with physical disabling conditions (like cerebral palsy and muscular dystrophy) in which there is a social and emotional component as well. By contrast, the home care program focused mainly on adults with long-term chronic illnesses who would probably be placed in a

nursing home or other institutional setting if they were in the United States. The alcohol treatment program focuses more on outpatient and community efforts, using a good deal of group support and interaction, and does not seem to be directly involved in in-patient detoxification and the like. The diabetes education and control program seems to focus on new diabetics...children as well as adults...and is intended to help them learn more about their illness so that they can live with it better. Each of these programs is located in a different institution or setting in Dubna, the home care program in the central social services program in the city administration, the infection control program in the main hospital, the rehabilitation program and the diabetes education program in another much smaller hospital/community health program. As a result, the range of projects involves a broad range of the community's services, programs, and people.

Results

A great deal has been accomplished in Dubna that is of value not only to that city but also to the rest of Russia. The development of the home care program with its "team" approach to the care of the elderly and the chronically ill, not only provides good care to people in Dubna, it is also an excellent model for other programs around Russia. The diabetes education program does the same for the diabetics of Dubna, as does the rehabilitation program for children. The alcohol treatment program breaks new ground in terms of public awareness and acceptance of alcoholism as an illness; it also provides a valuable learning example for the rest of the country. The greatest result of the Dubna partnership is not just that new programs have been developed in Dubna, but rather that new models of programs are being tried in problem areas that previously had not been well recognized or accepted. This combination of local service and national learning is a two-fold result of significant importance to note.

Issues for Consideration

- (1) There are a number of issues that are well highlighted by the Dubna experience, the first of which is the placement of this partnership in two smaller communities where total community involvement is more likely and possible. The potential impact of these projects on a smaller community, where it may be one of the only major projects going on in the community, is potentially much greater than in a larger city in which dozens of pilot projects may be taking place at the same time, each one vying for its place in public attention and understanding.
- (2) A second aspect of this project worth considering is the lack of involvement of tertiary, high-technology, teaching hospitals on the American side, allowing for more of a focus on community problems and community service. This is not to say that tertiary teaching hospitals are uninterested in community service, but rather that in the partnerships they are expected to focus on high technology matters. The fact that the LaCrosse partners are more typical community health care providers has allowed this partnership to focus on a different set of community issues.
- (3) The third important issue in Dubna has been the willingness of both partners to take on new, atypical and important health problems that the Russian side has not been able to address fully

and about which much can be learned. Home care services, rehabilitation programs for cerebral palsy, educational programs for diabetics, group support and treatment programs for alcoholics; these are not merely higher technology refinements of already existing programs in Russia, but rather are new and groundbreaking efforts from which the whole country can learn a great deal.

(4) An important part of these efforts has been the apparently decisive role the American participation has played in getting these new programs accepted. In the areas of rehabilitation for children with physical handicaps, alcohol treatment, and diabetic education, the Dubna partners stressed that they could not have gotten these programs accepted and started in their locality without the active American support and presence, technical "know how", and on-site training in the United States.

(5) Finally, an important part of this project is the almost complete absence of concerns about the exchange of supplies, equipment, commodities, or other "things". This is a genuine exchange of knowledge and support, not dependent upon anything other than the people involved and their individual participation.

Moscow

Moscow Site Visit

Moscow Ministry of Health Russian Federation Infection Control Division

The infection control division staff pointed out that due to the remarkable increase in the nosocomial infections and infectious diseases in the Russian Federation, the MOH issued regulatory order No. 220 which requires that each hospital create the position of hospital epidemiologist to oversee infection control practices. Various staff members of the infection control division participated in the AIHA-sponsored conference for representatives from all AIHA Russian partnerships and key city, oblast, regional and MOH officials, on improving infection control techniques. MOH will work with AIHA partnerships as pilot projects to develop case definitions for each nosocomial infection, to make recommendations on the proper use of microbiology labs, and to determine whether it is more feasible to introduce microbiology labs in each hospital or to use separate regional labs which would provide services to local health care providers.

The staff of the infection control division of the MOH were impressed by the performance of the American faculty members of the infection control conference and described it as "perfect" despite the fact that the team members had not worked together before. The staff of the infection control division of MOH listed the following issues as of utmost importance for them:

1. Closer coordination with AIHA in identifying priorities and selection of partners.
2. Improving the quality of services.

107

3. Training of trainers.
4. Training of nurses.

The infection control division at MOH is collaborating with WHO and the USA's CDC.

I. M. Sechenov Moscow Medical Academy

Background

The I.M. Sechenov Moscow Medical Academy is a public institution which is under the directory of the Russian Ministry of Health (MOH). The major departments are the: 1) General Medicine Department, 2) Dentistry, 3) Post-Graduate Education for Physicians, and 4) Continuing Education for Health Care Educators. It is the oldest medical institute in Russia celebrating 225 years in existence. Sechenov is the liaison between the MOH and the medical institutions. As a State-appointed committee for higher education, they organize the training of students and post-graduate education. They envisage their role to be that of translators of theory into practice.

Health Care Reform Strategies

Igor N. Denisov, Vice-Rector for Post-graduate Training defined the ingredients needed to reform the Russian health care system as follows: a) a system of primary health care which provides the transition of the traditional internist into the family practitioner; b) the development of a system of higher education for nurses; and c) the professionalization of health administration which does not require directors of hospitals to be physicians.

Sechenov has an agreement with AUPHA to train the health care managers in Russia which the Vice Rector feels should begin with MOH officials. Dr. Denisov feels the AUPHA workshops have been helpful but they need to implement their own system of training administrators. He feels the partnership program has not embraced the whole health care system but rather that it implements specific technologies. He recommends that the partnership have a more global approach and attempt to influence health care reform. This could be accomplished by taking the experiences of the individual institutions and disseminating them to the other regions. He is unaware of any clearing house for disseminating information from the partnership program. Moreover, he felt that the criteria for selecting the NIS partner institutions was not systematic and has concentrated on certain regions while neglecting others.

Dr. Denisov noted that the public health care system in NIS is very strong while the U.S. has a rich hospital system. He suggests there be a merging of these two areas by developing the referral system between the public health care clinics and the hospitals. Despite the developed infrastructure of the NIS, approximately 60-70% of patient visits begin and end in hospitals even though the patients present mostly simple conditions. He would like this ratio to be reversed by placing more emphasis on public health.

Professionalization of Nursing

Dr. Galina M. Perfiljeva, Dean of the Faculty of the Higher Nursing Education, was also interviewed. Three years ago, her department initiated the first "Master" program for nurses which is establishing a new role for nurses. She said nurses are traditionally trained to be doctors' assistants. In recent years, there has been a dramatic change in the face of medicine and nurses are leaving because of low pay and lack of recognition. Previously, the system employed nursing assistants. Because of the surplus of physicians, however, the physicians are functioning as nurses and the nurses are functioning as nursing assistants. In 1960, the ratio of physicians to nurses was 4.1:1 and today the ratio is 1.5:1.

