



AMERICAN INTERNATIONAL HEALTH ALLIANCE

**WEST NIS PARTNERSHIP PROGRAM
1998 – 2004**

FINAL REPORT

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Finally, AIHA gratefully acknowledges the contributions of dedicated staff in its regional and Washington, DC, offices in managing and implementing the program and preparing this final performance report.

AIHA's mission is to advance global health through volunteer-driven partnerships that mobilize communities to better address healthcare priorities while improving productivity and quality of care. Founded in 1992 by a consortium of American associations of healthcare providers and of health professions education, AIHA is a nonprofit organization that facilitates and manages twinning partnerships between institutions in the United States and their counterparts overseas. It has supported to date 116 partnerships linking American volunteers with communities, institutions and colleagues in 22 countries in a concerted effort to improve healthcare services. Operating with funding from the United States Agency for International Development (USAID), the Health Resources and Services Administration (HRSA) of the US Department of Health and Human Services, the Library of Congress, the Susan G. Komen Breast Cancer Foundation and other organizations, AIHA's programs represent one of the US health sector's most coordinated responses to global health concerns.

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ACRONYMS AND ABBREVIATIONS

AIHA	American International Health Alliance
CA	Cooperative Agreement
CDC	US Centers for Disease Control and Prevention
CEE	Central and Eastern Europe
CPG	Clinical Practice Guidelines
CQI	Continuous Quality Improvement
EBP	Evidence-Based Practice
EDM	Emergency and Disaster Medicine
EMS	Emergency Medical Services
EMSTC	Emergency Medical Services Training Center
FMC	Family Medicine Center
FMTC	Family Medicine Training Center
FPC	Family Practice Center
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
ICT	Information and Communications Technology
ICTC	Infection Control Training Center
INLI	International Nursing Leadership Institute
LRC	Learning Resource Center
MOH	Ministry Of Health
NGO	Non-Governmental Organization
NIS	Newly Independent States of the Former Soviet Union
NRC	Nursing Resource Center
NRP	Neonatal Resuscitation Program
NRTC	Neonatal Resuscitation Training Center
PHC	Primary Health Care
STI	Sexually Transmitted Infection
TB	Tuberculosis
TOT	Training-of-Trainers
USAID	United States Agency for International Development
WHO	World Health Organization
WWC	Women's Wellness Center

I. EXECUTIVE SUMMARY

Since 1992, AIHA has been creating and managing twinning partnerships that link American healthcare professionals with their counterparts in Belarus, Moldova, and Ukraine to improve both the quality and accessibility of health-related programs and services in these three countries, which are collectively known as the West NIS (newly independent states) region. The first eight partnerships established there were part of a broader USAID-funded Health Partnerships Program that encompassed the 12 newly independent nations of the former Soviet Union and focused on improving hospital-based care. In 1998, USAID awarded AIHA a second round of cooperative agreements to apply its unique volunteer-based partnership model to new regional health reform priorities, namely improving the quality and scope of primary healthcare services. Building on the many successes of those earlier partnerships, six new twinning alliances were formed during this second round of funding. Together, the dedicated efforts of partners on both sides have resulted in positive and sustainable changes at the individual, institutional, community, and even national levels.

Through AIHA's programs, partners have paved the way for many "firsts" in the West NIS region: introducing a neonatal resuscitation program in L'viv, Ukraine, that has since been adopted as the national standard of care; pioneering health promotion efforts targeting cardiovascular disease—one of the leading causes of death and chronic disability in Belarus—by opening the first Cardiovascular Wellness Center in Minsk; establishing in Chisinau, Moldova, the University Primary Healthcare Center and Clinical Skills Training and Assessment Center that work in tandem to train more than 700 physicians and 1,500 nurses in family medicine each year; and integrating mental and behavioral health services into the comprehensive primary care framework that is the cornerstone of partnership family medicine and women's wellness centers in all three countries in the region.

Healthcare practitioners have gained life-saving clinical skills at AIHA-sponsored training centers for emergency and disaster medicine, neonatal resuscitation, infection control, and primary care. Nursing professionals have been empowered and are now taking on expanded responsibilities for patient care and outreach. Healthcare administrators have adopted modern, cost-effective practices resulting in streamlined financial and management policies. Clinicians, students, and others have increased access to a wealth of evidence-based medical research, including the ability to consult with specialists around the world via the Internet, at partnership Learning Resource and Nursing Resource centers. And, patients have much better access to comprehensive, high-quality care at AIHA's network of 14 Primary Healthcare Centers and 10 Women's Wellness Centers spanning the West NIS region. Thousands of people have benefited, and will continue to benefit, from USAID-funded AIHA partnerships and programs.

Specifically, this translates into:

- 390,000 cumulative patient visits to the 10 Women's Wellness Centers established in the region;
- 10,000 healthcare professionals, first-responders, and non-medical professionals trained in first aid and urgent care at the five partnership EMS Training Centers in the West NIS;
- 15,300 women trained to perform monthly breast self-examinations and 350 healthcare professionals schooled in patient education techniques specific to breast health at the two Women's Wellness Centers in Donetsk and Kramatorsk;
- 7,030 patient visits to the Minsk Cardiovascular Wellness Center each year;
- 24,000 requests for medical information fulfilled by information coordinators at West NIS partnership Learning Resource Centers and more than 6,300 physicians trained in computer and Internet searching skills;
- 15,000 miners and their families now have access to high-quality primary care services at Miners Health Center in Donetsk, where 7,000 have taken part in bronchitis prevention courses and 2,000 more have participated in smoking cessation and substance abuse classes;

- 1,000 epidemiologists, healthcare practitioners, and policymakers trained in evidence-based infection control protocols at the Kiev Infection Control Training Center; and
- 60 family practice residents trained each year at the Family Medicine Training Center established by partners at the Odessa State Medical University; and
- 18 senior-level nurses in the region empowered through their participation in the International Nursing Leadership Institute.

AIHA and its partners have also been at the forefront of local and national health system reform, helping to:

- Create a family medicine model that has been replicated at 200 rural sites throughout Ukraine's Kharkiv Oblast;
- Develop guidelines for health facility disinfection procedures that have been approved by the Kiev City Health Administration and implemented in all city hospitals as of 2003;
- Serve as a model and training center for staff at three Cardiovascular Wellness replication sites throughout the city of Minsk;
- Establish in Odessa, Ukraine, a Voluntary Counseling, Testing, and Treatment Center where people can learn more about HIV/AIDS, get tested for the virus, receive counseling and, if necessary, referral to specialized medical services or psychosocial support—all in a comfortable, non-judgmental, community-based facility;
- Initiate standards of family nursing practice at primary healthcare centers and undergraduate family medicine training guidelines at L'viv State Medical University that were approved by the Ministry of Health in 2003;
- Produce a manual on marginal mental disorders that, at the request of the Ukrainian government and recommendation of the World Health Organization, was distributed to primary care practitioners throughout the country;
- Train a cadre of family medicine residents in Moldova and Ukraine; and
- Design a four-year nursing degree curriculum that has been introduced at the Kharkiv Post Graduate Medical Academy.

Whether by establishing and supporting skills-based training centers, creating comprehensive new models of prevention and treatment, or opening innovative, patient-focused care centers, AIHA and its partners have been pioneers of healthcare reform in Belarus, Moldova, and Ukraine, building critically-needed human and institutional capacity. The West NIS healthcare professionals involved in AIHA's partnerships have benefited not only from the knowledge and technical skills their American counterparts shared, but also from the collaborative learning process that drives partnership activities.

Thousands of doctors, nurses, and other healthcare professionals have received training through voluntary, peer-to-peer exchanges and other programmatic activities. The interaction with their counterparts in the United States and other countries in the region, as well as their exposure to new ideas and ways of approaching the provision of care, has enabled these professionals to rethink their roles as healthcare providers and become educators and agents of change at their institutions and in their communities. Nurses, in particular, have embraced the new educational opportunities the partnerships have afforded them and taken on increased roles and responsibilities, gaining the respect of physicians and patients alike who now view them as an integral part of the healthcare delivery system. The increased skills and knowledge of the West NIS health practitioners translated into clear improvements in healthcare, better preventative medicine, and healthier lifestyles for the public. Communities who worked with the partnerships benefited from the technical assistance of the US partners, but they also gained the intangible benefits of learning about the importance of taking responsibility for one's own health and the health of the community. The impact of the increase in awareness and improved health statistics were evident in two large household surveys which were conducted before and after the partnership interventions.

While many healthcare challenges remain in the West NIS region, the AIHA Health Partnership Program has created a new paradigm for international collaboration and the provision of technical assistance. By working directly with healthcare professionals and policymakers in Belarus, Moldova, and Ukraine, partners have helped lay a strong foundation for ongoing change. Political support and individual commitment have been critical to the success of AIHA's partnerships and the twinning model has demonstrated its viability by bringing about sustainable health system reform. Having strengthened existing institutions or created new ones, partners have ushered in programs that are more relevant and responsive to the populations they serve, leaving healthcare leaders in these countries better positioned to sustain these services and seek new opportunities to improve quality of care.

This final performance report is a comprehensive overview of AIHA programs in the West NIS between 1998 and 2004. The report describes AIHA's unique partnership twinning model, the development and evolution of the program in Belarus, Moldova, and Ukraine, and the main program components funded during this period. Section III of the report presents summary results of each partnership and cross-partnership program, as well as AIHA's inter-partnership conferences and a program-wide mid-term evaluation completed in 2001. Additional details and information on individual partnerships and projects can be found at www.aiha.com.

II. PROGRAM OVERVIEW

A. INTRODUCTION

AIHA's partnership program in West NIS between 1998 and 2004 (FY99-FY04) was built on a foundation of USAID support to healthcare reform efforts in the region that began after the collapse of the Soviet Union in 1991. Beginning in 1992, with USAID funding, AIHA established a total of 17 healthcare partnerships in the three West NIS countries of Belarus, Moldova, and Ukraine that addressed a range of health sector priorities including women's health, nursing, emergency medicine, and primary care. The Health Partnerships Program was designed to promote sustainable US/NIS partnerships that would foster more effective and efficient delivery of health services in Eurasia. In keeping with AIHA's partnership methodology and model, which is described in the following section, the program emphasized building institutional and human resource capacity to facilitate the sustainability and replication of successful healthcare interventions introduced through the partnerships.

“The type of work these partnerships are doing is not charity, it is sustainable development, and the benefits that accrue on both sides are priceless.”

—US Rep. Mark Udall (D-Colo.)

Under the initial cooperative agreement signed with USAID in 1992, AIHA established eight hospital-based partnerships—six in Ukraine, one in Belarus, and one in Moldova. The partnerships improved targeted healthcare services while strengthening the countries' capacity for ongoing improvements in quality of care. They addressed priorities such as expanding access to new women's health and neonatal services, improving emergency medical services, and institutionalizing changes through, for example, the creation of new clinical practice guidelines and new tracking systems. (Information on this first group of partnerships can be found in Section III.A.1 of this report and on the AIHA Web site at www.aiha.com.)

At the end of the first CA funding period in 1998, USAID awarded the competitively-solicited NIS Health Partnerships Program to AIHA. The award comprised a “Basic Agreement” that provided the overall scope, authority, and parameters of the program, along with five “Sub-regional Agreements.” Four of the sub-regional agreements focused on individual regions: Russia, Central Asia, the Caucasus, and West NIS. The fifth—a region-wide agreement—promoted inter-regional sharing, dissemination, and common initiatives, such as in neonatal resuscitation, nursing, and women's health, across the NIS. The program and underlying CAs were funded for an initial five-year period with provisions for an extension of up to five additional years.

Under the 1998 CA awarded by USAID/West NIS (EE-A-00-98-00014-00), AIHA was charged with establishing partnerships in Belarus, Moldova, and Ukraine in support of USAID's strategic objectives and intermediate results, particularly in the area of primary healthcare. AIHA's five-year program in West NIS (FY99-FY03) under this CA comprised: (a) one-year sustainability grants to five of the existing partnerships; (b) eight new partnerships focusing on primary healthcare (seven were launched in 1999 and the eighth in 2000); and (c) cross-partnership programs. Of the eight new partnerships, six were in Ukraine and one each in Belarus and Moldova.

At the end of the five-year award period in September 2003, USAID granted AIHA a one-year, no-cost extension to enable the Ukrainian partnerships to complete activities that had been postponed due to delayed funding allocations by USAID during 2003. The Moldova partnership was not affected and ended in September 2003, while activities in Belarus had ended earlier in 2001 as a result of the US government

decision to suspend foreign assistance to the country. The AIHA partnership program in Ukraine officially came to a close on September 30, 2004.

B. AIHA PARTNERSHIP MODEL

In the West NIS, as elsewhere in Eurasia, AIHA applied its central program methodology—a unique voluntary, twinning model—developed and refined over the years, in which a US community’s health-related institutions are partnered with institutions in communities in developing and transitional countries. By embracing city, county, and statewide relationships and conducting peer-to-peer professional exchanges, these partnerships work together to develop practical solutions to healthcare delivery problems; create model programs; disseminate lessons learned; and effect broad, systemic change during and after the AIHA-funded partnership period.

Key elements of AIHA’s twinning partnership model include:

- ❖ Voluntarism: significant in-kind contributions of human, material, and financial resources
- ❖ Institution-based partnering for capacity-building and systematic change
- ❖ Peer-to-peer collaborative relationships that build mutual trust and respect
- ❖ Transfer of knowledge, ideas and skills through professional exchanges and mentoring
- ❖ Benefits flowing in both directions
- ❖ Replication and scaling-up of successful models
- ❖ Sustainability of achievements and relationships
- ❖ “Partnership of partnerships” for networking, sharing, and creating common approaches and solutions

“AIHA programs are valuable not only for promoting changes in the NIS healthcare infrastructure, but also for fundamentally changing the thinking of the people involved in the programs, who are enriched with the knowledge and resources needed for successful reforms.”

—John Herbst,
US Ambassador to Ukraine

Over the years, external evaluations conducted of AIHA’s twinning model have consistently affirmed the positive and lasting contributions partnerships have made to efforts to improve healthcare—and, in fact, overall health status—in partner countries. These independent evaluations have also indicated that AIHA partnerships have played an important role in transitional nations by building local capacity, creating sustainable relationships, increasing international cooperation and understanding, and promoting democratic values (*See section III.E for results of the mid-term evaluation conducted of the overall Health Partnerships Program*). This model continues to flourish and make important contributions, particularly through human and organizational capacity building. In September 2004, AIHA was awarded a major new cooperative agreement from the US Department of Health and Human Services to apply its partnership model to combating HIV/AIDS in 15 countries of Africa, the Caribbean, and Vietnam by establishing an HIV/AIDS Twinning Center in support of the President’s Emergency Plan for AIDS Relief.

C. PROGRAM DESIGN

AIHA’s West NIS Health Partnerships Program was designed to build on the lessons learned and past accomplishments of partnerships in the region, while addressing new priorities identified by each country’s Ministry of Health and by USAID. The program was developed in close consultation with the USAID/Kiev Mission through a collaborative strategic planning process that took into account USAID’s objectives and priorities for the region, namely the strengthening of primary healthcare.

In October and November 1998, AIHA senior staff from Washington made several trips to the West NIS region and, together with AIHA regional staff, met with senior USAID officials in Kiev to discuss the development of a two-track strategy for moving ahead quickly with the sustainability-grant activities while at the same time developing the new partnerships. In anticipation of these meetings, AIHA prepared a preliminary three-year strategy for each of the three West NIS countries. This general strategy included the continuation of existing essential programs, completion of programs or activities planned but not yet completed under the previous cooperative agreement, limited support of past successful initiatives, and sustainability grants to existing AIHA partners. Following the meetings, AIHA presented USAID with a workplan for the sustainability grant program component and received approval in mid-November (This component is more fully described below).

AIHA also developed preliminary strategies for new programs consisting of partnerships and initiatives consistent with the USAID/Kiev strategic focus on community-based primary healthcare. In addition to the meetings with USAID/Kiev, AIHA held extensive meetings in Belarus, Moldova, and Ukraine with health ministry officials, local healthcare providers, former NIS and US partners, and other USAID contractors to assess existing health services, needs, and potential sites for new primary care partnerships and related activities. USAID/Kiev staff participated in AIHA's visit to Moldova in January 1999 and was briefed about the results of the Belarus visit.

At the same time, in order to address the reorientation toward primary healthcare called for under the new Health Partnerships Program, AIHA assembled a **Primary Healthcare Advisory Committee** of 24 NIS and US senior health officials. The committee held its inaugural meeting in Washington, DC, in December 1998. The purpose of this meeting was to engage key strategic partners in a consensus development process that would result in a new and feasible approach to designing primary healthcare partnerships in keeping with the unique needs of the NIS countries. AIHA's cognizant technical officer (CTO) from USAID/Kiev participated in the meeting, as did key leaders from three potential Ukrainian primary care partner institutions and representatives from Belarus and Moldova.



Partners are given the opportunity to view effective programs in action through professional exchanges and study tours that focus on a particular topic of interest. (Photo: Kathryn Utan)

Committee members from the region visited primary healthcare sites in the Washington, DC, area then met with US participants and AIHA staff to share information about the current state of primary care reform in both the United States and Eurasia. Participants identified essential elements of a PHC system, including core services that should be provided, and also made recommendations for assessing a community's primary care needs; the primary roles of and relationships among family practitioners and specialists; the roles of nurses and other healthcare providers; the relationship of primary care to community education and social services programs; related education, in-service training, and certification for health professionals; development, dissemination, and use of clinical practice guidelines (CPGs); the role of evidence-based practice; and continuous quality improvement. Finally, the Committee identified the types of partnerships and potential partner institutions that would support the evolution and improvement of primary care in the West NIS countries. The consensus reached by the Committee provided AIHA and USAID with valuable input and critical support and buy-in for pursuing a strategy for the new PHC partnerships, a strategy that included emphasis on community development and outreach, adherence to evidence-based practice, and the involvement of multi-disciplinary teams including social workers and educators. Additional information on

the work of the Advisory Committee, including proceedings of their meeting can be found at: <http://www.aiha.com/index.jsp?sid=1&id=7967&pid=1283>.

Each of the three major components of AIHA's overall workplan for West NIS—(1) the one-year extensions of existing partnerships (referred to as “sustainability partnerships”); (2) new partnerships; and (3) cross-partnership programs—is discussed in more detail in the following sections:

Sustainability Grants

As provided for in the 1998 cooperative agreement program description, AIHA awarded small-scale grants to selected partnerships established under the previous CA. The purpose of these grants was to provide partnerships with an additional year to further solidify their accomplishments and strengthen their capacity to sustain those achievements. In keeping with this purpose, AIHA set the following requirements for applications: a) joint submission by US and NIS partners reflecting collaborative development of a workplan and budget; b) a targeted workplan and realistic budget in support of discrete objectives; c) relatively little funding required to achieve objectives; and d) clear contribution to the sustainability of partnership achievements and/or the partnership relationship, or improved likelihood of replication/dissemination of partnership successes.

AIHA received applications from three partnerships in Ukraine and from each of the partnerships in Belarus and Moldova. After reviewing the five proposals to ensure compliance with the criteria, AIHA assisted the partners in refining their workplans and budgets to better address USAID priorities. Because limited funds were available, partners made every effort to maximize voluntary and in-kind contributions. After USAID's concurrence was received, AIHA issued subgrants to each of the five partnerships for the period of January to December 1999 and invited partners to an orientation session held in Washington, DC, in February 1999.

New Partnerships

The core of AIHA's program for West NIS from 1998 to 2004 was eight new partnerships, seven initiated in 1999 (six in Ukraine and one in Belarus) and one launched in 2000 (in Moldova). In keeping with country and USAID priorities, the partnerships focused on strengthening the delivery of PHC services. The partnerships were created within the framework of the overall NIS-wide primary healthcare approach described above. The USAID/Kiev CTO's active participation in discussions of AIHA's Primary Healthcare Advisory Committee allowed for close USAID collaboration in the design of both the overall strategy for the new PHC partnerships as well as the development of a preliminary design specifically for West NIS partnerships.

“I was very surprised by the attitude of the clinicians and the treatment they provided. They were very kind and careful, and they really took the time to answer my questions openly and with respect. It felt as if they were part of my family.”

*—Alexander Scherbakov, Student and Patient,
Kharkiv Aerospace University Primary Healthcare Clinic*

The seven West NIS sites—Donetsk, Kharkiv, Kiev, L'viv, Odessa, and Uzhgorod, Ukraine; and Minsk, Belarus—were identified in consultation with USAID. In selecting the local partner institutions, AIHA looked for those with open-minded leadership and the potential to contribute to the country's primary healthcare goals. In addition, the West NIS partners were required to commit to bearing the costs of any needed renovations and other infrastructure outlays, as well as staff salaries. In addition, they were required to provide staff time for partnership exchanges, travel, and training activities.

On the US side, AIHA used the newly developed programmatic framework for PHC partnerships to issue a solicitation for US partners in February 1999. The solicitation process was designed to identify applicants with the institutional capabilities and expertise for addressing one or more of the priority areas listed in the Request for Applications (RFA) and with the broad institutional commitment to participate under AIHA's

voluntary partnership model. The solicitation announcement was widely distributed among potential institutional candidates via AIHA's Web site and numerous listservs.

After an extensive proposal review process, AIHA selected US partners and submitted the matched West NIS/US institutions to USAID for concurrence. Once concurrence was obtained and the new partnerships were officially announced, AIHA issued subgrants to the US partner institutions then organized and implemented separate, detailed orientations for the US and West NIS partners. A two-day orientation meeting was held in Washington, DC, in June 1999, for the US partners, while the West NIS partners received their orientation in Kiev, Ukraine, later that month. Among other topics, these orientations covered the AIHA partnership model, USAID and AIHA policies and procedures, expectations of partners, best practices, and monitoring and evaluation. The orientation sessions also gave people the opportunity to meet other AIHA partners working in the same country and to begin establishing an ongoing dialogue.

Cross-Partnership Programs

Support for cross-partnership programs comprised the third component of AIHA's West NIS program during this period. As healthcare partnerships throughout Eurasia each sought solutions to common problems, AIHA established region-wide programs addressing specific healthcare issues to provide a mechanism for greater inter-partnership sharing, collaboration, and problem solving. These programs, developed beginning in 1994, covered: emergency and disaster medicine (EDM), healthcare management (HCM), infection control (IC), information and communication technology (ICT), neonatal resuscitation (NRP), nursing, and women's health. Through these cross-partnership programs, AIHA engaged partners from the West NIS region in region-wide task forces designed to develop new and innovative ideas and approaches to improving care, and in training activities to build human resource capacity.

During 1998-2004, funding for West NIS partners' participation in AIHA's cross-partnership programs came both from the West NIS CA as well as AIHA's separate NIS region-wide CA funded by USAID/Washington. Through numerous meetings and training events designed to reinforce the work of the partnerships, West NIS professionals had many opportunities to network, collaborate, and learn new practical skills in areas such as primary care nursing, infection control, neonatal care, development of clinical practice guidelines, improved screening and treatment for HIV/AIDS and sexually transmitted infections (STIs), prevention and interventions related to domestic violence, and emergency and disaster response. Many of the programs also targeted the creation of professional and institutional networks, such as in nursing, to facilitate the diffusion and sustainability of innovation.

“Virtually every member of Ukraine’s Mobile Hospital Unit—including the rescue workers and the emergency medical professionals—has had some type of hands-on training at the Kiev EMSTC. The practical, skills-based courses there most definitely improve the staff’s knowledge, confidence, and ability to perform well under tremendous stress.”

*—Pyotr B. Volyansky, Medical Department Head,
Ukrainian Ministry for Emergency Situations*

In addition, AIHA continued to provide limited support for educational and training materials and Internet connectivity to the Emergency Medical Services Training Centers (EMSTC), Neonatal Resuscitation Training Centers (NRTC), Nursing Resource Centers (NRCs), and Women's Wellness Centers (WWCs) in the three West NIS countries. The majority of these centers had been established in cooperation with partnerships under the previous cooperative agreement. Through its ICT program, AIHA also supported the establishment of a Learning Resource Center (LRC) at each new West NIS partnership site and provided limited support to existing LRCs in those countries.



Kiev/Philadelphia partner Bill Aaronson discusses healthcare management strategies with other partners during a training workshop. (Photo: AIHA Archives)

Management Training:

Recognizing that effective leadership and management practices are critical to sustained improvements in clinical care and services, AIHA also organized a special cross-partnership program comprised of a series of executive-style training courses for leaders from each of the new PHC partnership institutions. These courses, developed in collaboration with the Association of University Programs in Health Administration (AUPHA), provided training on management and leadership skills ranging from strategic planning, conflict management, and negotiation to human resources management, financial planning, and information management. Since 1994, AIHA has conducted more than 40 such workshops for some 100 partnerships. The courses are designed to augment clinical improvements

and other reform efforts of partners by strengthening the management competencies of key health professionals and cultivating an environment that welcomes change, as well as the capacity needed to sustain these improvements. The workshops emphasize a strong training-of-trainers component, focusing both on content and adult learning principles participants need to effectively share their knowledge with others.

Under this program, AIHA held in April 2000 a training-of-trainers workshop in Almaty, Kazakhstan, involving five West NIS partners. Subsequently, these trainers helped deliver an intensive six-day introductory management course for 31 PHC partners from all eight West NIS partnerships. The following year, in July 2001, 26 of those participants returned for an advanced management workshop.

Evaluation, Monitoring, and Reporting

Performance monitoring and evaluation (M&E) of the West NIS program was consistent with AIHA's overall M&E strategy, which is designed to provide timely feedback about program performance, ensure optimum use of available resources and improve programmatic decision-making, provide information to USAID and key stakeholders regarding progress and accomplishments, help disseminate knowledge of best practices, assist in expanded replication of successful models, and strengthen the capacity of local institutions to engage in continuous improvement processes through monitoring and evaluation activities.

In 2001, AIHA established an M&E unit at its Washington, DC, headquarters and designated a regional M&E coordinator in each field office, including in Kiev. An overall M&E strategy document was presented in May 2002 to USAID/West NIS and AIHA met with USAID staff to discuss and agree upon the approach and integration of AIHA's M&E activities into USAID's performance monitoring plan. This strategy document was subsequently approved by the USAID Mission in Kiev.

AIHA's M&E activities are organized at the partnership, country, and region-wide levels:

At the partnership level, AIHA provided M&E orientation to partners and worked with them to include measurable objectives and output/outcome indicators into their workplans. For comparative purposes, AIHA worked with partners to develop standard data sets for common program elements, such as primary health care and women's health. During their initial visits to the West NIS, US partners assisted their counterparts in identifying baseline data related to the workplan objectives and in assessing the feasibility of collecting such data where it was not available.

AIHA developed instruments for partnership monitoring and reporting purposes that included monthly progress reports, quarterly reports, and final self-assessment reports. AIHA also provided support to partners in establishing mechanisms for collecting, analyzing, and disseminating data. This included the development

of a standardized patient satisfaction survey tool that was implemented by the PHC partnerships and Women's Wellness Centers. Partnership quarterly reports to AIHA were incorporated into AIHA's quarterly progress reports to USAID. These reports described activities and outputs toward accomplishing objectives, significant events, and project developments that occurred during the reporting period. In addition to exchange visits, such activities included teleconferences, in-country training workshops or conferences, significant e-mail or phone consultations, and the transfer of medical or educational supplies and materials.

