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Evaluation of the Development Impact of USAID/AIHA's Health Partnerships Program in Central and Eastern Europe

January 18, 2006

This publication was produced for review by the United States Agency for International Development. It was prepared by RTI International.

Evaluation of the Development Impact of USAID/AIHA's Health Partnerships Program in Central and Eastern Europe

Contract GHS-I-06-03-00028-00

Prepared for
E&E Bureau
United States Agency for International Development

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Executive Summary

Introduction

The purpose of this evaluation of the American International Health Alliance's (AIHA's) Health Partnerships program in Central and Eastern Europe (CEE) is to provide USAID's Europe and Eurasia (E&E) Bureau with a better understanding of the developmental impact and legacy of the 12 year CEE Health Partnerships program, including lessons learned and best practices from the partnership approach, individual partnership programs, and regionwide cross-partnership activities that may be applied in other countries. RTI International assembled an evaluation team comprised of three health specialists, who conducted interviews with CEE and U.S. partners, past and present USAID/Washington and Mission staff, AIHA representatives, and others. From October 2-21, 2005, the team traveled to CEE and met with representatives of 18 partnership sites and 2 grantees in the Czech Republic, Slovakia, Croatia, Hungary and Romania. The sample covered over 60% of the 30 partnership sites, 66% of the grantees and 50% of the 10 countries participating in the CEE partnership program.

The team observed a range of partnerships programs including hospital, health management education, healthy communities and Women's Wellness Centers, as well as two types of support programs: the Nursing Resource Centers (NRCs) and the Learning Resource Centers (LRCs). The assessment focused on the human and institutional capacity left behind by program activities, especially in the areas of evidence-based medicine, quality improvements, nursing, health care delivery, community mobilization, and health management education. Following an evaluation published in February 1997 (Butler et al.) the program shifted focus from hospitals to reproductive health and primary health care. This evaluation report is organized to address the shift in focus of pre- and post-1998 partnerships.

Main Findings

The overall development impact of the AIHA partnerships approach can be summarized in one word – extensive. At the sites visited, the team found impact at four levels: as a tool of foreign assistance, a tool of foreign policy, as a mechanism for reforming individual institutions and as a vehicle for catalyzing systemic change. As a tool of foreign assistance, the AIHA partnership approach has proven highly effective at producing results that have a multiplier effect. As shown in Table 2 in Section V of the report, the vast majority of programs visited have been sustained and many have been replicated. As a tool of foreign policy, the partnerships reviewed had served as a bridge between former adversaries of the Cold War and produced extraordinary good will toward the U.S. among CEE partners, while U.S. partners have become advocates for foreign assistance. Foreign assistance and foreign policy now have a constituency on Main Street, USA. Institutional change was the primary objective of the partnerships, and the changes catalyzed by the partnership have multiplied and endured. For all CEE partnerships evaluated the experience brought structural change to established CEE institutions. Patient-centered care was introduced in hospitals, NGOs were founded to divest local governments of social care, health management education programs were established and advanced degrees in management offered in medical schools. Finally, success at the institutional level was leveraged to create system-wide impact. As a result of the partnerships, significant legislative and policy initiatives were undertaken. For instance, in Slovakia, laws have been passed that designate drug use and domestic violence as crimes (Petrzalka), and prohibit smoking in public buildings (Martin-Banska Bystrica). Constanta, Romania was successful in getting a law passed requiring sexually transmitted infections testing for pregnant women. Across Romania and Slovakia the cultural tolerance for domestic violence has diminished. In Croatia, Split partners are advocating for a nationwide school-based program to reduce alcohol use.

Overall the team found the partnership approach to have accomplished many impressive achievements. Some notable strengths of the partnership approach are:

- Demonstration of American values such as participatory decision-making ,transparency and use of evidence in decision-making
- Flexible design, allowing the partnership focus to evolve and giving partners control over the focus of their collaboration.
- Volunteer approach, which contributed to the strong commitment and “ownership” felt by U.S. partners, and which motivated CEE partners.
- Leveraging USAID funds to attract in-kind contributions, almost doubling the resources available for the program.

Some weaknesses of the approach were:

- The flexible design is not well-suited to the current performance model utilized by USAID, which requires that programs work toward pre-set strategic objectives.
- A lack of strong baseline data precluded quantitative demonstration of overall development impact, and most individual programs did not have sufficiently rigorous evaluation criteria at the outset of the partnerships.
- Cost data was not tracked in a way that allowed clear demonstration of cost-effectiveness.

However, despite the lack of quantitative performance data the team was able to draw confident conclusions.

Main Conclusions

USAID’s investment in the partnerships program has produced important results in the CEE that have had cascading impact in the years since program support ended. The collaborative and participatory approach of the AIHA model has brought meaningful, lasting changes at the personal, professional, institutional and policy levels in the CEE. By contributing to USAID Bureau goals and strategic objectives, the approach also fulfilled foreign policy goals that have accelerated the movement of the local medical communities, including hospitals, academic institutions and social service organizations, out of isolation and into the international medical community. Most importantly, it has fostered widespread friendship and good will among partners.

Main Recommendations

The report provides specific recommendations for all 10 major areas covered by the report. Some of the most important are as follows:

- USAID should revise its assistance mechanisms to accommodate the unpredictable path of participatory programs.
- While primary care remains a severely underdeveloped link in the health care system in many places, attention to hospital operations improvements should not be ignored when deciding the scope of work for future partnerships.
- Future partnerships should assure that partners have strong monitoring and evaluation skills so that they can gather and present data illustrating the extent of problems and the success of interventions at addressing them.
- Assuring access by all partners to Internet-based information technologies and communications systems, such as e-mail and learning platforms should be a priority in future programs.

Key lessons learned and best practices

Partnerships are a vehicle of foreign policy and foreign assistance. The partnership approach resulted in productive collaboration between citizens of countries that had viewed each other with suspicion during the Cold War. The CEE partnerships occurred at a fortuitous time when the CEE countries were transitioning from communism to a new system and eager for contact with the international community. The partnership model may be equally appropriate for other periods of either geo-political transition (e.g., post-conflict) or global health transition. In regions where new program interventions are being introduced (such as anti-retroviral treatment programs in Africa), the partnership model may be useful in strengthening outreach and treatment capacity, and accelerating effective implementation.

Bottom-up collaborative approaches generated change from inside. Through the bottom-up collaborative method, the CEE partners who felt ownership of the solutions were the linchpins to institutional change. The participatory structure of AIHA's partnership approach tapped the people closest to the problems to decide the partnership priorities and implement the program.

The partnership model has cross-sectoral application. The development impact of the healthy communities partnerships went well beyond the health sector, making an important contribution to civil society, transparency in local government, and promotion of democratic values. Because the model is generic and not specific to issues in the health sector, it has potential for a range of development sectors.

Human capacity building leads to institutional capacity building. The partnerships demonstrated that human capacity is best built by applying new skills and methods in day-to-day work. US partners were collaborators and mentors as the CEE partners practiced their new skills, and new thinking became the springboard for institutional change.

The partnership approach produces lasting results. Exchange visits to the U.S. in particular provided exposure to new technologies, methods and institutions that sparked the imagination of CEE partners. The opportunity to visit U.S. sites, especially prior to 1998, offered CEE partners the opportunity to observe for themselves specific technologies, behaviors, relationships, ideas, and activities that were appropriate to their own settings and could be integrated or initiated in their home institutions.

Modern communications technology catalyzed rapid change. Initiatives to provide CEE partners with modern communications enabled CEE partners to engage with the global medical community. These initiatives were especially innovative in the early years of the program when web-based communications were only recently widely available even in the U.S. Access to these technologies accelerated the use of evidence-based medicine and quality improvement systems by as much as 10-15 years.

The volunteerism spawned by the CEE partnerships reflects an important culture change. As a direct result of the example provided in the partnership model, many CEE partners, including Banska Bystrica, Turcianske Teplice, Vac, Constanta, Petrzalka, and Martin initiated their own volunteer programs that are attracting young people into unpaid community service roles. This reflects a higher acceptance of personal social responsibility than existed under the old regime and serves as a measure of the increased role of civil society organizations in these countries.

I. Background and Objectives

1. Objectives of the Evaluation

The U.S. Agency for International Development (USAID) requested that RTI International conduct an evaluation of the Health Partnerships program in Central and Eastern Europe (CEE) implemented by American International Health Alliance's (AIHA) to provide USAID's Europe and Eurasia (E&E) Bureau with a better understanding of the developmental impact (legacy) of the Health Partnerships program. The evaluation included an examination of the partnership approach, individual partnerships, and regionwide cross-partnership activities, in order to provide a record of the impact of the Health Partnerships program over its 12-year history and to provide guidance to USAID on how to improve the effectiveness of ongoing or future partnerships in other countries and regions. Specific objectives of the assessment were to

- Document the developmental impact of the CEE Health Partnerships program, including the partnership approach, individual partnerships, and regionwide cross-partnership activities
- Assess the sustainability of the partnership relationships
- Assess the sustainability and replication of models and outcomes
- Identify major "lessons learned" and best practices that USAID can apply in other countries.

The Scope of Work for the evaluation is included as Annex 2 and the evaluation workplan is included as Annex 3.

2. Evaluation Methodology

The evaluation team focused on determining the developmental impact of the Health Partnerships program on an overall and individual partnership basis. Special emphasis was placed on identifying changes to the health care delivery system, health status of the community, and the human and institutional capacities the program left behind, as measured by improvement in skills and services of individuals and institutions. USAID was particularly interested in knowing the extent to which capacity was developed in the following areas: evidence-based medicine, quality improvement, nursing, health care delivery, health profession education and community mobilization. Each of the three evaluators focused on one of the three partnership types (hospital and health care, health management education, and healthy communities). Evaluators interviewed CEE and U.S. partners, past and present USAID/Washington and Mission staff, AIHA representatives, and others and gathered information by telephone, e-mail, and in person, and via site visits to partnerships in Slovakia, Hungary, Croatia, and Romania, October 2–21, 2005. In consultation with USAID, AIHA selected the sites to be visited. The CEE Health Partnerships program included 30 partnerships and 3 grantees (a complete list of partnerships is included in Annex 4), and this evaluation substantively evaluated 18 partnerships and 2 grantees. A detailed discussion of the evaluation methodology is included as Annex 5.

3. Context of the Program

In 1989, the Soviet bloc collapsed, and the countries of the CEE became free to determine their own forms of government and the role that the central government would play in the lives of the citizens. There was a move across the region to adopt market-oriented reforms and democratic forms of government. The state governments began to decentralize functions to regional and local bodies. Citizens were suddenly free to

access information about developments outside of the Soviet bloc, and travel restrictions were lifted. All aspects of the social contract between the government and citizens that had existed since World War II were open to negotiation and redefinition.

Financing and provision of health care services were among the most sensitive areas of change. For decades, the government had provided preventive and curative health services without charge and operating funds to hospitals and other health care facilities on the basis of outdated information. Huge, inefficient hospitals dominated the health care system, and primary care was undervalued by both clinicians and citizens. Medical professionals were isolated; medical education was not grounded in modern science; and medical practice was decades behind the Western developed world. Health status was declining, and death rates from noncommunicable disease were among the highest in the world and growing. In addition, health services had long been underfunded; medical professionals were demoralized by low wages; facilities and equipment were antiquated; and pharmaceutical supplies were limited. The concept of health management was foreign to the communist world and there were no academic programs for health management education. Patients endured poor quality care, non-existent social services, complete lack of privacy and other indignities. Nonetheless, people still considered health care a birthright, and acceptance of changes in the health care system was seen as a litmus test for measuring the success of reform. In this period of political, economic, social, and cultural upheaval, there was no blueprint for the design of new health care systems or precedent for how to approach implementation of such comprehensive change. Communities, institutions, and individuals were inundated with unfamiliar demands and were seeking new strategies for survival. It was in this environment that the Health Partnerships program was initiated.