Dr. Perfiljeva proclaims that the quality of care administered depends on the technical and administrative skills of nurses. She feels nurses need to be their own advocates but the system does not permit this. There is a great need for faculty who know how to transfer teaching skills to nurses. Their goal is to train nurse leaders who will be the change agents.

In response to the dearth of nursing literature, Dr. Perfiljeva has written a manual for nursing leadership and management. She has also begun a radio program which attempts to amplify the image of nursing. She feels the partnerships are isolated demonstration sites and the nursing managers should be trained in educational and management research. This can be accomplished through nursing colleges that have a 3-4 year curricula aimed at developing the nursing process. Nursing academies also have been established which have four year curricula addressing nursing administration and research.

Management

Dr. Pavel L. Salmanov, Chief of the Department of Management was also interviewed. He described their Health Services Management Program which trains fourth year medical students in team work, communications, and health administration. They are not training the students to become administrators, instead providing them with the concept of management so they may better function within the system when they graduate.

Dr. Salmanov feels the weakest part of the partnership program is the training of trainers. He advised AIHA to start a workshop to attend to this problem. He also commented on the fact that the partnerships are really between hospitals, and not between institutions and universities as they claim to be. He suggests that the most valuable asset of the partnership program is how it sets an example for students to take the special programs they learn in theory and to put them into practice. He strongly warned that the partnership program should not be acting as a "tourist agency" for those people who have limited opportunities to travel (incidentally, this commentary was made by other participants at different sites). He would rather see the partnerships continue contributing to curriculum development which has been a great help to him.

Recommendations

The I.M. Sechenov Moscow Medical Academy is in an excellent position to provide the partnership program with the overarching structure it needs. This institution is more than capable of providing direction in the area of management and education which thus far has been underdeveloped as an overall strategy in the partnership program. They have the expertise to function as liaison between the NIS government and the individual partnerships with the hopes of providing the theoretical framework needed. The partnerships have done a good job of providing the technical pieces and Sechenov has the philosophical framework into which those pieces may be placed. Moreover, their emphasis on the professionalization of nursing is important. This message can be relayed more readily from a NIS institution than from a U.S. institution, especially since the NIS partners have the tendency to isolate the U.S. nursing experience as unique to them and not a concept which can be translated into the NIS health care system. Sechenov may wish to consider the transition of their four year nursing academies into the equivalent of a bachelor's of science university degree.

The limitations of Sechenov may be that they cannot exert their political influence outside of Russia. If this is the case, they will at least provide a role model for other countries which can seek to identify their own institutions to provide this function. Nonetheless, Sechenov demonstrates the capacity to provide the partnership program with the missing links between translating practice into theory.

Kunseva Hospital of the Russian Federation Premier Health Alliance Inc., Chicago, Illinois

Kunseva Site Visit

This is a partnership between Premier Health Alliance, Inc. and the government Hospital of the Russian Federation (Kunseva). The memorandum of understanding for this partnership was signed in the summer of 1993. This partnership focuses on the following areas: 1) Cardiology, 2) Hemodialysis, 3) Transplant surgery, 4) Hospital management, 5) Nursing, medical and allied health education, 6) Insurance management.

Prior to 1990 the Kunseva hospital was part of a closed health care system devoted entirely to serve the members of the government and the party. But since 1990 this system has been open to the public and the foreigners who can afford to pay for the quality of services provided by the system. About 30% of the patients of the center are not government affiliated and they pay for the services. Revenues from patients' fees are used to supplement staff salaries, purchase equipment and pharmaceuticals and maintain the facilities. The majority of the patients (70%) are government and parliament officials.

The hospital in Kunseva is very well equipped and the staff is well qualified and trained. However, they are still lagging in the areas of nurses' training and hospital management. The management of

Kunseva hospital aspires to establish the hospital as the central training center in Russia. Training of the medical staff, followed by information dissemination, is the most important aspect of the partnership, as cited by the Russian partners.

Savior's Hospital (No. 70), Moscow
Magee Women's Hospital, Pittsburgh

Moscow and Pittsburgh Site Visits

Background Description

Tanya Kotys, Program Coordinator at Magee Hospital, had been living in Russia attending conferences and visiting birthing centers. A few years ago, she decided to organize a program for women's reproductive health with a private physician. She approached Irma Goertzen, President of Magee Women's Hospital, initially for support in producing educational materials. Soon afterwards, Magee Women's Hospital joined the AIHA partnership program along with the private physician who was affiliated with World Learning. However, there were misunderstandings between Magee and World Learning and the latter organization was dropped from the program. The U.S. team went to Russia to find a hospital which was committed to reforming to a Western style of birthing model. They choose to work with Savior's Hospital (formerly Municipal Hospital No. 70) which is an 1100 bed general hospital with 135 maternity beds. Magee offered their support to this hospital since they are a referral center for high risk pregnant women with cardiac difficulties. Dr. Goldberg, Director of Savior's Hospital, has aspirations to garnish this support by involving the surgical department in the future. Savior had not prioritized women's reproductive health until approached by Magee to form this partnership.

The Ministry of Health (MOH) was not involved in this process which led to a poor relationship between Magee and the MOH. They eventually mended their relationship and are able to collaborate more effectively. The Russian government has contributed some money toward the cost of constructing a new building to house the birthing center. Magee administrators feel the MOH uses their relationship with a US hospital to leverage others funds and support.

Description of Activities

Tanya Kotys summarized the program activities as follows: a) education program center (totally financed by Magee and not administrated by Savior's Hospital) b) family planning center c) financial accounting system d) establishment of private non-profit foundation to raise funds. Dr. Goldberg, Director of Savior's Hospital summarized the three "problems" which have been addressed by Magee Hospital: education, equipment, and renovation.

Strengths

The partnership is focused on the single discipline of women's reproductive health which is of high priority because of the far reaching health impact it will have on women and children.

The preventative focus on the pre-natal calendar is a creative tool which invites the participation of the mother. The self-breast examination instructions to be displayed in the shower is a simple, easily reproduced tool which also enlists the involvement of the woman in taking responsibility for her own care.

Dr. Goldberg has adapted management strategies from both working with Ms. Goertzen and from reading the Magee Hospital constitution. This led to efficiencies in his administration style because he realized the concept of job descriptions and the need to delegate responsibility.

Cost recovery schemes have been addressed in innovative ways in addition to the more typical user fees for contraceptive medications. Such ideas include an auxiliary gift shop, folk festival to raise funds, newborn photography studio, and Russian recipe book. It is unlikely that these interventions will significantly contribute to the cost of the overall program. However, they are at least introducing the concept of self-financing. It was not ascertained the degree of Russian involvement and whether they had the resources and management skills needed to sustain these projects independently from Magee Hospital.