In early-2001, midway through the partnership cycle, AIHA conducted an internal assessment of each partnership that included a questionnaire completed separately by US and West NIS partners. The partners were asked to review the status of meeting each partnership objective and to reflect on the main weaknesses affecting their progress to date, future opportunities, potential threats to achieving future goals, priorities for the remaining partnership years, sustainability of partnership improvements, and unique features for dissemination and replication beyond each individual partnership. AIHA summarized these results to share with USAID and used the information to adjust and improve program implementation as needed.

As partnerships entered the final year of their workplans near the end of 2002, AIHA developed a standardized self-assessment questionnaire and asked the partners to complete the document. The purpose of the assessment was for partners to evaluate the extent to which the partnerships had accomplished workplan objectives and to report on results, as well as challenges faced. The West NIS partners worked on the self-assessments in collaboration with their US partners and the results were used in preparing this final performance report to USAID.

At the country level, AIHA collected and reported on data requested by the USAID/West NIS Mission corresponding to the mission's strategic objective and relevant intermediate results. Starting in October 2002, this data was provided in the form of annual statistical reports to USAID that covered the three West NIS countries individually and collectively. The reports were developed within the framework of AIHA's overall M&E strategy and reflected AIHA's output/outcome indicators for each program area, as well as country-specific indicators requested by the USAID mission. These reports presented aggregated annual data from the West NIS region and focused on progress toward meeting agreed-upon benchmarks and performance indicators in addition to containing data tables and success stories.

At the region-wide level, AIHA conducted assessments of several of its cross-partnerships programs throughout 2000-2004. These are described briefly under each of the relevant programs, such as neonatal resuscitation and women's health, in section III.B (a listing of the assessments/evaluations with links to full reports can be found on AIHA's Web site at: <http://www.aiha.com/index.jsp?sid=1&id=8535&pid=8695>). In addition, AIHA collaborated with USAID on a program-wide evaluation conducted by a panel of outside experts (described in section III.E) during 2000-2001.

III. PROGRAM RESULTS

A. PARTNERSHIPS

AIHA supported a total of 13 West NIS partnerships during the 1998-2004 funding period. Of these, the first five described below were one-year “sustainability” awards to pre-existing hospital partnerships initially established under the previous cooperative agreement. The remaining eight partnerships were launched between 1999 and 2000 and focused on community-based primary healthcare. The six Ukraine partnerships received four-year subgrants (1999-2003) that were later extended through June 2004 due to delayed funding allocations in 2003. The partnership in Belarus ended in 2001 and the Moldova partnership in 2003.

Each of the new PHC partnerships began by conducting a needs assessment using a standardized tool developed by AIHA. Partners used the assessment results to develop a workplan that addressed the priority needs identified for the targeted community. In support of community-oriented goals, AIHA encouraged partners to apply the “healthy communities”¹ methodology whereby stakeholders from diverse organizations within communities are brought together in a planning process to assess health issues and set priorities.

AIHA’s unique twinning model allows partners the flexibility and freedom to determine not only their own objectives, but their own path to achieving those objectives. So, while similar priorities were identified by multiple partnerships—women’s health, chronic disease management, clinical practice guidelines, development of the role of nursing, enhancement of physician skills, and promotion of healthy lifestyles, for example—each on devised creative solutions and models best suited to the local needs and resources within each community. At the same time, similarity in overall goals enabled the partnerships to benefit from regional conferences in which experiences were shared and successful approaches and models disseminated. Partners also shared a wide range of materials they had developed, such as manuals on integrating mental health services into primary care, using social marketing techniques to facilitate behavior change, and building community coalitions.

The following partnership descriptions include information about partner organizations, partnership objectives, key events by year, and achievements by focus area. These achievements are notable as they often go beyond the objectives originally established. Information for the summaries was drawn from partnership quarterly reports as well as partnership final reports and self-assessments described in the previous section. Additional information on each partnership, including contacts, can be found on AIHA’s Web site.



Members of AIHA’s L’viv/Cleveland partnership presented their highly successful work in children’s mental health at the 2004 Global Health Council Conference in Washington, DC. (Photo: Kathryn Utan)

¹*Healthy communities* refers to an international movement and a model of community health that broadly defines health as not merely the absence of disease, but the well-being of the population as a whole. Related to WHO’s Healthy Cities movement, the model is based on engaging citizens and public and private entities within a given community in promoting healthy behaviors and improving the quality of life for all its citizens.

A.1 SUSTAINABILITY PARTNERSHIPS

A.1.1 Minsk, Belarus/Pittsburgh, Pennsylvania (1999 – 2000)

The Partners

US: Magee Womancare International (MWI) is the international humanitarian outreach arm of Magee-Women's Hospital in Pittsburgh. MWI was established to improve healthcare conditions for women and infants in the former Soviet Union.

BELARUS: Maternity Hospital No. 2 and Minsk Medical Institute were the primary Belarusian partners. The Women's Consultation Center of Mozyr, Belarus, also participated.

Partnership Objective

The key objective of the partnership was to:

- Increase access to high-quality women's and adolescent health services in Mozyr.

Key Events

1999 • National *Partnership in Birth* seminar, Minsk, March.

- Presentation on the WWC's adolescent outreach program at the *Fourth World Conference on Childbirth Education*, Tallinn, Estonia, May.
- *Medical Update Symposium* with US ambassador, USAID representative, and of attending, Minsk, October.
- Presentation on WWCs at *AIHA Partnership Conference*, Arlington, Virginia, November.
- *National Adolescent Health Symposium*, Minsk, December.

- 2000
- Woman and Family officially registered as a nongovernmental organization by the Minsk WWC, January.
 - WWC opened, with minister of health, USAID representative, deputy head of Gomel Oblast Executive Committee, and head of Mozyr City Executive Committee attending, Mozyr, April.
 - Minsk WWC staff member completed Lamaze International Childbirth Educator Program.



Staff at the Minsk WWC regularly conduct patient education classes on subjects ranging from prepared childbirth to dealing with the symptoms of menopause. (Photo: Courtesy of Minsk WWC)

Achievements

Women's Health

- Partners trained health professionals, renovated a building, and provided equipment and supplies to open a Women's Wellness Center in Mozyr. Seminars and symposia covered childbirth and adolescent-health topics, including approaches to adult learning in class and care planning; labor support during birth; Lamaze method; perspective of clients; reproductive health in adolescents; teen pregnancy and abortion; decreasing incidence of sexually transmitted infections; dating violence; and behavioral health, including risk taking, drugs, alcohol and smoking. The educators demonstrated increased confidence in their teaching roles. Letters from patients and evaluations from families indicated a high level of satisfaction with services at the WWC.
- A physician from the Minsk WWC completed the Lamaze International Childbirth Educator Program and prepared for the exam to become a Lamaze Certified Childbirth Educator to enable her to better train health educators in the Minsk region.

- The partners sponsored three national symposia in Belarus that were well-organized, well-attended, and well-received by the health community. The Ministry of Health and the Minsk City Health Administration attended and consistently supported partnership initiatives.
- The partners developed two comprehensive information binders, one on childbirth education and the other on adolescent-health education for reference and training purposes.
- The goal of the newly-established Woman and Family NGO was to improve the quality of life and health of women and their families through education and healthcare. It applied to an international foundation for support and has implemented an adolescent reproductive health program for schools, health centers, and community centers; the Partners in Birth program in which spouses are trained to provide labor support; and breast cancer education. The NGO has also developed a program promoting equal rights for women and men in family planning decision-making. The program emphasizes participation of both men and women in productive and reproductive life, shared responsibility for childrearing and household tasks, and access to family-planning services.

A.1.2 Chisinau, Moldova/Minneapolis, Minnesota (1999)

The Partners

US: Hennepin County Medical Center (HCMC) is a major public teaching and research facility. A member of the National Association of Public Hospitals, HCMC has 910 licensed beds and admits more than 21,000 patients per year. It offers a full range of inpatient and outpatient services, including regional programs for kidney disease, rehabilitation, and community outreach. As a level-I trauma center, HCMC provides services to more than 87,000 emergency patients annually.

MOLDOVA: The City Emergency Hospital is a 645-bed facility specializing in emergency and trauma care. The hospital's ambulance units serve the city of Chisinau, as well as a large portion of the country. The Republican Clinical Hospital, a 1,200-bed facility, is the only cardiac surgery center in Moldova and performs pediatric and adult surgery. It serves as a tertiary care facility for the country in many specialty areas, including kidney transplantation and dialysis. The Nicolae Testemitanu State University of Medicine and Pharmacy (SMPU) is the primary center for medical education in Moldova.

“The domestic violence support center we established at the Dalila WWC in Chisinau provides psychological counseling on different types of abuse, medical evaluation and treatment, and legal assistance to victims.”

—Boris Gilca,
Former Director, Dalila WWC

Partnership Objectives

The key objectives of the partnership were to:

- Improve pre-hospital care with use of automatic external defibrillators (AEDs).
- Create a computerized residency tracking system, modeled after the US system, for SMPU.
- Refine clinical practice guidelines and quality-assurance standards at the Dalila WWC.

Key Events

- 1999**
- National conference, *Domestic Violence—a Multidisciplinary Approach*, Chisinau, January.
 - Assessment of readiness for using AEDs on ambulances, Chisinau, April.
 - Installation of AEDs and related training at City Emergency Hospital, Chisinau, August.

Achievements

Emergency Medical Services

- US partners canvassed AED vendors to assess which one would provide the best services for Moldova. Eight AEDs were installed and 60 emergency personnel were trained, with follow-up training during

direct observation of AED use on ambulance runs. Moldova was one of the first countries in the region to use AEDs in its EMS system.

- The Emergency Medical Services Training Center remained active and received increasing numbers of requests for training and participation in courses. The hospital decided to expand the training center's programs to include seminars for police and fire departments and to engage in public outreach.
- US partners provided consultations on updating the emergency receiving area and stabilization room in the emergency department.

Medical Education

- The partnership purchased a computer for the medical university to establish a residency tracking database. The software developed for the Moldovan partners—modeled after their US partner's system and meeting international standards—allowed residents to be tracked in each rotation and activity. Furthermore, it enabled the documentation of faculty teaching time, helped establish written standards and competency objectives, and aided in financial reporting and analysis, including internal audits.

Women's Health

- The Dalila WWC refined its CPG and quality assurance standards and improved educational practices.



Continuing education plays an important role in AIHA's partnerships and clinicians constantly strive to increase their knowledge of the latest evidence-based practices, as seen in this workshop at the Dalila WWC. (Photo: Courtesy of Boris Gilca)

The WWC received additional training materials and supplies, including the American College of Obstetricians and Gynecologists' training materials on colposcopy and Pap smears along with laboratory supplies for pregnancy testing, urinalysis, and specimen collection.

- WWC staff assisted SMPU in reviewing and adapting the curriculum for obstetrics and gynecology based on what they learned through the partnership.
- The national conference on domestic violence, held in conjunction with the American NGO Connect USA and funded by the US Department of State, was so successful that it was replicated in Russia and Ukraine.

A.1.3 Donetsk, Ukraine/Orlando, Florida (1999)

The Partners

US: Orlando Regional Healthcare System (ORHS) is a multi-hospital system recognized for postgraduate training programs. ORHS' level-I trauma center serves central Florida and is the main trauma resource for six counties. The trauma center admits in excess of 2,000 major trauma patients per year.

UKRAINE: The Donetsk Traumatology Hospital is the largest

hospital providing trauma care in eastern Ukraine. It treats more than 7,000 patients per year and provides consultation to another 63,000 patients from different regions of Ukraine. The hospital includes an



Trauma resident Dmitriy Anenko (left) learns proper CPR techniques from Saveliy Chirakh, director of the Donetsk EMS Center. (Photo: Vira Illiash)

emergency trauma-care unit, an orthopedic- surgery unit, a hand-trauma unit with microsurgery capabilities, a bone-infection unit, a unit for neurosurgery and neurotrauma care, and an EMS training center.

Partnership Objectives

The key objectives of the partnership were to:

- Enhance the hospital's orthopedic capabilities in knee arthroscopy.
- Maximize the potential of the Donetsk EMSTC and ensure quality of training.

Key Events

- 1999
- Panel session at *AIIHA Partnership Conference*, Arlington, November.
 - Observation by Donetsk partners of the emergency-department operations and emergency scene of helicopter response team, Orlando.

Achievements

Arthroscopic Surgery

- Three Donetsk physicians observed 16 arthroscopies and discussed the cases with American surgeons. Subsequently, they performed more than 20 arthroscopies in Donetsk with the assistance of ORHS orthopedic partners.
- Based on an assessment of equipment needed to optimize therapeutic and reparative arthroscopy services in Donetsk, US partners donated more than \$70,000 of arthroscopy equipment. The bulk of the equipment was for orthopedic care and vital to an ongoing arthroscopy program.

“Ambulance crews, family practitioners, mountain search and rescue teams and medical school students have taken part in our courses. It is gratifying to know that all of them utilize the skills acquired through our programs despite the lack of appropriate working conditions. We see strong and healthy people who could have spent the rest of their lives in a wheelchair or, worse still, have lost their lives entirely if it weren't for the work of our trainees.”

*–Saveliy Chirakh,
Director, Donetsk EMSTC*

Emergency Medical Services

- US partners conducted a refresher EMS training-of-trainers course and developed an assessment tool for EMS course graduates to evaluate the curriculum and identify barriers to implementation of skills gained. Partners also donated a projector to help facilitate the EMS training program.

A.1.4 L'viv, Ukraine/Buffalo, New York (1999)

The Partners

US: Kaleida Health's acute care hospitals include Millard Fillmore Gates Circle Hospital, Millard Fillmore Suburban, Buffalo General Hospital, Children's Hospital of Buffalo, and DeGraff Memorial Hospital. Kaleida Health's specialty areas are wellness programs, primary care centers, diagnostic services, rehabilitation and geriatric living, and acute and home care. With more than 13,000 employees and 1,830 medical staff, it provides 1,828 licensed acute-care beds, 557 long-term care beds, and 127 behavioral-treatment beds.

UKRAINE: The Railway Hospital, a 510-bed facility, is the designated healthcare provider for railway employees and their families. The hospital specializes in surgery, oncology, and cardiology. The Regional Perinatal Center, which provides full obstetrical and gynecological services, recently opened a Neonatal Intensive Care Unit. The L'viv Medical Institute has a student body of 5,000 undergraduate and graduate

students who are trained by a faculty of 700 professors, associate professors, and doctoral scientists. The Public Health Management faculty is one of the few departments of its type in the former Soviet Union.

Partnership Objectives

The key objectives of the partnership were to:

- Enhance skills and build capacity for treatment of premature labor and acute premature infant care, by developing academic and clinical instruction.
- Enhance skills in early detection of breast and cervical cancers.

Key Events

- 1999
- *Breast Health Quality Assurance Workshop*, L'viv, June.
 - Presentation on women's health and breast health, *AIHA Partnership Conference*, Arlington, November.

Achievements

Perinatal Care

- US partners provided clinical and didactic instruction for premature labor, neonatal care, and gynecological laparoscopy. Gynecologists and neonatologists from the L'viv Perinatal Center received training in prenatal diagnostic testing, treatment of premature labor, neonatal care, and management of pre-term birthing.
- An OB/GYN from the L'viv Perinatal Center received extensive hands-on training and training-of-trainers instruction in advanced laparoscopic surgery, including laparoscopic-assisted, and vaginal hysterectomy at partner institutions in Buffalo.

“The education of patients practiced at the Women’s Wellness Center is an effective method in the quest to improve health.”

*—Lyudmila Gutsal,
Director, L'viv WWC*

Women’s Health

- US partners assisted WWC staff on breast-health quality assurance. They examined Ukrainian patients, reviewed positioning and film processing, mammography and sonography image analysis and film reading, and diagnosis and treatment of breast lesions according to standards and protocols; and evaluated the radiology technologist’s competencies and equipment maintenance.
- Following the *Breast Health Quality Assurance Workshop*, US and Ukrainian partners continued to review detection and diagnostic procedures. In addition, a gynecologist from Buffalo assisted WWC staff to complete training in sonography and colposcopy, including treatment with loop electrocautery endocervical procedure.
- US partners presented a course on colposcopy, including cytology/pathology, at the Railway WWC and the L'viv Perinatal Center and demonstrated how a comprehensive Pap screening program can significantly improve overall departmental and institutional programs.

A.1.5 L'viv, Ukraine/Detroit, Michigan (1999 – 2000)

The Partners

US: Henry Ford Health System is a large, regional system comprised of eight general acute care hospitals, including Henry Ford Hospital and two specialty hospitals; a multi-specialty group practice of 1,000 physicians; 36 ambulatory care centers; two nursing homes; the state’s largest health maintenance organization; and related subsidiaries. The system is affiliated with the University of Michigan and the Case

Western Reserve University Schools of Medicine. More than 20 physicians of Ukrainian descent are members of the Henry Ford Medical Group and Detroit has a sizeable Ukrainian-American population.

UKRAINE: The L'viv Oblast Clinical Hospital (LOCH) serves as the referral facility for the entire L'viv Oblast and six adjacent regions of western Ukraine. As a large 1,300-bed facility, LOCH provides a broad range of primary and specialty care services and leads an extensive network of rural and district hospitals in the oblast. LOCH houses a premature baby unit, a level-III regional referral center providing tertiary care to infants, and the first Neonatal Resuscitation Training Center established in Ukraine.

Partnership Objectives

The key objectives of the partnership were to:

- Enhance skills in high-risk newborn care by developing educational models and programs for practitioners and parents.
- Enhance the financial independence of the premature baby unit.
- Support the establishment of a follow-up clinic for infants treated at LOCH.

Key Events

1999 • Presentation at *AIHA Partnership Conference*, Arlington, November.

- 2000 • Dissemination conference, *Neonatal Resuscitation Program: After the Training*, L'viv, April.
- Presentation on results of partnership at the annual *Global Health Council Conference*, Washington, DC, June.
 - Presentation of the partnership's work at the first *Ukrainian-Polish Neonatology Conference*, Kiev, June.

Achievements

Neonatology

- The head of the L'viv Health Administration agreed to a plan for the training of neonatologists and nurses from the region in the premature baby unit at LOCH.
- An agreement was reached with Children's Medical Foundation of Ventura, California—an institution that has supported educational trips of physicians from L'viv to Poland—for additional funding to complete the editing and printing of the *Manual for Newborn Care*.
- A foundation was established and legally registered to provide a financial base for the premature baby unit. The partners pursued various possibilities to raise funds, including paying stipends to the unit for the staff's support for outside training. The partnership tested this model during an exchange of physicians and nurses from Tver, Russia, as part of another USAID-supported project, and it was successful. Another source of proceeds was the sale of the *Manual for Newborn Care*. The US partners also contacted the Ukrainian Village Corporation to solicit assistance for the foundation.
- The partnership initiated collaboration with a rehabilitation service institute in L'viv that is engaged in the long-term growth and development of children and their families.



L'viv NRTC Director Dmitriy Dobrianskiy reviews a case with Olga Detsyk, head of neonatology at the L'viv Oblast Clinical Hospital. (Photo: Kathryn Utan)

A.2 PRIMARY HEALTH CARE PARTNERSHIPS

A.2.1 Minsk, Belarus/New Brunswick, New Jersey (1999 – 2001)

The Partners

US: The Robert Wood Johnson Health Network is an organization of integrated delivery systems that includes hospitals, primary healthcare centers, community physicians, and senior centers. The network includes the Robert Wood Johnson Medical School.

BELARUS: The Ministry of Health of Belarus, the Minsk City Health Administration, and Polyclinic No. 36 of Shabany District, Minsk, participated. The polyclinic serves a population of 27,000 people.

Partnership Objectives

The overall goal was to develop primary disease prevention and health promotion programs to improve cardiovascular health. Key objectives were to:

- Improve cardiovascular health in the community by establishing a Cardiovascular Wellness Center (CWC) to promote cardiovascular health screenings and healthy lifestyles.
- Expand community outreach and health promotion.

Key Events

- 1999 • Memorandum of Understanding signed, November.
- 2000 • Minsk CWC opened at Polyclinic No. 36, October.
• Health fair held in conjunction with center opening, Minsk, October.
- 2001 • Seminar on cardiovascular disease, Minsk, July.

Achievements

Cardiology

- The CWC, the first such center in Belarus, provided integrated cardiovascular disease screening and early detection, education, and counseling services to the 27,000 people of the catchment area.
- Seminars were conducted on cardiovascular disease prevention, patient education, US healthcare environment, and clinic administration for healthcare organizations.
- The partners formulated job descriptions for physicians and nurses and processes for moving patients through the primary care system.
- A self-administered screening questionnaire that assist nurses to triage patients and a referral guide for physicians were developed and fully implemented.
- Partners designed a computerized data collection system for patient records with the assistance of a database expert and a computer donated by US partners.
- As a result of increased patient satisfaction with services, the annual number of patient visits to the CWC increased from 5,903 in 2001 to 7,030 in 2003.
- In 2003, the Minsk City Health Administration opened three replication centers in other districts of Minsk and the staffs were trained at the CWC.

Community Health

- CWC clinicians developed patient education brochures on cardiovascular disease and health promotion and distributed at referral sites in local factories.



CWC staff screen patients for the telltale signs of cardiovascular disease during a community health fair. (Photo: AIHA Archives)

- Staff conducted a series of health fairs where patient education materials were distributed, cardiovascular risk factors, smoking cessation, blood pressure and blood sugar screening, and weight-to-height-ratio analysis were covered.
- Nurses at the CWC held classes on healthy lifestyles and on steps for developing healthy habits. The staff conducted a study of levels and prevalence of cardiovascular disease risk factors among 547 course participants, 186 males and 361 females. The results indicated decreased incidence of high blood pressure among women attending classes during 2001-2002, from 33.9 percent to 28.8 percent, and that four percent of male participants quit smoking during 2002.

A.2.2 Chisinau, Moldova/Norfolk, Virginia (2000 – 2003)

The Partners

US: The Eastern Virginia Medical School (EVMS) is a community-based, nonprofit medical school. EVMS was supported by the Portsmouth Family Medicine Residency Program, the Norfolk Department of Public Health, the Portsmouth Community Health Center, the Ghent Medicine Residency Program, Sentra Health Care, and the North Carolina Partnership for Peace Program.

MOLDOVA: The Ministry of Health, Nicolae Testemitanu State University of Medicine and Pharmacy (SMPU), the City of Chisinau Department of Health, the Botanica District Health Administration, and the Consultative Diagnostic Center of the Botanica District participated.

Partnership Objectives

The overall goal was to improve health status in Moldova by expanding community-based primary healthcare and family medicine training programs. Key objectives were to:

- Expand access to comprehensive primary care through the establishment of model community-based family medicine centers in Chisinau's Botanica district and on the campus of SMPU.
- Expand training opportunities for health professionals.
- Increase acceptance of family medicine-based primary care among the community and among healthcare providers by engaging them in the governance and operation of the model centers.
- Promote health education and disease prevention.



SMPU Rector Ion Ababii celebrates the opening of the university's PHC clinic.
(Photo: Francine Lutz)

Key Events

- 2000:** • Memorandum of Understanding signed, Norfolk, June.
- 2001:** • Community Pro San Family Medicine Center opened in Botanica District and family medicine conference hosted, Chisinau, June.
- 2002:** • Second conference on family medicine in coordination with the American Academy of Family Physicians, February.
- 2003:** • Computer Skills Laboratory established at SMPU, Chisinau, March.
- University Primary Healthcare Clinic and Clinical Skills Training and Assessment Center inaugurated, Chisinau, April.

Achievements

Family Medicine

- The Pro San FMC in the Botanica District and the University PHC Center in the Buiucano District were fully equipped and staffed by physicians and nurses who received clinical skills training. The centers provide primary healthcare services, family-medicine education, health education, health promotion, and disease prevention programs, serving patient populations of 12,500 and 12,000, respectively.
- The SMPU Computer Skills Laboratory was created with US donations and SMPU funds, including computers and servers contributed by the US partners. The laboratory allows SMPU faculty, medical residents, and students to view DVDs of EVMS “grand round” lectures and to access medical databases and other information.
- Videoconferencing equipment was installed at the SMPU main campus, the Pro San clinic, and the University PHC Center enabling remote family medicine training among all three sites.

Community Health Education

- Two community advisory boards were established in the districts of Botanica and Buiucano to focus on sustained community and business involvement in healthcare service delivery.
- Community health education teams comprised of family medicine physicians and residents, medical students, and nurses from the two FMCs provided continuing community education and outreach. The Pro San clinic held weekly lectures for pregnant women and their families and regular classes for patients with hypertension and diabetes.
- The Pro San FMC staff conducted classes on healthy diets, family planning, prevention of sexually transmitted infections, and substance abuse prevention. Classes were designed to reach various groups—students, the elderly, schoolchildren, and women of reproductive age. Patient education groups were also established for diabetes and hypertension.
- The University PHC Clinic, together with the department of family medicine, developed patient education programs in child birth and smoking cessation.
- A Web site for the University FMC Clinic was developed and contains patient education information and useful links for health consumers.

“The partnership’s programs coincided with the objectives of Moldova’s healthcare policy and have had a very favorable impact on reforms in the field of health care and medical education in Moldova.”

*—Ion Ababii, Rector,
Nicolae Testemitanu State University
of Medicine and Pharmacy*

Medical Education

- The SMPU Clinical Skills Training and Assessment Center was established at the University PHC Center. It contains three examination rooms specially equipped with video cameras and microphones to provide clinical skills training to medical residents and students and to retrain community providers in family medicine skills. The center adapted a “standardized patient” methodology from the US partners with eight paid actors trained to simulate various illnesses for the students.
- A family medicine residency training program was established at both FMCs.
- Rotations at the Pro San FMC for first and third year family medicine residents were initiated.
- The University PHC Center and the Clinical Skills Training and Assessment Center were selected by the World Bank as implementing partners and have trained more than 700 physicians and 1,500 nurses from across Moldova in family medicine.

*Please see Appendix A for the partnership’s case illustration on *Political Support for Developing Family Medicine Centers*.

A.2.3 Donetsk and Kramatorsk, Ukraine/Pittsburgh, Pennsylvania (1999 – 2004)

The Partners

US: Magee Womancare International (MWI) is the international humanitarian outreach arm of the Pittsburgh-based Magee-Women's Hospital. MWI was established to improve healthcare for women and infants in the former Soviet Union. Other participants were the Allegheny County Health Department, United Mine Workers of America, University of Pittsburgh Graduate School of Public Health, and University of Pittsburgh Medical Center's Department of Family Medicine and Clinical Epidemiology.

UKRAINE: Donetsk Oblast Health Administration, the Kramatorsk Central City Hospital, and Polyclinic No. 1 of Donetsk City Hospital No. 25 participated. Kramatorsk Central City Hospital has inpatient and outpatient facilities that provide care to 4,800 adults and 1,300 children annually. Polyclinic No. 1 provides outpatient ambulatory services for 20,600 miners and their families.

Partnership Objectives

The overall goal was to develop a model community-oriented women's wellness program at Kramatorsk Central City Hospital and a model community-based primary-care site at Donetsk City Hospital No. 25. Key objectives were to:

- Provide an increased range of health services to women of all ages.
- Improve prenatal care at the primary healthcare level.
- Enhance clinical capabilities of Donetsk Hospital No. 25 and Kramatorsk Central City Hospital in prevention, identification, and treatment of selected diseases.
- Expand community participation in the Primary Healthcare Center and Women's Wellness Center.
- Improve health status and awareness through patient education and patient support groups.

Key Events

- 1999 • Memorandum of Understanding signed, September.
- 2000 • Community board convened for development of family healthcare model, Donetsk..
- 2001 • WWC opened at Kramatorsk Central City Hospital, February.
- Miner's Health Center opened, Donetsk, February.
 - *Public Health Dissemination Conference*, Donetsk, June 19-21.
- 2002 • Miner's Health Center expanded to include a Family Medicine Center, Donetsk, July.
- Lamaze training-of-trainers workshop, October.
 - WWC in Donetsk City Hospital No. 25 opened, November.
- 2003 • Replication Family Medicine Center opened, Kramatorsk, September.