4. History of AIHA Partnerships Program

The AIHA was formed in 1992 in response to a request by USAID for the development and implementation of the Newly Independent States (NIS) Medical Partnerships component of the NIS Health Care Improvement Project. In 1994, USAID funded AIHA to further expand the program to CEE countries. USAID had funded partnerships in CEE since 1990; however, the original programs were managed through individual grant awards. Management of multiple grants proved inefficient, so in creating the partnership program for the NIS, USAID sought a consortium of national health care trade associations to select the partners and manage the partnerships. This approach was extended to the CEE partnerships when the original grant program terminated in 1994. Subsequent amendments extended the agreement to March 31, 2006. Funding for 1994–1998 totaled \$58 million for both CEE and NIS programs, and of that amount, the CEE partnership program received \$24.4 million. For 1999–2005, AIHA’s CEE program received approximately \$12.6 million primarily as buy-ins from USAID Missions for specific country activities. From 1994–2005, AIHA implemented 30 partnerships and 3 grants in CEE.

Prior to 1999, all health programs were subsumed under the Bureau for Europe and New Independent States (ENI) Strategic Objective 3.2: “Improved Sustainability of Health and Social Benefits and Services.” During this period, the ENI Bureau also had a mandate from the State Department to integrate foreign policy considerations into foreign assistance program design. The dual purpose of Bureau programs following the end of the Cold War was captured by the partnership program design.

The Health Partnerships program was fashioned after the Marshall Plan as a way to provide training and rebuilding support for improved health and social systems in the CEE and NIS region. It aimed to build relationships between the people of the former Soviet bloc and the people of the U.S. and, through these relationships, help improve the quality of life and demonstrate the values and principles of “Open Markets and Open Societies.” The intention of partnerships was also to help the professionals develop a positive

attitude toward the U.S., join the international medical community, and contribute to the modernization of their health care systems. Beyond improving the sustainability of health and social benefits and services, the State Department wanted to encourage opportunities for international cooperation with former Soviet bloc countries so that U.S. citizens would begin to view them as allies and become stakeholders in the redirection of the former Soviet states and the U.S.'s foreign assistance mission.

Not knowing what solutions to health system problems would be feasible and sustainable in the early years of the transition, USAID saw the partnerships as a development assistance tool that would allow CEE and U.S. counterparts to identify their priorities and determine how U.S. experience could help. USAID turned to the American health care system with its vast resources and expertise for help. It encouraged the formation of a consortium of the leading U.S. health care associations. USAID hoped that their collective generosity and goodwill would be a bridge between the two worlds. The informal consortium founded the AIHA, and USAID awarded it a cooperative agreement to provide flexibility in program design and management.

An evaluation published in February 1997 (Butler et al.) found that while the hospital partnerships had achieved sustainable improvements in care, they were not aligned with the agency's policy to focus on preventive and primary health care. It also noted that because the USAID strategic objectives structure required mission managers to focus resources on approved country objectives, there was tension between the partnerships program and the USAID missions. From the Butler evaluation a post-1998 "second generation" of partnerships emerged, reorienting the health care partnership program from hospitals to primary care to more closely align with USAID policy. Also, following 1998, the AIHA became more involved in initiating training and cross-partnership activities that could take advantage of economies of scale, bridge gaps in the individual partnership focus, and contribute to regional capacity building. This evaluation report is organized to address the shift in focus of pre- and post-1998 partnerships accordingly.

In 1998, a second evaluation was implemented by a Continuing Evaluation Panel (Vanselow et al. 2001). It provided ongoing oversight and feedback to the AIHA regarding the effectiveness of partnership operations in CEE and NIS. Over the panel's 2-year timeframe, improvements were incorporated into the partnership model and a formal monitoring and evaluation strategy was developed.

In 1999, the Bureau revised its strategic framework and the role of E&E Bureau programs in foreign policy changed as relations between the U.S. and the former Soviet bloc matured and the foreign assistance needs came into sharper focus. Health programs fell under Strategic Assistance Area III: Social Transition, which had the goal to "enhance the ability of all persons to enjoy a better quality of life within market economies and democratic societies." Under this goal the strategic objective guiding the health programs was S.O. 3.2 "Increased Health Promotion and Access to Quality Health Care."

The AIHA partnership program has been closely aligned and fully responsive to Bureau and foreign policy objectives since the inception of the program. Its program focus has evolved over the life of the project to be primarily Mission driven, as opposed to USAID/Washington and the State Department. Lessons learned from early activities and evaluations have been incorporated into operations. The AIHA partnership approach and overall impact are discussed in Section II A.

5. Summary of Country Programs

Of the five country specific programs evaluated by the team, the Czech Republic and Slovakia programs funded all of their partnerships before 1998. Hungary and Croatia introduced new partnerships in each of the two time periods (pre-1998 and 1999–2005). Thus, country programs in Hungary and Croatia reflect the original USAID partnership guidance in one group and the revised USAID partnership guidance in the other.

Romania introduced new partnerships continuously through both time periods, so the change in emphasis was gradually incorporated into the country program. Table 1 below summarizes the country programs by partnership type.

Table 1. Summary of Country Programs by Partnership Type

Country	Hospital	Health Mgmt. Education	Healthy Communities	Other
Albania	Tirana 1994–2000	Tirana 1996–1999 Tirana 2001–2004		Tirana 1999–2004 (WWC and cervical cancer) Lezha 2001–2004 (PHC)
Bosnia and Herzegovina	Tuzla 1996–1998			
Croatia	Zadar 1995–1998 Zagreb 1994–1998		Split 2001–2003	Stampar SPH 2004 HIV Stigma (Grant)
Czech Republic		Olomouc 1996–1998 Bohemia 1996–1997		
Estonia	Tallinn 1994–1996			
Hungary	Vac 1995–1998		Győr 2002–2004 Pécs 2002–2004 Vac 1998	
Kosovo				Gjilan 2001–2004 (PHC) Gjakova 2004– (RH) DOW 2003–05 (WWC grant)
Latvia	Riga 1995–1998 (with HC component)			Riga/Little Rock 2001–2004 (TB)
Romania	Cluj 1995–1997 (OH)	Bucharest 1996–1999 Bucharest 2001–2004	Constanta 1998–2002	Iasi 1998–2000 (WWC) Breast Health 2003–2006 (grant)
Slovakia	Kosice 1995–1999	Slovakia 1996–1999	Petrzalka 1996–1998 Turcianske Teplice 1996–1998 Martin/Banska Bystrica 1997–99	

The evaluation team was tasked with evaluating the extent to which the overall partnership model contributed to specific broad USAID objectives set forth in the cooperative agreement and its modifications. In addition, the team evaluated the success of the various partnerships models (hospital, health management education and healthy communities) in contributing to developmental impact. Findings, conclusions and recommendations for the overall program approach, each of the partnership types, cross-regional initiatives and intraregional knowledge sharing are set out in section II of the report.

II. Partnership Approach and Overall Impact

The AIHA model of partnerships includes the following features:

- A partnership connects one or more U.S. and CEE institutions that share common interests and purposes. Together, the partners decide on the goals and objectives of the collaboration.
- Volunteers provide technical assistance and training to their partners.
- Exchange visits in both directions give partners broad exposure to one another’s health care institutions and social services.
- Peer-to-peer relationships characterize the professional and institutional interactions. Both sides of the partnership derive benefits from the relationship.

- The U.S. partner agrees to donate financial and technological resources to the CEE partner.
- AIHA selects the U.S. partners and facilitates the development of workplans.
- AIHA manages the logistics of the partnership.
- AIHA sponsors programs that encourage networking between partners and arranges special initiatives, training, and technical support to address common needs shared by partners across the region and to build capacity.

The Health Partnership program approach fostered a sense of equality among partners. They worked as a team in determining the focus for their programs, resulting in a strong sense of ownership that energized and helped individuals, communities, and institutions adapt to the demands of the transitional period. The combination of the participatory nature of the partnership, volunteerism, peer-to-peer mentoring, and opportunities to observe new methods at work promoted the modernization of the health care system and formation of NGOs to provide a range of social services. The structure of the partnership model, particularly the healthy communities methodology, can be easily adapted and applied to address problems in communities and institutions.

Strengths and Weaknesses of the Approach

Some notable strengths of the approach are as follows:

Demonstration of American values such as:

- The approach promoted a self-help mentality.
- The approach opened doors for naturally gifted social entrepreneurs with vision and energy, empowering them to take action.
- People at all levels of an organization work as a team to implement programs.
- The people closest to the problem were recognized as the best qualified to do needs assessment, problem solving, and program implementation, (i.e., a bottom-up collaboration).
- Partnerships gave local government leaders their first experience at finding out the opinions of the population.
- Participatory decision-making underpinned the approach. In this way, partnerships showed how to be responsive to the needs of the citizens.
- Transparency and use of evidence in decision-making was required.
- CEE partners better understood democracy and democratic thinking after spending weeks at a US health care institution.

Flexible design

- During a period of rapid change, flexibility allowed the partnership focus to evolve. When opportunities arose to influence national policy, the partners were free to pursue them. The program had infinite possibilities, limited only by participants' imaginations.
- Use of a cooperative agreement funding mechanism allowed flexible planning and allowed partners to have greater control over the focus of their collaboration.

Volunteer approach

- The voluntary aspect of the program contributed to the strong commitment and "ownership" felt by U.S. partners. Their motivation to learn and to support change was very high. The commitment of time and resources motivated CEE partners.

- Co-mingling donor funds and private volunteer time and other in-kind donations maximizes the value of the government's investment.

Peer-to-peer relationship

- The program was based on peer-to-peer relationships that were designed to be professionally rewarding. These relationships built the confidence of the CEE partner and energized the partners. The CEE partners felt respected and trusted by their US partners.
- The AIHA selected CEE partners who were leaders in their field or community, either by virtue of being the only organization working on the issue or because of recognized prominence for past achievements.
- In the selection of the partners, high priority was given to organizations that were genuinely interested in learning from one other and that were able to involve individuals who were eager to adapt their thinking and knowledge to meet the needs of a new environment. Prior foreign assistance experience was not the primary criterion; rather, experience managing similar problems in a different context took priority.

Seeing and believing

- Exchange visits to the U.S. provided exposure to a multitude of community resources and institutions allowing CEE partners to see a range of options and choices that might be adapted to meet their needs.
- Observation of unfamiliar professional roles and responsibilities and interaction with the partners over several weeks were critical to changing the thinking about what was possible (e.g., nurse/physician relationships) and accelerated uptake of new ideas.
- U.S. partners gained exceptional opportunities to test theories accepted in the U.S..

Some weaknesses of the approach were

- The partnership approach, based on an inherently flexible design that allowed partners to set priorities, sometimes change objectives as the activities evolved, is not well-suited to the current performance measurement system utilized by USAID, which requires that programs work toward pre-set performance indicators.
- The full impact of partnership initiatives cannot be known for many years. With USAID's short term results requirements, Missions may underestimate the potential for the approach to sow seeds of change and may not be willing to support new partnerships.
- Several partners found that the approach did not have a sufficiently rigorous orientation to data collection and analysis. And regretted that evaluation criteria had not been established at the outset. AIHA corrected this issue with later partnerships, however, the opportunity for measuring impact from the baseline has unfortunately been lost.
- The voluntary aspect of the partnership may not be viable in future projects because of cost reduction pressures on U.S. health care institutions.
- Most partnerships relied on informal training conducted through short-term exchanges, which were not as effective at transferring skills as longer term, intensive training courses.
- After USAID support for the partnership ended, institutional relationships were curtailed as individuals involved moved to other organizations or became involved with other priorities.

- Since international travel was a substantial perk, sometimes politics and favoritism drove the selection of exchange participants from the CEE.

Findings

The overall development impact of the AIHA partnerships approach can be summarized in one word – extensive. The team found impact at four levels: as a tool of foreign assistance, a tool of foreign policy, as a mechanism for reforming individual institutions and as a vehicle for catalyzing systemic change.