Assessment and Impression

In Moscow, it was difficult to ascertain an objective assessment during our interview with the Russian counterparts because Rachel Mays, Moscow Program Coordinator, and a Magee intern were present. Ms. Mays viewpoints were sprinkled throughout the course of the interview despite our efforts to direct the questioning to the Russians. A Russian administrator stated that they did not need to be present for the interview since Ms. Mays often represented them when dealing with outside contacts and she could answer most of our questions on their behalf.

Magee Hospital appears to be providing the basis for the direction and management of the program. Without the support of Magee, it is unlikely the Russian partners would have the experience and resources to sustain the same level of sophistication that Magee has established. They seemed to have limited knowledge of what other partnerships are accomplishing, especially the one at Erebuni Hospital in Armenia which is working on women's reproductive health. They were also not aware of great strides made in infection control in other NIS hospitals and, in fact, they perceived themselves to be the forerunners in this activity. There were several similar comments made by both the U.S. and Russian members in regard to their accomplishments vis a vis the other partnerships which were inaccurate.

Attention to nursing is minimal because the prevailing attitude seemed to be that the nurses and midwives are not capable to advance due to their limited educational background. This sentiment was relayed by Ms. Mays both through her verbal comments and the fact that no nurses had been invited to attend our meeting. After requesting a nurse be present, a midwife, who also functions

as the office secretary, sat in the back of the room. She had limited contributions, usually echoing the physicians input when asked directly for her opinions. Ms. Mays assisted the midwife in her responses (as she did for each of the other Russians) by providing additional interpretation after the question was posed by our translator. Moreover, the nurses have not attended AIHA conferences. Hence, the involvement of nurses in this partnership has been as an adjunct to care provided by physicians. The U.S. partners are supporting the traditional Russian attitude toward nursing. They do not appear to be portraying the Western style of nursing, whereby it is treated as a profession in its own right which stands separately, yet in conjunction, with medicine.

Dissemination of project outcomes was discussed in reference to future plans; unfortunately, is not yet occurring. The rationale given was that the birthing center building has not been completed, however, at the very least the translated materials could be shared with other NIS partners working in women's reproductive health.

Recommendations

Rachel Mays, Magee Program Coordinator in Moscow, mentioned an important lesson learned which was to include their Russian counterparts in the decision making process, assuring the implementation plan reflects both partners' desires. Magee may wish to consider phasing out this position of a Program Coordinator in an effort to promote more independence for the Russians.

Dr. Goldberg was satisfied with the overall strategic position but suggested that more time be devoted to detailed planning. He also recommended that more attention be given to administration for the managers. It would behoove the Russian counterparts to participate more actively in the administration of their own projects. Dr. Goldberg and his physician and nurse managers should provide written reports which reflect their monthly progress in relation to a plan of action they have developed themselves. They should actively utilize electronic mail themselves as a means of understanding what the other partnerships are accomplishing since there seems to be a misperception.

The Russian physicians would like more input in planning their US visits. Thus far, this has been handled by the US partners and the Russians feel, at the very least, they would like a minimum of two months advance notice so they may make the necessary logistic preparations for their trip.

A philosophy of nursing could be promoted by the Magee staff which can be accomplished by the involvement of nurse managers and educators. More nurses should be involved in the exchange trips. The goals for the trips should be more streamlined. For instance, rather than attempting to cover clinical skills, training, and administration in a two week U.S. visit, select one of those objectives for the appropriate personnel who can continue to focus on the particular discipline. The Russian nursing administrators and educators should be trained to train others before honing in on very specific issues such as infection control. Clinical skills will be more efficiently realized if the nurses are provided with the necessary foundation first.

Careful thought should be given in terms of the feasibility of reproducing some of the educational materials. Before Magee creates more materials, the Russian counterparts should be able to independently produce the existing ones. These educational materials should be offered to the partnerships in Yervan, Odessa, and any other sites which have activities in women's health.

Murmansk

Murmansk Regional Hospital, Murmansk
St. Vincent's Medical Center with Memorial Hospital, Jacksonville

Jacksonville Site Visit

Background Description

Drew A. Synder, Chief Operating Officer of St. Vincent's Medical Center, stressed the importance of visiting Russia himself. Initially, he did not appreciate his role on a trip visit, however, after he went to Murmansk his attitude changed. He now feels it is essential for U.S. hospital directors to visit their counterparts in the NIS.

St. Vincent's Medical Center and Memorial Hospital each have their own staff coordinators for this project who work in collaboration with the partnership program coordinator. Their enthusiasm and involvement are readily apparent. These hospital administrators emphasized how important the NIS visits were for their own personnel because it has given them a clearer perspective on the benefits of working in a U.S. system. They feel that the staff is more appreciative and in some ways it has led them to be more cohesive as a group. The partnership program also has helped the working relationships between the staff in the two U.S. hospitals who are normally competitors.

The U.S. hospitals are private, and consequently their physicians need ample planning time in order to obtain coverage for their practices when they are in Russia. The administrators noted the difficulty with planning since they have been budgeted in six month blocks of time.

Description of Activities

The main activities of the partnership noted were laparoscopy, screening for prostate cancer, medical cardiology, cardiovascular surgery, and recently, infection control was added. Nursing was mentioned not as a separate activity, but in terms of how it related the operating room, maternity, and to a lesser degree in the infection control program. Nonetheless, nursing was not the emphasis of these activities. Managed care educational programs have also been offered.

St. Petersburg

**St. Petersburg Medical Institute (a.k.a. Pavlov Medical Institute), St. Petersburg
Georgia Baptist Medical Center, Atlanta, Georgia**

St. Petersburg Site Visit

Background Description

Dr. Michael Herndon from Georgia Baptist Medical Center was collaborating with the Pavlov Medical Institute on his own behalf (and with vendor support) two years before the AIHA partnership program began. He and Dr. Larisa Kochorova had been actively seeking funding from other sources in order to continue their program when they submitted a proposal to AIHA.

The original proposal had Georgia Baptist Medical Center and Jewish Hospital in Louisville, Kentucky working together with both Hospital No. 122 and Pavlov Medical Institute. Eventually, Jewish Hospital allied with Hospital No. 122 and Georgia Baptist allied with Pavlov Medical Institute. Several people noted difficulties arising from competing efforts between the two St. Petersburg hospitals. Apparently, Pavlov personnel felt that more equipment and supplies were directed toward the other hospital and efforts were made to allay this concern.

Dr. Nicolai Yaitsky, Rector, dominated the interview, and his staff echoed their agreement with his viewpoints. Dr. Yaitsky eluded to some misunderstandings in the beginning of the partnership between the hospitals. He felt this was to be expected since the professional exchanges did not fit the interests of the parties involved. He attributes part of the problem to selecting participants because of their English language skills rather than their areas of expertise. According to the rector, the situation has been ameliorated, yet others have mentioned the continuation of this problem.