Victor Kryvosheyev, head of the Kramatorsk City Administration, Lyudmila Konovalova, head physician at the Kramatorsk Central City Hospital, and US partnership coordinator Irma Goertzen cut the ribbon marking the opening of the Kramatorsk Women's Wellness Center. (Photo: AIHA Archives)

Achievements

Women's Health

- The Kramatorsk Women's Wellness Center has provided comprehensive services to 10,500 women.
- The Kramatorsk WWC offered classes on childbirth education, Lamaze, and preparation for delivery, as well as education programs on adolescent health and breast health. More than 80 Lamaze classes were conducted at the Donetsk "Mother's School" and 200 women attended these classes.
- The Kramatorsk WWC sponsored a four-day *Childbirth Education Workshop* for West NIS partners.

- In 2004, the partners trained 65 medical professionals from 22 women’s health centers in Donetsk to become Lamaze instructors.
- The Kramatorsk WWC trained young people as peer educators on substance abuse, contraception, HIV/AIDS prevention, and healthy lifestyles. Some 2,700 students were reached by the peer educators.
- The Donetsk WWC offered comprehensive healthcare services to 15,000 women.
- Staff from both WWCs developed patient education brochures on osteoporosis, HIV/AIDS, breast self-examination, hygiene, sexuality and puberty, and contraception.
- WWC and FMC staff implemented treatment protocols on cervical cancer and dysmenorrhea.
- The WWCs trained 350 professionals and 2,300 women in Donetsk, and nearly 13,000 women in Kramatorsk, in breast self-exam techniques.
- The WWCs reported that between 2001 and 2002, cases of sexually transmitted infections decreased by 34 percent; the abortion rate decreased by 28 percent; and the percentage of mothers who breastfed increased from 80 to 90.

Primary Care

- The Miner’s Health Center in Donetsk provided comprehensive PHC, occupational health, and women’s health services to miners and their families.
- A family physician from the center received one of the Best Family Practitioners in Ukraine awards presented by the Ministry of Health during its first annual Family Medicine Congress held in 2001. The criteria for the award included professional experience, clinical skills, and improved health status indicators in the areas served, as well as the outcomes of patient surveys.
- After a second primary healthcare clinic opened, the percentage of patients referred to specialists decreased from 67 percent in 2001 to 13 percent in 2002.
- Three clinical practice guidelines drafted by the partners—*Health Lifestyles during Menopause, Pneumonia, and Peptic Ulcer*—were reviewed and approved for publication by AIHA’s regional CPG advisory committee.
- TB and HIV diagnosis and treatment were improved by training staff and onsite diagnostic lab technicians.

Occupational Health

- The Miner’s Health Center served 15,000 miners and their families.
- The Miner’s Health Center staff created a series of 10 targeted brochures on nutrition, hearing loss, alcohol, smoking, and muscular-skeletal disease.
- More than 7,000 miners participated in a bronchitis prevention campaign and 2,000 more participated in smoking cessation and substance abuse prevention classes.
- A database on morbidity tracking temporary disability and occupational morbidity of miners was set up, expanding information management through better data collection and analysis.

Community Health

- The community boards allowed representatives of medical professions, schools, businesses, and miner’s, women’s, and professional organizations to help develop the model PHC centers and WWCs. The board raised funds to renovate centers and participated in health promotion and disease prevention campaigns.
- Donetsk and Kramatorsk community board members conducted surveys and implemented action plans in their communities for AIHA’s cross-partnership coalition on smoking prevention.
- Patient clubs and support groups were established for diabetes, cancer, and bronchitis.
- Donetsk partners initiated “Youth for Youth,” an adolescent, peer-education program, at six schools. One of the activities was a tobacco use survey of 200 students conducted by student volunteers.

A.2.4 Kharkiv, Ukraine/La Crosse, Wisconsin (1999 – 2004)

The Partners

US: World Services of La Crosse, the lead partner, was supported by Gundersen Lutheran Medical Center, which is part of the Western Campus of University of Wisconsin's School of Medicine, and by Franciscan Skemp Healthcare, an affiliate of the Mayo Health System. Other organizations contributing resources included the University of Wisconsin-La Crosse, Western Wisconsin Technical College, and Viterbo College.

UKRAINE: The Kharkiv Oblast Health Administration, Kharkiv Student Polyclinic, and Chuguev Rayon Hospital participated. Kharkiv Student Polyclinic provides healthcare services to 80,000 college students in Kharkiv Oblast and has a network of 16 satellite primary care clinics on various area campuses. Chuguev Rayon Hospital is located in a rural district and offers inpatient and outpatient services to 90,000 people.



Members of the Student Communication Club established by staff at Kharkiv Student Polyclinic's Student Counseling Center. (Photo: Vira Illiash)

students at Kharkiv Aerospace PHC Clinic and Kharkiv Student Polyclinic.

- Enhance emergency medical services in Chuguev Rayon and Kharkiv Student Polyclinic to support PHC clinics.

Key Events

- 1999** • Memorandum of Understanding signed, November.
- 2000** • Health risk assessment conducted of 700 Kharkiv area university students to help plan education and awareness programs.
- 2001** • Model PHC centers opened at Kharkiv Aerospace University and Korobochkino Village in Chuguev Rayon, January.
 - Patient education room, with trained staff, established at the two PHC clinics, July.
- 2002** • TB prevention health fair at Aerospace University clinic for World TB Day, March.
 - Health fair at Chuguev PHC Center, April.
 - Student Counseling Center affiliated with Kharkiv Oblast Students Hospital opened, May.
 - Kharkiv Oblast Nursing Association established, February.
- 2003:** • Counseling training for psychologists and PHC physicians of Kharkiv Oblast, April.
 - Workshop on development, implementation, and evaluation of clinical practice guidelines, November.

Partnership Objectives

The overall goal was to improve delivery of primary care in the Student Polyclinic System in Kharkiv and within the Chuguev Rayon Health System. Key objectives were to:

- Improve access to primary care through the establishment of model primary healthcare clinics and women's health programs in Kharkiv and Chuguev.
- Enhance the status of family physicians and nurses in Kharkiv Oblast.
- Establish a counseling program to address psychosomatic and stress-related symptoms of

“Before the partnership with La Crosse, the hospital staff had not been very successful in addressing the behavioral health problems of students. The collaboration with our La Crosse partners gave us a chance not only to establish the Students Counseling Center and train medical personnel, but also to convince the Ukrainian Ministry of Health to allocate additional funds for hiring healthcare providers with different specialties to better address the psychological needs of students.”

*–Maya Fomina, Former Head Physician,
Kharkiv Student Polyclinic*

- Health fair at Student Counseling Center and Kharkiv Student Polyclinic for World Health Day, April.
- 2004:
- Workshop on adolescent counseling, Kharkiv, January.
 - Nursing conference, Kharkiv Oblast, January.

Achievements

Primary Care

- A model PHC Center at Kharkiv Aerospace University was established. It currently serves 7,000 students aged 16-28 and, by offering high-quality, comprehensive services, has decreased the rate of patients referred to specialists from 65 percent in 2001 to 32 percent in 2002.
- A model PHC Center serving 4,000 people in Korobochkino Village was established to provide family planning, patient education, and counseling services. Referrals to specialists decreased from 60 percent to 25 percent in the first year of this center's operation.
- Six CPGs were implemented, leading to a reduction in both costs and unnecessary hospitalizations. In Korobochkino, the rate of hospitalizations was reduced from 22.2 to 5.5 per 1,000 patients.
- Fifty PHC nurses, 120 polyclinic nurses, and 30 hospital nurses received training in infection control and preventative measures were instituted against occupational exposure to HIV.
- A healthy lifestyles course was introduced at Kharkiv Aerospace University and is required for first-year students. The curriculum is updated regularly based on student input.
- A six-month family medicine course for physicians and nurses covering didactics, clinical skills, and case studies was introduced at Kharkiv Post Graduate Medical Academy. A total of 20 physicians and 18 nurses graduated from the family medicine/general practice course.
- Nurses at the Kharkiv and Korobochkino PHC clinics began providing direct patient care, becoming the primary contact for patients and thereby redefining the role of nurses and reducing physician workloads.
- The Kharkiv Nursing Association, established by a nurse from the Kharkiv Aerospace PHC Clinic, initiated the revision of nursing job descriptions, expansion of their scope of practice, and delegation of certain physician functions during office visits to midwives and nurses.
- Nurses at Kharkiv and Korobochkino PHCs organized health education classes and conducted community outreach campaigns.
- The Kharkiv and Korobochkino PHCs served as replication models for the Kharkiv Oblast Health Administration. By mid-2004, 200 FMCs in rural areas of the oblast and six PHC clinics on university campuses were funded by the Health Administration and by Kharkiv universities.



Nurse educator Anna Lobunets teaches a smoking cessation class at the Kharkiv Student Clinic. (Photo: Elena Voskresenskaya)

- The percentage of patients who said they were satisfied with PHC services increased from 73.0 percent in 2001 to 95.7 percent in 2003.
- Korobochkino staff initiated community education programs in farm safety and hypertension.
- Kharkiv Post Graduate Medical Academy introduced a four-year nursing degree program incorporating training components developed through the partnership.

Mental Health

- The Student Counseling Center provides advice and support on substance abuse, smoking, reproductive health, crisis intervention, and stress. It is equipped with a telephone hotline operated by trained volunteers.
- Kharkiv partners and AIHA's Mental Health Task Force presented the integrated model of mental health in PHC and a manual for family doctors at the XIII Congress of the Russian Society of Psychiatrists in Moscow.

Emergency Medical Services

- Primary-care physicians from Kharkiv and Chuguev were trained at the Donetsk EMSTC and now serve as trainers for other medical personnel and community members, organizing courses on CPR and first aid techniques.

Women's Health

- The partners organized breast cancer screening, self-examination training, and community education for early detection of breast cancer and prevention of sexually transmitted infections among the female population of Kharkiv Aerospace University and Chuguev Rayon.
- Family planning centers were established as part of the PHCs in Kharkiv and Chuguev. More than 8,000 patients were served at the centers during the partnership.

A.2.5 Kiev, Ukraine/Philadelphia, Pennsylvania (1999 – 2004)

The Partners

US: Temple University Center for Healthcare Management and Research was supported by the University Primary Care Institute; the Departments of Family Medicine, Health Studies/Public Health, and Risk Insurance and Healthcare Management; Widener University; Crozer-Keystone Health System; and the Health Federation of Philadelphia.

UKRAINE: Kiev City Health Administration, Darnitsky District Central Polyclinic, Darnitsky District Family Practice Center (FPC), and the Kiev Postgraduate Medical Academy participated.



This bright and cheery examining room at the Kiev Family Medicine Center will help young patients feel comfortable and relaxed. (Photo: AIHA Archives)

Partnership Objectives

The overall goal was the development and promotion of community-based primary healthcare in the Darnitsky District of Kiev. Key objectives were to:

- Expand access to primary care and mental health services through the establishment of new models of family practice and increased integration of mental health services into provision of healthcare.
- Expand use of clinical practice guidelines.
- Enhance disease prevention and health promotion programs.
- Monitor quality through implementation of continuous quality improvement (CQI) processes at the Family Practice Center.
- Expand training and training capacity of health professionals.

Key Events

- 1999 • Memorandum of Understanding signed, October.
- 2000 • West NIS PHC conference on the integration of mental health services, September.
 - The new FPC opened, with minister of health and US ambassador attending, October.
- 2001 • Mental health task force training on counseling, screening, and early detection of mental disorders, August.
- 2002 • *Behavioral Health Conference*, Kiev, January.
 - Patient database developed by oblast health administrations completed, November.
- 2003 • Conference on CQI project, Kiev, October.
- 2004 • All-Ukrainian conference on the standardized-patient approach, March.

Achievements

Primary Care

- The Kiev FPC was established and provides prevention and education programs, mental health and social services, prenatal care, and basic laboratory tests to 10,500 people.
- The FPC adopted a multidisciplinary approach, assembling a team of physicians, nurses, a psychologist, and a social worker.
- A patient satisfaction survey in 2002 found that 83 percent of patients were completely satisfied with services.
- FPC staff received clinical skills training and developed clinical protocols for asthma, diabetes, and sexually transmitted infections.
- A family physician from the Kiev PHC Center received one of the Best Family Practitioners in Ukraine awards presented by the Ministry of Health during its first annual *Family Medicine Congress* in 2001. The criteria for the award included professional experience, clinical skills, and improved health status indicators in the areas served, as well as patient opinions.
- Nurses provided more direct patient care, becoming the primary patient contacts and conducting health promotion and education activities.
- The head nurse of the FPC developed a training program on clinical breast exams and trained nurses at the FPC and other PHC facilities in the district.
- Nurses organized education and outreach on developing healthy lifestyle habits, TB prevention, smoking and drug abuse cessation, breast self-exam, childbirth education, and breastfeeding.
- In 2003, FPC staff provided clinical skills training to multidisciplinary teams from three replication sites. They also provided training on the use of donated equipment.
- The percentage of patients referred to specialists decreased from 60 percent in 2000 to 21 percent in 2002.

Mental Health

- US partners trained a mental health team in detection and treatment of mental health problems at the primary care level and identified key objectives for integrating mental health into primary care, namely the decentralization of services; increased access to mental health services; decreased stigmatization of mental diseases; early detection of mental disorders; improved care of psychosomatic and other conditions; a team approach to prevention, diagnosis, and treatment; and improved knowledge and skills of general practitioners.
- A guide on marginal mental health disorder diagnostics and treatment was developed for PHC staff. Based on recommendations by the World Health Organization, the National Institute of Mental Health, the Institute for Clinical System Improvement, and the Ukrainian government, the guide was presented at the *Behavioral Health Conference* in 2000 and distributed among PHC professionals.
- A strategy on the integration of mental health services into PHC was presented at the regional *Behavioral Health Conference*, which was attended by representatives of West NIS PHC partnerships, the MOH, and the Kiev City Health Administration. The MOH presented reforms of mental health services in Ukraine. Eight workshops were held: *Substance Abuse, Depression, Domestic Violence, HIV, Difficult Patients, Post-Traumatic Stress Disorder Studies, CQI, and Counseling Skills*. Educational models for family doctors, mental health specialists, social workers, nurses, and other staff were discussed and representatives of all AIHA PHC partnerships agreed to integrate mental health issues into PHC center services.



Skills-based practical training plays a critical role in AIHA's partnership model. During an exchange visit to Philadelphia, Kiev physician Oksana Yashchenko learns how to screen for behavioral health problems using the "standardized patient" approach. (Photo: Kathryn Utan)

- A training workshop to upgrade PHC skills in counseling, screening, and early detection of mental disorders was attended by 28 representatives from Ukraine and Moldova.
- The partners served as faculty at a follow-up behavioral health conference in Kiev during which West NIS partners discussed barriers and strategies for strengthening mental health services in PHC.

Health Management

- The partners adopted a US-style curriculum and conducted a training series on healthcare management for representatives of Darnitsy District. A team of trainers was formed at the FPC and the Department of Management at Kiev Postgraduate Medical Academy.
- A system of automated medical records was established at the FPC.
- Partners developed a CQI tool based on healthcare quality indicators and adoption of CPGs on an institutional level, continuous monitoring of indicators, and periodic chart audits.
- The results of three qualitative evaluations of the multidisciplinary approach were incorporated into the FPC's operations.

Medical Education

- From 2001 to mid-2004, 18 residents were trained in the FPC residency program. Six residents graduate from the program annually.
- Clinical skills of medical students and residents were improved by the standardized patient approach to teaching, in which actors who have been trained to present specific, standardized symptoms are examined and diagnosed.
- The effectiveness of the standardized patient approach, clinical skills training and assessment, and methods for training standardized patients were presented at a series of workshops and conferences.

*Please see Appendix A for the partnership's case illustration on *Clinical Practice Guidelines*.

A.2.6 L'viv, Ukraine/Cleveland, Ohio (1999 – 2004)

The Partners

US: The Cleveland International Program (CIP), a non-profit organization promoting world peace through international professional exchanges, led the effort. CIP works in alliance with the Federation for Community Planning, the Cuyahoga County Board of Health, Case Western Reserve University, Cleveland State University, the Cleveland Clinic Foundation, the Ohio Department of Health, the Center for Health Affairs, Fairview Center for Family Medicine, Cuyahoga County Board of Mental Health, Heartland Behavioral Health/Ohio Department of Mental Health, Case Western Reserve University School of Nursing, Free Clinic of Cleveland, and other hospitals, local service institutions, and agencies.

UKRAINE: L'viv Oblast Health Administration, L'viv City Polyclinic No. 5, and Zhovkva Rayon Hospital participated. Polyclinic No. 5 is affiliated with two Family Medicine Clinics in L'viv and nearby Rudno. Zhovkva Rayon Hospital is affiliated with two ambulatory clinics in the villages of Zibolky and Dobrosyn.

Partnership Objectives

The overall goal was to strengthen primary healthcare services at L'viv Polyclinic No. 5, Rudno Family Medicine Center, Zibolky Ambulatory Clinic, and Dobrosyn Ambulatory Clinic by training physicians, nurses, medical students, and other personnel for the Family Medical Centers. Key objectives included to:

- Increase clinical and management skills of family physicians, nurses, and clinic managers.
- Increase the use of modern medical equipment at FMCs.
- Improve skills of mental health professionals.
- Improve family medicine education at L'viv State Medical University.

- Improve health status by developing assessment tools and encouraging community involvement.

Key Events

- 1999 • Memorandum of Understanding signed.
- 2000 • L'viv FMC, affiliated with L'viv Polyclinic No. 5, opened, November.
• Rudno FMC opened as a satellite of the L'viv FMC, November.
• Zibolky FMC, affiliated with Zhovkva Central Rayon Hospital, opened, November.
- 2001 • Dobrosyn FMC, affiliated with Zhovkva Central Rayon Hospital, opened, August.
- 2002 • Postgraduate, training program for nurses approved and recognized by L'viv Oblast Health Administration.
• Red Flags, a training program to identify youth at risk for depression, was implemented.
- 2003 • *The Practical Manual of Mental Health*, a guide for assessing and screening mental health problems in family medicine, was published.
• Undergraduate family medicine curriculum approved by the Ukrainian Ministry of Health.
• Public health councils established in Dobrosyn and Zibolky.
- 2004 • Presentation on Red Flags program at *Global Health Conference*, Washington, DC, June.

Achievements

Primary Care

- Four FMCs were established and equipped.
- Physicians were trained on medical and computer equipment; subsequent assessments found their diagnostic capability and scope of patient care had improved and the equipment was well utilized.
- The head nurse of the Zhovkva Central Rayon Hospital, a graduate of AIHA's International Nursing Leadership Institute, developed a postgraduate training program for nurses, "Training of Qualified Nurses is an Essential Component of High-Quality Health Care." She developed standards of care for family nurses that were implemented at the Zibolky and Dobrosyn FMCs.
- Training modules for physicians and nurses on diagnosis and management of common diseases, such as asthma, diabetes, hypertension, otitis, and coronary heart disease, were introduced.
- An electronic patient chart was introduced in the Dobrosyn, L'viv, Rudno, and Zibolky FMCs.
- The percentage of patients referred to specialists in the L'viv and Zhovkva clinics decreased from 52 percent in 2001 to 24 percent in 2002.
- In a patient satisfaction survey administered after Zhovkva nurses were trained, 92 percent of patients positively rated the PHC nurses.
- Eight PHC nurse training courses were held and 223 nurses from the region were trained.



AIHA's L'viv/Cleveland partners implemented a program dubbed "Red Flags" at local middle schools to raise awareness about childhood depression.
(Photo: Ella Kocharyan)

Mental Health

- Mental health needs were assessed and a framework was devised for a mental health training manual and a preventive youth education program.
- The L'viv FMC provided the consultation services of a mental health specialist who works with all age groups and with general family problems.
- The Red Flags program, designed to raise awareness of depression in adolescents and link efforts of school mental health professionals and parents, was implemented in two schools in Zibolky and Dobrosyn and at Ulybka Summer Camp. Seventy-two teachers were trained, 18 classes were held for 270 students, and 63 parents participated. Zhovkva partners conducted seminars for the Childhood Council, Zhovkva Rayon State Administration and 13 school-based psychologists of the rayon.

- The Red Flags program led to increased awareness among teachers, children, and parents of the signs of childhood depression; a 15 percent increase in the number of visits to child psychiatrists; increased realization of childhood depression in the community; and decreased stigma associated with a “mental patient” diagnosis.
- Partners published *The Practical Manual of Mental Health*. The manual is targeted at mid-level medical professionals, non-medical professionals and social workers and discusses screening, detection and management of mental disorders observed in family practice.

Curriculum Development

- L’viv State Medical University initiated a family-medicine training program for undergraduate medical students with the goal of improving theoretical knowledge and clinical skills. Some 600 undergraduate students participated in the family-medicine training program
- A draft national standard for undergraduate training in family medicine was approved by the Ukrainian Ministry of Health.
- An English version of the *Family Practice Manual* was used in training 24 international students at L’viv State Medical University.
- In 2003, the partnership published a Ukrainian textbook, *Polyclinic Care and Family Doctor*.

Public Health

- Public health councils with broad community representation were established in Dobrosyn and Zibolky and held regular meetings to discuss health concerns and develop health policy, funding support and intervention strategies. A *Public Health Leadership Development Guide* was created to assist communities in forming public health councils.
- Key staff were trained in Geographic Information System (GIS) software to enable data analysis and mapping for developing the public health system.

A.2.7 Odessa, Ukraine/Boulder, Colorado (1999 – 2004)

The Partners

US: Boulder Community Hospital (BCH) is a not-for-profit, 270-bed, full-service hospital serving the city and county of Boulder, Colorado. BCH collaborated with the Department of Family Medicine at University of Colorado’s School of Medicine, the Boulder County Health Department, the Beacon Clinic, and Boulder County Healthy Communities Initiative.

UKRAINE: Odessa State Medical University (OSMU), Odessa Seaport Occupational Polyclinic, Family Medicine Clinic, Odessa City Council, and the Odessa Oblast Health Administration participated.

Partnership Objectives

The overall goal was to improve community health by developing disease prevention and health promotion models in family medicine. Key objectives were to:

- Establish a model Family Medicine Center at the Odessa Institute of Family Health and increase skills of primary-healthcare practitioners.
- Increase access to primary care for railroad workers and their families.
- Improve family practice nursing and develop a core of nursing leaders for PHC nursing.
- Expand services in dentistry, poison control, breath health, and HIV/AIDS.

Key Events



Odessa/Boulder partners Galina Popik and Dean Beasley celebrate the official opening of the Odessa Family Medicine Training Center.
(Photo: Oksana Ivaniouk)

- 1999 • Memorandum of Understanding signed, August.
- 2000 • FMC opened at Odessa Institute of Family Health, May.
- 2001 • Pulse of Odessa, an information analysis center, opened, June.
- 2002 • Poison control center opened, March.
- Odessa Family Dentistry Clinic opened, June.
- Odessa Institute of Family Health opened, June.
- FMC launched the breast health program, September.
- 2003: • HIV/AIDS voluntary counseling and testing (VCT) center established at FMC, January.
- Social marketing conference on techniques for HIV/AIDS prevention, Odessa, December.
- Family-medicine conference at the opening of the Railway FMC, Odessa, December.

Achievements

Primary Care

- The FMC provides breast and cervical cancer screening, family planning, health education, and counseling services.
- The percentage of patients referred to specialists decreased from 55 percent in 2001 to 28 percent in 2002.
- The Pulse of Odessa's computing and data analysis facilities assisted providers to increase knowledge and skills and develop health promotion activities.
- FMC nurses participated in AIHA's International Nursing Leadership Institute and implemented projects to improve service quality.
- A smoking cessation program was undertaken in the city and the seaport district.

Medical Education

- The Family Medicine Training Center at OSMU was equipped with training models and equipment and 60 family residents are trained annually.
- OSMU adopted the postgraduate PHC nursing curriculum and requires it for all nursing students.

Dentistry

- The Odessa Family Dental Clinic integrated family medicine and dentistry and dental conditions are now considered when assessing overall patient health. By 2004, the clinic was providing dental care to 60 families.
- Through a school dental hygiene program, staff of the dental clinic examined 120 children and applied 100 dental sealants to prevent caries.

Toxicology/Poison Control

- The poison control center serves as a toxicological resource for the general population and medical personnel in Odessa and is equipped with a hotline to provide information on poison control.
- Four clinical practice guidelines on treatment of poisoning were developed.

Community/Breast Health

- Medical students from OSMU were trained to administer the Expert Opinion Survey to identify and prioritize the health needs of the population.
- The breast health program provided training in clinical breast exams and in teaching self-examination techniques. The program provided breast prostheses to women who had undergone mastectomies.
- Sixteen nurses and physicians were trained as breast health educators and 500 female employees of the Odessa Seaport were taught breast self-exam techniques and received information on breast health.
- US partners donated breast prostheses for Odessa Seaport employees and a US nurse trained four physicians and nurses from the Odessa FMC on properly fitting prostheses.
- Breast-health literature was distributed to seaport workers.

HIV/AIDS

- The HIV/AIDS VCT center provided confidential and non-stigmatizing services.
- The Odessa partners implemented community education programs related to HIV/AIDS, including a portable health-promotion display focusing on HIV/AIDS prevention that has been on exhibit at a number of Odessa high schools.
- As a result of the partnership's active involvement in coordinating community mobilization efforts, an association of HIV/AIDS NGOs was established. The main goal of the association is to ensure coordination and rational use of limited resources by avoiding duplication of efforts and developing complementary programs.

A.2.8 Uzhgorod, Ukraine/Corvallis, Oregon (1999 – 2004)

The Partners

US: Corvallis Sister Cities Association collaborated with the Oregon Health Sciences University Department of Family Medicine, Corvallis Family Medicine, Western Oregon University Department of Health Education, Benton County Health Department, Benton County Community Outreach, Benton Hospice, Good Samaritan Hospital, Corvallis Clinic, Oregon State University Health Care Administration Program, and Oregon Academy of Family.

UKRAINE: The Zakarpatska Oblast Hospital, Central Velykiy Berezny Rayon Hospital, and Zakarpatska Oblast Health Administration participated. Zakarpatska Oblast Hospital serves the population of Zakarpatska Oblast and Central Velykiy Berezny Rayon Hospital serves Velykiy Berezny Rayon, a rural area on Ukraine's border with Hungary.



Peer educators host a healthy lifestyles game show at one of the secondary schools in Velyky Berezny. (Photo: Courtesy of AIHA Archives)

Partnership Objectives

The overall goal was to improve access and quality of community-based primary healthcare and health status in the Transcarpathian Oblast. Key objectives were to:

- Increase access to, and use of, healthcare services and information in Velykiy Berezny and Uzhgorod.
- Establish a Women's Wellness Center to serve women's health needs.
- Increase personal health responsibility through community and school health campaigns.
- Increase community trust in physicians, nurses, clinic services, and the healthcare system.
- Increase access to dental services
- Enhance training opportunities for healthcare professionals.