First, as a tool of foreign assistance, the AIHA partnership approach has proven highly effective at producing results that have a multiplier effect. As shown in Table 2 in Section V, the vast majority of programs to improve health and social services have been sustained. Many have been replicated. The CEE partners are providing more and better services and management improvements have penetrated deeply into day-to-day operations. Many people credit the partnerships with “changing their lives” and indicate that they adopted a new mindset inspired by visits to the U.S. and acquired professional skills through partner mentoring. They continue to be motivated and energetic in pursuing improvements. At the systemic level, CEE partners from Vac, Turcianske Teplice, Banska Bystrica, Constanta and Petrzalka were among the first to establish non-governmental social service organizations, changing the role of local governments and bringing desperately needed new services to the population.

Second, as a tool of foreign policy, the partnerships served as a bridge between former adversaries. The approach produced extraordinary good will toward the U.S. and its health care professionals. Many CEE partners are eloquent spokesmen about the improved quality of life that has come from working in a more open and democratic institution. CEE partners from Olomouc, Constanta, Bucharest, Zagreb and others have been appointed to national leadership roles and have used these platforms to change policies and to bring democratic principles alive. Within the U.S., the partnerships have given hundreds of Americans first hand knowledge of transitional economies, and have personalized international policy and budget debates U.S. partners from Kentucky, North Carolina, Missouri, Rhode Island and New York have become advocates for foreign assistance, taking their stories to the U.S. Congress. Foreign assistance and foreign policy now have a constituency on Main Street, USA.

Third, institutional change was the primary objective of the partnerships, and the changes catalyzed by the partnership have multiplied and endured. For all partnerships evaluated, the experience brought structural changes to established CEE institutions. Hospital partnership initiatives were complex and included several medical specialties in clinical training and improved management of patient care. They adopted new roles, responsibilities and relationships between staff, and integrated continuous improvement methodologies into their programs. Patient care was greatly improved. Medical schools added programs to train managers and accepted non-clinicians as students. City governments divested responsibility for social services to newly formed NGOs. Sections II B and C of this report describe the changes that occurred in each type of partnership with specific examples. Annex 8 includes detailed descriptions of the impact at the institutional and community level for individual CEE partners. Examples of the institutional changes observed are as follows:

- CEE physicians and nurses described the shift in their thinking towards the concept of “patient-centered care,” a new practice in the CEE region at that time. In Vac and Kosice, while they had heard the concept, the physicians described the importance of understanding the policies and practices that support its implementation as a major impact of the partnership. This shift in how care is delivered influenced the institution at many levels – affecting hospital visitation policies (i.e., increased family visiting hours), requiring restructuring of some physical facilities (e.g., creation of mini-apartments to allow parents to stay near their children in the intensive care units),

down to the level of patient-provider interaction (e.g., respecting patients' privacy during examinations).

- The Slovakia health management education partnership has produced university programs in health management at the undergraduate and post-graduate levels and has an MOU in place to continue collaboration with their partner at Scranton University over the next five years. Most recently they have collaborated in the development of a BRIDGE model and are working together on management improvements through partnerships in Africa, Mexico and Tbilisi, Georgia.
- In Petrzalka, the partnership approach uncovered the prevalence of domestic violence, a festering consequence of the unemployment caused by the economic transition in Slovakia. There was no center for abused women in Slovakia in 1997 when their work began. The Hope Center was founded to provide counseling for women and children, help women find safe housing, employment and legal assistance. And developed a media campaign to inform the community. They believe that the attitude of the whole society is changing as a result of their efforts.

Fourth, success at the institutional level was leveraged to create system-wide impact. Through the partnerships, there were legislative and programmatic gains at the regional, national, and/or community levels.

- The status of nurses was identified early as an important area of change that would significantly impact hospital efficiency and quality of care. At all hospital sites visited, nurses reported increased authority, self-confidence, and greater involvement in direct patient care and clinical decision making.
- CEE partners were instrumental in establishing some of the earliest NGOs in the region which serve as models for provision of social services to the population. From five of the eight healthy communities partnerships, NGOs evolved. Through the partnerships, hidden or unaddressed problems such as alcoholism, smoking, lifestyle, and violence against women were identified. These issues are now among WHO's highest public health priorities in the region and the CEE partners are leaders in region-wide forums on these topics. The partnerships gave naturally gifted "social entrepreneurs" a voice that has helped to improve the health status of the population in the region.
- Partners have taken and are taking leadership roles in advocating for changes in laws and policies. For instance, in Slovakia, their efforts have resulted in passage of laws that designate drug use and domestic violence as crimes (Petrzalka), prohibit smoking use public buildings (Martin-Banska Bystrica), and establish foundations as non-governmental organizations that can raise funds from private entities (Petrzalka). Constanta was successful in getting a law passed making STI testing a requirement for pregnant women. In Croatia, Split partners are advocating for implementation of a nationwide program in the schools to curb alcohol use among children and youth. In Slovakia and the Czech Republic, schools of health management education are lobbying for creation of a new wage classification for health care managers, currently an unofficial professional class.
- The approach was a catalyst for changing the mindset of the CEE partners, who were leaders in their institutions, professions and communities. Many CEE partners became intellectual leaders nationally (Zagreb, Constanta, Petrzalka, Martin, Vac, Olomouc, Split, Bucharest, Slovakia, Kosice) and in some cases internationally (Martin, Bucharest, Slovakia, Kosice, Petrzalka, Constanta) as a result of their partnership initiatives. The ripple effect of their leadership role

helped to accelerate the modernization of medical practice; acceptance of modern management principles in health care facilities, and the movement to democratic institutions and principles.

Conclusions

USAID's investment in the partnerships program has produced important results in the CEE that have had cascading impact in the years since program support ended. There is convincing evidence that the collaborative and participatory approach of the AIHA partnerships model has brought meaningful, lasting changes at the personal, professional, institutional and policy levels in the CEE. As such it has established a track record of success as a tool of foreign assistance. By contributing to the ENI (later the E&E) Bureau goals and strategic objectives, the approach also fulfilled foreign policy goals that have accelerated the movement of the local medical communities, including hospitals, academic institutions and medical service organizations, out of isolation and into the international medical community. Most importantly, it has fostered immeasurable friendship and good will among partners.

Recommendations

USAID should revise its assistance mechanisms to accommodate the unpredictable path of participatory programs. For instance, through the SWOT analysis, the community may find, as in the case of Petrzalka, that there are hidden problems that need immediate attention. If the scope of work for the partnership is too directive, the partners may not have the latitude to organize around the problem that the community believes is their highest priority.

1. The Impact of Each Type of Partnership Established before 1998

The evaluation methodology was organized around the three different types of partnerships. A second level of analysis looked at the partnerships funded before 1998 as compared with those funded after 1998, when the clinical program objectives shifted from improving hospital care to establishing primary health care programs. The team's findings below are based on the sample of programs observed during the field visit and interviews with CEE and U.S. partners. A detailed list of contacts is included as Annex 7, and summaries of partnership sites visited are included as Annex 8.

The AIHA partnership model could be adapted for use in resource-poor settings. The model's flexibility and its use of peer-to-peer relationships which fostered positive interactions and much good will would be appropriate in other settings. If applied to a situation such as the roll-out of antiretroviral therapy to address the HIV/AIDS pandemic in Sub-Saharan Africa, the partnership could provide opportunities for mutual benefit which could stimulate US participation. The urgency and compelling nature of the situation as well as the growing cadre of academic institutions involved in international HIV/AIDS care and treatment could provide a solid pool of potential US partners.

However, differences between resource-poor countries and the US would necessitate adaptation of the model for application in these settings. For example, the greater resource disparity between partners might lessen the usefulness of and need for large bi-directional exchange visits. In addition, the urgency of the situation may require more intensive activities geared at more immediate results. A potential obstacle to implementing the partnership model in an African context is the health worker shortage which could limit partnering possibilities. Also, unlike the CEE countries in the early 1990's, most African countries are not politically isolated and in fact their academic elite are already strongly established in, and recognized by, the international community. Furthermore, mobilization of the African-American diaspora could be much more challenging. Lastly, more complicated travel logistics and increased health risks to the US partners could

potentially discourage US participation. Many of these challenges could be overcome by careful selection of US partners who have experience working in the chosen resource-poor countries.

Hospital Partnerships

All nine hospital partnerships in the CEE region were formed before 1998. Of these, five were visited by the evaluation team: in Slovakia, Kosice/Providence; in Hungary, Vac/Winston-Salem; in Croatia, Zagreb/Lebanon, Zadar/Franciscan Sisters; and in Romania, Cluj/Philadelphia.

The overarching goal of the hospital partnerships was to modernize clinical practice in the CEE partner institutions through peer-to-peer technical assistance and training. In general, the individual partnerships identified the following objectives for achieving this overarching goal:

- Enhancing professional knowledge and skills of medical staff
- Introducing and promoting evidence-based medicine
- Instituting continuous quality improvement methodology
- Elevating the status and role of nurses
- Improving hospital management and administration
- Improving hospital infection control practices
- Reducing lengths of hospital stays
- Developing a clinical care team approach
- Establishing both Nursing Resource Centers (NRCs) and Learning Resource Centers (LRCs).

Site-specific activities varied at each partnership depending upon the perceived needs of the CEE institution and the clinical and institutional areas recognized as having the greatest potential for improving care and patient management. Thus, the emphasis might have been on orthopedic surgery in one institution (Biograd) and pediatric and neonatal intensive care in another (Kosice), but all of the above general objectives were integrated into the focus of the hospital partnerships across sites. See Annex 8 for information on site-specific objectives and clinical areas addressed by each partnership.

Findings

In all sites visited, clinical care had improved through CEE partnership activities and these changes had had been sustained due to the success of the partnerships in building human and institutional capacity. In addition, the hospital partnerships showed evidence of meeting the majority of the site-specific objectives. The impact of the hospital partnerships on human capacity was most evident in the following areas: acquisition of professional knowledge and skills that bridged the gap in clinical practice standards, an increased appreciation for the usefulness of data-driven evaluation to improve clinical and administrative practices, the reorganization of hospital operations to incorporate modern techniques of health care management and quality in health care practice, and an expansion of the roles and responsibilities of nurses. Underlying all of these gains was the shift in mindset that resulted from the CEE partners being able to envision doing things differently.

CEE hospital partners benefited from trainings designed to increase professional knowledge and skills in specific clinical areas and procedures, which had immediate benefits for patients. For example, surgeons at the Orthopedic Hospital of Biograd were trained to perform arthroscopic knee surgery, and obstetricians/gynecologists in Zagreb were trained in laparoscopic surgical techniques, paving the way for other laparoscopic procedures throughout the surgery department. Replacing traditional surgical approaches

with these less invasive techniques is known to significantly reduce the complication risk for surgical patients. The Croatian partners commented that initial training conducted by the U.S. partners was too basic for them; however, eventually they found clinical areas where each had something to offer the other. Professional development also occurred largely through adaptation of the services and practices of the U.S. partner for CEE institutions. For example, Zagreb implemented continuing medical education for physicians and nurses, the Cluj and Zagreb partners reported that they improved patient care by organizing clinical care teams and the Kosice and Zadar partners adopted modern infection-control practices from U.S. partners.

Many CEE hospital partners developed skills in using data to inform policy and practice. For example, training and implementation of Continuous Quality Improvement (CQI) and evidence based medicine at many sites enabled CEE institutions to use the most modern techniques to improve clinical practice. The sites trained in CQI techniques by U.S. partners are still utilizing the technique to ensure quality. For example, Zagreb partners are using CQI in the Infectious Disease Hospital to evaluate nursing duties and improve efficiency. In Vac, the CEE partners were among the first to use CQI in Hungary. The introduction of evidence-based medicine at several CEE institutions opened a new world of resources to clinicians. Soviet research had been isolated from the global medical community for decades and often did not meet Western standards of scientific rigor. First trained were LRC staff, who later trained physicians and nurses to perform medical literature searches via Medline and use of the Cochrane Library. Prior to the establishment of the LRCs and the introduction of internet search engines, the medical literature available was limited to publications from within the Soviet bloc.