The tour of the facilities was from the outside of the buildings only. We were not invited to enter any of the hospitals despite the initial offer to observe a U.S. ophthalmologist while he was training his Russian counterparts.

Description of Activities

Maternal Child Health and Family Planning were noted to be the main activities, however, no concrete information was given that concurred with their stated commitment to these topics. Instead, they discussed activities in endoscopic surgical procedures, diagnostic laparoscopy, and ophthalmologic surgical techniques. The Vice Rector, a urologist, said his personal interest is endoscopy for urology, however, he realizes that Maternal Child Health projects are more pertinent to the health care priorities of their patients.

Other achievements include upgrading the medical library. In regard to administration, they discussed the donation of computers and the adaptation of an "international network". Many of the activities mentioned were described in terms of future plans, such as establishing a center for National Board Licensing (ECMOG).

The Rector described the biggest success of the partnership to be their exposure to high-technology. Previously, he and his staff had thought that they had the state-of-the-art technology and were ranked among the best facilities in the world; now they realize their need to adopt the U.S. model. The Rector mentioned that the University of Pennsylvania may join into their partnership program in the future, however, this was not confirmed by AIHA.

Written documents were provided which included plans for the reorganization of the Ophthalmology Hospital, a list of the necessary equipment for the Ophthalmology Hospital, and a brief background description of the Obstetric and Gynecology activity goals.

The administrators mentioned on several occasions the international recognition of the Pavlov Medical Institute. In regard to the dissemination of their partnership activities, they feel this will be accomplished through the numerous foreign students whom they train, representing countries from all over the globe. A more specific strategy for dissemination was not offered. The U.S. counterparts said it was difficult to disseminate the program activities within the Medical Institute itself due to the large size and decentralized administration. Each specialty hospital functions independently from the others. They said it was difficult to get the most efficient use of the technology and equipment donated because the power was diffused among the various facilities. For example, there are operating rooms in each of the hospitals the partners are working in so it is not possible to share the surgical equipment.

With regard to the nursing activities, the Rector feels that the nurses have failed since they do not have the conditions the U.S. nurses have. Moreover, without an experimental unit such as Hospital No. 122 has, it is very difficult to develop a nursing project. They need the material capabilities before they can learn. During this conversation, the Rector contradicted himself on numerous occasions. Basically, it appears that there is no real activity in nursing.

Strengths

The Pavlov Medical Institute receives funding from the Ministry of Health based on the number of beds. They receive more money than the average hospital because the mayor realizes that they are "helping citizens". Since they are given more funding than Hospital No. 122, it would be reasonable to expect the same degree of progress, if not more, than observed at the latter hospital. However, this did not seem to be the case.

Their international recognition affords them ample opportunity to interface with potential donors and the administrative staff has had a long history of foreign relations. Their powerful posture both within the NIS and internationally should give them an advantage over their lesser known Russian colleagues.

Assessment/Impression

The Rector's position is that more material donations are needed in order for the partnership to progress. The future activities were emphasized more than what has already been accomplished through this partnership. There is resistance against developing the role of nursing which is fostered by arguments that could also be applied to the medical staff's professional growth. Therefore, such rationalizations seemed rather hypocritical.

It was difficult to ascertain the overall direction of the partnership and it appears that the professional exchanges between physicians have led to ad hoc training opportunities. The concept of management was not clearly delineated, nor was a concrete plan for dissemination of their program activities included.

It is difficult to make a comprehensive assessment from one meeting and without observing the physical facilities. However, given the information offered, it appears that this partnership is not functioning well, nor is it very productive.

Recommendations

Given the international recognition and increased government financial support, the Pavlov Medical Institute theoretically should be in a better position than most of the other NIS partnership hospitals to function independently. They are in a better position than most to be able to achieve their institutional goals. Clearly, the most important contribution derived from their partnership has been the material donations of equipment and supplies. This does not suffice as a response to concrete program activities. There does not seem to be any clear direction in this partnership. This impression, juxtaposed with the Rector's authoritative management style, leaves one with little rationale to continue developing this partnership. I would suggest phasing out this partnership, if at all possible. The political ramifications of discontinuing the partnership should be taken into consideration in terms of the maintaining the stability of the partnership with Hospital No. 122.

**Hospital No. 122, St. Petersburg
Jewish Hospital, Louisville, Kentucky**

St. Petersburg Site Visit

Background Description

Jakov Nakatis, MD, became the president of Central Hospital No. 122 approximately four months before the partnership program began. He claims he has never administered "the Russian way" but rather he has adopted a team approach whereby he is the unnoticeable referee. This management style was exemplified during our interview with Irena Bakhtina, MD, Dean of the Post-Graduate School of Nursing and Program Coordinator; Jane Younger, Vice President of Nursing and Program Coordinator, Jewish Hospital; and Galina Orlova, Director of Nursing, who joined the meeting after my request. Dr. Nakatis distinguishes his dual role as an administrator and clinician by donning a

white lab coat when he gives patient care and wearing street clothes when he is involved with management activities.

Previously, the hospital received 60-70% of its budget from the Ministry of Health which was based on the number of patient days. Now, Dr. Nakatis receives 25% of his budgeted needs and he is responsible for recovering the remainder. He is one of the more innovative hospital administrators interviewed in terms of his schemes to recover costs. Because of the hospital's good reputation, medical suppliers use the hospital as a demonstration site for their supplies and equipment, while both drug and ambulance companies are competing for contracts with them. The hospital also has been selected to pilot private insurance. He has contracts with the Mayor's office and other private enterprises. Revenues are also generated from a sector of the general population which pays for services.

Description of Activities

Dr. Nakatis described three directions the partnership program has taken: a) professional exchanges with personnel from medicine, nursing, materials management, administration and finance, b) health care economics and management (includes a computerization scheme), and c) education with an emphasis on advanced nursing education. They are adopting an evaluation system in nursing education observed in the U.S. and applying it to their nursing school. There was also some discussion of their involvement with the Emergency Medical Services which has begun by their staff attending conferences and sending a U.S. physician who is now teaching classes at their hospital.

The Goodwill Games will be held in St. Petersburg this summer and the partnership is using this as an opportunity to test an experimental department to care for the foreign spectators. The nurses have been undergoing special training and testing in order to gain permission to work in this unit. Also, the director of nursing is developing the role of a nursing assistant so that her educated nurses do not need to do unskilled tasks.

Strengths

Jane Younger, RN, Vice President at Jewish Hospital, is the program coordinator and has had previous experience working in Russia as an advisor to the Ministry of Health in a project unrelated to the partnership program. Her background as a nurse, combined with the active support of the hospital director and dean of the nursing school, have made a great difference in the success of the nursing component of this partnership. This is not to underestimate the devotion and determination of Galina Orlova, Director of Nursing.