Key Events

- 1999 • Memorandum of Understanding signed, October.
- 2000 • Velykiy Berezny Family Medicine Center opened, December.
- WWC at the Zakarpatska Oblast Hospital opened, December.
- 2001 • *Family Medicine Conference*, Uzhgorod, September.
- 2002 • Nursing conference, Velykiy Berezny, May.
- Healthy lifestyles conference on school curriculum, June.
- Family Medicine Training Center (FMTC) opened at Uzhgorod State University, October.
- Roundtable discussion on healthcare financing, October.
- 2003 • *Healthy Lifestyles-Healthy Communities* conference, Uzhgorod, October.
- 2004 • Two dental clinics opened at Uzhgorod State University FMTC, March.
- Follow-up *Healthy Lifestyles-Healthy Communities* conference, Uzhgorod, May.

Achievements

Primary Care

- The Velykiy Berezny FMC provides quality family medicine services to a rural population of 9,500.

 - The FMC at Uzhgorod State University provides services to 140 families as well as students at the university.
 - Some 50 nurses learned about diabetes patient education, adolescent health, community outreach, and improving nurses' roles in patient care.
 - More than 300 physicians learned about healthcare financing models, family physician training and curricula, the role of nurses in family medicine, and family medicine models for Ukraine.
 - A physician from the Velykiy Berezny FMC received one of the Best Family Practitioners in Ukraine awards presented by the Ministry of Health during its first annual *Family Medicine Congress* held in 2001. The criteria for the award included professional experience, clinical skills, and improved health status indicators in the areas served, as well as patient opinion.
 - Information management systems developed for the FMC and WWC streamlined data collecting procedures and facilitated data reporting.
- FMC centers in Velykiy Berezny and Uzhgorod implemented the results of a roundtable discussion on strategies for financial sustainability of family practice centers.
- The percent of patients referred to specialists at the Velykiy Berezny FMC decreased from 53 percent at opening to 27 percent in May, 2004.

“Thanks to our partners, now the doctors and nurses care for entire families, from birth to the last days of their lives. Such continuity has improved the quality of healthcare and patient satisfaction. Now, approximately 40 percent of our patients come in for preventive counseling, screenings and check-ups, as opposed to only 10 percent a few years ago.”

*—Bobdaniya Mykyta, Head Physician,
Central Velykoberezhniansky Rayon Hospital*

Women's Health

- The WWC was established after surveying 350 women on their health needs. Women expressed concerns about infertility and recurrent miscarriages, sexually transmitted infections, reproductive health, and late identification of pelvic and breast cancers. Only 21.3 percent of women of reproductive age reported using contraceptives.
- The WWC implemented programs to increase awareness of modern means of contraception and thousands of women received services and information on breast health, reproductive health, STI treatment and counseling, gynecological cancer, and healthy lifestyles.
- The WWC held classes for adolescents on contraception, STIs, HIV/AIDS prevention, and family planning.

Community Health

- Three community health coalitions were formed in Uzhgorod and Velykiy Berezny, one each for health education in schools, community trust of physicians, and managing community health education resource centers.
- Health education resource centers were established at the WWC, the Uzhgorod State University FMTC, and the Velykiy Berezny FMC. The centers improved access to health education information and served as a venue for health-related community meetings.
- Velykiy Berezny and Uzhgorod started peer education programs. Two peer-education groups in Velykiy Berezny promote healthy lifestyles among 1,200 students.
- In light of traffic conditions faced by children walking to school, a road safety campaign, Reflect-a-Life, was launched. Staff from the Velykiy Berezny FMC administered a road safety survey among area youth,

with results used to create a road-safety curriculum for parents and educators to teach road safety. Children were given red reflectors to wear or attach to book bags.

- School children in Velykiy Berezny were surveyed to assess risky behaviors and results were used to develop a healthy lifestyles curriculum for teachers. The curriculum focused on prevention of substance and tobacco abuse, responsible sexual behavior, good nutrition, physical activity, and mental health.
- Fifty teachers and 400 school children participated in a smoking cessation program, leading to a school and college in Velykiy Berezny being classified as non-smoking areas and 120 students and teachers quitting smoking.
- The Uzhgorod and Velykiy Berezny Youth Smoking Prevention Coalition began in autumn 2002 to raise awareness of the dangers of smoking, and an anti-smoking peer mentor group was formed.
- The Cross-partnership Smoking Prevention Coalition conducted a youth smoking knowledge, attitudes, and practices survey in December 2003

Dental Health

- Dental facilities were established at the Uzhgorod State University FMTC and the Velykiy Berezny FMC. A pediatric dental clinic provides services for the city's children, including orphans and disabled children. The second clinic provides dental services to adults.
- A dental education and prevention program, including fluoride rinse, at the boarding school in Velykiy Berezny resulted in a 28 percent decrease in the number of children with caries from 2001 to 2004.

Medical Education

- Physicians staffing the FMCs were retrained at Uzhgorod State University, Oregon Health Sciences University, and family medicine clinics in Corvallis.
- The FMTC at Uzhgorod State University is a model family medicine clinic with instructors qualified to train family physicians.
- A skills lab for residency training was established at Uzhgorod FMTC to teach and assess clinical and communication skills of medical students and residents. The lab is equipped with two cameras to record trainees' interactions with patients and TV/VCR equipment in an adjacent room allows for evaluation of the trainees' performance.

*Please see Appendix A for the partnership's case illustration on *Patient Education*.

A.3 KEY PARTNERSHIP CHALLENGES AND LESSONS LEARNED

As with all technical assistance programs, the AIHA partnerships faced a number of challenges and, in the process of addressing them, developed strategies for overcoming them.

Political support

Interest and commitment at all levels of government from local health administrations to the ministry of health within the countries of West NIS was crucial to the success of the partnerships. To garner this support, AIHA staff and partners from the outset met with key political and institutional leaders to convey the value and goals of the partnership program and the importance of having their backing. This support was often tenuous as both institutional and government leadership changed frequently during the course of the partnerships, requiring renewed efforts to build relationships. AIHA's regional staff worked diligently to maintain contacts with local leaders, assuring their participation in events such center openings, regional and national conferences, and other activities to keep them informed and involved in partnership activities. Their input and involvement was also sought in planning for replication of successful projects.

Legislative framework

The primary healthcare centers established by the partnerships were part of a reorientation toward primary care in the region and a key activity was retraining physicians in family medicine. Although in Ukraine primary care reform began with the re-training of doctors as family doctors in the L'viv Oblast in 1988, one of the barriers to training initially reported by the partners was the lack of a legal framework addressing the scope of practice of the family physician and, more specifically, the training that should be required. What was commonly encountered among the partnerships was the lack of practical skills among the group designated as “family physicians.” The US partners provided family physician training based on the model practiced in the United States and frequently found it difficult to teach something that was not common practice in the region. For example, the role family physicians play in the diagnosis and treatment of mental illness was very limited, including a limitation on what medications they could prescribe. Very often the practice level of physician was well below that of many advanced practice nurses in the United States.

Three of the partnerships in Ukraine developed skills-based training sites for medical students and physicians who were being retrained in primary care as part of their primary care centers. In Ukraine, five of the partnerships worked with the medical academies in their oblast to improve the curriculum in primary care. Over the life of the partnerships in Ukraine, the training standards and curricula developed by the partnerships were instrumental in the creation of the practice standards for family physicians. This enabled the replication of the AIHA model and in one oblast resulted in the replication of the AIHA model into 200 primary care sites. What AIHA hoped to achieve, but was not able to accomplish by the end of the cooperative agreement, was to create a program to develop a core faculty who would train primary care physicians.

Changes in leadership at partner organizations

AIHA's partnership methodology builds on the capability of the local health leaders and practitioners to enable them to take on the responsibility for continuing the changes and improvements that began as a result of the relationships that have developed over the life of the partnership. The peer relationships that developed between the US partners and their WNIS colleagues should have enabled them to work together as equals and empowered the local partners to take ownership of programs they mutually developed. Frequently, however the leadership within a region—and more often the partnership coordinators who are generally the chief physician at the PHC—would be terminated or would change unexpectedly for a variety of reasons. The resultant gap would often halt the improvements that had been made or even precipitate reverting back to old practices. AIHA uses study tours, leadership training, and skills-building workshops as educational methods for those expected to be agents of change in the partnerships. Partners developed various approaches to help overcome this barrier. One method they learned was to get local officials and other stakeholders involved from the beginning of a new program and to keep them involved throughout the process. In addition, a training-of-trainers approach was used whenever possible as a tactic to assure program continuity. In some cases, however, partners needed much dedication and perseverance to start anew to build the confidence and motivation to work hand-in-hand with a new partner.

Communication

Communication is a common challenge in most international development work. In the case of West NIS, AIHA partners experienced problems with both language and technology. Medically trained translators were not always available or used, which created difficulties in communicating clinical terminology and complex medical pathophysiology. The names of medications were often different, making discussions of medical treatment difficult. This became less of a problem over time as partners became aware of the need to clearly articulate in multiple ways more complex issues and to always ensure that they were understood afterwards. However, this process increased the time needed for otherwise straightforward clinical discussions. From a technological perspective, the US partners found that the telephone and Internet connections with the West NIS countries were unreliable, especially in those cases where the partnership sites were outside the capital cities. This, too, improved over time as Internet communication became more readily available and more

efficient. The AIHA regional office staff played an important role in facilitating partnership communications by serving as a liaison between the US and West NIS partners.

Collaborative model

Overcoming challenges faced by the partnerships was facilitated by the strong sense of collaboration that grew among the West NIS and US partners. Because both sides participated as volunteers, peer-to-peer relationships and a sense of mutual trust developed more easily. The selection of partners is key to this relationship-building and, ultimately, to program success. On the West NIS side, AIHA looked for institutions with open-minded leadership and commitment to the long-term healthcare goals of the country. The dedication and commitment of the individuals beyond that required by their jobs was integral to the success of the program. On the American side, AIHA solicited partner institutions with professionals willing to donate their time, effort, and expertise. The partnership methodology enabled West NIS partners to feel less like trainees and more like professionals working jointly with the Americans to improve their skills and to establish a more professional and technically up-to-date workplace. Side-by-side work with US experts in clinical settings and exam rooms, as well as multiple meetings and mentoring sessions, were used to overcome lack of experience in many practice areas among the West NIS partners and to develop new skills in them over the life of the partnerships. Ultimately, the success of partnerships depended on the tremendous commitment and dedication of the partners on both sides.

PHC lessons learned conference

In an effort to learn from the experiences of the PHC partnerships in developing model primary care centers, AIHA convened a 3-day meeting in Kiev, Ukraine, in April 2002. Participants included representatives from primary healthcare partnerships throughout the NIS, including all the West NIS partnerships. Using small group discussions and other brainstorming techniques, partners identified essential elements necessary for achieving a successful community-based primary care program. Partners shared experiences about factors that promoted and/or impeded their program planning and implementation. Through these interactive sessions, partners identified seven elements they considered essential for developing and sustaining successful primary care initiatives in their respective countries and political environments. These were: 1) policy framework, 2) political support, 3) financing, 4) professional training and education, 5) community outreach, 6) patient education, 7) clinical practice guidelines. Each partnership was then asked to develop a case study of how they had addressed one or more of these key elements, describing their work in developing, implementing, and measuring the results of their pioneering efforts. From the group of resulting case studies, AIHA selected seven that best illustrate common partnership experiences and that could serve as a guide for future efforts to enhance the quality of primary healthcare services, inform replication of effective community outreach models, and shape ongoing efforts to improve the health status of individuals and their families. The three selected cases from West NIS partnerships can be found in Appendix A.

B. CROSS-PARTNERSHIP PROGRAMS

AIHA's cross-partnership programs grew out of a desire to search for common solutions to common problems and needs that had been identified by multiple NIS partnerships. These programs, which address priorities such as women's health, constitute a key aspect of AIHA's "partnership of partnerships" concept that encourages and facilitates networking, sharing, and common approaches within and across borders. The programs helped to avoid duplication of efforts and maximize resources through provision of shared training opportunities, development of common guidelines and protocols, and dissemination of model programs. Drawing on the knowledge and experience of its wide network of partnerships and other key strategically allied organizations, AIHA coordinated efforts to link partners within countries and throughout the region through task forces, workshops, and conferences that paved the way for collaboration. Through these programs, human and organizational capacity has been strengthened and new and improved healthcare

services introduced in many areas of the health sector; in several instances, the programs also played a key role in influencing national policies supportive of needed reforms.

During 1998-2004, AIHA supported the continued involvement of West NIS partners in six of its cross-partnership programs: 1) emergency and disaster medicine, 2) infection control, 3) information and communication technology (Learning Resource Centers), 4) neonatal resuscitation, 5) nursing and 6) women's health. AIHA's support for these programs was mainly in the form of ongoing opportunities for training and networking, Internet connectivity, and limited re-supply of selected equipment and supplies. The descriptions below provide a background and overview for each program, as well as goals and objectives, key events and achievements.

B.1 EMERGENCY AND DISASTER MEDICINE

Background

After the dissolution of the Soviet Union, death rates due to accidents and cardiac incidents in the region were nearly three times the rate in the United States. Healthcare institutions had limited capacity to respond to unexpected illnesses, accidents, and disasters due to weak emergency infrastructure and lack of trained staff. In the process of reforming health systems, the authorities in West NIS countries were concerned about improving pre-hospital and hospital emergency care.

AIHA and partner institutions contributed to improving emergency care by establishing 16 EMS Training Centers (EMSTCs) in 12 countries in Eurasia, including five centers in West NIS: Minsk, Belarus; Chisinau, Moldova; and Donetsk, Kiev, and L'viv, Ukraine. The centers were furnished with training equipment and supplies, computers, and Internet connectivity. A uniform training curriculum adapted by AIHA partners to existing healthcare structures was introduced.

“Since the very first months of its existence, our EMS center has been extremely popular among all categories of trainees—from ambulance doctors to non-medical first-responders. The teaching methodology that we use is very accessible and thus there are many people who want to take our courses.”

*—Mikhail Natsuiik,
Director, Kiev EMTC*

The EMSTCs provide hands-on training in emergency techniques, emphasizing practical skills. The courses are monitored and evaluated for relevance to local conditions. The EMSTCs assist in training medical and nursing students and building regional professional associations. This model is allowing expansion of educational programs in emergency medical services throughout the West NIS.

Program Goal and Objectives

The overall goal is to create sustainable capacity within countries to respond effectively to emergencies, ranging from routine medical cases to trauma to disasters with mass casualties. Specific objectives are to:

- Increase capacity for quality training and education in emergency and disaster medicine (EDM).
- Improve knowledge and skills in first aid and emergency care among first responders, medical providers and others trained at EMSTCs.
- Increase sustainability of EDM programs.

Program Overview

Since 1994, the five EMSTCs established in the West NIS countries have been using a common emergency medical services (EMS) curriculum based on international standards and adapted to conditions in the region. Of the five centers, only the one in Minsk, Belarus, was established during the current Cooperative

Agreement. AIHA provided limited and gradually decreasing support to the centers, in Internet connectivity, basic re-supply of training materials/equipment, and occasional networking and training events.

The EMSTCs teach healthcare professionals emergency techniques—including cardio-pulmonary resuscitation, emergency obstetrics, intubation, spinal immobilization, disaster response, and triaging



A group of Ukrainian emergency physicians and nurses who had undergone training at the Kiev EMSTC brought life-saving care to the victims of the earthquake that ravaged India on January 26, 2001.
(Photo: Courtesy of Ukrainian Mobile Hospital Unit)

practices—that can be performed at an accident site, in an ambulance or at a hospital. EMSTCs play a critical role in upgrading urgent care skills of primary healthcare practitioners for managing medical emergencies. The centers also teach life-saving skills to non-medical professionals, such as flight attendants, firefighters and traffic police, who are sometimes called upon to provide emergency care. The courses focus on practical skills and include computer presentations, slides, overheads, handouts and hands-on training on manikins. Training modules are updated to reflect current trends in emergency care and are adapted to meet the unique needs of each country. The EMSTC staff monitors and evaluates the quality of courses and their impact on local practitioners, assists schools of the health professions in improving training of medical and nursing students, and builds regional professional associations and related nongovernmental organizations.

Key Events/Milestones

- 1999 • Harmony I regional medical response exercise covering a simulated radiation accident exposure, Yerevan, Armenia, August.
- 2000 • Minsk EMS Center opened, February.
 - EMS directors meeting and curriculum review workshop and agreement to establish an association of NIS EMSTCs, Kiev, June.
 - Course on radiation disaster preparedness, Kiev, October.
- 2001 • West NIS EMSTCs directors meeting on PHC training curriculum, Kiev, March.
 - EMSTC TOT refresher course, Tashkent, Uzbekistan, May.
- 2003 • New EMSTC funded by Oblast Health Administration and Ministry of Emergency Situations opened, Uzhgorod, June.
- 2004 • TOT workshop on first-responder curriculum, Tbilisi, Georgia, April.

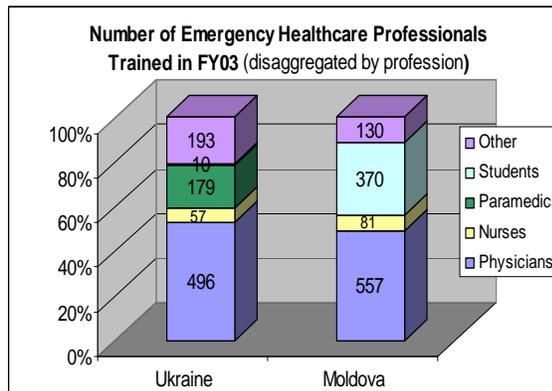
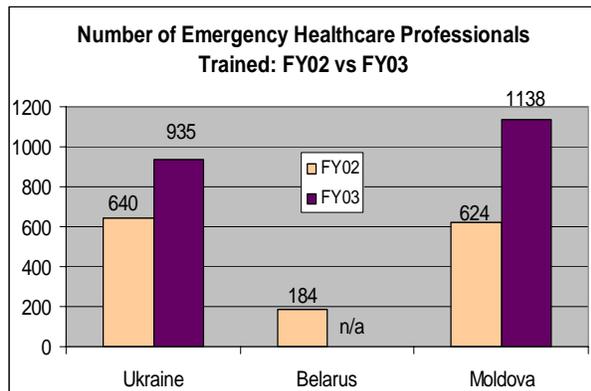
Achievements

Training Capacity

- Thirty-six trainers were trained at the EMSTCs with the assistance of US partners and through workshops and cross-center training. Thirteen EMSTC trainers received specialized training in nuclear disaster preparedness and response at the International Atomic Energy Agency. AIHA encouraged collaboration among EMSTCs and provided refresher training and forums to discuss curricula.
- By the end of FY04, each EMSTC was fully staffed with five to 10 trainers and courses were being offered regularly.
- All EMSTCs in West NIS expanded course offerings, independently devising courses in response to community needs. Some examples are a 20-hour introductory course for the general population; a 16-hour course for navy officers; a 48-hour emergency first-aid course for firefighters and road police; a 16-hour pediatric trauma care course for schoolteachers; a 144-hour course for family physicians; and a 48-hour course on emergency care in nursing. The Donetsk EMSTC designed and integrated curricula for mine rescuers and the Chisinau EMSTC added courses in emergency care during regional and national disasters.

- Trainers from the Chisinau EMSTC provided outreach courses in Baltys and Kaushen for ambulance physicians and feldshers. The courses are now being carried out by regional ambulance stations in all oblasts in Moldova.
- The Chisinau EMSTC reached outside its borders to integrate an EMS program at the Iasi City Ambulance Hospital in Romania by providing EMS training to the heads of the hospital.
- Trainers at the Donetsk EMSTC provided a TOT workshop in pre-hospital emergency care for two trainers from the Russian Ministry of Emergency Management.
- Kiev EMSTC staff provided a TOT course for three trainers for the new center in Uzhgorod.
- According to the midterm evaluation From CEP report: “The director of the Emergency Medical Center in Kiev recalled watching the American television show *911* in 1990 and realizing the possibilities that existed for improving emergency care. Subsequently, she was able to visit and observe emergency medicine in the United States [through the partnership program]. Since that time, she has been instrumental in establishing emergency medicine training programs for professionals throughout Ukraine. Adopting the American entrepreneurial spirit, she is marketing training to private security companies, the tourist industry, and others as a means of maintaining the center.”

The numbers of personnel trained and the professional distribution of trainees are presented here.



Knowledge and Skills

- From 1998 to 2004, the EMSTCs trained more than 10,000 physicians, nurses, and other medical and non-medical personnel, playing a critical role in upgrading urgent care skills of healthcare workers and providing life-saving skills to non-medical personnel.
- The Chisinau EMSTC began an EMS training promotion using television and radio to educate the public. The center also delivered a two-day course on emergency care during earthquakes in cooperation with the Ministry of Extreme Situations.

Sustainability

- The EMSTCs are all recognized by their governments and many have been integrated into local medical education. In Moldova, the EMS course was incorporated into the curriculum of the medical university, the school for feldshers, the police academy, and the medical unit of Chisinau Airport. In Ukraine, L’viv’s EMS program was approved by the Ministry of Education; Kiev’s EMS program was integrated into the curriculum of Kiev Medical Academy for Post Graduate Education, the Ministry of Internal Affairs (for firefighters and traffic police), the Ministry of Transport (for drivers), and the Academy of Science (for members of scientific expeditions); and Donetsk EMSTC’s curriculum on trauma among miners was adapted by the mountain search and rescue unit of the Donbass region (in Donetsk and Lugansk oblasts).
- The centers have generated revenue from nongovernmental sources by charging course fees.
- The centers in Ukraine continued to engage Ministry and university officials to discuss new training needs.

B.2 INFECTION CONTROL

Background

When AIHA's partnership program began in the NIS, internationally recognized infection control principles and practices were rarely applied in the region. The control of tuberculosis, hepatitis, and other infectious diseases was a significant problem in the West NIS countries, and nosocomial infections (i.e., infections acquired during hospitalization) were the leading adverse outcomes of hospitalization. Microbiology laboratories were not using evidence-based procedures and were severely understaffed, and lab results were not readily available to healthcare workers. Without accurate lab results, inappropriate antimicrobial agents were often used, leading to increased antimicrobial resistance.

To support and supplement individual partnership efforts addressing these issues, AIHA established its infection control program in cooperation with health authorities and healthcare centers. AIHA used a combination of strategies to address critical infection control organization and practices at the national, regional, and hospital levels, covering: 1) training-of-trainers and establishment of Infection Control Training Centers (ICTCs); 2) clinical standards for judicious use of antibiotics and reduction of antibiotic resistance; 3) improving surveillance, patient care, and clinical outcomes through upgrading of laboratory services, appropriately using antibiotics in hospitals, and establishing antimicrobial surveillance sites supported by the World Health Organization's *WHONET* software for monitoring resistance.

Program Goal and Objectives

The overall goal is to improve quality of healthcare services in the NIS and CEE through regional and institutional infection-control programs to reduce hospital-acquired infection rates and control antibiotic resistance. Specific objectives are to:

- Improve surveillance and assessment capacity for nosocomial infections and antibiotic resistance.
- Strengthen training capacity in infection control, clinical epidemiology, and evidence-based medicine.
- Improve infection control practices using evidence-based clinical and management protocols.
- Enhance sustainability of infection control programs.

Program Overview

In cooperation with Ukrainian authorities, AIHA supported the establishment of a model training center for continuing education in infection control. The center, located at the Kiev Scientific Research Institute of Epidemiology and Infectious Diseases, opened in September 2001. Faculty from the Kiev ICTC attended three sessions of a five-part TOT series modeled on the training at the ICTC in St. Petersburg, Russia.

The Kiev ICTC supports dissemination of infection prevention and control practices among practitioners. It offers training courses on modern methods of hospital infection control under limited resources, covering identification and treatment of blood stream infections, surgical wound infections, and urinary tract infections. It also provides training courses on implementation of nosocomial infection surveillance, patient-care practices, and microbiology lab functions. The primary training offered is in prevention of nosocomial infections, with courses designed for both practitioners and policymakers. The Kiev ICTC has been expanding training to meet emerging needs. For example, a course on prevention of blood-borne infections has been developed to address Hepatitis and HIV/AIDS prevention. In response to the SARS outbreak, the ICTC conducted training courses for the Sanitary Epidemiological Stations (SES) of Kiev.

In addition, AIHA supported the establishment of a network of three WHONET laboratories in Kiev, L'viv and Odessa, Ukraine, to upgrade microbiology labs, improve microbiology and antibiotic resistance monitoring, gather data on resistance using a specialized WHO database, and implement mechanisms based on data analysis to minimize the misuse of antimicrobial agents.

Key Events/Milestones

- 1999 • WHO Laboratory Training Course, Tallinn, Estonia, September.
- 2000 • TOT course on infection control, Tbilisi, Georgia, May.
- International infection control seminar at University of Minnesota, June.
 - Workshop on quality assurance at School of Public Health and Republican SES, Almaty, June.
 - L'viv WHONET lab opened, October.
 - TOT seminar, Tbilisi, October.
- 2001 • Fourth of five TOT seminars, Almaty, Kazakhstan, January.
- International infection control seminar at University of Minnesota, May.
 - Planning meeting for international study on antibiotic resistance to *E.coli*, Moscow, July.
 - Kiev ICTC opened; workshop on *Occupational Health and Infection Control* for PHC and WWC providers, September.
- 2002 • TOT workshop and training course on drug and therapeutics committees, Chisinau, June/July.

Achievements

Surveillance and Assessment Capacity

- Three WHONET laboratories were established in Ukraine to improve microbiology and antibiotic-resistance monitoring. Hospital microbiologists are using databases to track and analyze resistance, enabling physicians and hospital administrators to use appropriate antibiotics and identify outbreaks.
- AIHA conducted a survey of WHONET labs in 2003 to determine whether they were still performing the functions for which they were established—collecting and processing data on antimicrobial resistance. Of the 18 labs, 13 (including the three in West NIS) were found to be using the WHONET database for data collection, storage, and analysis. The labs reported conducting surveillance of antibiotic resistance for their own institutions, as well as for outside groups, and maintaining current databases.
- The WHONET lab in Kiev participated in an AIHA international study on antibiotic resistance to *E. coli*, the main cause of urinary-tract infections. The study produced a cross-section of data to compare similarities and differences in antibiotic resistance throughout the NIS.

Training Capacity

- More than 1,000 medical professionals, including hospital epidemiologists, clinical bacteriologists, neonatologists, and healthcare managers, received basic training in infection control. Hospital epidemiologists were identified as especially important for training and the number of trained hospital epidemiologists in Kiev increased from two in 2001 to 24 in 2003.
- The training capacity of the Kiev ICTC was strengthened due to the support of the City Health Administration; the number of trained specialists rose from 107 in 2002 to 900 in 2003.
- The Kiev ICTC coordinates closely with Kiev State Medical University to improve the quality of epidemiology training. A training module for residents in clinical epidemiology was developed by the ICTC and used during training of residents in 2002-2003.

Evidence-Based Practice

- A total of 38 health professionals from Primary Health Care Centers and Women's Wellness Centers in Belarus, Moldova, and Ukraine trained in evidence-based practices related to occupational health hazards and prevention strategies. Participants learned about minimizing exposure of medical workers to infections such as Hepatitis B and C, tuberculosis, and HIV, and about appropriate use of antibiotics.
- AIHA completed the second edition of the *Infection Control Manual*, which is available in English and Russian. It provides information on the organization of infection-control programs, surveillance, common microorganisms, and antibiotic resistance. Copies of the manual (including a CD-ROM) were distributed to ministries of health, partners, regional health authorities, ICTCs, SES offices, and USAID missions.