The elevation of the nursing profession in the region is a clear success story of the hospital partnerships. CEE partnership nurses stated that through both exchanges to the U.S. and discussions in their own countries, they learned about the potential of the nursing profession. The example of U.S. nurses instilled a professional pride in the CEE nurses who observed that U.S. nurses are not subordinate to physicians.

Nurses from nearly all CEE institutions evaluated related stories of how the partnerships empowered them to seek changes in their roles. Their assertiveness brought increased authority and self-confidence, as well as greater involvement in direct patient care and clinical decision-making. Some examples as follows: as a result of partnership training, Vac Hospital nurses provide most of the care to diabetic patients and have influenced the reorganization of the layout of the wards; in Zagreb, nurses participated with physicians as collaborators in a study of care of bed sores; in Cluj, as a result of an increase in confidence, the head nurse initiated the development of an outpatient respiratory diseases unit; and in Zadar, the nurses now prepare discharge instructions for patients. Both physicians and nurses interviewed commented on the elevated role and increased professionalism of nurses in their institution.

Many changes in hospital policies and protocols are still in effect today, demonstrating the impact on institutional capacity made by the pre-1998 hospital partnerships. The main areas in which institutional capacity was increased were related to the adoption or expansion of infection control practices and policies, decreased hospital stays for certain diagnoses, development of clinical care teams, institution of various clinical protocols, use of the strengths, weaknesses, opportunities, and threats (SWOT) analysis in strategy planning and creation of both NRCs and LRCs.

Clear examples of improved hospital practice include the establishment of a comprehensive emergency services department at the hospital in Vac, where, the Emergency Department was reorganized with the combination of previously separate outpatient walk-in clinic and trauma services. Borrowing the design of its U.S. partner institution, the Vac Hospital built a state-of-the-art emergency department which includes a triage center and had essential emergency services (e.g., CAT Scan) in close proximity to the patient care areas. Another example of improved hospital protocols includes the establishment of family-friendly care at

the hospitals in Kosice and Zagreb, where policies were to allow fathers to be present at the births of their children. In Kosice, the number of births with the father present nearly tripled from 2000 to 2005.

Several CEE partners commented that although they had an excellent theoretical understanding of infection control, in many areas they had not implemented the practices necessary to control nosocomial infections. In Zadar and Zagreb, the partners adapted U.S. partners' infection control policies and practices for use in their own facilities since they had not previously had written guidelines. The Kosice partners said the partnership enabled them to argue persuasively for renovations to both the Pediatric Intensive Care Unit and the Neonatal Intensive Care Unit (NICU) to improve infection control in these two units; examples include the installation of a sink at each patient's bedside with single-use paper towels and liquid-soap dispensers and an isolation room complete with negative-pressure ventilation to reduce the risk of airborne disease transmission. Although pre-partnership data are unavailable, the Perinatal Centre of Kosice Hospital documented a 70% reduction in nosocomial infections (from 29 in 1999 to 8 in 2004) over the past 5 years. Similarly, the pediatric intensive care unit at this site experienced a 40% reduction in mortality over the same period (from 8.4% in 2000 to 4.9% in 2003).

Several hospital partnership improved patient care while reducing hospital spending. These included decreasing the length of hospital stay for certain diagnoses and following certain procedures and improved diagnostic protocols in some settings. In Vac, the average hospital stay for stroke patients decreased from 10 days to 7 days because of the improved clinical pathways. In addition, chemotherapy for cancer is now delivered on an outpatient basis. In Kosice, better surveillance of infections and new clinic protocols led to faster identification of infections in the NICU and cost-savings of US \$9,000. In Zagreb, an adult day hospital was opened, reducing inpatient admissions by 30% over two years.

In several partnerships the creation of clinical care teams and clinical protocols resulted in improved care for patients. The Kosice partners presented favorable trends in neonatal mortality achieved after improved patient management protocols were instituted. In addition, the partners described better communication among neonatologists, surgeons, and other specialists, which they had observed in U.S. institutions. For example in Vac multispecialty oncology teams were formed during the partnership and continue to provide coordinated care to cancer patients. Similarly, care teams were established in the Critical Care Unit and on the Renal Service in Zagreb. Furthermore, the adoption of standard protocols for many nursing procedures has established a standard for quality care.

Some CEE partners discussed the need to establish measurable indicators at the start of the partnership to allow them to better evaluate their partnership's success. Although CEE partners do track some indicators—which can serve as proxy indicators for the partnership activities (e.g., nosocomial infection rates)—no partnership had a set of indicators that were measured over time to monitor the effectiveness of their partnership's interventions (e.g., trainings, exchanges, new policies).

A “change in mindset” was described at almost every hospital partnership visit. This consequence of the visits to the U.S. and the collaboration with the U.S. partners clearly enabled—and in some instances appeared a necessary requirement for—many of the other partnership goals to be achieved. It played a critical role in building human capacity. In Kosice, one physician stated that the link to the U.S. partner was crucial for countering resistance and feelings of “we can't do that here” because they were able to see firsthand different approaches in practice at their partner institution. In Zagreb, one physician stated that the “change in attitude” that came with seeing a different system was the greatest benefit of the partnership to the Zagreb partners. In Vac and Zagreb, the partners learned about and discussed the importance of shifting to “patient-centered care” and implemented programs in their hospitals.

Conclusions

Hospital partnerships set in motion a series of changes at the human and institutional levels that have had lasting impact. Dedicated CEE clinicians working with U.S. partners have led their colleagues and institutions to adopt modern clinical practices guided by the latest published research which has greatly improved the quality of patient care. Exchanges to U.S. partner institutions were important to allow the CEE partners to see the organization of health services in practice. The exchanges in both directions contributed to the change in mindset that allowed adoption and implementation of new approaches and policies. Once the U.S. partners escorted their CEE partners into the global medical community, the CEE clinicians became active participants, seeking out collaborations with other institutions and thriving on the depth and breadth of new knowledge they could access. In the years since USAID/AIHA support ended, the CEE partners' advancement has been limited only by their imagination and their financial resources. In general, they have continued to focus on new approaches to health care delivery and the organization of hospital systems to improve the quality of care. The status of nurses has now been elevated significantly at every hospital partnership visited.

Recommendations

While primary care remains a severely underdeveloped link in the health care system in many places, attention to hospital operations improvements should not be ignored. Cost savings and improved quality of care at this level can have beneficial effects across the health care system. Support for hospital partnerships on a south-to-south basis should be evaluated by USAID as a foreign assistance model.

Health Management Education

Prior to 1998, five health management education partnerships were implemented. The evaluation team examined four of these partnerships: three programs from Slovakia and the Czech Republic (Slovakia/Scranton, Bohemia/Nevada, Olomouc/Richmond) whose participants attended a group discussion in Bratislava, and one program in Romania (Bucharest/Chicago) whose site the team visited. The fifth program (Tirana/New York) was not visited, nor were partners interviewed.

Findings

Partnership objectives were developed in a participatory process through discussions between the partners about their shared interests. As a result, the objectives of the health management education partnerships prior to 1998 vary somewhat by partnership. Partnership-specific objectives are identified in Annex 8. However, broad common objectives were to establish health management education programs in CEE countries; develop curricula and faculty for health management; promote evidence-based medicine; establish LRCs; and enhance professional skills of medical staff through in-service training.

All four partnerships reviewed were successful in meeting their objectives. Health management courses are now part of the standard curriculum at Trnava University School of Public Health and Nursing (Slovakia), Palacky University Faculty of Medicine (Olomouc), Faculty of Management in Jindrichuv Hradec of the University of Economics (Prague), Faculty of Informatics and Management University of Education (Hradec Kralove), and Carol Davila University of Medicine and Pharmacy, Department of Public Health and Management and the Institute of Health Services Management (Bucharest). All four partnerships developed curricula for health management. The Bucharest curriculum stands out as the most comprehensive and highest quality, incorporating the broadest range of management issues and modern concepts of what management for health services encompasses. The least successful curriculum is at the Faculty of Management in Jindrichuv

Hradec where the focus is too narrowly on health care financial management. All of the partnerships promote evidence-based medicine and established LRCs to increase access to the evidence base.

In addition, all four partnerships have contributed at some level to the systemic change that has taken place in their CEE countries since independence, some by influencing legislation and public health school curricula and some by preparing graduates to attain influential management and policy-making positions, as in Romania. Many CEE partners have continued to develop and expand their individual programs since the end of the AIHA partnership programs. For example, the Slovakia/Scranton partnership has developed into a strong, ongoing partnership that involves student exchanges to facilitate health management knowledge and learning among master's degree students from the U.S. and Slovakia and joint third-country activities in Kenya and Cambodia.

It may be too soon to see the longer-term impact of improved management of health systems because most of the health management education programs spent the project years setting up management courses, developing curricula, and training professors. Bucharest has been producing graduates since 1998 and Bohemia since 2000. Each of these programs has 20 to 30 graduates annually. It will take additional time before a critical mass of graduates reaches senior management positions and is fully able to have an impact on health systems. Similarly, it is too soon to see the degree to which these partnerships have affected improved health status because the impact of improved management in health facilities is yet to be fully realized.

In the health management education partnerships, the partnership exchanges were very important for human capacity building. CEE partners reported that their visits to the U.S. exposed them to new management concepts and teaching methodologies. For example, Prague partners reported that they were able to learn new information technologies and saw computer rooms that enhanced students' ability to work together. Czech and Slovak partners reported that specific education techniques were observed during U.S. visits (e.g., teaching in small groups, encouraging questions from students, using case studies, conducting role plays, and playing other managerial games). These techniques were embraced and incorporated into both the improved teaching approaches and the health management education curricula.

The Bucharest/Chicago partnership undertook more intensive capacity building than the other health management education partnerships, including a three-month course in management at the University of Chicago for 12 young Romanian doctors. Their studies included health care management, health economics, and quantitative applications for public health, sociology, and quality assurance. The breadth and depth of the training helped establish a cadre of health care management teachers for the University of Medicine & Pharmacy and the Institute of Health Services Management. They developed the first CEE-specific case studies based on examples from Romania, a methodology that has since been presented to other AIHA partners in the region, including a one-week training course in Kazakhstan in 2001 to introduce the Romania experience. Country-specific case studies have now become the norm for health management education in the region.

The partnerships helped establish health management education programs in three of the four pre-1998 partnerships (Bucharest had already established a program in partnership with London School of Hygiene and Tropical Medicine, Montreal, and New York University) with varying degrees of success. Slovak and Czech partners agreed that before the partnerships were formed, the profession of health management did not exist, and most health management positions were filled by clinicians. The AIHA partnership was instrumental in establishing the concept of health management as an essential tool in improving the cost-effectiveness and efficiency of health service delivery. The partnerships also demonstrated the importance of bringing nonclinical professionals into the field to improve management of health services.

When asked if there is a cadre of professional health care managers in the country, partners gave mixed answers: they noted that hospital directors are still medical doctors, not professional managers. In Slovakia, there is no specific employment tariff for health managers. This precludes official recognition of the profession and serves as an obstacle to attracting young professionals to the field.

CEE health management education partners in Slovakia and the Czech Republic were emphatic about the importance of the partnership programs in changing their mindset and stated that the change in mindset was essential to adopting the concepts, technologies, and techniques to which they were exposed. Olomouc partners remarked that the input of the U.S. partners was critical to establishing the health management program and that interaction with the partners had accelerated progress by as much as 15 years. In contrast, Bucharest partners did not consider a change of mindset to be a product of the partnership. They had engaged in previous international training and partnership activities and were well prepared to adopt new technologies and skills.