The hospital administrator is young and began his first administrative position with a "clean slate" as he notes. He has taken the initiative to focus on the U.S. management model emphasizing alternative financing strategies. Planning was difficult at first for them, however, they have now developed a written work plan which guides their progress.

The partnership has focused on two key areas: nursing development and hospital management. They utilize the professional exchanges to meet their objectives related to these areas.

Assessment and Impression

Dr. Nakatis is one of those unique individuals who is a visionary with the capacity to put his ideas into action. With relatively little experience as an administrator, he has been able to prioritize the hospital's needs and choose areas which will provide him with the necessary foundation from which to absorb the multi-faceted activities the partnership can offer. Unlike many of his colleagues in other partnerships, he is laying the groundwork which allow for the sustainability of the individual activities.

Ms. Orlova can progress with her nursing staff because she has been accepted as an active participant in the partnership by the hospital director. The Dean of the Nursing School has also been appointed Program Coordinator.

Jewish Hospital has selected a nurse as their Vice President which may be an indication of their appreciation of the expanded role of nursing. Ms. Younger believes her nursing experience to be a major asset in her ability to coordinate the partnership program. Her previous experience working in Russia undoubtedly also contributed to her successful working relationship with her partners.

Recommendations

This partnership should not have to compete with the Pavlov Medical Institute for program resources. Pavlov personnel have had an equal opportunity to demonstrate their ability to progress but have so far been unsuccessful in their attempt. The apparent jealousy directed toward the personnel at Hospital No. 122 is counter productive and continues despite the attempts of the U.S. partners to appease them. If at all feasible, Hospital No. 122 should be delegated as the primary partnership for St. Petersburg. This may not be possible due to the historical and political power wielded by the Pavlov Medical Institute wields.

At the very least, the partnership between Hospital No. 122 and Jewish Hospital can be used as a role model for other partnerships. They provide definition to the word "commitment" and are demonstrating the importance of prioritizing their activities into two key areas, which is a necessary ingredient for institutional success.

Vladivostok

**Vladivostok Hospital
Medical College Of Virginia**

Virginia Site Visit

Background Description

Dr. Trani, President of Virginia Commonwealth University (VCU), has had a long relationship with Russia and has taught at the University of Moscow. He particularly sought to have a partnership with the Vladivostok Hospital because he feels it wields political power and it serves a major metropolitan area. VCU has four other projects in Russia: Eurasian Foundation (venture capitalists), exclusive contracts with the Ministry of Science & Technology (biotechnical transfer), VCU Business School (sponsoring internships for Russian fellows), and a program supporting Russian athletes at VCU.

Description of Activities

Initially, the Medical College of Virginia decided to focus their efforts in emergency care and services, infection control through the nursing department, and general hospital administration with an emphasis on cost reimbursement and insurance schemes. Subsequently, the infection control program activity was replaced with a health education model with an accent on nursing. Although the nursing activity was initiated late into the program, it is well defined and focuses on formal education, staff development, and management services for organizational services.

UKRAINE

Kiev

Children's Hospitals No. 1 and No. 2

Obstetric and Gynecological Hospital No. 2

University of Pennsylvania Medical School, Hospital of the University of Pennsylvania, and Children's Hospital of Pennsylvania

Kiev Site Visit

The Kiev institutions are embarked on a major effort to develop a center of maternal child care which would be a model for replication elsewhere in the country. The Center serves the population of the "Left Bank" (east side of Dniester River) of Kiev with a population of about one million and an estimated 200,000 women of reproductive age. Facing increasing death rates concurrent with markedly lower birth rates, there is growing emphasis on quality of birth. They further noted that infant mortality has been increasing from 13 up to 16 per thousand and that this has become a political issue. This, in turn, has led to increased emphasis on antenatal and perinatal protection of the child through improved care to the mother.

With drastically reduced budgets they consider their support from their American partners as critical,

and they are highly appreciative of the support they have already received from their Pennsylvania partners. The University of Pennsylvania has helped significantly in determining the necessary steps to improve treatment and diagnosis for the newborn, and the development of educational materials for the public with substantial emphasis on family planning. In addition to improvement of training programs, the University of Pennsylvania hospitals have provided equipment and supplies and counsel in the improvement of financial management.

The 1994 plan for the partnership includes improving procedures and techniques for delivery and particularly for anesthesia at time of delivery. Also family planning is to be expanded with substantial support from Project Hope on commodities.

Among changes already introduced with support of the U.S. partners has been keeping the newborn together with the mother. The Center's outreach program has extended to identify pregnant women within the communities and establish a continuing relationship between the pregnant woman and her doctor, including monitoring at home.

The NIS participants expressed a high level of concern for control of sources of infection within the hospital. They note that they shut down the hospital for total cleanup twice a year and have been shortening the hospital stay for deliveries from an average of about 7 days to about half of that over the past ten years.

Ultrasound diagnosis is now being used extensively; indeed the University of Pennsylvania has questioned whether it has not been used excessively for normal deliveries and should be restricted more to identified higher risk pregnancies. The people working with the Maternal Child Care Center say that their statistics indicate a reduction in infant mortality already of about 28% as a result of the various activities including the activities supported by the Partnership, but also including other activities supported by other agencies and donors.

Further, relative to the Partnership Program, the NIS partners see an impact already on medical school curriculum following two Partnership Program conferences to which students as well as faculty were invited. They note that the impact of the program tends to be more on practice than on teaching materials since medical school teaching materials have to be developed in the first instance by the Ministry of Education. NIS participants noted that many representatives from Kiev had participated in and gained much from a January, 1994 conference sponsored by AIHA in Lviv concerning computer applications in hospital systems.

Most of the participants in our interviews had attended the two Partnership conferences held in Kiev. They noted that none of their nurses have yet been to the United States under the Partnership Program because of the lack of ability in English, but that several American nurses had come to Kiev under the program. The people in charge of the ultrasound lab had been trained in the United States under the Partnership Program and the laboratory was following the U.S. model in its operation. Also they had started some use of amniocentesis in high-risk pregnancies as a predictor of natal problems. Although the practice of keeping newborn babies with their mothers had been

successfully introduced they noted that fathers were still not ready to participate in the birthing process although they were being invited to attend courses for parents.

Relative to dissemination of the technology acquired and the lessons learned via the Partnership Program, training was of course given high priority, along with quality control by the authorities, exchange of delegations among hospitals and seminars. Health care management was mentioned as a subject of particular concern for seminars. Also noted was the importance of the Ministry of Health in providing support for dissemination, and the need to connect with the formal education system. They noted that their current system of certification included no requirement for continuing professional education for either doctors or nurses.

They gave the AIHA credit for expediting reform but noted the importance of initiatives originating from the Ukrainians themselves.

They noted that, although the equipment was available, the electronic communication introduced under the Partnership Program was virtually unused.

They noted that in general about 30% to 40% of pregnancies are considered "high risk". As causes of high risk in pregnancy they mentioned hypertension, infection, kidney disease, heart disease, anemia and diabetes, with infection and anemia as the principal causes of premature labor.