Sustainability

- In consultation with the Kiev City Health Administration, the Kiev ICTC developed draft guidelines on disinfection for preventive purposes. The recommendations were approved and introduced in all Kiev hospitals in 2003.
- In 2004, the ICTC drafted a program for nosocomial infections prevention and submitted it to the Ukrainian Ministry of Health for review. The program was in accordance with international standards and evidence-based practices and used material from the second-edition *Infection Control Manual*.
- To assess the effectiveness of its infection control program, AIHA conducted a telephone survey in 2002 with representatives from 50 NIS hospitals, including 12 hospitals from Kiev, Ukraine, where staff had been trained in infection control at AIHA-supported ICTCs. The survey revealed that 50 percent of the sampled Kiev hospitals demonstrate acceptance and use of basic infection control practices by clinical staff, and 42 percent of the hospitals demonstrate having an active infection control program. Universal precautions were reported to be accepted and implemented by more than 83 percent of these institutions.

B.3. LEARNING RESOURCE CENTERS

Background

The Learning Resource Center (LRC) program promotes improvements in healthcare practice and policy by providing professionals access to research information and a framework for applying this knowledge in clinical, educational and policy settings. AIHA has established LRCs within existing institutions, providing computers with Internet access and online and CD-ROM-based health and medical databases. Each LRC is managed by specially trained staff responsible for providing training, outreach and information support to a broad audience. LRC staff assists professionals at their institutions to conduct periodic literature reviews for evidence-based evaluation of current standards of practice in diagnosis and treatment, preventive health services and health promotion.

Program Goal and Objectives

The overall goal is to promote improved healthcare practices through increased access to, and use and understanding of, available knowledge resources. Specific objectives are to:

- Increase access to up-to-date health and medical information, primarily through the Internet.
- Increase adoption of evidence-based practice (EBP).
- Increase development and use of information and communications technology (ICT) tools and applications, including databases, local area networks, telemedicine and Web sites.
- Improve ability of partner institutions to sustain access to knowledge resources.

Program Overview

There were several elements in overcoming barriers to information. One was to give health professionals information access at the point of care, thereby making it more convenient. Another element was active staff outreach and education by developing a cadre of staff at partnership institutions to serve as “change agents” or “opinion leaders” at their institutions. Each LRC is managed by an information coordinator responsible for making resources accessible to staff, patients and the local community. Each LRC also has an evidence-based practice specialist responsible for promoting the adoption of EBP and an information technology (IT) specialist for technical aspects of LRC operation. These change agents are charged with encouraging their colleagues to begin to use information and communication integrally in their day-to-day practice. The core list of LRC activities includes: 1) staff outreach and training; 2) promotion of evidence-based medicine; 3) communications and information exchange; 4) information dissemination and health promotion; 5) building support and sustainability for the LRC; 6) Web site development; 7) database creation; 8) information systems planning; and 8) community activities and support.

Since 1995, AIHA has established 25 LRCs in the West NIS region (four in Belarus, four in Moldova, and 17 in Ukraine), 11 of which were established during this Cooperative Agreement. (See Appendix B for list of institutions where LRCs are located.)

The LRC project at each institution was executed as a two- to three-year program that included periodic training workshops and ongoing project activities. A series of training workshops held during the first years of the program introduced a range of skills and themes that helped LRC staff and their colleagues to develop a more sophisticated attitude toward information. These training workshops cover such topics as basic and advanced Internet tools and applications, medical information searching techniques, principles of evidence-based practice and critical appraisal of information, training and outreach, strategic planning for sustainability, Web site development, basic database design, computer networking, and information systems planning.

In establishing each LRC, AIHA's approach is grounded in the belief that West NIS partners needed to commit their own resources to the project. This commitment was formalized in each case through the signing

“The LRC is a very important tool for changing the way people who work in healthcare think because it gives them an opportunity to learn to make the maximum use of existing information resources, both for themselves and for the people around them.”

*–Yuri Vorokhta, Partnership Information Coordinator,
Odessa State Medical University LRC*

of a project agreement that outlines the responsibilities of AIHA and the West NIS partner institution. AIHA equipped each LRC with computers and other equipment (e.g., printer, scanner, digital camera, LCD projector) determined by a needs assessment; access to e-mail and the Internet; and various online and CD-ROM databases and educational resources. The NIS partner agreed to establish a separate, secure room for the center that must be open and accessible to all staff and to designate staff (compensated by the institution) to serve as the information coordinator, evidence-based practice specialist and information technology specialist.

Key Events

- 1999
- *West NIS Regional Information Coordinator Workshop*, L'viv, July 26-30.
 - LRC opened at Darnitsky Rayon Polyclinic, Kiev, September.
 - LRC opened at Odessa State Medical University, Odessa, Ukraine, October.
 - *First Information Coordinator Training Workshop*, Almaty, Kazakhstan, October.
 - *Second Information Coordinator Training Workshop*, Washington, DC, November.
- 2000
- LRCs opened at Trans-Carpathian Oblast Hospital, Uzhgorod; and Kharkiv Oblast Student Polyclinic, Kharkiv, February.
 - LRCs opened at City Polyclinic No. 36, Minsk; and Odessa Sea Port Polyclinic, Odessa, March.
 - LRCs opened at Donetsk City Hospital No. 25, Donetsk; Zhovkva Rayon Hospital, L'viv region; and L'viv City Polyclinic No. 5, L'viv, April.
 - LRCs opened at Botanica Rayon Polyclinic, Chisinau; and Chuguev Rayon Central Hospital, Kharkiv Region, May.
 - *Third Information Coordinator Training Workshop*, Almaty, June.
- 2001
- *Fourth Training Workshop for Information Coordinators*, Almaty, June.
 - *Medical Informatics Study Tour for Information Coordinators*, Palo-Alto, California, and Portland, Oregon, March/April.
- 2002
- *West NIS Regional LRC Dissemination Conference*, Odessa, June.

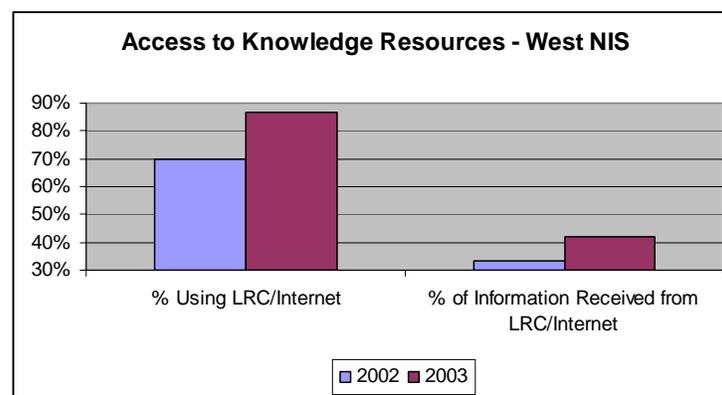
Achievements

Capacity Building of Health Professionals

- Since 1997, the LRC staff in West NIS has trained more than 6,300 physicians and other professionals in using computers and the Internet, enabling them to independently carry out searches.
- In 2002, the LRC at the Darnitsky Rayon Polyclinic in Kiev organized training for the staff of district healthcare institutions on basic computer skills.

Access to Information

- Information coordinators and EBP specialists have fulfilled more than 24,000 information requests, helping colleagues to find information related to clinical practice, health policy, curricula and health management.
- Since 2001, about 36,000 staff and visitors have used LRC resources. Cumulatively, the LRCs in West NIS have served 35,241 professionals from their institutions and 6,255 visitors.
- The LRCs continue to be important for access to knowledge for healthcare institutions, as indicated here:



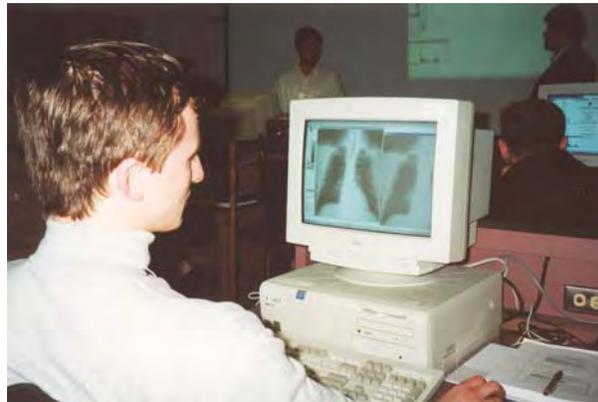
- In 2003, the staff at the Minsk City Polyclinic No. 36 LRC Center for Primary Prevention of Cardiovascular Diseases and the LRC staff organized two education sessions at other facilities for patients suffering from chronic cardiovascular conditions. More than 50 people attended and learned about cardiovascular health and self-management measures and received patient information brochures.
- LRC staff at the Chuguev Rayon Central Hospital LRC in Kharkiv region used Internet resources to prepare a workshop for hospital nurses on alcoholism and smoking among women. The workshop participants received printed materials and brochures and the LRC staff videotaped the session for future educational purposes.

Evidence-Based Practice

- The LRCs have actively promoted evidence-based practice principles among practitioners and institutions. Eighty-three percent of institutions with functioning LRCs have demonstrated successfully the use of evidence-based methods in reviewing standards of clinical and educational practice by conducting practice-standards reviews twice per year. In addition, 30 percent of institutions have established regular and ongoing processes for routinely evaluating standards using the latest available evidence.
- Based on practice-standards review, the staff at City Polyclinic No. 36 LRC in Minsk changed the treatment of arterial hypertension for diabetes patients. The literature review raised questions about the effectiveness of diuretics and beta-blockers for treating hypertension in diabetics. The staff updated treatment protocols and disseminated new standards to all PHC physicians at the polyclinic.
- Beginning in February 2001, the Kharkiv Oblast Student Polyclinic adopted diagnostic and treatment guidelines for acute bronchitis developed at the LRC. The clinic staff has since observed positive treatment results. Physicians had been prescribing antibiotic therapy to 87.2 percent of diagnosed patients and 8.8 percent of diagnosed patients had been hospitalized, 84.6 percent of them unnecessarily. Based on an expert evaluation of patient records six months after guideline adoption, physicians prescribed

antibiotic therapy to only the 0.6 percent of cases in which purulent sputum was present (i.e., the mucus produced in the lungs indicated possible bacterial infection), and hospitalized no patients. A team of physicians and the LRC staff are collaborating with PHC clinics in Kharkiv to implement guidelines on the treatment of acute bronchitis and ulcer. The results of the three-year implementation of CPGs on acute bronchitis at seven PHC clinics showed a decrease in hospitalization rates from 29 percent in 2000 to 3 percent in 2003 and a reduction in antibiotic use. Similarly, the hospitalization rate for ulcer patients at six PHC clinics decreased from 43 percent in 2000 to 0 percent in 2002.

- The LRC at Donetsk City Hospital No. 25 assisted in diagnosing and treating a pregnant patient using the Internet. A group of obstetricians and gynecologists confirmed the preliminary diagnosis—fibroadenoma, a benign lump in the breast—for the 21-year-old by consulting a local oncologist and researching similar cases online. They sought information on the most effective treatment given the pregnancy. A medical literature review revealed that 12 percent of fibroadenoma cases were among pregnant women and specialists recommended surgery in 95 percent of cases. The patient was successfully operated on using local anesthesia.
- In 2003, the Faculty of Preventive Medicine of Odessa State Medical University approved a new elective course, entitled Foundations of Evidence-Based Medicine, for sixth-year medical students and residents. This 36-hour course includes 10 hours of lectures on introduction to evidence-based practice, study design, biostatistics, and CPGs; and 26 hours of practical individual and group sessions on levels of evidence, journal article assessments, online searches, and the Cochrane Library, an online collection of evidence-based-medicine databases.



Clinicians, medical students, and even patients or other members of the community are able to access the latest evidence-based medical research at partnership Learning Resource Centers. (Photo: Courtesy of Yuri Vorokhta)

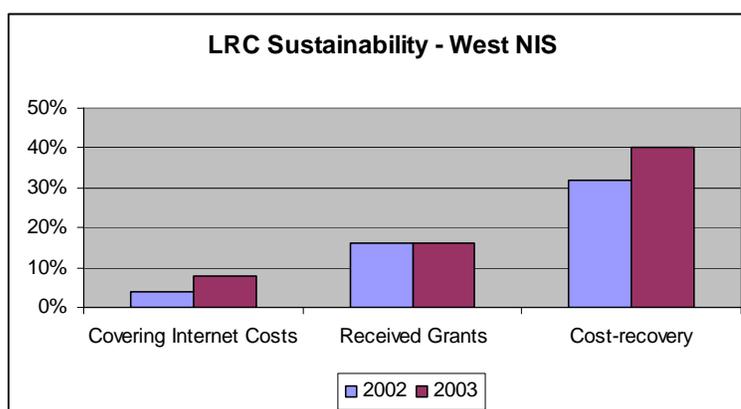
ICT Tools and Applications

- The LRC at the Darnitsky Rayon Polyclinic in Kiev has been designing statistical databases for the local health district. In 2001, the staff developed numerous databases including: a perinatal mortality database which helped identify families at high risk for genetic disorders, an infectious disease database, and a morbidity database for children suffering from the Chernobyl nuclear accident. In 2003, the LRC initiated the development of a database of children with congenital abnormalities for the City Genetic Consultative Center.
- In 2002, the staff at City Polyclinic No. 5 LRC in L'viv developed a database program for the payroll department, leading to a reduction in payroll costs of \$4,000. The polyclinic had been paying a company to print payroll documents (a state requirement) for 1,000 employees at a cost of \$2,000 per year. The database helped bring other accounting procedures in-house, adding to the savings. Due to the success and significant cost savings from information technologies, the administration invested in enhancing other technical and programming capabilities at the polyclinic.
- Staff at the LRC at Trans-Carpathian Oblast Hospital in Uzhgorod developed in 2003, in collaboration with the Regional Medical Information Center, a database of patients with insulin-dependent diabetes. The e-mail capabilities of the LRC were used to collect data from all districts in the Zakarpatska Region. The database contains a wide range of data, which is being analyzed for preventive, diagnostic, and treatment purposes.
- As part of a long-term plan to develop automated electronic health records at the Odessa Seaport Polyclinic, the LRC staff helped implement a health information system for general practitioners and diagnostic specialists in 2002. The system included patient records, prescription verification, an inventory

of discounted prescriptions, a listing of port pensioners and veterans, data on port staff and their family members, morbidity reports, a drug index, WHO's International Classification of Disease, occupational health checks, and vaccination schedules.

Sustainability

- In 2004, 13 percent of active LRCs in West NIS were being supported through their institutions' budgets and 35 percent expected their institutions to cover Internet access and other maintenance costs after AIHA funding ended.
- During the program, 22 percent of LRCs in West NIS received grants supporting Internet connectivity or other resources and infrastructure that enhance their capabilities.
- Sixty-one percent of West NIS LRCs are partially recovering maintenance costs by, for example, renting equipment and facilities and charging external clients for information/clerical services.



- In 2001, the LRC at City Polyclinic No. 5 in L'viv became an Internet sub-provider, offering the best-quality Internet connection in its city district. The LRC was thus able to improve its own Internet connection and its status in the community. As paying customers increase, the Internet connection will become self-sustaining.
- The Odessa State Medical University LRC began in 2002 to partly cover its operating costs by renting presentation equipment to local companies and organizations.
- In 2003, the LRC at the Moldova State University of Medicine and Pharmacy's Department of Public Health and Health Management received a \$20,000 grant from the US Centers for Disease Control and Prevention and the Open Society Institute to develop e-learning courses in public health.

Other Accomplishments

- In 2002, the Donetsk City Hospital No. 25 LRC recruited volunteers among school children to spread health promotion messages. Using the Internet, the staff created age-appropriate educational brochures on substance abuse, HIV/AIDS, and STI prevention which were distributed by local adolescents among their peers. The information coordinator also trained six teenagers on HIV/AIDS and STI prevention and three are to become instructors for student educational sessions.
- In 2002, the LRC staff at the Moldova State University of Medicine and Pharmacy LRC organized popular weekly trivia contests to attract users and engage students in learning. University students, nurses, and upper-level school and lyceum students tried to answer medical and paramedical questions published on the university Web site and local area network.

For LRCs established during this Cooperative Agreement, additional information is provided in Appendix B. Further information and examples of best LRC practices are available in "Learning Resource Center Project Best Practices and Lessons Learned: A Guide to Improving Healthcare through Information and Communication Technology," at <http://lrc.aiha.com>.

B.4 NEONATAL RESUSCITATION

Background

AIHA partnerships initiated the Neonatal Resuscitation Program (NRP) as a cost-effective clinical approach with great life-saving potential for newborns. Essential neonatal resuscitation techniques in delivery rooms and birth houses serve to not only decrease infant mortality rates but to reduce the number of developmental disabilities resulting from blood and oxygen deprivation in the first minutes of life. Several partnerships formalized this program by opening Neonatal Resuscitation Training Centers (NRTCs) which served as a model for other NRTCs established over the years with AIHA support.

“As a result of the spread of the neonatal resuscitation techniques, the leading causes of neonatal mortality have declined substantially. Compared with figures from 1997, by 2003, fatalities from newborn respiratory disorders had decreased by 62 percent and mortality from asphyxia by 47 percent.”

*–Elena Sulyma, Director, Kiev NRTC
and Head Neonatologist,
Ukrainian Ministry of Health*

The AIHA neonatal resuscitation training course gives healthcare professionals the set of basic skills in newborn care which are standard practice in delivery rooms in the US and Western Europe. This training enables practitioners to assist infants when they experience difficulty breathing on their own through techniques of thermal management, infant positioning, suctioning and stimulation, with minimal use of equipment. The training curriculum and materials are based on the American Heart Association/American Academy of Pediatrics (AHA/AAP) neonatal resuscitation program. AIHA and its partners translated the AHA/AAP *Textbook of Neonatal Resuscitation* and *Instructor's Manual for Neonatal Resuscitation* into Russian. In addition, other teaching and educational materials, including student evaluation tests and data collection forms, were created or translated for use in the West NIS.

The NRTCs are responsible for disseminating knowledge and conducting monthly training courses in neonatal resuscitation, as well as gathering statistics from medical institutions that have had personnel trained at the center. This statistical information is used to evaluate the impact of training. The NRTCs serve as reference centers and provide training for medical professionals from other regions.

Program Goal and Objectives

The overall goal of the program is to decrease infant mortality and morbidity rates in the immediate newborn period through the implementation of appropriate, neonatal resuscitation skills in delivery rooms. Specific objectives are to:

- Increase capacity to provide training in evidence-based neonatal resuscitation care as the standard of clinical practice.
- Improve sustainability of the neonatal resuscitation program.

Program Overview

The first Ukrainian NRTC was established in L'viv at the L'viv Oblast Clinical Hospital in January 1994 through the L'viv/Detroit partnership. With the cooperation of the Ministry of Health, a national program was started in Ukraine following the *First Annual Neonatal Conference* in L'viv in 1996. The MOH identified five regions for NRTCs. AIHA ultimately established six NRTCs in the West NIS countries from 1994 to 2001, in: L'viv in 1994; Kiev and Odessa in 1997; Kharkiv in 1998; Donetsk in 1999; and Dnipropetrovsk in 2001. US partners assisted in replication by training instructors and supervising the initial training courses held at each NRTC.

In 1998 and 2001, AIHA conducted an evaluation of hospitals where staff received neonatal resuscitation training from Ukrainian NRTCs. In April 1998, AIHA evaluated three hospitals in the L'viv region; and in February 2001, AIHA evaluated six hospitals in the Kiev and L'viv regions. The evaluation indicated that

NRTCs are conscientiously training physicians and nurses and that those trained in NRP are applying it in practice. AIHA established an NIS region-wide NRP steering committee to develop standards for the practice of neonatal resuscitation and to provide guidance on legislation for neonatal resuscitation in the NIS. Through the efforts of the committee, which includes MOH representatives, academics, and NRTC medical professionals, progress has been made in strengthening the program in each country.

Key Events/Milestones

- 1998 • Kharkiv NRTC opened, October.
- 1999 • Donetsk NRTC opened, April.
- National NRP faculty meeting and TOT course, L’viv, April.
- NRTC directors’ meeting and neonatal conference, L’viv, September.
- 2000 • *Neonatal Dissemination Conference*, L’viv, April.
- NRP peer review meeting, Moscow, November.
- First NRP steering committee meeting, Moscow, November.
- 2001 • Dnipropetrovsk NRTC opened, April.
- Neonatal Resuscitation Training for providers serving internationally displaced persons and refugees, Mir Kasimov Hospital, Baku, Azerbaijan, May.
- Region-wide NRP steering committee meeting, Tbilisi, Georgia, May/June.
- Region-wide NRP guidelines training on new AAP guidelines, Moscow, November.
- Region-wide NRP steering committee and NRTC directors’ meetings, Moscow, November.
- 2002 • NRP steering committee meeting, Kiev, May.
- 2003 • Ukrainian MOH approved the national NRP for 2003-2006, giving legal status to the country’s six NRTCs.
- NRP Dissemination Conference, L’viv, November.



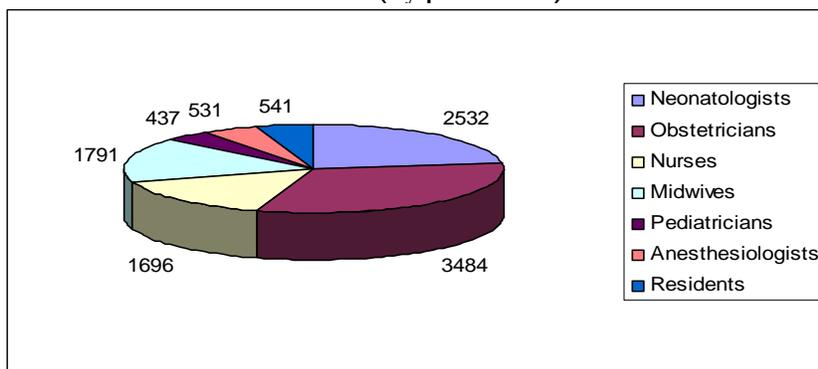
Thanks to the life-saving skills taught by the L’viv Neonatal Training Center, the survival rate of very low birth weight babies increased by more than 12 percent during the Center’s first year of operation alone.
(Photo: Kathryn Utan)

Achievements

Training Capacity

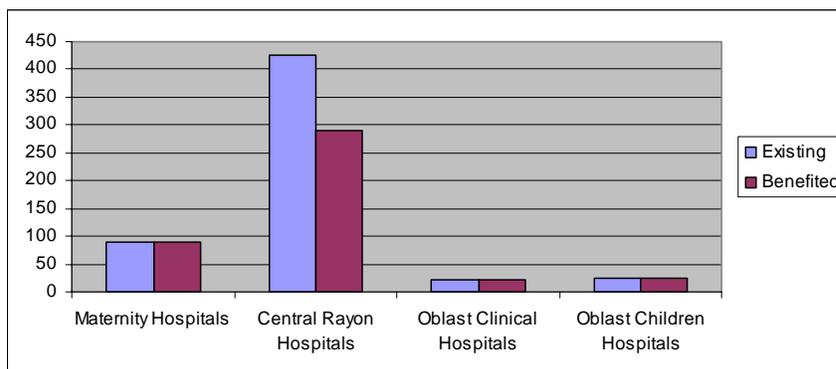
- In collaboration with local and national ministries of health, AIHA and its partners facilitated mandatory training in neonatal resuscitation for delivery room staff and the inclusion of the training in medical school curricula. As of March 2004, over 10,000 NRP practitioners and 54 instructors had been trained in Ukraine.

Total Number of Healthcare Providers Trained in NRP in Ukraine (by profession)



- The six NRTCs in Ukraine continue to offer courses in neonatal resuscitation and provide consultations relevant to improving neonatal care in hospital obstetrical units and maternity houses.
- According to Ukrainian MOH officials, enhanced capability of OB/GYNs, midwives, neonatologists and pediatricians to manage high-risk women and infants contributed significantly to a decrease in early neonatal mortality rates, especially in the oblasts where NRTCs are located.

Ukrainian Medical Facilities Benefited from NRP Trainings



Sustainability

- In May 2003, the Ukrainian MOH adopted by special decree on National NRP for 2003-2006. The decree bestowed legal status to the six AIHA-established NRTCs in Ukraine and designated the Kiev NRTC as the main training center for providing guidance and support to the regional NRTCs located in Donetsk, Dnipropetrovsk, L'viv, Kharkiv and Odessa. In the decree, the Ministry encouraged Oblast Health Administrations throughout Ukraine to establish NRTCs in their jurisdictions and included a list of recommended equipment, materials, and supplies for a model NRTC.
- The decree placed the responsibility of financing the five regional NRTCs on the oblast health administrations and the responsibility of financing the Kiev NRTC on the Kiev City Health Administration. The decree designated responsibility to the MOH, the Kiev City Health Administration, and the oblast health administrations to continue neonatal resuscitation training in Ukraine.
- Neonatal resuscitation techniques, based on the AAP guidelines of 2000, are to be introduced at each Ukrainian maternity hospital or department.
- The Ukrainian MOH also ordered a coordination board to be established to monitor the program's implementation, coordinate the efforts of the regional centers, monitor and evaluate the quality of training at the centers, and organize workshops and conferences on neonatal resuscitation. The directors of the NRTCs and AIHA are represented on the coordination board.
- AIHA conducted two rounds of studies evaluating the Neonatal Resuscitation Program in the NIS. The six centers from Ukraine participated in the survey. The objective of the first-round study, conducted in 2001, was to determine the effectiveness of the NRP and was part of a larger quality-improvement initiative. The objective of the second-round study, conducted in 2003, was to monitor clinical outcomes and assess the effectiveness of the NRP program in improving outcomes. The results of the two studies, covering 15,000 infants, were consistent and confirmed the positive effect of organized NRP training on morbidity and mortality of infants. In the first study, the percentage of all medical staff trained was linked to improved outcomes. In the second study, the training of the key medical staff member, the neonatologist, was linked to improved outcomes. The findings indicate that the critical factor in improving outcomes for infants in the current circumstances in the NIS is training 100 percent of neonatologists in neonatal resuscitation.

B.5 NURSING

Background

AIHA's nursing program has built capacity, improved care, and provided sustained leadership and vision for nursing in the NIS and CEE. As AIHA's first partnerships began in 1992, nursing emerged as a key concern. The partners identified challenges, such as lack of professional standards for nurses and lack of an independent nursing-care structure. AIHA assembled nursing task forces which organized annual international nursing conferences to identify and address needs.

The nursing program addressed concerns raised by the nursing task forces through development of curricula, clinical practice guidelines, standards, Nursing Resource Centers (NRC), national nursing associations, and the International Nursing Leadership Institute (INLI). In the context of the new model primary care clinics and the development of team-based clinical practice guidelines and patient care protocols, AIHA's partners established training programs and created central roles for nurses in patient care and community health outreach.

The INLI program promoted leadership development. The curriculum, taught by US nurse faculty, used adult learning principles and focused on skills in project development, management ethics, supervision and quality management. INLI graduates had the opportunity to apply for small grants to implement projects developed during the INLI course.

Program Goal and Objectives

The overall goal is to improve patient care by strengthening nursing practice and nurses' contribution to systemic health care reform in the NIS/CEE. Specific objectives are to:

- Enhance nursing education to meet international standards and to increase status of the nursing profession.
- Improve nursing practice through nurse training and by introducing new models of nursing care and nursing roles.
- To increase access of nurses to information resources and networking opportunities through sustainable NRCs.

Program Overview

The nursing program has contributed to enhancing the professionalism of nurses and nurse administrators, reforming undergraduate and graduate nursing education, and developing and strengthening regional and national nursing associations. The development of nurse leaders at AIHA partner institutions has resulted in effective nursing leadership at local, national, and regional levels.