Partners on both sides saw English language skills as a critical element of a successful program. Mary Jo Keshock, former Cleveland partner and former AIHA field staff member, noted that English language capability was one of the most important aspects of successful partnerships during her tenure. Bucharest partners recognized this early and prepared their participants with English language training. Other U.S. and CEE partners noted that English language capability ensured that LRCs were better utilized, as medical literature is most readily available in English, and that training courses were more effective. Perhaps most importantly, because U.S. partners were unlikely to speak Eastern European languages, English language capability by CEE partners allowed individual partners to become friends and close colleagues and permitted partners to work on sensitive and contentious issues with mutual confidence.

Conclusions

Overall, the health management education partnerships helped to establish and strengthen the curricula for health management education programs by promoting modern principles and techniques of health care management education and increasing the availability of information for decision making.

Exchange visits to the U.S. were a critical factor in opening the minds of CEE partners to the realities of U.S. health care systems and management approaches, allowing them to overcome preconceived views and observe firsthand approaches and techniques that could be implemented in their own settings. Unlike visits from external consultants, where the visitor determines what is introduced, these exchanges allowed CEE partners to select for themselves potentially useful practices.

The most successful individual health management education partnerships were those in which the CEE partners had good English language skills that facilitated communication and enabled professional and personal relations to develop between individual partners. Additionally, where CEE partners had already studied abroad or had participated in professional activities abroad, the partnership activities were able to build on existing knowledge of what such a partnership might offer, as well as existing aspirations for obtaining knowledge, skills, and technologies.

Recommendations

Intensive structured training courses of several months duration, such as that implemented through the Bucharest/Chicago partnership, should be included in future health management education programs (rather than short-term training) as a means of ensuring human and institutional capacity development.

Healthy Communities Partnerships

USAID modified the AIHA cooperative agreement in 1995 to add healthy communities partnerships to the scope of the program. The model for healthy communities originated in U.S. communities struggling to recover from military base closures or other economic shocks to the area. The concept was to mobilize community stakeholders around common goals and objectives related to health and social needs. AIHA's healthy communities initiatives are often confused with the World Health Organization (WHO) Healthy Cities program. CEE partner institutions that have participated in both describe Healthy Cities as an urban planning program in which participants consist of city government officials and a group of designated decision makers from the community. In contrast, the AIHA healthy communities partnerships use a community-based planning strategy and programs are implemented through collaboration and mobilization of a cross-section of community stakeholders. All three pre-1998 healthy communities partnerships were established in Slovakia (Petrzalka/Kansas City, Turcianske Teplice/Cleveland, and Banska Bystrica-Martin/Cleveland) and had the same general objectives: to assess community needs, to empower citizens to prioritize program activities, and to mobilize the community for implementation.

Findings

The three partnerships met all the objectives. Over the 8-9 years following the inception of the program, they formed financially sustainable NGOs to deliver health and social services to the community. Prior to the partnership, only one of the CEE partners was familiar with community-based organizations; today the NGOs are financed by a mix of public and private funding and are providing more extensive and higher quality services than at the time the USAID/AIHA funding ended.

In Slovakia three of the four partner communities had the same U.S. partner, however *the SWOT analysis was effective in identifying the unique needs of each community.* Turcianske Teplice partners focused on lifestyle issues and established health screening services to prevent disease. Banska Bystrica undertook efforts to create long-term care and hospice services, and Martin identified tobacco use and hospice services as the priorities. Petrzalka, which already had an established organization, chose to build on its program to address drug use by children. As a result of the community assessment, their attention evolved into an initiative to stop domestic violence. CEE partners' advocacy efforts have produced systemic impact. Six to seven years after the partnership ended, Slovak partners have leveraged knowledge, skills, and experience gained through the partnership into national legislative changes. National laws have been enacted to recognize drug use and domestic violence as crimes and to protect victims of domestic violence, to require public health warnings on tobacco products, to prohibit smoking in many public buildings, and to authorize national health insurance coverage of Hib immunizations. Martin has opened a hospice and Banska Bystrica has secured authorization from the state to build a 16 bed hospice.

The opening of new integrated health and social service programs under the auspices of an NGO had far reaching effects throughout Slovakia and enhanced the health care delivery system nationwide. They served as models for collaboration between the public and NGO sectors in the development of community initiatives. Across the country, there are now NGOs financed in part by grants from local governments that address diverse needs, such as homeless shelters, safe houses for abused women, retirement homes, community centers for the elderly, and playgrounds in housing projects. While measurable outcomes are not known, the quality of life has clearly improved for consumers of the NGO services spawned by the partnerships and the volume of clients has steadily increased. Through media campaigns, the Martin partnership has made important progress in raising awareness about the problem of smoking, reporting that the number of daily smokers in Martin had decreased from 36% in 1995 to 29% in 2001. While pursuing their objective to improve community health, the Slovak partners built substantial, durable human and institutional capacity in

their NGOs that went well beyond the initial community health theme. During the visits to the U.S., they observed the interconnectedness of different aspects of a democratic society and discovered ways to make use of the freedoms they are afforded to promote their causes. They developed human capacity in fundraising, advocacy, communications, use of mass media, networking, recruitment and management of a volunteer core, and integration of myriad stakeholders into a unified campaign to benefit the community. They learned how to conduct and analyze community assessments and then use the data to build support for their programs. They adapted models to their own setting and created new indigenous models in the process. Finally, and most importantly, they reported that they developed a new mindset that all things were possible and that a better future was ahead under the new system of government. This motivation and enthusiasm provided inspiration for them, and importantly, for those who did not have a chance to visit the U.S.

CEE partners have created a whole new line of services within the delivery system and built institutional capacity to provide these new health and social services on a sustainable basis. In all cases, NGOs have been organized around the healthy communities topics and have been sustained through fundraising skills developed through the partnership experience. The original champions of the social cause promoted by the NGOs have groomed others, including many from the younger generation, to assume responsibility for program management. There is a core of community health educators. The institutions now have acquired a track record of success in both service delivery and fundraising from the city and community that is being leveraged to attract additional support. Volunteer coordination positions exist in the larger organizations, and all have internships and other volunteer programs to assist the staff. All are members of the WHO/Slovak Healthy Cities program, which has officially embraced the healthy communities processes and now promotes use of these methods in its programs.

Within only a few years, these partnerships were effective in building human and institutional capacity. They catalyzed changes throughout Slovakia by organizing and delivering a new type of service to the community—one that combines health and social services. In the process, community stakeholders were introduced to the concept of “community stakeholders” and proceeded to learn how to use their newfound status to identify problems, and cooperate and mobilize to seek solutions. They also redefined the government’s role in health and social service delivery, creating models of private sector NGOs. Most importantly, they increased awareness of each person’s responsibility for his or her own health.

Common to all three CEE partnerships was a talented CEE champion who had been a “closet social entrepreneurs” under the old system. Exchange visits gave them exposure to a diversity of professional groups, programs, services, and institutions in the U.S. Seeing programs in action opened the minds of the Slovak partners to new possibilities and motivated them to build the skills needed to actualize their own vision. Many noted that the confidence U.S. partners expressed in their ability to bring about change gave them a sense that they were respected and being treated as equals, which was also motivating.

Despite years of political, economic, and social turmoil, the CEE partners were successful at implementing changes in the health sector which simultaneously accelerated the formation of a civil society in Slovakia. Thus, healthy communities partnerships demonstrated how opportunities in the health sector could be harnessed to achieve USAID’s democracy and governance goals.

Conclusions

Pre-1998 healthy communities partnerships are effective tools of foreign assistance. They provide powerful evidence that systemic health reforms can be achieved by using a bottom-up, community-based strategy. Many features of the healthy communities model account for these results, but the most important is its emphasis on human capacity building. Strengthened human capacity led to stronger institutional capacity,

which brought forth durable change. Three aspects of strengthened human capacity stand out as providing the greatest impetus for other changes. First, the buy-in from stakeholders who are closest to the problem energized and accelerated the change and development process. Citizens took ownership of community problems, experienced participatory democracy and fomented civil society in Slovakia. Whether viewed through the lens of civil society formation, health systems or changes in health status, development impact is evident across the board. Second, the enhanced organizational and advocacy skills nurtured by the U.S. partners were immediately applied to the social problem, giving real time feedback on what would work and allowing for collaboration on course corrections. Third, the new mindset that developed through observation of U.S. models and encouragement from U.S. partners provided inspiration to CEE partners and convinced them that all things were possible.

Recommendations

USAID should incorporate the healthy communities partnership methodology into future partnership programs. Groups of local facilitators should be trained in the SWOT process in order to overcome language barriers that could impede free expression of opinions. Follow-up surveys to measure impact and guide course corrections should be conducted in all partnerships, and funding should be reserved for conducting and analyzing the survey.

2. The Impact of Each Type of Partnership Established after 1998

Health Care Partnerships and Other Initiatives

No hospital partnerships were established after 1998, reflecting the significant shift in USAID's strategic objectives toward primary care. In the post-1998 period, two primary health care partnerships and six "other health" partnerships or initiatives were launched. Two of these, the Romanian Breast Health Project and the Gjakova/Hanover Reproductive Health Partnership were on-going at the time of the evaluation. The evaluation team interviewed representatives from three post-1998 health initiatives: an effort to reduce HIV/AIDS stigma, the Romanian Breast Health Project and the Iasi/Minneapolis Partnership to develop a Women's Wellness Center (WWC).

Findings

All three projects met their respective goals. The impact on human capacity was evident for both the Iasi program and the breast health program. In Iasi, training focused on the development of professionalism (e.g., appropriate provider-patient interactions), provision of patient education, and operational aspects of the WWC. The breast health program is an excellent example of a successful "training-of-trainers" experience: the Romanian radiologists trained by U.S. experts in the first course on "Quality Assurance for Mammography" in April 2004 served as the trainers for the second course held one year later.

Both centers appear to provide high-quality care. The Iasi WWC, with its location adjacent to the primary care clinic, nicely integrates women's health into primary health care services. While initially the WWC was not well-linked with national programs in terms of coordinating care and training, eventually these relationships were established. The WWC introduced the notion that providers other than obstetricians can provide family planning care, at the time a fairly radical concept. The mammography center is a standalone site, and partners noted the need for better links with primary health care providers. Standards of excellence incorporated into these centers make them stand out as successful ventures.

Made possible when a grant to another organization was terminated due to allegations of improper financial practices, the initiative to eliminate the stigma and discrimination suffered by victims of HIV/AIDS in Croatia was carried out through a small AIHA grant to the Stampar School of Public Health. This initiative took a first step toward raising awareness among the media about the right to privacy and the human rights of the people with HIV/AIDS.

Conclusions

The post-1998 health care initiatives gave the evaluation team an opportunity to compare outcomes from partnership activities and more traditional grant programs. Results from grants were generally one-dimensional and buy-in from professionals in the CEE was limited to fewer individuals. Future progress was also largely dependent on their continued involvement. Partnerships, on the other hand, were multi-dimensional, involving people at all levels in the institution and producing durable changes that penetrated the operations of institutions. In addition, they effectively broke through the isolation that the CEE professionals had endured, providing access to a global network of peers and up-to-date information and methods. The HIV/AIDS stigma activity provides an illustration of this difference. While successful in educating the media about HIV/AIDS, the initiative would have benefited from a US or regional partner with media experience to bring an international perspective on these issues into the discussions.

Recommendations

Partnership activities should be utilized when cross-cutting institutional changes are the goal whereas the health care initiative model is recommended for targeted disease control or prevention interventions.

Health Management Education Partnerships

Two health management education partnerships funded after 1998 were evaluated: Bucharest/Lexington and Tirana/Bucharest. The first partnership built on the pre-1998 Bucharest/Chicago partnership and provided support to Bucharest partners for social marketing and communications skills development. The Tirana/Bucharest partnership was the only intra-CEE partnership and was intended to transfer health management education skills to Tirana partners through the same Bucharest partners.