The NIS partners noted that for every delivery in the hospital there are approximately two abortions and that this situation is a major factor in the increased emphasis on family planning. Unfortunately at the present time there are no birth control pills available in the Ukraine because of the breakdown in trade links that existed prior to the breakup of the former Soviet Union.

During the course of our visit we noted that the infants were still tightly bound in swaddling clothes even during the middle of summer. The staff expressed awareness of the desirability of looser clothing for the babies, but said that they just couldn't afford it. Relative to the treatment of respiratory distress in premature babies, they noted that they have the necessary equipment but lacked the essential commodity of surfactant. Among other problems noted was a lack of transport for handling referrals.

In addition to the Partnership Program the Kiev hospitals also are partnered with a Canadian hospital associated with the University of Alberta in Edmonton.

While at the hospital we witnessed a program of monitoring placentas and mother's milk, carried out with the assistance of the United Kingdom, in determining the impact of industrial pollution and contamination from Chernobyl.

Lviv

**Lviv Oblast Hospital, Lviv Medical Institute
Henry Ford Health System of Detroit, Michigan and Kaiser Permanente of Cleveland, Ohio.**

Lviv Site Visit

The Oblast Hospital is a 200 year old institution founded by Empress Maria Theresa of Austria. It has become the leading hospital serving the western third of Ukraine with 1100 beds and 22 departments in 27 buildings, and provides the clinical base for the medical university of 6000 students, including nurses and dentists.

For this institution the Partnership Program has focused on the treatment of heart disease and control of infections within the hospital. The Partnership has also helped in the introduction of a computerized management information system.

The Hospital is receiving support from the Knights of Malta in the areas of neonatal resuscitation and emergency medical services. They also receive help from the Canadians.

The Partnership has worked out a division of labor whereby Kaiser works on the management component and Henry Ford works on the medical component. So far there has not been much involvement of Kaiser but a pickup in activity is planned for the fall of 1994. In general the Medical Director of the Hospital praised the support from the U.S. partners. He noted that rheumatic heart disease was of high prevalence and special concern for the western region of Ukraine and that Henry Ford's interventions had helped significantly to raise the level of medicine; they have trained Ukrainian doctors to train other doctors, and good dissemination had been achieved through the use of video, books and journals as well as seminars. He noted that the exchanges had been particularly helpful, but he thought that they would be more effective with more time in the United States. He said two weeks was not enough to get much beyond the necessary acclimatization and orientation, that two to three months would be far better for getting to the substance of technology transfer.

He noted that, of some 30 tons of equipment that had been shipped under the program, all was old, much out of order, some not worth repairing nor the freight for shipment. He noted that critical parts were sometimes missing from sets, that there were problems of adaptation to higher voltages, and that such adaptation could be done more efficiently in the United States in view of the difficulties in obtaining transformers and other necessary adaptation equipment in the Ukraine. Critically lacking in many of the shipments, he said, was an inventory of the items shipped. He stressed the importance of the Partnership for scientific exchange and transfer of experience and skills; but, concerning the equipment, he said there should be more attention to what was needed in the Ukraine as distinct from what was excess in the United States. He stressed that it would be far better to have less equipment in good shape responsive to the Ukrainian needs, and, where the equipment was of a relatively high level of technology, to include technicians to explain the use and maintenance of the equipment.

They say their current program includes substantial emphasis on participation of nurses and the role

of nursing in the medical care system. As to participation in the exchanges, however, about 10 Ukrainian doctors have been to the United States for about two weeks each, but no nurses as yet; and from the United States about 30 to 40 people had come, including 3 or 4 nurses.

**Lviv Regional Parinatal Center
Millard Fillmore Hospitals, Buffalo, New York**

Lviv Site Visit

This large hospital includes 200 beds in its delivery facility and 150 more in its gynecological facility. Its services include prenatal care. In general newborn are still kept separate from their mothers, although there is provision for "rooming in" for a fee. Also provided for a fee are some impressive science fiction looking gadgets whose utility would appear to be more psychological than physical. We were assured, however, that they did not represent a significant investment.

This institution seemed very happy with its relationship with Millard Fillmore; already three groups have been in Lviv from the United States and two groups have gone from Lviv to the United States. These groups have included one nurse from the United States but no Ukrainian nurses going to the United States.

The staff noted that Millard Fillmore had been particularly helpful in providing access to the latest medical technology and practice through books being translated from English into Ukrainian and a good supply of recent books and journals from which Lviv had been substantially cut off since the collapse of the USSR. Millard Fillmore had also been helpful in providing vitally needed reagents and other supplies, including medicine, sutures, contraceptives and surfactant for premature babies with underdeveloped lungs.

They expressed some resentment that the exchange between the partners was not more equal. They sensed that often the U.S. doctors did not indicate much interest in learning from Ukrainian experience, particularly in how to do more with less technology. They felt that Ukrainian doctors were actually better at Caesarian section than their American colleagues. They felt that Ukrainian doctors had the most to learn in the area of diagnosis. They felt the partnership could be more productive if planning were conducted more jointly rather than predominantly by the U.S. partner.

They noted that initially much of the equipment provided by Millard Fillmore was coming through without any instructions but that situation has improved. Here again we heard the frequently-voiced complaint that the visits to the United States are too short, that two weeks is not enough to provide for efficient technology transfer since much of that limited period has to be taken up with logistics, settling in, getting to know each other; far more could be learned during a third and fourth weeks than during the initial two.

They felt that the area in which the U.S. partner could be most helpful would be in the use of computers and in the use of ultrasound and other relatively high technology equipment for diagnosis. They noted that, like the hospital in Kiev, they too lack an ambulance for referral of premature babies from outlying facilities.

In order to reduce exposure of newborn infants to infection within the hospital the average hospital stay has been cut down to four to five days following delivery and nine days following C-section.

**Western Ukraine Regional Railroad Hospital
Millard Fillmore Hospitals, Buffalo, New York**

Lviv Site Visit

This hospital's name derives from its original establishment to serve railroad employees, but its clientele is now not limited in any way to railroad personnel. It is a 520 bed facility serving approximately 10,000 patients per year with a staff of 1100. The service area includes approximately 30% of Lviv.

This hospital enjoys a good relation with its American partner. A group of surgeons has already been to Millard Fillmore, including one nurse, and one nurse has also come to the Ukraine from the United States. One concern expressed is that the surgeons spend a lot of time learning the use of expensive, sophisticated equipment which is not available in the Ukraine.

One of the principal areas of focus for the Partnership has been ophthalmology because subsequent to the Chernobyl disaster there has been a substantial increase in incidence of cataracts in the region. Already, with the help of the Partnership, laser treatment of cataracts has been introduced.