AIHA and its partners established a PHC nursing steering committee to identify the needs and priorities of primary care nurses. The committee formulated a basic agenda for the PHC skills-building workshops held in each region. With the goal of providing nursing faculty, students, and practitioners with the resources to support evidence-based learning, AIHA established three Nursing Resource Centers in Ukraine. The NRCs were supplied computers, textbooks, videotapes, and anatomical models. By linking the NRCs to the Internet, AIHA fostered a supportive community of nurse leaders connected to their professional counterparts worldwide.

Through the International Nursing Leadership Institute—an integrated, year-long curriculum designed to develop a core of skilled nurse leaders—18 West NIS nurses, one from Belarus, two from Moldova, and 15 from Ukraine, received intensive training in leadership and management skills. The program contributed to the professional development of nurses and to increased status of the nursing profession. Seven INLI graduates in the West NIS received small grants to complete projects in association building, clinical practice,

leadership, and curriculum development. The projects benefited the nurses' partnerships and local communities.

Key Events/Milestones

- 1999
- First session of INLI, Class I, London.
 - Second session of INLI, Class I, Louisville, Kentucky, November.
- 2000
- American Organization of Nurse Executives (AONE) study tour to Chicago, Illinois, March.
 - International nursing conference on PHC methods, models and practice, Tbilisi, Georgia, April.
 - NRC community outreach workshop, Yerevan, Armenia, June/July.
 - Final session of INLI, Class I, St. Petersburg, Russia, July.
 - First session of INLI, Class II, St. Petersburg, July.
 - Nursing association building workshop, Kiev, August.
 - PHC nursing steering committee meeting, Moscow, December.
- 2001
- Second session of INLI, Class II, Washington, DC, April.
 - International Council of Nurses (ICN) Congress, Copenhagen, Denmark, June.
 - Sigma Theta Tau Nursing Honor Society induction, Copenhagen, June.
 - Final session of INLI, Class II, Copenhagen, June.
 - PHC nursing skills-building workshop, Kiev, July.
 - PHC nursing steering committee meeting, Kiev, July.
 - Workshop on technology and health education for nursing, St. Petersburg, August.
 - *Global Nursing Perspectives Workshop*, Atlanta, Georgia, October.
 - First session of INLI, Class III, Indianapolis, Indiana, November.
- 2002
- Second session of INLI, Class III, Tbilisi, March.
 - Second skills building workshop for primary care nurses, Kiev, March.
 - Third session of INLI, Class III, St. Petersburg, June.
 - PHC nursing steering committee meeting, St. Petersburg, June.

Achievements

Professional Development

- The INLI program contributed to professional development of individual nurses and, through them, to increased status of the nursing profession. AIHA conducted a qualitative assessment of the International Nursing Leadership Program during the spring/summer of 2003, with the purpose of evaluating it from the perspective of participants. Of the 17 participating nurses from West NIS, 15 reported that INLI helped them gain respect from physician colleagues and 13 reported participating in nursing associations.
- The assessment also indicated that the INLI program was, for the majority of graduates, a significant factor in their career advancement: 29 percent of the West NIS graduates received a promotion; about 22 percent were offered a new job; and most of the others were granted increased responsibilities.
- Four Ukrainian nurses joined international nursing groups, such as the International Council of Nurses and Sigma Theta Tau.
- National nursing associations were strengthened significantly. The national association in Belarus now has in excess of 15,000 members; in Moldova, more than 13,000 members; and in Ukraine, more than 32,000 members.
- The Nursing Association of Ukraine established regional associations in 19 oblasts of Ukraine.
- In Belarus, the national nursing association developed a nursing code of ethics and designed a postgraduate education course for senior nurses. With active participation of the nursing association, nursing-practice standards were developed and submitted to the Ministry of Health for review and approval.
- In Moldova, the national nursing association initiated a national nursing development program that was approved by the Ministry of Health. The association also introduced a new home-care model.

Nursing Practice

- AIHA workshops during 2000-2002 trained 113 primary-care nurses from Belarus, Moldova, and Ukraine in physical assessment, communication, health promotion, patient education, time management, mental and adolescent health, asthma, gerontology, and dental health. Each participant was given a physical assessment kit consisting of a stethoscope, blood pressure cuff, ear scope, penlight, and tuning fork.
- The partnership self-assessments conducted in 2003 indicated that all West NIS PHC partnerships institutionalized new nursing roles and responsibilities, including independent patient assessment and care planning, infection control, and patient education and counseling. All the partnerships also implemented written standards for nurses.
- As a result of the program, INLI graduates initiated 17 individual projects, 10 of which were successfully completed, leading to considerable changes within the healthcare environments where the nurses work. Seven West NIS INLI graduates competed for and received small grants to complete projects. Among the West NIS nursing projects were:
 - A chief nurse from Zhovkva Rayon Central Hospital designed and successfully implemented a training project titled Increasing Nursing Qualification. Thirty-six practicing nurses from four outpatient units and 29 feldsher and midwife stations of Zhovkva District were trained in management and leadership. According to test results, the level of knowledge of participants increased by 37.4 percent.
 - A chief nurse from the Chuguyev Central Rayon Hospital undertook a leadership project with the goal of improving performance of nursing staff in that institution.
 - A nurse from Chisinau Clinic No. 1 developed two training programs for nurses. The family medicine program trained 14 nurses from the polyclinic on the role of family practice nurses and the leadership and management program trained 50 senior-level nurses in rural areas.
 - The Leadership without Boundaries program for Belarusian senior nurses was implemented by the president of the Belarus Nursing Association. The leadership training was conducted for 240 chief and head nurses of healthcare institutions who were members of the Belarus Nursing Association.
 - The Training Rural Nurses in Palliative Care program developed by the chief nurse at the International Health Care Management and Social Security Institute in Chisinau trained 20 nurses from rural areas as trainers in palliative care. About 40 patients were provided palliative care services, including psychological and moral support. This created a new model of care for patients with advanced disease and short life expectancy, with an emphasis on the quality of life.
 - A nurse from Donetsk City Hospital No. 25 implemented a program to develop leadership roles for nurses in the oblast. A total of 82 nurses were trained at four seminars and they now serve as trainers at their institutions. The director of the program received a request from the Donetsk Region Nursing Association to conduct similar seminars in other cities in the region.



Natalia Halapats, chief nurse at Zhovka Rayon Hospital, displays an educational manual she created for the partnership's Nursing Resource Center. (Photo: Kathryn Utan)

Nursing Resource Centers

- A network of NRCs was established to provide nursing faculty, students, and practitioners with a facility to support alternative forms of learning, information resources, and opportunities for networking and professional collaboration. Three NRCs had been established in Ukraine (L'viv, Kiev, and Odessa) under the previous Cooperative Agreement. All three centers continued to operate with minimal financial support from AIHA during 1999-2004. An assessment conducted by AIHA staff between December

2002 and February 2003 revealed that all three West NIS centers are fully operational and engaged in the types of activities for which they were established.

- The three NRCs in Ukraine conducted courses on clinical practice, maternal and child health, information systems, and emergency care. The courses reached 3,141 nurses and others in FY02 and 3,583 nurses and students in FY03.
- In addition to clinical-skills training, the NRCs initiated activities advocating for the nursing profession. The L'viv and Odessa NRCs organized meetings and activities, including outreach certification tests and training courses. The centers are used by nurses of various specialties, faculty members, nursing students, and members of local nursing associations.

B.6 WOMEN'S HEALTH

Background

The Women's Wellness Center concept resulted from AIHA's initial involvement in hospital-based partnerships. Demonstrated need for a comprehensive and integrated approach to women's health inspired AIHA to bring together a task force of women's health clinicians and educators from the NIS and United States, and in 1995, AIHA launched its Women's Health Initiative. WWCs are the cornerstone of this program. Built on existing programs, administrative structures, and professional relationships in family planning, health education, clinical training in obstetrics, and neonatal resuscitation, the WWCs integrated and streamlined provision of services, even as they expanded services and accessibility. The task force guided the development of WWCs, encouraging delivery comprehensive services tailored to the needs of women from adolescence to post-menopause. WWCs provide both primary and specialized clinical services using a client-centered approach and also promote wellness, disease prevention, and patient empowerment through education.

Program Goal and Objectives

The overall goal is to provide a client-centered approach to women's healthcare through services addressing women's health needs throughout their lifetimes. Specific objectives are to:

- Increase capacity to deliver comprehensive services to women of all ages.
- Increase implementation of clinical practice guidelines in women's health.
- Increase access to contraceptives among women of reproductive age wishing to avoid pregnancy.
- Improve sustainability of WWCs.

Program Overview

Twelve WWCs located in West NIS communities provide a comprehensive range of clinical outpatient services. In addition, they undertake health promotion, disease prevention, and educational programs, including classes, public awareness campaigns, and telephone hotlines. WWCs also host support groups addressing topics from intimate partner violence (IPV) and substance abuse to coping with cancer. These are the core services of WWCs, with some variation by center:

- Perinatal care, including pregnancy, breastfeeding, and childbirth classes.
- Family planning and reproductive health, including fertility and contraception counseling.
- Education and clinical intervention for peri- and post-menopausal women.
- Health promotion, including education, nutrition, and exercise counseling.



A physician at the Mozyr WWC discusses the importance of performing monthly breast self-examinations to a patient and instructs her on the proper technique. (Photo: Courtesy of Mozyr WWC)

- Adolescent health, including sex education and peer support groups.
- Prevention, diagnosis, and treatment of HIV/AIDS and STIs.
- Cancer education and screening, including Pap smears and clinical breast exams.
- Mental health education, counseling, and support groups for depression, IPV, and rape.
- Substance abuse education, problem identification, and treatment.
- Education, screening, treatment, and referral for specialty services addressing chronic diseases.
- Community outreach on women's health issues.

According to community needs, available local resources, and individual strengths, each WWC focuses on specific areas. For example:

- The L'viv WWC is a referral clinic for victims of human trafficking and works in cooperation with Winrock International's Woman to Woman Center on a trafficking prevention project.
- The Kiev WWC has social and psychological counseling and maintenance therapy for patients diagnosed with breast or reproductive system cancer. It serves walk-in patients and patients referred by other physicians and center staff.
- The Odessa WWC provides services to HIV-positive patients and plays a key role in the implementation of AIHA's successful prevention of mother-to-child transmission (PMTCT) of HIV project.
- The Uzhgorod WWC is a member of a coalition of healthcare professionals and NGOs that encourages community participation in solving healthcare problems and engages active support of the media. More than 60 percent of patients at that facility make use of its information office, where patient education classes and group meetings are held.
- The Kramatorsk WWC focuses on childbirth education and offers Lamaze training for expectant parents.
- The Donetsk WWC develops educational programs on prevention of HIV/AIDS and other sexually-transmitted infections.
- WWCs in Cahul, Drochia, and Chisinau, Moldova offer comprehensive services to victims of IPV through a multidisciplinary team that includes psychologists, attorneys, police officers, and social workers.
- Belarusian WWCs in Minsk and Mozyr are proactive in adolescent health and have introduced services and educational programs targeted to young people.

Key Events

- 1999
- *Childbirth Education Seminar*, Minsk, March.
 - Kiev WWC opened, April.
 - *Breast Health Quality Assurance Workshop*, L'viv, June.
 - *STI Case Management Workshop*, L'viv, September.
- 2000
- *Breast Health Community Outreach Workshop*, Kiev, April.
 - Women's Health CPG steering committee meeting, Kiev, April.
 - Drochia WWC opened, April.
 - Mozyr WWC opened, April.
 - Workshop on sexually transmitted infections, L'viv, May.
 - *Breast Health Case Study Review Workshop*, Kiev, May.
 - Consultation-line training sponsored by Winrock International, L'viv, June.

“The value of these centers is that, besides delivering quality midwifery services, the staff can counsel patients on a wide range of issues, including family planning and the prevention of sexually transmitted infections, as well as offer assistance in solving problems related to family violence. Just a couple of years ago, all of this would have been extraordinary for Moldova,”

–Ion Ababii, Rector,
Nicolae Testemitanu State University
of Medicine and Pharmacy

- *Adolescents-at-Risk Study Tour*, Washington, DC and Philadelphia, Pennsylvania, August.
- *Contraceptive Technology Workshop*, Kiev, October.
- *Adolescents-at-Risk Workshop*, Kiev, November.
- Uzhgorod WWC opened, December.
- 2001
 - Kramatorsk WWC opened, February.
 - *Breast Health Case Study Review Workshop*, Chisinau, May.
 - Cahul WWC opened, July.
- 2002
 - HIV/AIDS pre- and post-test counseling training, Kiev, May.
 - *Breast Health Case Study Review Workshop*, Odessa, July.
 - Lamaze training, Kramatorsk, October.
 - Donetsk WWC opened, November.
- 2003
 - *Women's Health CPG Workshop*, Odessa, September.
 - Kiev Railway WWC opened, March.
 - Kharkiv Railway WWC opened, April.

Achievements

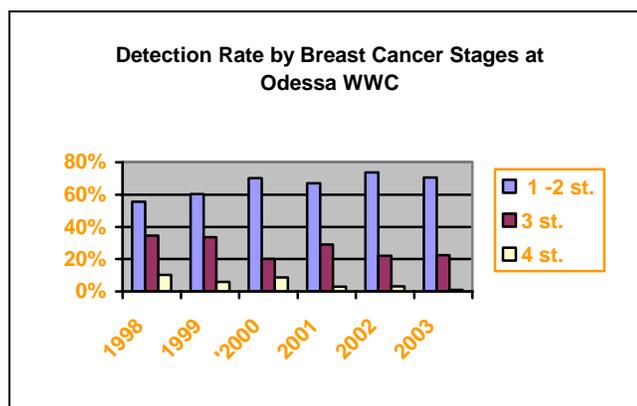
Service Capacity

- Physicians, nurses, midwives, and administrators were trained in childbirth education, including counseling and educational support to expectant couples.
- Forty-five physicians and nurses from the West NIS received Lamaze training.
- Twenty representatives from the Odessa, L'viv and Kiev WWCs, two representatives from the National Oncology Institute, a representative from the Bennett Division of Trex Medical Corporation, three instructors from Buffalo, and Kodak representatives from Kiev and Moscow participated in the three-day *Breast Health Quality Assurance Workshop*.
- Healthcare and media professionals from West NIS participated in the *Breast Health Community Outreach Workshop*. Three US trainers reviewed the components of breast health and early detection and assisted in identifying resources and strategies to promote breast health. Participants developed action plans for follow-up in their home communities.
- The *STI Case Management Workshop* included an epidemiological update on STIs and HIV in Eastern Europe and Ukraine, a session on the transmission and control of STIs and HIV, and sessions on diagnosis and treatment.
- Physicians and psychologists from Ukrainian and Moldovan WWCs received HIV/AIDS pre- and post-test counseling training.
- Representatives of L'viv, Odessa, and Kiev WWCs received training in hotline services at Winrock International's consultation-line training.
- Representatives of Ukrainian WWCs participated in the *Adolescents-at-Risk Study Tour* to Washington, DC, and Philadelphia to learn about risk reduction and health programs for adolescents.
- The follow-up *Adolescents-at-Risk Workshop* introduced the adolescent health situation in Ukraine, covering reproductive health, mental health, substance abuse and social problems. Participants discussed community mobilization, action plans, and guidelines for adolescent-health services.

Service Delivery

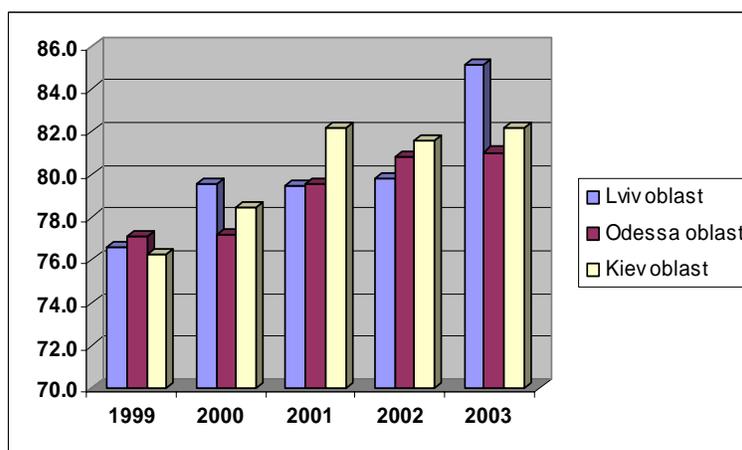
- All WWCs offered breast health programs that included teaching the basics of breast self-exams and performing clinical exams.
- Six of the West NIS centers (Chisinau, L'viv, Odessa, Uzhgorod, and two WWCs in Kiev) offered mammography screening. Full ultrasound and mammography facilities substantially expanded the scope of diagnostic services to include needle localization of non-palpable growths, sonographically-monitored aspiration biopsy of new glandular growths and core-biopsy of glandular growths. The facilities and labs enabled the WWCs to offer diagnosis at pre-clinical, non-palpable stages, and provide treatment options in an efficient and timely manner.

- While breast screening has not decreased the number of cancer patients, early detection (stages 1-2) has increased, thereby increasing survivability. For example, the following graph shows data from Odessa:



- All WWCs offered prenatal services and introduced childbirth education programs which encouraged timely registration for prenatal care (within the first 12 weeks of pregnancy).

% of Women Receiving Prenatal Care in First 12 Weeks



- Telephone hotlines are operating at the Kiev, L'viv, and Odessa WWCs to offer women counseling on family planning and domestic violence.
- In 2003, 10 WWCs conducted a patient satisfaction survey designed by AIHA. Seven centers exceeded the target average (5.8 on a 7-point scale) for the mean satisfaction ratings for variables included in the survey. Following the patient satisfaction survey, some centers used the results to formulate quality improvement plans.

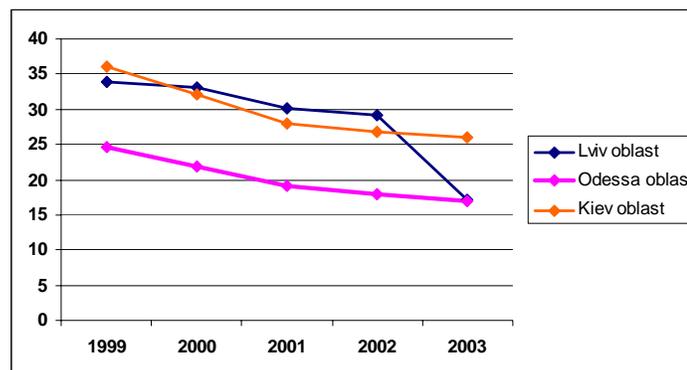
Clinical Practice Guidelines

- Representatives of the three, Ukrainian, breast-health centers, together with colleagues from Armenia, participated in the *Breast Health Case Study Review Workshop*. They reviewed accomplishments and challenges facing their centers. They also discussed processes for development of clinical practice guidelines and quality-control methods, analyzed mammography cases, and agreed to form an inter-partnership network for consultation and collaboration.
- Representatives from the Cahul, Chisinau, Kiev, L'viv, and Odessa WWCs participated in a *Breast Health Case Study Review Workshop*. They attended lectures, analyzed mammography and sonography images, formed an inter-partnership network, and reviewed and revised the breast health section of the *Women's Health CPG Reference Manual*.

Contraception and Abortion

- The WWCs reported that family planning counseling and services led to an increased use of contraceptives among their clients and a significant decrease in the number of unwanted pregnancies. The success of family planning interventions are believed to have contributed to a decrease in abortion rates in areas served by the WWCs, as shown in this graph.
- An assessment of the WWCs took place between August and September of 2003. Twenty-nine WWCs participated in the standardized survey including 12 from West NIS. The WWC self-assessment revealed that AIHA's partnerships helped 10 West NIS centers (83 percent) to expand their services, diagnostic procedures, counseling and patient education. The physical facilities of most of the WWCs were improved, leading to better patient care and outcomes.

Abortion Rate per 1,000 Women of Reproductive Age



Sustainability

- In recent years, additional centers have been started based on the AIHA model. Some of these centers have received financial assistance from AIHA, but many have received substantial resources from local authorities or other agencies:
 - The Moldovan Ministry of Health, together with the World Bank and World Health Organization, recommended the Chisinau WWC as a model for restructuring primary healthcare in the country.
 - The United Nations Population Fund and AIHA jointly funded the WWCs in Drochia and Cahul.
 - Based on the L'viv model, the Ukrainian Ministry of Transport established the Railway WWCs with assistance from AIHA and Carelift International.
- The L'viv staff provided training to the WWC teams at replication sites, helped design the organizational structure, introduced continuous quality improvement, and provided patient education materials.
- Replication of the WWC model was included in the National Health Strategy of Ukraine for 2002-2011, as part of a policy for improving the quality of women's health services.
- As part of the 2003 assessment, AIHA surveyed the WWCs regarding sustainability issues. The majority of centers indicated that paid services contribute to the sustainability of their operations, as well as other factors such as agreements with insurance companies, funds from private and institutional donors, access to international grants, and support from local health authorities. In Uzhgorod, partners created a charitable foundation, "Women's Health," to help in the WWC's transition to full sustainability. Based on the centers' current financial situation and ongoing sustainability activities, the center directors were asked to indicate their level of confidence that the center will be fully operational one, five, and ten years hence. Using a scale of 1 to 7, with 1 being "not at all confident" and 7 being "completely confident," the 11 West NIS centers that answered the question had a average answer of 5.6, with six centers rating "7, or

“The Women’s Wellness Centers represent a wonderful model for replication and we are very interested in re-organizing existing Women’s Consultation Centers into Women’s Wellness Centers, with greater emphasis on prevention and patient education.”

*—Nadezhda Zbilka, Lead Specialist,
Children and Mothers Healthcare Department,
Ukrainian Ministry of Health*

completely confident” of their center’s sustainability within one year. Projecting ahead five years, the average response was 4.7, with seven centers giving a rating of 5, 6 or 7.

C. SUCCESS STORIES

The following stories have been selected to illustrate the impact that AIHA partnerships and cross-partnership programs have had on individual lives in the West NIS.

Primary Health Care

The Kiev/Philadelphia partnership implemented a model for integrating mental health services at the primary level and as a result has had a major social impact on patients. One of the patients seen by the mental health team was a 32-year-old woman infected with tuberculosis. She initially went to the center for assistance in getting medication and was referred to the social worker by her family doctor. As part of the assessment process, the social worker learned that the woman was single and had an eight-year-old son who did not attend school because he worked to help support the family. The social worker, family doctor, and a psychologist worked as a team to address both the physical and social conditions of the woman and her son. The woman was successfully treated for TB and is now employed at a local department store. Because of her employment and the assistance she has received, she was persuaded to return her son to school. He is attending first grade and has tested negative for TB.

Neonatal Resuscitation

A baby boy weighing 3.5 pounds was born at 30-31 weeks of gestation to a 25-year old mother in a rural area outside of L’viv. The delivery started unexpectedly and the baby was born at home. The mother had received no prenatal care. She took the baby to a rural hospital where it was decided that he should be transferred to the L’viv Oblast Clinical Hospital, the site of the L’viv Neonatal Resuscitation Training Center. The transport team from LOCH found the baby in severe respiratory and cardiac distress with potential neurological damage. The team immediately intubated the infant, started mechanical ventilation and heating, and corrected his hypoglycemia. The baby was treated at the neonatal intensive care unit (NICU) at LOCH. Neurosonography showed that he had not sustained any severe cerebral injury and he was discharged after 32 days, in satisfactory condition and weighing approximately 5 pounds. This little boy owes his happy ending to the knowledge and skills demonstrated by the transport and NICU medical teams—medical professionals who were able to translate the training they received through the L’viv/Detroit partnership and AIHA’s Neonatal Resuscitation Program into effective management of his critical case.

Nursing

When Natalia Florina attended her first session of the International Nursing Leadership Institute, she was intimidated by the accomplishments of some of the other participants. But she used the opportunity to learn from them and went on to form the Nursing Association of the City of Kharkiv and Kharkiv Oblast. “Many of the INLI sessions that year were devoted to the formation of professional associations,” Florina says. “So I had an excellent opportunity to get the knowledge I needed, along with the support of my more experienced colleagues, which ultimately inspired me to form the association in Kharkiv.” The organization’s work is focused on improving nurses’ skills and training. Florina, a midwife, has also been successful in the area of obstetrics and gynecology. Her project to reduce sexually transmitted infections among students, which she began working on at INLI in 2001, is still operating and producing positive results. The outreach efforts take place regularly at the Kharkiv Aerospace University Primary Healthcare Clinic in the form of discussions, lectures, surveys, and individual walk-in meetings. The program also emphasizes early detection of STIs, which reduces the transmission rate of these diseases and minimizes their effects. “We have not yet been successful with all the diseases,” Florina explains. “But the most important thing is that we have put together a good team and started working actively to educate students on issues of preventing HIV and STIs. This is gradually changing young people’s attitudes toward these problems. They are becoming more responsible

about their behavior and health.” (Additional information about Florina’s successes and those of another INLI graduate are in *Appendix C*.)

Emergency and Disaster Medicine

On August 19, 2001, one of Ukraine’s worst mining disasters occurred, killing 54 coal miners and leaving 22 others severely injured. Ninety of the rescue workers who responded had completed the full EMS training curriculum offered by the Donetsk EMS Training Center. The EMS teams delivered survivors to area hospitals, including Donetsk Oblast Trauma Hospital, an AIHA partner institution where five of the most seriously wounded victims were successfully treated. In recognition of their professionalism and for the disaster management skills demonstrated during the emergency efforts, 10 nurses and six physicians who had trained at the Donetsk EMSTC and work at the trauma hospital received recognition from Ukraine’s President.

Healthcare Knowledge Resources

Following the successful implementation of diagnostic and treatment guidelines for acute bronchitis at the Aerospace University Clinic in Kharkiv, Ukraine, a team of physicians and the Learning Resource Center staff from the Kharkiv Oblast Student Hospital collaborated with three other clinics to introduce the new protocol elsewhere. The primary healthcare clinics at the Auto Transportation University, the Agriculture University, and the National Law Academy implemented the new guideline with impressive results. The findings of six- and nine-month follow up evaluations showed that the rates of unnecessary antibiotic therapy have dropped to 17 percent at the Auto Transportation University, to 0 percent at the Agriculture University, and to 25 percent at the National Law Academy. The hospitalization rate for acute bronchitis at all three clinics dropped to zero.

D. AIHA CONFERENCES

An important and signature component of AIHA’s partnership program is the regional and international conferences that provide a forum for networking and sharing ideas and successes among partners. West NIS partners actively participated in these conferences, which provided them with opportunities to practice professional presentation skills, to meet colleagues from other regions and countries with similar experiences, and to gain information and skills on topics of common interest. Regional conferences specifically for West NIS partnerships further promoted cooperation among partners in the neighboring countries of Belarus, Moldova, and Ukraine, building bridges between healthcare providers and communities. Between 1999 and 2004, dozens of West NIS partners benefited from their participation in the annual partnership conferences, three West NIS regional partnership meetings, and a final West NIS sustainability conference convened by AIHA. These are briefly described below in reverse chronological order.

2004 West NIS Regional Sustainability Conference & Workshop, Kiev, Ukraine, May 18-20, 2004

AIHA and USAID held a three-day conference and workshop to mark the graduation of the eight primary healthcare partnerships initiated in the West NIS in 1999 and 2000. The conference brought together representatives from regional health-related institutions involved in AIHA partnerships and their counterparts from the US to highlight their joint accomplishments, share best practices, and discuss lessons learned. The event included a skills-building workshop that offered sessions on community mobilization, grant writing, and other methods of supporting the further development of partner institutions and improving the sustainability and replication of the innovative community-based programs they had initiated.