Findings

Both partnerships successfully achieved their stated objectives. The Bucharest/Tirana partnership's overall goal was to improve the quality of primary health care services through institutionalizing health management skills and training for general practitioners (GPs). Specific objectives included developing advanced training skills of 15 Albanian trainers as part of postgraduate education for clinicians and increasing the knowledge of GPs in health management techniques. Bucharest reported that Tirana partners successfully implemented health care management training for GPs in Albania and formalized a curriculum adapted to the Albanian environment.

The contribution of these partnerships to systemic change in Romania was less significant. Both the Romanian and Kentucky partners acknowledge that the Romanian partners were a highly talented and well-trained group that was already thoroughly engaged in efforts to bring about national change in public health systems in Romania. However, the Bucharest/Lexington partnership provided valuable new skills that could be used in this effort. The evaluation team was not able to assess the contribution to systemic change in Albania. The partnership did contribute to improvements in health care delivery by increasing the capacity of the Romania partners to train providers and health managers in essential health education, marketing, and advocacy skills.

Both partnerships resulted in strengthened institutional capacity for Bucharest. The public health master's degree program has fully integrated the concept of communications as a critical management tool. In addition, partners have demonstrated mastery of a variety of communications techniques, including advocacy among policy makers for legislative change, promotion of health initiatives, and improved communication skills for managers and educators. The Bucharest/Tirana partnership was reviewed only through interviews with Bucharest, so the evaluation team cannot comment on impact in Tirana. However, Bucharest clearly benefited from the activity, implementing a well-prepared strategy for training and assessment of skills among trainees, and Bucharest partners reported that as a result of the partnership, the Albanian partners have requested additional support.

Conclusions

These two post-1998 partnerships built on the expertise developed through the Bucharest/Chicago partnership. Of particular value was a serendipitous challenge faced by the Lexington partners at the time of the partnership, to reopen a closed rural hospital. Over the life of the partnership, the Romanian partners were able to participate in key meetings, activities, and planning sessions and observe firsthand the strategies employed and skills used that led to the reopening of the hospital. Participants felt that the example was similar to problems currently being faced in Romania and that it provided the opportunity to develop practical skills they could put to direct use.

The Tirana/Bucharest partnership provided an excellent opportunity for Bucharest partners to hone their skills as trainers and curriculum developers. The activity is reported to have been well-received by Tirana, perhaps reflecting that the time has come when regional, rather than U.S., partners may be more effective models for development in the region.

Pairing partners who are currently facing similar problems and challenges in their own health care systems was an extremely effective learning opportunity for both sides of the partnership, allowing them to share the experience of addressing and overcoming the same obstacles and enabling them to learn from each other's successes and mistakes.

Recommendations

To optimize the opportunity for learning, partnerships should link institutions that share common real-life problems and concerns that partners can work on simultaneously. In the CEE region, this may increasingly mean intraregional partnerships.

Healthy Communities Partnerships

The evaluation team interviewed partners from four of the five post-1998 healthy communities partnerships: Vac/Winston-Salem, Split/New Jersey, Gyor/Pittsburgh, and Constanta/Louisville. The goals and objectives of the post-1998 partnerships were similar to those of the pre-1998 partnerships.

Findings

All four partnerships reviewed met both general and partnership-specific goals, and the increased level of publicity about personal health issues has motivated citizens to be more proactive about improving their health.

In Vac an NGO was created to qualify for charitable funding and to operate a Healthy Community Center that is conveniently located and accessible to Vac's citizens. The center's programs target citizens of all ages and range from competitions to increase the physical activity of overweight boys to successful smoking cessation

programs for adults. In Split, a U.S. program to educate youth about the dangers of alcohol was adapted for use. This program, which had been successful in delaying drinking among adolescents in Minnesota and Russia, included a rigorous research component, which showed that a statistically significant difference between the behavior of youth in the control and intervention schools. At the request of USAID and the AIHA, the Gyor/Pittsburgh and Constanta/Louisville partnerships gave priority to women's health. Gyor's program focused on teen pregnancy, educating teens through a sophisticated public relations campaign, titled "Love Safely." Media involvement helped to publicize the information. As a result of the partnership, Gyor now has a women's resource center with two satellite centers and eight information kiosks. Impact data on teen pregnancy has not been collected, however human capacity has been built through training of district nurses in community outreach.

In Constanta, the community assessment found that domestic violence was a serious, unacknowledged problem in Romania. With the help of a grant from one of its partners, Humana Foundation, the Constanta Community Foundation was founded. Soon thereafter, it opened an Office for Women that offers counseling, safe houses, and legal assistance to victims of domestic violence. By the end of the partnership, more than 900 women had received services from the center and the number of women seeking help continues to grow. Constanta has expanded the program to six communities, opened a health promotion center for youth, as well as a weekly radio call in show to help educate youth about healthy lifestyle choices. In addition, the partnership focused on STIs among pregnant women, helped to initiate testing in rural areas and worked with physicians to resolve conflicts of who would be authorized to conduct STI testing.

To date, three of the local partners have expressed ambitions to change national policies and bring about a systemwide response to the problems they have targeted. Constanta partners gained national prominence, and leaders from the Foundation were recruited into national policy-making positions. These positions were excellent platforms for initiating legislation to protect victims of domestic violence. In April 2002, a national strategy on fighting domestic violence was approved. It includes provisions for all levels of government to be active, and requires counties to establish an Office for Women and a shelter for victims. In 2003, Parliament enhanced laws protecting victims, increased the power of police in domestic violence cases, and classified domestic violence as a crime. The scientific component built into the Split program gives it scientific validity, and demonstrated program effectiveness. The findings are being used to convince the Ministries of Education and Health to add it to the curriculum of all primary and secondary schools in Croatia. Vac's program to educate men about prostate cancer was so successful that it has inspired a nationwide campaign on men's health.

All four of the partnerships have had a positive impact on the health status of the customers they have served: some young women have avoided pregnancy; other citizens have stopped smoking; many have sought relief from abusive partners; cohorts of children have learned the dangers of alcohol and have delayed drinking. Most importantly, the partnerships have played an important role in changing the mindset of the citizens about their own health.

In three of the four communities, NGOs were formed with a mission to sustain and enhance the achievements made through the partnership collaboration. These NGOs are still operating and are financially self-sufficient. They have improved health care delivery by bringing new services and educational resources to the community.

All four of the partnerships have had a positive impact on the health of the community: some young women have avoided pregnancy; other citizens have stopped smoking; many have sought relief from abusive partners; and children have learned the dangers of alcohol and have delayed drinking. Most importantly, the partnerships have played an important role in changing the mindset of the citizens about their own health.

Through their success at building human and institutional capacity all partnerships were able to improve the lives of professionals through enhanced training, professional, and networking skills. The prestige and legitimacy of NGOs was increased and fundraising skills and volunteerism have been either developed or enhanced to secure the future of the organizations. People and groups have been identified as stakeholders who never before knew the meaning of the term and had no understanding of their connection to a community health issue. People have learned how to adapt models observed in other settings to meet their own needs and have committed themselves to continuous improvement. Advocacy skills and appreciation of the power of mass media to influence the population's opinions and behavior has grown in each community group. Public policy is being changed at the local and national level, and gaps in social services are being filled. The new services have improved health care delivery, national health systems, and awareness of health status.

Conclusions

The post-1998 experience further confirms the usefulness of the healthy communities model for mobilizing communities around health issues and strengthening the role of civil society in emerging democracies. All activities have been sustained and several have already had impact beyond the community level to change national laws and policies, and will likely have greater impact in the future.

Recommendations

Capacity for data collection, analysis, and interpretation should be built into partnerships so that they are better able to participate in and use the information being collected.

3. Impact of Cross-Partnership Regionwide Initiatives

As part of the partnership program, the AIHA sponsored cross-partnership regionwide initiatives, where partners working on the same issues gathered to share ideas, knowledge, and experience. The team had relatively limited discussions with partners about cross-partnership activities and was not able to explore these as thoroughly as other program areas. There were three main types of cross-partnership activities: annual conferences and partnership meetings, regionwide task forces and initiatives (health management education, nursing, women's health, emergency medical services), and intra-regional partnership sharing through site visits to each other's partnerships. The evaluation team talked with partners who had been involved in the initiatives related to the Nursing Task Force, Women's Wellness, and health management education. The evaluation team sought to determine the extent to which these special initiatives contributed to the achievement of individual partnerships' objectives.

Findings

Regionwide task forces and initiatives were intended to build upon partnership workplans and provide additional training opportunities in specific topic areas, as well as to create a community of professionals across countries. AIHA's workshops on topics such as case studies for healthcare management, association-building for nurses, and CQI for WWCs, supplemented individual partnership efforts and added resource to partnerships activities. Annual conferences and workshops are discussed in Section II.4.

The Nursing Task Force provided an important mechanism to support selected nurses to attend international conferences and training. It offered access to international nursing associations, moral support, and a sense of solidarity for a beleaguered profession. Nurses were very pleased to be able to participate in these conferences. However, visits and interviews at partnership sites did not identify the AIHA's regionwide initiatives as a key factor in increased competence and skill development. Rather, the key factor was the

project-specific training and skills development that took place during partnerships. For example, in Olomouc, programs for a bachelor's degree in nursing and one in rehabilitation were initiated after observing the bachelor in nursing program in Richmond and the inclusion of nursing management in the curriculum.

The AIHA hosted a 3-day Case Studies Workshop in September 1998 for the five health management education partnerships. The workshop focused on developing and using case studies based on local conditions for health management education. CEE partners had an opportunity to present their techniques and case studies at the workshop and to discuss the approach. AIHA has called on CEE partners to conduct management training for the healthy communities, Nurses Task Force, and hospital partnerships. CEE partners generally reported that these initiatives were interesting but did not result in ongoing relationships. The Tirana/Bucharest health management education partnership, on the other hand, was a successful partnership and established the Bucharest partners as a regional training institution.

AIHA supported CEE partners to visit other partnership sites. Healthy communities partners were helpful in educating others in the region about healthy communities concepts and methods. Two examples of successful cross-regional initiatives are as follows: first, Turcianske Teplice hosted several delegations of CEE and NIS partners to visit its Community Health and Education Center and review the healthy communities methodology. The Turcianske Teplice partners viewed themselves as “the bridge” between East and West because they could show how the concepts were implemented in a post-Soviet environment. Second, after learning about the healthy communities initiatives at an AIHA meeting in Latvia, five community health leaders from Vac, Hungary, spent the day with Latvian partners to learn about the community health project in the towns of Tukums and Engure and took home ideas and materials that could be used in Vac.

Conclusions

Overall, the evaluation team found that cross-regional initiatives were more likely to succeed in instances where the AIHA took a strong role in orchestrating and funding successful partnerships and interactions, such as Tirana/Bucharest and the healthy community examples cited above. While the regional meetings and other initiatives with less specific outcome objectives were clearly valued by interviewed CEE partners as a means of showcasing their activities, a strong contribution to enabling individual partnerships to meet program objectives was not clearly demonstrated.

The regionwide nursing initiatives were not as effective at improving the role and status of nurses as the individual partnership training activities and observation of the role of nurses in other settings (during exchange visits). However, they gave the nurses recognition and moral support by providing an opportunity for nurses to feel part of a larger movement within the region. The psychological impact and motivational value of this should not be underestimated. The CEE partnership program has been instrumental in redefining the role of nurses in the former Soviet bloc.

Recommendations

Investment in cross-regional initiatives should be a secondary priority for future programs.

4. Impact of Intra-regional Sharing of Knowledge

The AIHA hosted Annual Partnership Meetings from 1996 to 2002, as well as regional conferences for specific issues to foster sharing of information and ideas. Evaluators sought to determine the extent to which the LRCs and AIHA publications, media relations, and Web sites contributed to the achievement of program objectives.