The Ukrainian surgeons have been highly interested in the use of endoscopic surgery to perform surgery much more efficiently with a minimum, if any, of hospital stays and exposure to infections. Unfortunately, however, while the instruction is available from Millard Fillmore, the hospital lacks the funds to acquire the necessary equipment. Incident to the focus on surgery has been technology transfer on anesthesiology. They noted, however, that this is another area in which the Ukraine has been cut off from supplies following the break up of the former Soviet Union.

Another area that is considered highly beneficial to the Ukrainians has been exposure to the U.S. systems of hospital management and financing of hospital services through medical insurance. Here again, as elsewhere, we heard high praise for the AUPHA management seminars which, in addition to the content conveyed through the program itself, provided valuable contacts with other NIS hospital administrators for consideration of common problems. The American partner has also been helpful in bringing the hospital's medical library up to date with books and journals.

In discussing dissemination the staff noted the utility of exchanges within the Ukraine and within the countries of the former USSR as well as exchanges between the NIS and the United States.

Odessa

Odessa Oblast Hospital, Odessa
Coney Island Hospital, Brooklyn, New York

Brooklyn and Odessa Site Visits

Background Description

Howard Cohen has been the Director of Coney Island Hospital (CIH) since 1982 and is supported by a strong administrative staff. He was on the board of the National Public Health Association when he discovered AIHA's partnership program. CIH's patient population has a significant number of Ukrainians and Russians to the extent that all written information is presented in English and Russian. For this reasoning, Odessa Ukraine was selected as their counterpart site despite the lack of full cooperation on the part of the Odessa Oblast Health Administration. Mr. Cohen's democratic style of administration and the purported autocratic style of the Odessa Hospital director has led to inherent difficulties in the development of program activities. Mr. Cohen is applying for a SABIT management grant which would allow a Ukrainian administrator a six month fellowship to Coney Island Hospital.

According to the CIH staff, the Odessa Hospital was described as poorly coordinated with a compartmentalization of individual efforts that resulted in a lack of collaboration amongst departments and individuals. Individuals are accustomed to controlling their own information. In an effort to contend with this difference, Ukrainians attending a seminar were asked to make presentations describing their individual problems and the strategies they employed to solve them.

A few of the Odessa administrators have been focusing on the continued donation of equipment and supplies as a prerequisite to further progress with their program activities. The Director of Internal Medicine feels the strongest about this and she is also a person who apparently wields much power within the Odessa institution. The Chief of Obstetrics and Gynecology has some viable suggestions for cost effective activities which would have the potential to make a greater impact on the overall health of the region, but unfortunately she has very little political clout.

The on site interviews corresponded to the CIH assessment with the exception of the hospital director's behaviour. He was extremely cordial and non-controlling. He was most interested in my assessment and did not mention the need for further donations. On the contrary, he discussed his interest in the development of the State insurance system. He arranged for me to meet with all of the department heads and important participants in his absence. However, the Chief of Internal Medicine refused to have a joint interview with all those involved in the partnership. She strongly

urged to have individual meetings with each department. In the interest of time, she agreed to a separate meeting with personnel from Obstetrics and Gynecology. A second meeting took place with her leading the discussions and input from chief surgeons. The participants from urology, accounting, and elsewhere were initially invited by the hospital director, but were not invited back for this meeting with the Chief of Internal Medicine, and consequently were not interviewed.

The CIH administrators stressed the importance of understanding the referral system from outlying clinics to the Odessa Hospital. Additionally, they feel the Odessa Hospital has an obligation to disseminate their information throughout the region. The CIH staff emphasized they would like the Odessa staff to begin teaching other hospitals as a condition for continuing with their program activities. This issue was not discussed during the Odessa interviews.

Description Of Activities

The strongest activity of the Coney Island/Odessa partnership is the area of infection control. Other foci seem to have been short lived and less successful due to various constraints. Such activities included childhood ophthalmology, orthopedic surgery, childhood oncology, and obstetrics. Health financing has also been addressed but the overall strategy to tackle this issue was not apparent. Out of the thirty two people sent to the U.S., only three of them have been nurses. Mr. Cohen said these nurses were sent only after his insistence. The Odessa physicians claim that there is no point in sending nurses since they do not have the power to make changes within their institution. They said it is more important for the physicians to go to the U.S. because they can come back and train the nurses.

The Chief of Obstetrics and Gynecology has implemented some specific interventions which she attributed to the input from her U.S. partners. She mentioned that her department was invited just recently to participate in the exchange of professionals. She has prepared a report for internal circulation which describes the advances made in her department (i.e. decreased incidence of eclampsia since improvements in the monitoring protocol of high risk pregnant women, and infection control surveillance in the neonatology intensive care). In her report, she proposes a new activity which would ameliorate the monitoring system in the pre-natal clinic. However, she voices skepticism that her ideas will come to fruition since her department historically has received less support than the surgical departments.

Strengths

CIH has a long history of caring for Ukrainian and Russian patients. The director of the Odessa Oblast Hospital noted that he met patients while visiting CIH who had been patients in his hospital before they immigrated to the U.S. Hence, there is a very strong connection between these two hospitals which provides the foundation for the partnership.

Regina Napolitano, Director of Infection Control at CIH, has done an excellent job in preparing the necessary basis for an infection control department. She wrote a "Report on the Principles and

Practice of Infection Control at the Odessa Oblast Hospital in the Ukraine" which clearly and thoroughly covers this topic from Ministry of Health regulations to statistics on nosocomial infections. The Odessa administrators have responded by developing an Infection Control Department which will be staffed by a nurse who has a college degree in micro-biology. There will be a physician who will supervise her work, but it seems that she will have the majority of the responsibility.

The Director of Obstetrics and Gynecology has had relatively little involvement with the partnership program in comparison with the surgeons but has adopted a few cost effective measures which have had dramatic results. For instance, without adding any appreciable cost, she increased the frequency of monitoring high risk pregnancies by having their vital signs and simple lab tests done every 1-2 hours. She noted that there were only 2 cases of eclampsia this year compared to the average 10 cases per year. She has also begun to screen patients for infections and log this data into a record which has decreased the incidence of hospital induced infections.

Assessment/Impression

The Odessa Oblast Hospital department heads have difficulty working together in this partnership program. The hospital director is a surgeon and there does seem to be favoritism for the surgical departments. In fact, the other departments were not represented during the interview with the exception of Obstetrics and Gynecology. The latter was only invited because CIH had mentioned their progress in infection control, and I therefore personally requested to meet with them. This meeting was permitted, but the surgeons insisted it be a separate meeting.

The Chief of the Surgical Department is quite interested in learning how to perform kidney transplants. He said there are about 50 patients per year who will die without a transplant. Incidentally, there are other hospitals in Ukraine which perform kidney transplants. The Chief of Internal Medicine is interested in equipping two new intensive care units in addition to the existing one. These physicians are fixated on the need for more supplies and equipment as a pre-requisite for continuing with their partnership activities. However, when queried further, they responded by saying there were other activities they could work on which were not dependent on material donations, such as learning more about finance and the development of professional standards.