2002 AIHA Annual Partnership Conference, Washington, DC, July 31- August 2, 2002

In addition to celebrating the organization’s 10-year anniversary, the 2002 conference focused on disseminating partnership successes and discussing the emerging health challenges created by HIV/AIDS. More than 500 health professionals representing current and graduated partnerships participated. Graduating

partnerships—including the Minsk, Belarus/New Brunswick, New Jersey partnership—were recognized during a ceremony on the conference’s first day.

West NIS Regional Partnership Conference, Kiev, Ukraine, April 24- 25, 2002

Some 70 representatives from PHC partnerships in West NIS and their US counterparts gathered to present their accomplishments, share their best practices, and discuss plans for future development. The partners were also introduced to the AIHA monitoring and evaluation framework and given the opportunity to discuss their workplans for FY2003.

2001 AIHA Annual Partnership Conference, Washington, DC, April 9-11, 2001

The conference had as its theme, *Primary and Community-Based Healthcare Solutions: Building on Models of Change*, in keeping with AIHA’s programmatic emphasis on developing community-based approaches to improving the quality of primary healthcare in the NIS and CEE. Conference participants included key healthcare leaders from 18 countries, including the ministers of health of Kazakhstan and Tajikistan, and more than 500 health professionals from the NIS, CEE, and United States. AIHA partners participated on panels throughout the conference to present their successful healthcare models and ways they have met the challenge of providing primary healthcare services and training family physicians. Additional topics included: health promotion and education, effective methods of conducting needs assessments, the development of clinical practice guidelines, methods to encourage community involvement, infection control and multidrug-resistant strains of infections, integrated approaches to women’s health services, and mother-to-child transmission of HIV.

West NIS Regional Partnership Conference, Kiev, Ukraine, Feb. 21- 22, 2001

Representatives from all West NIS community-based primary-care partnerships attended the regional conference. Representatives from each partnership presented their activities over the past year. Representatives from the ministries of health of Belarus, Moldova, and Ukraine each presented on the current status of healthcare in their countries and emphasized the importance of the PHC clinics as pilot sites for further development and improvement of healthcare service delivery. The conference included breakout sessions in which the partners discussed the following topics: development of programs to train primary care residents, clinical practice guidelines and reference manuals, financing and financial management in PHC centers, methods of gaining community support, patient flow in an outpatient setting, and patient registration and data collection.

West NIS Regional Meeting, Kiev, Ukraine, February 15-17, 2000

Representatives from all West NIS community-based primary-care partnerships attended the AIHA conference *Delivering Community-Based Primary Care Services in the 21st Century*. Representatives from each partnership presented their workplan to other West NIS partners and discussed the following topics: evaluating the delivery of primary care services; disease prevention, health promotion and wellness; financing a primary healthcare system; integrating mental health in basic primary healthcare services; and primary care residency training.

2000 AIHA Annual Partnership Conference, Budapest, Hungary, July 17- 19, 2000

More than 250 healthcare professionals from Eurasia and the United States participated in the conference on *Developing Common Strategies for Improving Primary Care and Community Health*. The event offered plenary presentations and breakout sessions focusing on community mobilization, health promotion strategies, and practical skills-building for primary care providers. Partnerships also met in sub-regional sessions to share best practices and facilitate coordination on issues related to workplan implementation, primary healthcare CPGs, and performance indicators and outcomes. Throughout the conference, partners had opportunities to meet and work on their respective workplans and US partners attended meetings on administrative and financial issues and on AIHA’s evaluation activities specially designed for partnership coordinators.

1999 AIHA Annual Partnership Conference, Washington, DC, November 14- 16, 1999

Representatives of all current partnerships attended AIHA's 1999 Annual Partnership Conference, entitled "Partnering for Healthier Communities." Approximately 700 US, NIS, and CEE partners and distinguished guests gathered for the event, which focused on past successes of partnerships as well as future directions in primary healthcare and community health for new NIS partnerships. Selected partners also participated in pre- and post-conference meetings addressing health management education, infection control, women's health, and emergency medical services.

D. MID-TERM EVALUATION

In March 2000, an independent team of senior academicians, health service researchers, and health professionals began convening as the Continuing Evaluation Panel (CEP) to conduct a comprehensive examination of AIHA's partnership program. In a unique approach to evaluation endorsed by USAID, which was closely involved in the process, the CEP spent one year assessing accomplishments of the AIHA Partnership Program and evaluating the sustainability and ongoing impact of graduated partnerships, as well as the mid-term status of partnerships established since 1999.

During the assessment the CEP visited 10 West NIS partnership locations and conducted structured interviews with 35 individuals associated with the AIHA partnership program in the West NIS. Based on the gathered qualitative data, the panel concluded that "the AIHA Partnership Program has been highly successful and is an exemplar of the use of the partnership model in international development [p.5]." The evaluators discovered that most of the original partnership programs continued despite termination of AIHA program support and that "many of them have expanded their work to additional sites and have become increasingly influential in the development of new health services, better education for health professionals, and improved governmental decision-making in healthcare [p.5]."

In particular, the CEP found that the original partnerships had been successful in: connecting NIS and CEE health institutions with current medical science and practice; developing healthcare leaders in the NIS and CEE; and "influencing the development of health policies that promote continued advances in healthcare, lead to more cost-effective use of services, and engage consumers in efforts to advocate for their own health" [p. 7]. The evaluators were impressed with how well the original partnerships had not just met but, in many cases, far exceeded their goals. They included in their evaluation report examples of the ripple effects that AIHA partnership activities could have:

While data collection and outcome measurement are problems throughout the NIS/CEE, efforts are underway to improve them. An example from the original partnerships is Odessa (Ukraine) Regional Hospital, which has developed selected quality of care markers including infections and length of stay. An internal, system-wide data program has been developed to track data related to care provided in the system's 1,120 bed hospital, which has 32,000 to 35,000 admissions a year, and in its women's wellness center, which has served more than 12,000 women. The hospital system has expanded to include smaller, rural hospitals in the region and to serve as a regional data center for Ukraine. [p. 28]

In Ukraine, physicians, nurses and other health professionals have banded together to organize a national advocacy group (Pulse of the Ukraine) for the purpose of sharing information among the membership and working with local and national political leaders to improve health and health care. A number of the members are involved in AIHA partnership programs. They view this organization as an important avenue for

promoting health policies that will improve clinical practices and workplace conditions in health care facilities. [p. 36]

The effects of the partnerships, then, only began with the goals laid out in the partnership workplans. Success in changing fundamental attitudes about health care would have larger implications for future reforms. The CEP was impressed that the AIHA partnerships were accomplishing just such a change through “a more rational approach to resource use” and “more positive provider attitudes” [p. 71]. Both the original, hospital-based partnerships and the newer PHC partnerships shared certain characteristics that contributed to this success. Among these were the “valuable and effective” cross-partnership initiatives [p. 7], which continued to grow under the second collaborative agreement; the “programmatic focus on low-cost technology and training;” that could be sustained even under conditions of limited resources; and the “non-prescriptive, peer-based approaches to decision-making,” which raised morale and helped develop effective leadership within partner institutions in the West NIS and other areas [p. 6]. Thus, the CEP concluded that “the new community-based programs at the mid-term of their funding are following in the successful trajectory of the original hospital partnerships [p.9]”

The full report of the CEP evaluation can be found at the following link on AIHA’s Web site:
<http://www.aiha.com/resources/Doc/CEP%20Final%20report.pdf>

IV. CONCLUSIONS

During 1998-2004, together with its West NIS and US partners, AIHA implemented a successful health partnership program that leaves behind a legacy of new institutions and services that are making valuable contributions to improving healthcare delivery in the countries of Belarus, Moldova, and Ukraine. In addition to the many facilities and services that provide tangible evidence of success, the partnerships effected change on a more fundamental level. They enabled participants to develop new conceptual frameworks and gain new knowledge and skills, bringing about a profound shift in thinking about health and healthcare. Partnerships with US institutions encouraged and facilitated the introduction of difficult but necessary changes and created a consensus among the West NIS professionals involved about the directions those changes should take.

As the summaries of the partnerships and cross-partnership programs in this report indicate, the West NIS Health Partnerships Program achieved success in integration and improvement of primary healthcare services within the targeted communities, in building human and institutional capacity at local and national levels, and in developing leaders and change agents. Throughout the process, AIHA and the partners emphasized the sustainability of programmatic achievements as well as of the relationships forged among partners on both sides of the ocean and within the region.

Integration and Improvement of Services

AIHA partnerships and cross-partnership activities have done much to bring about more integrated healthcare services in West NIS countries that are also more responsive to the needs of the population. They have emphasized a comprehensive approach to health that is community-based and focused on primary care and prevention. With this more integrated and collaborative approach among healthcare professionals, providers have gained a more expansive view of their patients' health as well. Consequently, they have significantly increased their emphasis on preventive care, health screenings, and outreach activities. Targeted populations are receiving more comprehensive care through the PHC centers and Women's Wellness Centers and report, overwhelmingly, that the quality of their care has improved.

There have been considerable changes in healthcare practices in West NIS countries related to primary care and women's health. Most partnerships supported the reorientation from specialized care to primary care, where comprehensive services cover the spectrum from screening and prevention to disease management and treatment. They integrated previously separate services, such as mental health and dental care, into primary care. AIHA's partnerships strengthened health promotion, screening for diseases, and patient education and made these an integral part of primary healthcare services. Local communities were involved in assessing needs and promoting healthy behaviors and community outreach became a part of the mandate of healthcare.

Nurses, in particular, have played a key role in improved services as they have taken on increased roles and responsibilities in addition to working more collaboratively with physicians. They are more active in the provision of patient care, are leading community health activities, and strengthening education and training for future cadres of nurses.

A cornerstone of AIHA's approach to improved services is the introduction of concepts and practices in healthcare leadership and management, evidence-based medicine, practice standard reviews, and continuous quality improvement. Knowledge and skills related to these topics have been developed at each partner institution through partnership exchanges and cross-partnership workshops and conferences.

Capacity-building

A central element of the AIHA Health Partnerships Program is the creation of capacity within countries to build on and continue reforms and to address ongoing and new challenges. This is accomplished through training and education activities, including a heavy emphasis on training-of-trainers to create a core group of

future trainers. This approach has been institutionalized in **22 training centers** created through AIHA programs in the West NIS addressing neonatal resuscitation, infection control, emergency and disaster medicine, and primary healthcare. In the case of the NRTCs and EMSTCs, although the centers were established during the previous cooperative agreement period, through AIHA's continued support during this funding period they solidified their status as centers of training excellence receiving official recognition from governments, and continued to expand and sustain their activities. In primary healthcare, training centers were established in Moldova and Ukraine. In Ukraine, a capacity now exists for re-training physicians and nurses in primary care. Moldova has gone one step further as the family medicine training center established through the partnership has quickly evolved to become the only academic center for producing new family practitioners.

Learners, Leaders, and Change Agents

The West NIS healthcare professionals involved in AIHA partnerships and programs have benefited not just from the very relevant technical skills that their American counterparts shared, but from the collaborative learning process that drives partner activities. Thousands of doctors, nurses, and other healthcare professionals received training through AIHA and partner activities between 1998 and 2004. Equally important, these professionals have used their new skills and knowledge to create in-service training programs for their colleagues, as well as more formal educational programs for future doctors and nurses. These professionals have developed a new view of their role, coming to see themselves not just as providers or managers of healthcare, but as educators and catalysts for change.

This is especially the case with the nurses, many of whom now have a new-found professionalism and pride in their profession, in addition to demonstrating critical leadership, educational, and clinical skills. The INLI program greatly contributed to this development as participating nurses were exposed to international nursing leaders and ideas. AIHA's support for nursing association building also encouraged a wider group of nurses to seek higher professional goals.

Sustainability

AIHA and its partners leave behind affordable programs, sustainable institutions, and the human capacity for ongoing education and change. Some of the most significant results of AIHA's program in West NIS are low-cost interventions, such as community education and outreach that have continued after the formal end of the partnerships and yield significant results in early diagnosis and treatment, promotion of healthy lifestyles, and disease prevention.

The partnership program also contributed to sustainability by mobilizing and enabling communities to increasingly take responsibility for their own health matters. These communities are now more likely to be able to identify future problems affecting their community's health and design workable solutions. Partnerships also played a role in accelerating health policy reforms at the national level by creating new institutional capacities and developing model programs that could be scaled up.

In addition, all of the new centers established by AIHA partnerships have been able to continue full activities after funding ended. The Minsk Cardiovascular Wellness Center continues to provide integrated services in cardiovascular disease screening and early detection, education, and counseling services. The model primary care centers created under the Ukrainian and Moldovan partnerships continue to provide quality care to patients, while the Women's Wellness Centers still offer high-quality, comprehensive services to women. The Learning Resource Centers have demonstrated their importance to the healthcare institutions where they are located and succeeded in securing internal and external funding. Other centers established by AIHA partnerships in the previous funding cycle, such as nursing resource centers, emergency medical services training centers, and neonatal resuscitation training centers, have also been able to sustain their activities without AIHA funding.

Building Relationships

One of the most important legacies of the partnership program is the relationships formed between US and West NIS partners, among West NIS and other NIS partners, and among the West NIS partners themselves. If past experience is a guide, these relationships can be expected to last long past the end of the formal partnership arrangements. Some US and West NIS partners may seek new funding to continue their joint efforts. Chances are very good that the West NIS partners will continue to communicate with and learn from AIHA's wide family of partnerships for many years to come. For the West NIS partners themselves, participation in the AIHA program has brought them together through shared experiences and shared successes. The goodwill exhibited by the individuals at all levels of the partnerships has resulted in a lasting and valuable contribution to international understanding and respect.

Remaining Challenges

While AIHA and its partners have made important contributions to the efforts of USAID and the ministries of health of West NIS countries to improve healthcare delivery for the citizens of the three countries, the health sector continues to face challenges in achieving universal quality primary care. While the model centers and programs developed through the partnerships and cross-partnership programs have fostered significant changes within the targeted cities and regions, as well as at the national level in some cases, the limitations of scope and funding have prevented wider replication. A related challenge is to develop a more widespread acceptance of the primary healthcare model throughout the region, together with increased numbers of health professionals trained in primary care/family medicine and facilities equipped to provide those services. It will require, in the case of Ukraine, faculty and curriculum development to create a national standardized university-level training program in family medicine. In Moldova, the partnership contributed to the development of such a training program at the state university.

Another remaining challenge is the continued expansion of the role of the nurse in primary care. While great strides have been made through the partnerships and AIHA's nursing program in establishing nurses as key personnel within the model primary care centers, the profession has not yet been developed to its full potential. Improvements are still needed in nursing education and certification, and nursing professionals need to be re-trained and provided with opportunities to use their advanced skills. These changes need to be implemented on a wider scale than was possible within the scope of AIHA's program, with the support of national governments.

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APPENDIX A: PHC LESSONS LEARNED CASE ILLUSTRATIONS

Case 1: Political Support for Developing Family Medicine Centers (Chisinau/Norfolk)

I. Abstract

The overall goal of the partnership was to improve the health status of the population of Moldova by expanding community-based primary care and family medicine training programs. This case illustration describes the partners' experience in gaining and sustaining political support from the Parliament of Moldova, government agencies, and the national and local authorities to accomplish this goal. Partnership activities began at a time when the Parliament and the Ministry of Health of the Republic of Moldova had already developed a legislative framework for a primary healthcare system built upon family medicine principles. In 1997, the MOH issued two plans: 1) "Reforming the Health Care System in the Republic of Moldova in the New Economical Conditions for the Period 1997-2003" and 2) Act 200, "Primary Health Care Development." That same year, the government passed Resolution 1134, "Reforming the System of Primary Health Care in the Republic." Within this context, the partnership established two model primary care centers. The Pro San Family Medicine Center in Botanica District opened in 2001, and the University Primary Healthcare Center opened in 2003.

Political support at the national level was essential for facilitating a primary health services delivery model with the legal status and government sanction to ensure its acceptability, sustainability and replicability. Support was also essential for establishing a solid foundation and framework for training and re-training a cadre of competent family medicine health professionals.

II. Partnership Institutions

US: The Eastern Virginia Medical School (EVMS) is a community-based, nonprofit medical school located in Norfolk, Va. EVMS was supported by the Portsmouth Family Medicine Residency Program, the Norfolk Department of Public Health, the Portsmouth Community Health Center, the Ghent Medicine Residency Program, Sentra Health Care and the North Carolina Partnership for Peace Program.

Moldova: The Ministry of Health, Nicolae Testemitanu State University of Medicine and Pharmacy (SMPU), the City of Chisinau Department of Health, the Botanica District Health Administration and the Consultative Diagnostic Center of the Botanica District participated.

III. Problem(s) to be Addressed

The Chisinau/Norfolk partnership must be viewed against the broader background of events transpiring in the healthcare system of the Republic of Moldova as a whole. The Ministry of Health had been pursuing a strategy of national healthcare reform in the country since the mid-late 1990's through governmental decrees and MOH decisions. The culmination of this work was an August 1998 consensus meeting held in Chisinau on healthcare reform sponsored by the MOH and attended by representatives of the Ministry of Finance, the Ministry of Economy and Reforms, the State University of Medicine and Pharmacy, national and regional health authorities, and the National Public Health and Health Management Center. The World Health Organization (WHO), the United Nations Children's Fund, and the International Bank for Reconstruction and Development (World Bank) also sent representatives.

Key healthcare system reform strategies that emerged from this meeting included: 1) the implementation of a national health promotion and disease prevention program to educate individuals about health and lifestyle choices, 2) a shift in scarce resources from expensive hospital-based care to community-based primary health

care, and 3) an expanded role for family physicians and other key primary care practitioners, including nurses and health educators.

In fact, at this time, a model of providing primary healthcare by family physicians did not exist in the Republic of Moldova. Primary healthcare was provided by polyclinic specialists: general practitioners, pediatricians, obstetricians and gynecologists. Moreover, lack of community participation, and major economic, philosophical and technical challenges impeded the development of family medicine as a system of care. Opportunities for training were limited. Practical skills teaching and assessment, using modern “standardized patient” methods, did not exist.

IV. Approaches Taken to Address the Problem(s)

To keep step with the reforms, the partnership developed a work plan with explicit goals and priorities related to the establishment of two model community-based family medicine clinics focused on healthcare delivery, health promotion and disease prevention. Such ambitious and rapid reorientation of the healthcare system towards family medicine would pose a challenge to even more resource rich nations, let alone to a nation like the Republic of Moldova with scarce resources to devote to healthcare. To successfully develop and implement an innovative model to deliver healthcare services and to build capacity to train family medicine practitioners, the partners needed political support from Moldovan authorities in the following areas:

- Renovation and provision of additional medical and educational equipment for the two new pilot family medicine sites.
- Improvement of the existing family medicine training and retraining programs (e.g., new opportunities for family medicine faculty to increase expertise in family medicine, more modern educational tools such as computer-based training software, practice guidelines, books, teaching mannequins and audio-visual training materials).
- Development of a professional certification program in family medicine.
- Development of an accreditation process for ambulatory healthcare facilities.
- Promotion of family medicine as a profession.

Key approaches for implementing a family medicine delivery system were:

1. **Involvement of local government:** Government representatives took an active part in the partnership activities from the very first stage. As the work plan was being developed, partnership coordinators and AIHA representatives held meetings with parliament members, the Vice Prime Minister of the Republic, the Minister of Health, the Mayor of the city of Chisinau, the city health department and members of the district administration. During these meetings, government representatives were involved in discussion of partnership goals and objectives. Main directions for partnership activities were elaborated and agreed upon. The importance and complexity of the problems to resolve were emphasized, and the authorities granted their support to partnership activities. In addition, policy makers were invited to participate in AIHA-sponsored conferences, workshops and round-table discussions, enabling them to gain a broader vision of healthcare development internationally.
2. **Partnership exchanges:** To develop a common vision regarding the organization of a primary care clinic, city and district administrators responsible for health and social issues participated in exchanges to the US, visited partnership institutions, and met with representatives of the Virginia state government. These exchanges served as opportunities to observe the US healthcare system, understand the role of the community in resolving healthcare problems, and learn about the system used to train health professionals at Eastern Virginia Medical School.
3. **Development of two model clinic sites:** The first clinical site selected by the partners was the Botanica Territorial Medical Association. This particular facility was chosen based on the Association’s prior participation in an AIHA partnership (1994-1999) that had established a Women’s Wellness Center. The goal of the new partnership was to expand capacity of the Botanica Territorial Medical Association to

provide comprehensive primary care services by adding family medicine services. The new Pro San Family Medicine Clinic was developed as a pilot site to serve a population of nearly 12,000 people. The city department of health not only provided the facility for the Pro San center but also funded the renovations. The partners decided to pilot the new clinic, refine it as needed and replicate it throughout Chisinau with support from local authorities. The pilot site was also to serve as a training site for the University Residency Program in Family Medicine.

However, this new model center alone could not meet the demand for training and re-training medical professionals in family medicine. The Government of Moldova issued Act 177, “Developing the University Community-Based Family Medicine Center Located in the Campus of the State University of Medicine and Pharmacy,” on February 28, 2001. According to the act, funding was obtained from the state budget for renovating the building on the premises of the university center. The World Bank also provided funds for renovation. Thus, the partners established a second site, the University Primary Care Clinic at the University of Medicine and Pharmacy’s former hospice facility. The new clinic was intended to: 1) expand capacity to provide primary care services to the assigned population of 12,000 people, and 2) serve as a clinical site to train faculty and residents, and to re-train physicians and other healthcare professionals in family medicine.

Both clinics were intended to disseminate the philosophy and concept of family medicine-based primary care among community members and other healthcare providers. The ministry of health helped to ensure collaboration between the two centers and other medical institutions of the city.

4. **Community advisory boards (CABs):** CABs were established for each of the two new clinics. Each board included representatives of local authorities, NGOs, schools, businesses, faith-based organizations and partnership institutions. Each board met on a regular basis to discuss planning and implementation.
 - The University Center Community Advisory Board included Buyukan District local authorities who supported the center’s development and disseminated information to the public about services provided. Community involvement resulted in an agreement with a private firm that provided furniture for the center on deferred payments. Botanica District community involvement mobilized volunteers who helped renovate the premises and set up a veterans’ support group.
 - The Pro San Center Community Advisory Board also enjoyed support by local authorities who assisted in providing resources, including volunteers for the center’s development and implementation, and by informing the community about the goals and objectives of the model center’s development.

V. Results/Achievements

Regular meetings and collaboration among partnership coordinators and representatives of AIHA, the Chairman of Parliament, the Prime Minister and Vice Prime Minister, representatives of the Parliament Committee on Health Care and Social Policy, the Minister of Health, and the Mayor of Chisinau enabled the stakeholders to:

1. Remain well informed about the latest developments in healthcare reform in the country and thus to plan activities accordingly.
2. Reach agreement and develop a common approach for implementing the latest advances in medical education and skills training (e.g., telemedicine, standardized-patient training model).
3. Define the legal status of the model centers and designate them as training sites.
4. Receive funding necessary for renovation of the selected sites. By order of Chisinau Mayor’s Office, a detailed plan of reconstruction of the facility in Botanica District was developed, and funding was provided. In the process of program implementation, the model center was given 12 rooms instead

of six, as was originally planned. This change was due to the very active involvement of the head of the city health administration and allowed the center to expand to include a Learning Recourse Center and educational rooms.

5. Determine the organizational structure and receive substantial funding for the renovation of an old university hospice building via the Ministry of Health's decree, "On the Establishment of a University Primary Health Care Clinic at the State Medical and Pharmaceutical University Named After N. Testemitsanu."
6. Receive funding from the municipal budget to support the operation of the two centers. The city health administration assigned populations to both clinics and allocated funding to cover the scope of health services as well as staff salaries and building maintenance costs.
7. Attract funds from the World Bank, Soros Foundation and other international organizations to compliment partnership activities and purchase additional equipment and supplies.
8. Mobilize local resources to play an active role in designing and implementing a model of healthcare services delivery tailored to the community's needs.
9. Establish a Community Advisory Board for each center to discuss community-health-related problems and develop strategies to solve them.

VI. Lessons Learned and Conclusions

Political support is crucial for launching a model program that will be accepted locally and nationally, for obtaining funding for renovations and equipment, and for establishing legal status. Policy makers and local and national government authorities need to be involved in program development from the outset.

In this partnership's experience, political support was gained through 1) open discussion of initial goals and objectives, 2) a common vision mutually developed, 3) regular meetings held to inform stakeholders on program progress, challenges and accomplishments, 4) partnership exchanges, and 5) participation in AIHA-supported regional and region-wide conferences and meetings.

Broad political support and success of partnership activities helped the National Health Care Assessment and Certification Committee work out certification standards for primary health centers in the Republic of Moldova. AIHA played a vital role in engaging policy makers and offering a broader perspective based on the experience of other countries and programs. Cross-partnership seminars and conferences made it possible for the Moldovan partners to assess other partnerships' achievements, share experiences and evaluate partnership goals. Cross-partnership events also informed strategies for refining partnership activities and for addressing strategic concerns and politically significant issues.

Case 2: Clinical Practice Guidelines (Kiev/Philadelphia)

I. Abstract

The overall goal of the partnership was to develop and improve community-based primary healthcare in the Darnitskii district of Kiev to serve as a model for the country. Based on data analysis, the target condition to be addressed was arterial hypertension (AH), a risk factor for serious conditions that include heart attack, brain circulation disorders and renal damage. The ultimate aim was to increase the quality of care delivered to patients with AH as well as to detect risk factors and implement actions to eliminate them. This case study describes: 1) the process the primary healthcare staff and US partners engaged in to ensure quality control of AH services, 2) development and implementation of clinical practice guidelines (CPGs) for early detection, 3) training offered to facilitate sustaining the guidelines, and 4) challenges and successes experienced during the change process.

II. Partnership Institutions

US: Temple University Center for Healthcare Management and Research was supported by the University Primary Care Institute; the Departments of Family Medicine, Health Studies/Public Health, and Risk Insurance and Healthcare Management; Widener University; Crozer-Keystone Health System; and the Health Federation of Philadelphia.

Ukraine: Kiev City Health Administration, Darnitsky District Central Polyclinic, Darnitsky District Family Medicine Center and the Kiev Postgraduate Medical Academy participated.

III. Problem(s) to be Addressed

In October 2002, the Kiev/Philadelphia partnership opened a Family Medicine Center in the Darnitskii district of Kiev. The center serves a catchment area with a population of approximately 7,600 adults ages 18 to 70 (3,500 male; 4,100 female). Of the total adult population, 30 percent are ages 41 to 50. A unique feature of the center is a strong emphasis on disease prevention and early detection.

The center's routine data collection identifies the most common patient conditions. Analysis of statistical data indicated a high prevalence of cardiovascular risk factors:

- Ischemia (blockage of blood and oxygen to the heart), one percent
- Overweight, five percent
- Smoking, more than 30 percent
- Drinking more than one drink/day, 70 percent

Elevated arterial pressure was also noted in 20 percent of adults. Baseline blood pressure readings for these patients ranged from 140/90 to 220/110 (normal blood pressure is about 120/80). In 2002, 60 percent of deaths (18/30) in the catchment area were caused by ischemic heart disease. Early detection of AH, and its prevention and treatment, play a critical role in decreased cardiovascular morbidity and mortality.