Findings

AIHA Conferences

Annual partnership conferences were designed to facilitate sharing of experiences and networking, to provide opportunities to practice preparing and giving presentations; and to provide a forum for US partnership coordinators to meet with AIHA on issues of partnership management and coordination. CEE partners generally reported that they attended the AIHA annual meetings and found them interesting but said that the meetings did not result in any specific sharing of information or techniques or intraprogram collaboration. Some partners, for example, the Romania University of Medicine and the University of Economics–Prague, reported that they did not find them useful because the meetings were too large, with too many participants with different priorities and interests. A noteworthy exception is that Zagreb partners reported that at AIHA conferences in Zagreb and Budapest, the topic of infection control was raised, models for CEE hospitals were presented, and partners heard for the first time that HIV/AIDS is not as dangerous as they had feared. The conference enabled physicians, nurses, and lab technicians to become educated and to all “speak in the same way” about infection control. Infection control is now a routine part of the curriculum for doctors and nurses.

The evaluation team found that individuals and groups who had less access to international conferences and fewer opportunities to meet with peers were more likely to appreciate the opportunity to meet with colleagues. Virtually all CEE partners demonstrated the capacity to make formal technical presentations, and counted themselves as members of an international medical community. In general, the evaluation team did not see evidence that the regional meetings resulted in development of intraregional partnerships or replication of models in other sites. Some CEE partners stated they preferred to establish relationships with partners outside the region, where they believe they can learn the most. Others reported that establishing regional partnerships was not an objective of their program.

Learning Resource Centers

A key initiative for promoting evidence-based medicine and improving access of health care professionals to information was the LRCs. LRCs were established at all health management education and hospital partnership sites and were a key element of the evidence-based medicine component of the health management education partnerships. The evaluation team was able to visit several LRCs in Slovakia, Croatia, and Romania. In all of the sites visited, the LRCs provided the necessary infrastructure and tools to advance evidence-based medicine and allowed physicians and nurses to stay informed about developments in the international medical community. Training for LRC staff included use of Medline and Ovid for literature searches and use of the Cochrane Library. LRC staff later trained physicians and, more recently, nurses in these skills.

Internet connectivity was an especially important contribution of the partnerships. In some sites (e.g., Cluj), the LRC provided the first Internet access within the hospital. The LRCs often provided the first e-mail accounts for physicians and nurses. Then (as now), e-mail was the primary means for CEE and U.S. partners to stay in touch.

The LRCs also introduced a variety of other information and communication technologies, some of which were widely adopted by CEE institutions (e-learning, Web-based transfer of information, real-time transmission of training). In some institutions, the mechanisms for increasing access to data have since surpassed the LRC model, such as in Bucharest, where professionals have access to data in offices through a network. Other LRCs have flourished. For example, at the Postgraduate Medical School in Prague, an internal network has been created, and last year, it recorded 22,000 users. In Olomouc, the LRC coordinator views her job as promoting evidence-based medicine by increasing links between the medical library services and

clinical pregraduate and postgraduate education. She teaches a course for third-year students on “Best Medical Education,” which focuses on information retrieval skills for students. For some (e.g., the LRC director in Zadar), the LRC provided the physical infrastructure and the U.S. exchanges provided an opportunity to “look ahead” and visualize for the future. A few sites (e.g., Zagreb and Banska Bystrica/Martin) have expanded their use of information technology to include an Intranet and Web site for their institutions.

AIHA continues to maintain an active Internet mailing list for the project through which LRCs continue to exchange information with each other (mostly about new information resources they have found). In addition, over the years of CEE partners have used the LRCs to communicate and consult with each other. AIHA reports that over half of the CEE partner institutions have joined the recently launched online regional LRC Network Association. However, the ability of LRCs to support the branches of their institutions housed in other locations was unclear. In fact, one U.S. partner reported that the LRC activities within the partnership operated so independently that she could not comment on them. In the Bohemia/Nevada partnership, at least two of the CEE partner institutions reported that they had never used the LRC in their partnership.

In addition, the AIHA established nine Nursing Resource Centers (NRCs) at partnership sites. At every hospital partnership site visited, NRCs provided a locus for nursing educational activities. Although the designation of a physical location was important, it was the recognition of nurses’ educational needs that marked a significant development in nursing as a respected and skilled profession. Even though many of the English language textbooks in the NRCs appeared unused and are now outdated, the rooms remain the center for postgraduate nurse training. Each site hosts several nurse training sessions each month. In only one site (Zadar) was the NRC inactive due to reconstruction of the building housing the NRC. In some sites, the NRC was the first place where nurses had access to the Internet and did not have to compete with physicians for computer time. Over the years, most hospitals have installed computers throughout the hospital so that access is less of an issue (and by now the computers in the NRCs are outdated and therefore rarely used). The significance of providing nurses their own computers at a time when computers in the hospital were scarce should not be underestimated. The NRCs further contributed to the improvement in nurses’ status brought about by the partnerships. An AIHA internal assessment of the NRCs in the CEE and NIS found that depending on size and operational status, the NRC can be used by only 10 visitors a month (Cluj) or by as many as 140 people a month (Almaty). Usually, the numbers range between 20 and 80 users monthly.

AIHA Web site and publications

The evaluation team questioned CEE partners about whether they continued to use the AIHA Web site, and for what purposes. CEE partners generally reported that they used the AIHA Web site to keep up to date on program activities. AIHA’s Web site includes the EurasiaHealth Knowledge Network, which is frequently accessed by former partners to obtain specific health-related information. AIHA reports that the EurasiaHealth Knowledge Network has increasing number of visitors (6,500 in August 2003 up to 15,500 in August 2005) and frequent downloading of materials (approximately 10,000 per month).

Conclusions

In retrospect, AIHA meetings and conferences were not a particularly important method of sharing information or facilitating achievement of individual partnership goals. However, program evaluations conducted while partnerships were still on-going gave the intraregional initiatives high marks for facilitating and encouraging synergies between individual partnership projects, suggesting that the contribution of such meetings may be more easily observed during implementation of the program.

LRCs were a very valuable tool for increasing health professionals' access to data and medical literature, and they contributed significantly to the achievement of partnership goals. Information technology and the Internet had a profound effect on the medical profession in these sites. The LRCs introduced these tools to the CEE partners well ahead of most of their peer institutions. NRCs were less valuable in terms of providing increased access to information, but they did contribute to nurses' enhanced status.

Recommendations

Assuring access by all partners to Internet-based information technologies and communication systems, such as e-mail and learning platforms should be a priority in the future.

III. Sustainability of the Partnership Relationships

Findings

Inherent to the partnership model was the hope that U.S. and CEE partners would develop permanent individual and institutional relationships that would outlast the formal partnership. One U.S. partner noted that the mere use of the label “partnership” was significant for promoting equality between the U.S. and CEE partners and focused them on relationship building. Several partners interviewed had sustained relationships beyond the official end date of the partnership.

The health management education partnership between Scranton and Slovakia provides the best example of how a partnership can grow beyond the original scope and expectations. The CEE and U.S. partners have been co-authors on academic articles and co-sponsors of conferences, including one to be held in Bratislava next year. More than simply continuing their original programs, the partnership between these two schools has blossomed into several new activities. The faculty and administration remain supportive and committed to funding these activities, so they are currently self-sustaining.

The continuation of the Slovakia partnership among those evaluated, however, is clearly an exception. In most instances, partners remained in contact for a few years after the end of the partnership and then gradually lost touch, especially as U.S. partners changed positions and left their original institutions. Nearly a decade after the first partnerships were established, only a few of the partnerships evaluated actively maintain a working relationship based on some form of professional collaboration. In those cases, it was individual personalities—best characterized by a motivated “partnership champion”—and the ability to leverage new resources that appeared to drive the continuation of relationships. Without this support, relationships could not be sustained after the partnership officially concluded.

Conclusions

Personal relationships from the partnership program have been more enduring than institutional relationships. However, as one partner pointed out, they have used the Internet to find other organizations that are doing similar work and have developed relationships with them. The partnership program was very effective in helping to “break the ice” and open the CEE partners to the resources available in the rest of the world.

On-going institutional partnerships were most likely when both sides of the partnership see continued benefits from the relationship, such as the mutually beneficial relationship between Scranton and Slovakia.

Recommendations

Future partnerships' programs should seek to assist local partners to identify funding sources for necessary hardware, software, service-provider fees, and training once the partnership has ended, so that host country partners will continue to have Internet access and be able to fully utilize the resource.

IV. Sustainability and Replication of Models and Outcomes

Findings

All of the CEE institutions that participated in the partnerships program are still operating. The vast majority of the activities and programs implemented years ago under the partnerships have been sustained. In fact, at most sites visited, the legacy of the program was found in the systems and organizational changes that were brought about through the work of the partnerships. For example, the clinical care teams at the Vac Municipal Hospital still serve as a viable model for the provision of coordinated patient care in several medical departments. In Kosice, Zagreb, Zadar, Vac and Cluj where the partnership led to an improvement in the status and role of the hospital nurses, the nurses continue to enjoy their elevated status today.

In the healthy communities programs, sustainability and replicability have generally gone hand in hand. For instance, not only has the Hope Center in Petrzalka provided counseling for women and children and helped women find safe housing, employment, and legal assistance, but it continues to serve as a model for the integration of health and social services for victims of violence. The center's example has launched a nationwide and regionwide movement. Healthy communities initiatives in Constanta, Vac, Turcianske Teplice and Martin have been a springboard for the formation of NGOs and capacity building to mobilize the community around a cause, recruit volunteers, conduct fundraising campaigns, influence legislation and engage the media in advocacy efforts. The models and outcomes have been replicated through changes in legislation or development of community networks.

The Scranton/Trnava and Tirana/Bucharest partnerships are examples health management education programs that were replicated. The Trnava partners created their own outreach program to address public health issues in Kenya, Cambodia and South Sudan. The scope of these programs is broader than the original partnership with Scranton. Bucharest partners shared with the Tirana partners the training and skills they had acquired through their two previous partnership activities.

Replication of the hospital partnership models and outcomes in other facilities or countries was less apparent during the evaluation site visits. AIHA encouraged replication through the regionwide meetings, and most of the hospital partners had presented various results at more than one AIHA or other international conference. But there was no way for the evaluation team to know whether the examples presented were embraced unless the presenting partnership requested AIHA assistance or assumed a leadership role in their field. (One notable exception is the Romanian Breast Health Project where the initiative was scaled-up, rather than replicated.)

It was evident to the evaluation team that replication would require more than dissemination of findings at meetings. For instance, the healthy communities' activities were replicated as a result of both high-profile public information campaigns and participation in meetings sponsored by WHO and the European Healthy Cities program.

Conclusions

Programs introduced by the partnership became sustainable either by being incorporated into the operations of an existing organization or by being sponsored and nurtured by an existing organization.

Partnerships that expanded their reach or program activities had successfully managed to find new means of raising funds and engaging stakeholders.

AIHA encouraged replication through the regionwide meetings, but there was no way for the evaluation team to know whether the examples presented were embraced unless the presenting partnership requested assistance or assumed a leadership role in their field. Replication was clearly apparent in the healthy communities programs that were part of a national and international trade association.

Recommendations

Membership and active participation in local, national, and international trade and professional associations will improve the chances that innovations introduced through the partnerships will be adopted by others. Partnership programs should encourage the formation of such associations where they do not already exist and should encourage participation where they do already exist.

Future partnership programs should assure that partners have strong monitoring and evaluation skills so that they can gather and present data illustrating the extent of problems and the success of interventions at addressing them. Such data is a powerful tool for advocacy and fund-raising.

Future partnership programs should include stronger emphasis on capacity development for partners for increasing community awareness and fund-raising to assure sustainability.

V. Summary of the Impact, Sustainability, and Replicability of the Partnership Models

As seen in Table 2 below, the evaluation team found that of sites included in the evaluation, virtually all of the partnership activities had been sustained, and all of the partnerships contributed to improved human and capacity development. Many of the partnership activities had been replicated and had national policy impact, and most had contributed to improvements in health care delivery and health status. There was no difference found in the effectiveness of pre-1998 partnerships versus post-1998 partnerships, though generally pre-1998 partnerships demonstrated more advanced accomplishments due to their greater complexity and longer history. In addition, the team concluded that the program met USAID's broad development objectives.