The development of nursing is not being addressed actively. Nurses are involved in the partnership only as they fit in the plans the physicians have for themselves. Mr. Cohen successfully persuaded them to send the first nurses to the U.S., however, they did so reluctantly.

Dr. Gogulenko, Director of Odessa Oblast Hospital, apparently appreciates the need to appear less controlling with U.S. visitors. He portrayed a very different personality than had been painted. His sincerity notwithstanding, he has apparently taken some of the suggestions of others and tailored his personality accordingly.

Despite the initial misunderstandings and difficulties between the partners, there seems to be an

inherent likelihood for this partnership to bear fruition. Perhaps part of the problem was the clashing of two cultures which are known for their strong personalities. Regardless, both sides seem to be committed to make the partnership program work. In the end, this may prove to be one of the more successful partnerships because they will have endured these struggles which will result in a better understanding for each other.

Recommendations

The Odessa physicians feel that their visits to the U.S. have been too brief to be optimally effective and they suggest that the visits be one to three months duration. They would prefer that the U.S. delegations be smaller and that they come with a more specific agenda to focus on specific medical procedures and technologies. They would also like to work on management issues such as insurance principles.

Much work needs to be done to relay a new role for nurses. The Odessa physicians see the expansion of the nurses' responsibilities as easing their workload but not in terms of their ability to exist as professionals. Mr. Cohen has had to use extreme measures to relay this point. He has actively enlisted the support of nurses from CIH to help him convey this message. He seems to have an understanding of which tactics will work to convince the Odessans to include nursing. Other U.S. partners have chosen not to try to cross this impasse with nursing. Yet, ignoring the problem will only create future problems since almost all of the partnership activities involve nurses.

The Department of Obstetrics and Gynecology should be allowed to have a larger role within the partnership program. This will not be easy, but with time, it may be accomplished. The Director has some excellent ideas which involve the pre-natal clinic within the Polyclinic and she needs to have the opportunity to realize these goals.

The development of the infection control program should continue and perhaps it can help provide a framework by which the various departments can learn to collaborate. The neonatology intensive care staff has been the most successful in this realm and perhaps they could provide guidance to the other departments. On the other hand, I do not recommend attempting to progress with the technology within the intensive care unit before addressing women's reproductive health first. Intensive care is so ill-equipped and lacking the bare essentials, that children are actually at a higher risk for morbidity and mortality when they enter. It is not a true intensive care unit and would take a great deal of money and resources to bring the staff and unit to a functioning level. This cannot be justified when the Director has important ideas for the pre-natal clinic and patient management which would cost less, take less time to prepare the staff, be more likely to sustain given their limited resources, and most importantly, have a greater impact on more people.

Program Management
Central Asia
AIHA

Almaty Site Visit

AIHA is represented in Central Asia by a Regional Coordination office in Almaty, Kazakhstan. This office serves a region including Kazakhstan, Kyrgyzstan, Turkmenistan, Uzbekistan and Tajikistan. At the present time there is no program in Tajikistan, although some exploratory work has been undertaken.

The regional representative and his staff work out of office space provided by the Almaty City Hospital in its headquarters building. The office has four regular employees headed by a young American journalist with an AB degree who is fluent in Russian. He had worked in the AIHA office in Washington and become thoroughly knowledgeable in its programs and its operations before assignment to Almaty as replacement for the first regional coordinator in the summer of 1993. The second staff member is a Kazakh doctor with a PhD and an MD, fluent in English, who also acts as an interpreter/translator. The third employee, also part time, serves as an interpreter/translator as well as executive assistant to the regional representative. The fourth employee is an administrative assistant who specializes in the handling of USAID paperwork, particularly the USAID participant training requirements. For logistical support the office contracts the services of one or more drivers as needed, along with their automobiles. One such driver is retained by the mission on a fairly regular basis, but not on a full time basis.

The coordination function of the regional representative's office includes assuring that adequate arrangements are made for all U.S. visitors in the Central Asian region and for Central Asian visitors in the United States. The regional representative's office is also the point of coordination between AIHA and the USAID/Central Asia regional office in Almaty.

In the first instance it is the responsibility of the Central Asian partners to see that adequate arrangements are made for their visitors and similarly for the U.S. partners to see that adequate arrangements are made in the United States for their Central Asian visitors. It is the role of the regional coordinator's office to assure that such arrangements have been made and to assist in their facilitation as appropriate. The regional coordinator or a member of his office ordinarily meets all U.S. visitors as they arrive, and serves as a backup for U.S. visitors if there are any problems with their Central Asian partners. The regional coordinator also participates in briefing the Central Asian visitors to the United States prior to their departure. In the present AIHA scheme of program management and implementation the regional coordinator's office provides little to no technical input on partnership program content, but rather deals with the administrative and logistical functions.

During our six day visit to Central Asia we were impressed that the regional coordinator and his staff are performing their roles exceptionally well. They appear to have established good working and personal relationships with both the U.S. and the Central Asian partners, with the USAID mission

in Almaty, and with the various U.S. Embassy offices throughout the region. The Regional Coordinator and AIHA are to be congratulated on the notably lean, low cost, efficient manner in which their regional representative's office has been established and operated.

USAID

Almaty Site Visit

USAID has established in Almaty, Kazakhstan a regional office for Central Asia whose jurisdiction includes Kyrgyzstan, Tajikistan, Uzbekistan, and Turkmenistan, in addition to Kazakhstan. Since early 1994 USAID has had a direct hire career officer who can give full time to projects in the health sector, including that mission's role with respect to the partnership program. That officer is in turn supervised by a general development officer, who in this case has an extensive background with USAID in public health and served as the public health sector manager prior to the arrival of the present health sector project officer.

Although the Partners program has been funded through a cooperative grant agreement between USAID/W and AIHA, USAID/CA has taken an active interest in the program which, thanks to its rapid implementation, has been among the first if not the first, active program in their respective countries. The USAID Project Officer and General Development Officer say that USAID would prefer more emphasis in the program on the traditional USAID interests in preventive medicine, vaccination, primary health care, maternal child health, etc., and less on such areas as cancer and heart disease treatment. On the other hand, USAID/CA strongly endorses the present inclusion of management/administration among the activities of the partnerships now active in Central Asia.

The AIHA representative has suggested the desirability of more coordination and information flow among the various U.S. government financed programs and agencies active in the health sector within the region. The USAID responded by offering to set up a periodic health sector round table meeting at least monthly.

There appears to be some confusion between USAID/W and the USAID mission in Almaty concerning the role of USAID/CA with respect to any future funding of partnership program. We were informed by USAID/W that the regional mission would have the predominant role in determining whether and to what extent the partnership program would continue active in the region, whereas USAID/CA, as of June 26th, 1994, at least, appeared to believe that such decisions were still for USAID/W.