Because high blood pressure is usually asymptomatic, individuals with high pressure often do not know they have a problem and thus do not attempt to treat it. The partners provided free blood pressure checks during a World Health Day celebration and collected the data. These data confirmed the substantial number of individuals who were unaware they had a problem. The results of the screening showed that 20 percent of people with high blood pressure did not know about their problem and had never discussed it with a physician. There are national programs to control arterial hypertension and there have also been special decrees issued by the Ukraine Ministry of Health. Nevertheless, many individuals who would benefit from treatment are not getting it. The partners felt that the existing "orders from above" style of management in healthcare (decrees, regulations and legislative acts) was not taking advantage of the strengths and benefits of clinical practice guidelines and standards that could be developed and implemented locally. Having reviewed the existing statistical data on morbidity and mortality in the area on the prevalence of AH in the catchment area, the partnership embarked on development of an action plan for screening, monitoring and control of AH.

IV. Approaches Taken to Address the Problem(s)

A number of partnership exchanges were devoted to methodological issues of CPG adaptation. US partners and primary healthcare staff from Ukraine jointly conducted sample chart audits, discussed clinical practices in the country, and, with the help of Learning Resource Center staff, collected resources and information about AH protocols. Partners conducted case conferences where they developed a common understanding of the best methods to detect and treat AH, based on medical evidence.

After a series of such collaborative case conferences, a task force consisting of two doctors and two nurses was formed at the primary healthcare center to improve quality of care for the population diagnosed with or at risk of AH. One objective of this group was the formal development and implementation of clinical practice guidelines on AH. The outcome expected was an increase in the percentage of patients who reduced their blood pressure below 140/90.

Members of the task force conducted AH screening, identified patients with hypertension and offered them an opportunity to participate in the testing of the new clinical approach. A special form was designed to be attached to the patient's chart to ensure that patient monitoring would be conducted. Once every three months the group conducted chart audits.

At first the suggested action plan was approved with enthusiasm. But as the Ukrainian team moved ahead, they faced a number of difficulties:

- Team members lacked experience in analytical work. This was resolved with the help of the training conducted by the US partners. Continuous practice also led to significant improvement of staff skills.
- When the group had been working for a while, a lack of staff initiative was noted. Mechanisms of moral and material incentives were suggested for project participants. These included ranking the best doctor and best nurse, free trade union tours and salary incentives. The partnership also spent a lot of effort on creation of a favorable psychological environment for team members and for the center in general. Exchanges and partnership meetings devoted to team building methodologies took place.
- Implementation of new CPGs demands additional funds for paperwork and time. The Ukrainian partners established a charity foundation to help cover the cost of supplies.
- Because management of AH involves many lifestyle changes, patients who participated in the project established a patient support group. This also helped staff and patients to recognize the patient's role and responsibility in health maintenance.
- Up-to-date specialized literature was lacking, but Internet connectivity at the center has partially solved this problem.
- The greatest challenge was coordination of new CPG implementation with the health authorities. It is very difficult to win approval of new CPGs from health administrations at the rayon, oblast and national levels and require a great deal of time and effort.

V. Results/Achievements

The CPG for AH focused on 1) increasing patients' responsibility for his/her health, 2) utilizing evidence-based therapeutic principles, 3) monitoring blood pressure treatment effectiveness, and 4) diagnosing and treating AH according to a systematic approach. The following results were achieved:

1. Thirty percent of patients who participated in the project kept their blood pressure below 140/90 during six months of the monitoring period. This proved to be the best moral incentive for the staff who participated in the task force.
2. Quality control of the CPGs is conducted according to the following system: The medical director and heads of the departments monitor current clinical practices on an ongoing basis. This includes comparing the approaches the locally developed CPGs with CPGs developed around the world, and conducting chart audits. Chart audits are conducted quarterly and reports are written by management to describe findings. The staff of the center then discusses the reports, defines problems and potential causes, and formulates and sets targeted results. A task force is formed to evaluate different stages or components of the clinical process, distinguish weak points, determine strategies to resolve problems, and identify additional data needed for analysis. An adapted CPG is then implemented. The team periodically monitors the output indicators (audit of 100 charts monthly), evaluated changes, and develops a further quality control plan (acceptance or refusal of the CPG)

VI. Lessons Learned and Conclusions

Continuous revision and adaptation of CPGs is a critical evidence-based quality control tool. It is vitally important for the management of medical institutions to think about the development of CPGs as an ongoing process that requires continuous review and monitoring, including written evaluation and data analysis. CPGs can help doctors and nurses improve their work, create opportunities for learning, increase customer satisfaction, and improve health outcomes, but they must be kept current.

Case 3: Patient Education (Uzhgorod/Corvallis)

I. Abstract

Patient education represents new approach to medicine in the NIS. Patient and community education about wellness and disease prevention have not been explored in most areas. The primary goal of the Uzhgorod/Corvallis partnership was to improve access and quality of community-based primary healthcare and the overall health status of the population in the Zakarpatye Oblast through patient education, with particular focus on patients' responsibility for healthy behaviors and lifestyle changes. The overall approach of the Family Medicine Center established by the partnership was to provide patients with relevant and usable health information through individual counseling, group education, and family and community involvement. The center initially planned to focus its education efforts on heart disease, diabetes, cancer, lung disease and other chronic non-infectious diseases, but expanded the scope of its programs to include sex education and road-safety components for youth due to community need. This case study describes how family medicine professionals established a patient education and health outreach programs in Velykiy Berezny Rayon, a rural area of Ukraine.

II. Partnership Institutions

US: Corvallis Sister Cities Association collaborated with the Oregon Health Sciences University Department of Family Medicine, Corvallis Family Medicine, Western Oregon University Department of Health Education, Benton County Health Department, Benton County Community Outreach, Benton Hospice, Good Samaritan Hospital, Corvallis Clinic, Oregon State University Health Care Administration Program and Oregon Academy of Family.

Ukraine: The Zakarpatska Oblast Hospital, Central Velykiy Berezny Rayon Hospital, and Zakarpatska Oblast Health Administration participated. Zakarpatska Oblast Hospital serves the population of Zakarpatska Oblast and Central Velykiy Berezny Rayon Hospital serves Velykiy Berezny Rayon, a rural area on Ukraine's border with Hungary.

III. Problem(s) to be Addressed

In 1999, the leading causes of death in Ukraine were cardiovascular diseases (899.8 deaths per 100,000 people) and respiratory disorders (74.3 deaths per 100,000 people). To identify the prevalence of major risk behaviors in the community, the partnership designed and conducted two initial surveys:

1. The first survey was targeted at assessing health risk behaviors among 13-18 year-old high-school students of Velykiy Berezny. Survey results demonstrated that smoking and alcohol abuse were the most prevalent risk factors among this population:
 - More than 76 percent of respondents had tried smoking.
 - Among respondents, 19.4 percent smoked on a regular basis.

- Of special concern was an early onset of smoking; most of the adolescents who smoked had started smoking at 13-14 years of age.
- Thirty-seven percent of respondents drank alcohol once or twice in a month.
- Twelve percent had tried smoking marijuana.

Scores on knowledge about safe sexual behaviors were also low, indicating another area where health outreach efforts were necessary.

2. The second survey focused on the prevalence of smoking among adults in Velykiy Berezny:
 - Fifty-one percent of respondents smoked on a regular basis.
 - Among smokers, 60.9 percent indicated that they would like to quit smoking.

These data confirmed that smoking—a major risk factor for both cardiovascular and respiratory disease—was prevalent in Velykiy Berezny. It also permitted identification of some additional priority areas for health education and health promotion activities, including alcohol abuse prevention and sex education for youth.

More anecdotal evidence indicated that patients often lacked even basic information about how to manage their chronic conditions. For example, healthcare professionals noted that many patients with diabetes did not know that living with diabetes requires specific lifestyle modifications that can prevent complications.

The partners were, therefore, interested in addressing a broad range of health issues. The unifying need was to empower individuals to take more responsibility for preventing disease and for managing their own health.

IV. Approaches Taken to Address the Problem(s)

In order to provide greater community involvement in planning and implementing health education activities, a Community Health Coalition (CHC) that united active and energetic people from the community was established in early 2000. Coalition members represented different community groups and included health professionals, local authorities, leaders of youth organizations, teachers, high school students, representatives of NGOs and members of religious organizations. It was believed that such a coalition was essential to reaching as many individuals from as many different segments of society as possible.

Health education programs are more effective when various approaches – from individual patient education sessions conducted by a physician to community-wide campaigns – are implemented simultaneously. Therefore, the FMC staff and the CHC developed a multi-pronged approach for implementing health education programs:

1. Community-based health education campaigns:

- An Uzhgorod and Velykiy Berezny Youth Smoking Prevention Coalition, including a broad range of community members, was formed in the fall of 2002 to raise awareness about the risks and dangers of smoking. An anti-smoking peer mentor group was established for youth.
- Sex education programs were conducted for high school students, and 400 brochures were distributed.
- After observing the traffic conditions children contend with on their walk to school, the partners launched a road safety campaign, Reflect-a-Life. Staff from the Velykiy Berezny FMC administered a road safety survey among area youth. The survey results were used to create road safety curricula to support parents and educators in teaching children about road safety. The partners also distributed red reflectors to children to wear or attach to their book bags.

2. **Collaboration with local authorities.** For example, the CHC actively participated in meetings of the district council in which they discussed various health promotion needs.

3. **Cooperation with local media to reach the community.** The local newspaper , *Karpatska Zirka* (Carpathian Star), introduced a regular column, *Your Health*, in which health professionals from the Family Medicine Clinic published materials about healthy lifestyles and disease prevention, and offered advice to patients with chronic and acute diseases.
4. **Education of patients served by the Family Medicine Clinic.** The clinic staff developed and implemented educational programs for patients with bronchial asthma and diabetes. Classes are regularly held at the Healthy Lifestyle Office of the Family Medicine Clinic. Through this office, patients can also use Internet services to search for health information.
5. **Development of a healthy lifestyles curriculum for teachers.** The results of the survey of high-school students were used to develop a healthy lifestyles curriculum for teachers. In June 2002, the partners held a *Healthy Lifestyles Conference* where they unveiled the curriculum to teachers from Velykiy Berezny and Uzhgorod.
6. **Continuing education for health professionals.** The partnership found that even healthcare professionals lacked the skills to undertake patient education and health promotion campaigns. The Uzhghorod-Corvallis partnership therefore conducted a series of conferences for FMC staff where health educators from Corvallis presented sessions about how to teach patients to manage diabetes and asthma as well as other chronic diseases. Physicians and nurses of the FMC conducted nursing conferences on patient education, discussed community health problems and developed strategies for patient education.

V. Results/Achievements

Health education programs, and especially patient education programs, have proven to be very successful and popular in the community. Before the initiation of these programs, many patients lacked even basic information about how to manage their chronic conditions. Group classes for diabetics, in which nurses teach patients how to administer insulin shots, care for feet, and measure blood-sugar levels, turned out to be of great interest to patients. During these classes patients also share their problems and discuss best approaches to disease management.

Partnership health education efforts achieved the following:

- Community-based access to health education services and resources were expanded to meet patients' ongoing needs for information, educational programs and written materials.
- Education about road safety increased awareness and sensitivity among youth about accident prevention.
- Fifty teachers and 400 school children participated in a smoking cessation program.
- Due to the efforts of the anti-smoking peer mentor group, local authorities strengthened control over the illegal sales of tobacco and alcohol to teenagers.

VI. Lessons Learned and Conclusions

As the partnership worked to develop a health education program it was recognized that patient education had not been a high priority in the country. Nevertheless, partners received positive feedback from the community and local authorities, reinforcing the need for, and interest in, these types of initiatives.

Several factors that impeded both development and implementation of the health promotion campaigns were identified. First, the knowledge or skills needed for effective patient education interventions, or for organizing community-health-promotion campaigns, were lacking. Skills building opportunities in aspects of community outreach for health professionals and other community leaders are essential if health education programs are to succeed and to grow. Second, inadequate funding, scarce resources and lack of logistical support hampered

health promotion activities. Human resources were mobilized through cooperation with local media, schools and other community organizations, but it was still necessary for the increased emphasis on health outreach and education activities to be reflected in funding. Finally, patients who live far from the clinic could not be easily reached by healthcare professionals; others can attend educational classes only on weekends or after work. Therefore, patient education must be tailored to the needs of individual patients.

Analyzing the factors that helped create an effective health education program, partners identified the following key elements:

- Structured patient-education training programs for healthcare professionals. The training should stress different patient education approaches and methods.
- Development of visual aids for patient education (e.g., videos, brochures, newsletters, posters).
- Increased funding for patient education programs.
- Active use of the media and other community partners in conducting health education campaigns.

To be effective, patient education must receive targeted and sustained attention. While health professionals play a vital leadership role in patient education, mass media, local businesses, regional administration, teachers, representatives of religious organizations, and representatives of various NGOs are also necessary in contributing to long-term success.

APPENDIX B: LEARNING RESOURCE CENTERS

Lessons Learned

A decade of experience in setting up and guiding the activities of the Learning Resource Centers has highlighted several important lessons and factors that contribute to the LRC success. Among the most critical is the selection of appropriate staff to lead and manage LRC activities. In general, physicians, other medical professionals and librarians have been the best fit for LRC activities in terms of professional expertise and abilities. In addition, human factors such as leadership qualities, the ability to engage others, and superior communication skills have proven to be critical components for the success of many LRCs.

Another factor that plays a significant role in the success of LRCs is the support of institutional leadership. Many chief administrators in West NIS and other regions have become proponents of information resources and technologies after witnessing their positive impact on clinical effectiveness, cost savings and staff training. The engagement of institutional leadership is especially critical in helping LRCs to build the support necessary for long-term sustainability. In recognition of this, new LRC programs being established by AIHA in other regions include chief administrator participation in workshops and other activities from the beginning of the project.

Ongoing support and regular contact with each LRC by AIHA ICT staff has also been an important aspect of smooth and successful LRC activities. Keeping the lines of communication open and regular between the information coordinators and the ICT staff in Kiev and Washington has helped LRC staff to feel connected to the project and engaged in the activities of their own LRCs and the virtual LRC community. The LRC network, which is sustained through an electronic mailing list (lrc@mail.aiha.com) and individual contacts between LRCs within and outside the region, provides access to the broad expertise and experience developed by LRCs in a variety of medical, institutional and regional settings. To sustain this important link, AIHA has initiated a virtual LRC Association, which will provide opportunities for collaboration among LRCs and other interested institutions in the NIS/CEE region.

BELARUS

City Polyclinic #36 LRC (Minsk)

Opened: March 2000

Total staff trained: 115

Serves a community of 270 staff health professionals and 89 external visitors per year

www.policlinic.infonet.by

MOLDOVA

Botanica Rayon Polyclinic LRC (Chisinau)

Opened: May 2000

Total staff trained: 961

Serves a community of 123 staff health professionals and 106 external visitors per year

www.aiha.com/english/partners/chisinau/index.htm

Moldova State University of Medicine and Pharmacy LRC (Chisinau)

Opened : June 1997

Total staff trained: 999

Serves a community of 7,000 staff health professionals and 1,440 external visitors per year

www.usmf.md

UKRAINE

Chuguev Rayon Central Hospital LRC (Kharkiv region)

Opened: May 2000

Total staff trained: 620

Serves a community of 1,121 staff health professionals

City Polyclinic No. 5 LRC (L'viv)

Opened: April 2000

Total staff trained: 42

Serves a community of 727 staff health professionals and 157 external visitors per year

www.doctor.lviv.ua**Darnitsky Rayon Polyclinic LRC (Kiev)**

Opened: September 1999

Total staff trained: 128

Serves a community of 548 staff health professionals and 92 external visitors per year

Donetsk City Hospital No. 25 LRC

Opened: April 2000

Total staff trained: 164

Serves a community of 245 staff health professionals and 113 external visitors per year

www.faho.dn.ua**Kharkiv Oblast Student Polyclinic LRC**

Opened: February 2000

Total staff trained: 85

Serves a community of 639 staff health professionals and 11 external visitors per year

www.iatp.kharkov.ua/osh**Odessa Sea Port Polyclinic LRC (Odessa)**

Opened: March 2000

Total staff trained: 40

Serves a community of 67 staff health professionals and 60 external visitors per year

www.port.odessa.ua/medic**Odessa State Medical University LRC (Odessa)**

Opened: October 1999

Total staff trained: 160

Serves a community of 6,000 staff health professionals and 78 external visitors per year

www.aiha.com/english/partners/osmu/osmu_en.htm**Trans-Carpathian Oblast Hospital LRC (Uzhgorod)**

Opened: February 2000

Total staff trained: 320

Serves a community of 1,013 staff health professionals and 912 external visitors per year

www.omiac.uzhgorod.ua**Zhovkva Rayon Hospital LRC (L'viv Region)**

Opened: April 2000

Total staff trained: 118

Serves a community of 667 staff health professionals and 71 external visitors per year

www.lviv.uar.net/~zhosp**LRCs in West NIS established prior to 1998:**

1995	Children's Hospital No. 4 (Minsk, Belarus)
1996	Minsk Medical Institute (Minsk, Belarus)
	City Ambulance Hospital (Chisinau, Moldova)
	Republican Clinical Hospital (Chisinau, Moldova)
	Donetsk Oblast Trauma Hospital (Donetsk, Ukraine)
	Children's Hospital No. 2 (Kiev, Ukraine)
	Maternity Hospital No. 6 (Kiev, Ukraine)
	EMS Training Center (Kiev, Ukraine)
	L'viv Oblast Clinical Hospital (L'viv, Ukraine)
	L'viv Regional Perinatal Center (L'viv, Ukraine)
	L'viv Regional Neonatal Center (L'viv, Ukraine)
	Odessa Oblast Hospital (Odessa, Ukraine)
1997	Institute of Radiation Medicine (Minsk, Belarus)
	State University of Medicine and Pharmacy (Chisinau, Moldova)

APPENDIX C: EXPANDED NURSING (INLI) SUCCESS STORIES

INLI Inspires Kharkiv Midwife to Become Leader of Nursing Association

When Natalia Florina applied for a job at the Primary Healthcare Center that was about to open at Oblast Student Hospital No. 20 in Kharkiv, she was warned that the job would require her to travel. At that time, Florina—a midwife with 20 years of experience—says she never imagined that this would mean attending the International Nursing Leadership Institute and that these trips would change her life: “The first session of the Institute was held in St. Petersburg,” Florina recalls, “and at first I had a very hard time. I’m an ordinary midwife, and the students there included head nurses of ministries of health and heads of national nursing associations. But the atmosphere of mutual support helped me a lot. The teachers created an excellent environment to get to know people and to work together with them. Looking back, I can say with confidence that everything I have achieved in my professional life is due to my experience with INLI.”

And Florina’s achievements are numerous. After graduating from INLI in 2001, she founded and led the Nursing Association of the City of Kharkiv and Kharkiv Oblast. “I promoted the idea of forming an association at the XII Congress of the International Union of Nurses in Copenhagen, which I had the pleasure of attending through the INLI program,” Florina recalls. “Many of the sessions that year were devoted to the formation of professional associations. Also, my classmates at INLI included Tatyana Shudra, the president of the Kiev Nursing Association, Galina Kulagina, the head of the Belarusian Nursing Association, and other leaders of the nursing movement. So I had an excellent opportunity to get the knowledge I needed, along with the support of my more experienced colleagues, which ultimately inspired me to form the association in Kharkiv.”

According to Florina, it became necessary to organize a professional union of nurses for several reasons: “We had to energize our nurses and prove to them that they can be leaders, they can develop their practice and improve themselves. This was important because for many years, nurses were accustomed to performing strictly defined duties. They had no initiative, no voice,” she says. As Florina describes it, the Nursing Association that was formed in Kharkiv became a platform to protect the social, creative, economic, and other interests of nurses. The organization’s work was focused on improving nurses’ skills and training. The Association spends a lot of time on research programs involving disease prevention and implementing progressive methods for diagnosing and rehabilitating patients. “Generally, our work is coming along,” Florina laughs, admitting that it was difficult at first.

“Not everyone accepted us right away. Many were cautious. After all, joining professional organizations is a new thing for our nurses, but things got going gradually. We are now working actively with the Nurses Union and the Nurses Council of Kharkiv, and we have a friendly relationship and work together actively with the Kiev Nursing Association, our colleagues in Belarus, and the Kharkiv Medical Post Graduate Academy, which opened a department of advanced training for nurses last year.” Florina herself is a student in that department, and she is very happy to be learning again. “Studying at INLI gave me the opportunity to recognize the potential and value of continuing professional education. I often think that I would not be a student now if I hadn’t attended the sessions of that institute. But after the INLI, I began to feel the need to grow constantly because learning new things is always useful and there’s no harm in reinforcing what you already know,” she says confidently.

Florina has also been successful in the area of obstetrics and gynecology. Her project to reduce sexually transmitted infections among students, which she began working on at INLI in 2001, is still operating and producing positive results. “It was extremely important to implement a program to reduce STIs because these diseases make up 61.3 percent of gynecological problems,” she explains. “We have not yet been successful with all the diseases, but the most important thing is that we have put together a good team and started

working actively to educate students on issues of preventing HIV and STIs. This is gradually changing young people's attitudes toward these problems. They are becoming more responsible about their behavior and health."

According to Florina, the outreach efforts take place regularly at the Primary Healthcare Center in the form of discussions, lectures, surveys, and individual walk-in meetings. The program also emphasizes early detection of STIs, which reduces the transmission rate of these diseases and minimizes their effects. STI treatment protocols have been developed and introduced at the center. In particular, a team comprising Florina and three physicians specializing in women's health care has implemented a protocol to treat bacterial vaginosis. Using this protocol, a midwife working independently can prescribe patients' treatment herself. Work is also being done to prevent STIs among at-risk students. The Primary Healthcare Center is working closely on this with the Kharkiv AIDS Center, which is providing STI prevention tools and educational materials.

Recently Florina began working at the Kharkiv Academy of Post Graduate Education as an instructor in the post Graduate nursing department, where nurses from 53 specialties receive additional training. In the area of student health, she has passed the baton to a colleague, who is successfully continuing the program at the Primary Healthcare Center. Florina herself is now busy with new plans and projects that she intends to implement in her new position. "I feel that I have been very lucky in life," she says. "First in my profession, and second in that I had the opportunity to study at INLI. It's just great when you can use your knowledge and skills to help someone who is ill, and it's even better when you have the ability to teach others to do this, to get your colleagues to believe in their abilities, to study, to improve their skills, and to expand their opportunities, which ultimately improves the health of our nation. This is our challenge now, and it inspires us!"

INLI Gives Graduate Opportunity to Provide Nursing Reform in Moldova

Elena Stempovskaya, the head nurse of the Moldovan Ministry of Health and the president of the Moldovan Nurses Association, was one of the first people in her country to recognize the value of developing strong leaders in the medical community. As she tells it, the idea for the nursing leadership project, which was introduced in Moldova four years ago, came to her while she was a student at the International Nursing Leadership Institute. This opportunity was made available to Stempovskaya through an AIHA nursing program in 1999. The goal of her INLI project was to provide training for head nurses from medical institutions at the republic, city and district levels in economics, management, psychology, quality-improvement methods and, most importantly, teamwork.

"My project was successful because I had exceptional teachers at INLI," Stempovskaya says, "and I tried to convey everything they taught me to my colleagues." The 25 nurses who participated in her project developed and implemented their own programs at their workplaces and the most successful ones were chosen as model projects for the whole country:

- Veronika Adamakeu, the head nurse at the National Neurosurgery Center, founded the first multidisciplinary department in the country and put together a team of specialists in different disciplines involving the rehabilitation of patients with various complications.
- Aleksandra Tetyu, the head nurse of one district, developed her own program to train nursing leaders at the district and village level. Through this project Tetyu created a system to survey nurses to determine their professional capabilities and developed an outline of the functional duties of leaders in the nursing profession. Tetyu also created new jobs by convincing the personnel of a local hospital to form a rehabilitation ward for senior citizens and people with disabilities. She inspired her colleagues and the local population to refurbish the building that now houses this ward. There are many such examples.

The success of the program that Stempovskaya prepared for this group was obvious. Since 2000 it has been used as the baseline program for head nurses and senior nurses at the Chisinau School of Continuing Education for Mid-Level Medical Personnel. Stempovskaya, who teaches the leadership program at that school herself, believes that spreading knowledge leads to activism by nurses as a group, which gradually produces new leaders.

The project to train leaders in the nursing profession also helped to create a model of home health care, which has become a necessity as the country makes the transition to a medical system in which patients must pay for care. “Eighty percent of medical care is now provided in patients’ homes because most people cannot afford treatment at a hospital,” Stempovskaya explains. “Therefore, it is very important that the physician, the nurse, the social workers, the volunteers, and the medical specialists work together in harmony, like a machine, as a single cohesive team. And this depends to a great extent on the capabilities of the leader. If the leader is well trained, the whole team can do its job easily,” she states confidently, emphasizing that the leadership program also helps nurses improve their skills. “The program gives nurses the knowledge and confidence they need to make decisions independently, which is crucial in the home care of patients with cancer, diabetes, or mental illness—in situations when the nurse is with the patient one-on-one and she must decide what to do.”

Stempovskaya combines her teaching work at the nursing school with a teaching job at the Nicolae Testemitanu State University of Medicine and Pharmacy, in the department of advanced nursing education and family medicine. Both departments are relatively new, and they are training the new type of specialists needed to implement medical reform in the country. “INLI helped me become a teacher. I acquired teaching skills there, and I learned how to argue, explain, persuade, and prove a point, to say nothing of the knowledge that helps me implement new programs and make timely decisions,” says Stempovskaya. She explains that until recently, nurses worked in a specialty, but now the new concept of the family nurse is being introduced in the health care system. A family nurse must care for all members of the family, regardless of their age and state of health. “If it weren’t for the Institute, I would have trouble finding my way in complex situations because I am responsible for the work of all the nurses in the country. In light of the reforms in the area of primary healthcare and the introduction of medical insurance, I often have to give explanations and information to my colleagues, and in that process I try to make nurses aware of and prepared to deal with the changes that are occurring. Without the special skills taught at INLI, it’s hard for me to imagine how the nursing profession could succeed in our country.”

Stempovskaya acknowledges that she did not only learn to be a teacher at INLI, but she also took a course on how to write scholarly papers, which helped her to move to a higher professional level and provided the impetus to write and defend her doctoral dissertation on the psychology of teaching.

In addition to her work in academia and in the Ministry, for almost 10 years Stempovskaya has led the Moldovan Nurses Association. “The association brought us together,” she says, adding that she means not only nurses in Moldova, but also their colleagues in other countries of the former USSR. “At AIHA conferences and at INLI, I met the leaders of nursing associations in other countries. Ever since, we have been working closely with the Romanian and Belarusian Nurses Associations. We hold joint meetings to share experience and we organize conferences together. By the way, we are planning to hold a conference on leadership this December, and of course our partners from Romania and Belarus will participate very actively. After all, we are working toward a common goal, and we are successful to the extent that we can understand and support each other, speak with a single voice, and solve problems together.”

According to Stempovskaya, nursing in Moldova is enjoying its best years, despite the economic difficulties. “Nurses are operating on their own enthusiasm,” she says, noting that she has passed on to her colleagues the faith in their own strength that she says she received at INLI. Leaders in the nursing profession have drafted a law on nursing that expands the rights and duties of nurses and establishes a more independent status for

the profession. The draft law is expected to be heard in parliament soon. The first republican congress of nurses was held recently. For the first time in the country, standards for quality of care of patients have been drafted for literally every nursing specialty. Even more importantly, a department of advanced education for nurses has been established at the Nicolae Testemitanu State University of Medicine and Pharmacy.

“Doctors envy us now because we are so organized and friendly with each other and we have so much initiative,” Stempovskaya laughs. “Now we are getting exposure in the press and on television, and a book has even been published about our leaders—the first book about nurses ever published in our country.”