The program promoted democratic values through the partnership approach which brought peers together to work and learn as equal members of a team on jointly-designed and implemented activities. Through the healthy communities partnerships, the program focused on building capacity for social change by effectively mobilizing communities around vital issues, and providing role models for the newly emerging civil society. Notably, the development impact of the partnerships went well beyond the health sector, and the program also led to achievement of the E&E Bureau's democratic transition objectives related to civil society, transparency in local government, decentralization and citizen participation.

Table 2. Summary of the Impact, Sustainability, and Replicability of the Partnership Models

Partnership Name	Achieved Objectives	Human Capacity Development	Institutional Capacity Development	Sustained Partnership Relationships	Sustained Model and Outcomes	Replicated Outcomes	National Impact (Legislation, NGO Dev., TOT)	Contributed to USAID Goals and Objectives
Pre-1998								
Health Management Education								
Scranton	x	x	x	x	x	x	x	x HCD
Bohemia	x	x	x		x		x	x HCD
Bucharest	X	x	x		x	x	x	x
Olomouc	x	x	x		x	x	x	x HCD
Healthy Communities								
Petrazalka	x	x	x		x	x	x	x D&G
Martin/Banska Bystrica	x	x	x		x	x	x	x D&G
Turcianske Teplice	x	x	x		x			x D&G
Hospitals								
Kosice	x	x	x	x	x			x MCH
Vac	x	x	x	x	x		x	x HS
Zagreb	x	x	x		x	x	x	x MCH
Zadar	x	x	x	x	x			X
Cluj	x	x	x		x			xENV
Post-1998								
Health Management Education								
Bucharest	X	x	x	x	x	x	x	x
Tirana	X	x	x	x				x
Healthy Communities								
Gyor	X	x	x	x	x	x	x	x D&G
Pecs	unable to obtain information							
Split	x	x	x	x	x	x	not yet	x
Constanta	x	x	x	x	x	x	x	x
Vac	x	x	x	x	x			x D&G
Other Health Activities								
Iasi	x	x	x		x			x WH
Breast Health (contract)	x	x	x	(ongoing)	(ongoing)	x	x	x WH
HIV/AIDS Stigma (grant)	x	x					x	x

TOT= training of trainers; HCD = human capacity development; D&G = democracy and governance; MCH = maternal and child health; HS = health systems; WH = women's health

VI. Contribution to USAID Mission Goals and Objectives

The partnerships reviewed for this evaluation contributed to USAID Mission goals in expected and unexpected ways. In the mid-1990s, the Czech and Slovak Missions' goals and objectives were specific to the health sector. According to a 1999 health sector evaluation, the Slovak objectives were to improve health, clinical quality, and social conditions. The hospital and healthy communities partnerships directly related to these objectives, whereas the health management education partnership was oriented toward building capacity in the country to strengthen its response to the health and social status of the population. In the Czech Republic, the 1997 health sector evaluation indicated that the Mission's health sector program (which included two health management education partnerships) met the Mission's goal of promoting health markets in a democratic society.

In Romania, the partnerships contributed to health sector, environmental, and democracy goals and objectives. In the late 1990s, USAID/Romania's overarching Strategic Objective (SO) for health was *Individuals receive more effective and sustainable health and social services and benefits*. The partnership activities focused on addressing women's health and HIV/AIDS, as well as strengthening linkages between health management training and applications (Bucharest/Chicago, Constanta). Also in the late 1990s, the Cluj/Philadelphia partnership was aligned with the environmental SO, *Reduced environmental risk to public health*. In 2000, the SO shifted slightly to *Improve welfare of women and children*, with activities focused on child welfare and women's health (Constanta). The Constanta partnership (funded from 1998 to 2002) also supported the Mission's democracy objectives to have better informed citizens and to promote better citizen participation by aggressively pursuing use of volunteers.

Unable to identify an SO for the health sector in 1995, the team concluded that USAID/Hungary's democracy SO (1997–1998), *Better informed citizens increase their participation in decision making*, provided a relevant framework for the partnerships as they matured. The hospital partnership at Vac stimulated teamwork among physicians and nurses. It also demonstrated participatory decision making in the management of the partnership, and ultimately, the hospital. The healthy communities activities in Vac and Gyor are excellent examples of health sector initiatives that support democracy objectives.

The evaluation team was also unable to locate information on the goals and objectives for Croatia in the mid-1990s when the hospital partnerships were first funded. However, in 2000, the democracy SO was *Increased, better informed citizen participation in political process*. By 2003, the SO had changed to *Mitigation of adverse social conditions and trends* (to address social problems typical of countries with high unemployment, disaffected youth, and illegal drug use and availability) and was addressed by the Split partnership activity.

Cost Effectiveness

The evaluation team was asked to assess the cost-effectiveness of the overall approach of the Health Partnerships program. Funding for 1994–1998 totaled \$58 million for both CEE and NIS programs, and of that amount, the CEE partnership program received \$24.5 million. For 1999–2005, the CEE partnerships received approximately \$12.8 million primarily as buy-ins from USAID Missions for specific country activities, for a total of \$37.3 million for the partnerships being evaluated. During 1994–2005, the AIHA implemented 30 partnerships and 3 grants. A detailed cost analysis was not possible because AIHA was unable to provide detailed cost data for the project period prior to 1999. The evolution to collecting better cost data began in 1998, partly in response to USAID's request for partnership and line item information.

Findings

At the country level, the largest investments were made in Albania (~\$6.5 million), Slovakia (~\$6 million), Croatia (~\$5.2 million), and Romania (\$4.2 million). The 17 funded activities prior to 1999 cost on average \$1,438,869. The average cost for the 14¹ activities funded from 1999 to 2005 was \$892,857 per partnership.

AIHA provided grants to each U.S. partners for individual partnership programs. The size of the grants varied according to the kind of partnership, its duration, and the specific activities and number of exchange visits conducted during the project term. The AIHA was not able to provide subgrant amounts by partnership; however, based on the information received by the evaluation team for 14 partnership activities supported during the post-1998 period, subgrants for project implementation and exchange travel ranged from as little as \$93,483 for the Tirana/Bucharest partnership to \$862,289 for the Gjilan/Hanover partnership.

Although AIHA was not able to provide any information on how costs were broken down for the 17 partnerships funded prior to 1999, several factors contributed to the higher cost per partnership. Specifically, prior to 1999, several partnerships were made up of multiparty partnerships with several U.S. partners (e.g., Cleveland partners: MetroHealth System, The Institute for Public Health Sciences of the Medical School at Case Western Reserve University, Federation for Community Planning, and the Cleveland/Bratislava Sister Cities organization) and/or several CEE partners (e.g., the Bohemia/Nevada partnership, which had five CEE partner institutions). These more complex partnerships undoubtedly required more management and coordination by the AIHA, resulting in much average higher costs for each partnership. Additionally, prior to 1999 more AIHA field offices and more LRCs were established. And finally, the hospital partnerships were all funded prior to 1999, and the hospital partnerships generally received larger grants (an average of \$1.8 million per hospital partnership v. \$1.1 million for all activities).

AIHA was able to provide a cost breakdown for USAID funds received from 1999-2006. Though this represents only approximately one-third of the total resources allocated, it provides some insight into how resources were allocated. The proportion of USAID funds spent on various cost categories for partnerships funded from 1999–2006 is shown in Table 3 below.

Table 3. Proportion of USAID Funds Spent on Various Cost Categories 1999-2006

Cost Category	Total	Percentage of Budget
Partnership subgrants, exchange travel costs & regional initiatives	\$4,669,961.00	47.82%
Washington and field office support, and TA visits	\$3,798,690.00	29.51%
Communications, Video conferencing and ICT support	\$1,294,821.00	10.06%
Annual and intraregional conferences & task forces	\$824,888.00	6.41%
LRCs	\$647,659.00	5.03%
Monitoring and evaluation support	\$150,348.00	1.5%
TOTALS	\$12,871,870.00	100%

Of particular note was AIHA's success in leveraging significant additional resources from US partners, including equipment and supplies valued at \$1.7 million, and volunteer time of US partners valued at \$32

¹ Does not include the small grant to Stampar School of Public Health for HIV/AIDS Stigma

million, for a total in-kind contribution of \$33.7 million². These in-kind contributions accounted for virtually all of the technical assistance provided, and nearly doubled the total resources available to the Health Partnerships program. In-kind contributions were particularly significant during the period pre-1999. Unfortunately, AIHA was unable to provide detailed information on how equipment and supplies and volunteer time were allocated on specific projects, so the evaluation team is unable to make any assessment of the cost-effectiveness of these estimated contributions.

As a proportion of the budget, AIHA's management costs at near 30% percent are high. AIHA provided management, logistic and administrative support that would, under a traditional subgrant program model, would have been undertaken by the partners. The LRCs, annual conferences and other meetings, and non-partnership initiatives are implemented and managed by AIHA field and Washington staff. Management and technical support varied by country and activity, depending upon the complexity of the activity and the amount of assistance provided by the U.S. partners. AIHA found that amount of management assistance provided by AIHA could be a factor in the willingness and ability of individuals and institutions to donate professional time and to forego traditional overheads while working on AIHA partnership programs, and that AIHA technical assistance was critical to ensuring progress by CEE partners against their workplan objectives between partnership exchange visits. If in-kind technical assistance were taken into account in the calculation, management costs as a proportion of overall costs would be significantly smaller.

Conclusions

It was not possible to determine the cost-effectiveness of the CEE partnerships because of the limited financial data provided to the evaluation team for activities funded prior to 1998. Projects funded after 1998 were less costly than those funded from 1994 to 1998. One explanation for this difference in cost is that post-1998 partnerships involved fewer partner institutions, established fewer LRCs, and involved fewer management inputs.

AIHA's partnership model successfully leveraged extensive private resources to provide technical assistance to the program, however data was not available in a form that would allow analysis of the cost-effectiveness of the model.

Recommendations

USAID should specify a standard cost-tracking system in future partnerships to allow better tracking and analysis of project costs and cost-effectiveness. In particular, a system that allowed for analysis of the costs of managing volunteers would provide valuable information to USAID on the relative cost-effectiveness of such a model.

VII. Lessons Learned

1. Partnerships are a vehicle of foreign policy and foreign assistance. The partnership approach resulted in productive collaboration between citizens of countries that had viewed each other with suspicion during the Cold War. Key elements to this success were the enthusiasm and encouragement of U.S. partners, the opportunity for CEE partners to see for themselves what the U.S. health care system offered (both good and bad), and genuine respect and openness on both sides that fostered relationships based on trust and true collaboration.

² AIHA conducted annual in-kind audits to estimate the value of in-kind contributions. Analysis of the estimation methods was beyond the scope of this evaluation.

The CEE partnerships occurred at a fortuitous time when the CEE countries were transitioning from communism to a new system and eager for contact with the international community. The partnership model may be equally appropriate for other periods of either geo-political transition (e.g., post-conflict) or global health transition. For example, Croatian partners reported that they were grateful for the opportunity to participate in the international arena following their isolation resulting from war, and this made the partnership program especially welcome. In regions where new program interventions are being introduced (such as anti-retrovirals in Africa), the partnership model may be useful in strengthening institutional capacity for outreach and treatment, and accelerate effective implementation.

Partnerships are potentially important methods for achieving foreign policy and foreign assistance objectives. Professional and institutional exchanges provide a non-threatening, non-political way to open doors with other countries whether in a historical transition period or not.

2. Previous international experience is not necessary for success. U.S. partners with no prior foreign assistance experience were effective in helping CEE partners transform their operations. The most important partner qualities were the ability to work as a team and experience managing similar problems.

3. Bottom-up approaches generated change from inside. Through the bottom-up collaborative method, the CEE partners who felt ownership of the solutions were the linchpins to institutional change. The interdisciplinary and participatory structure of AIHA's partnership approach tapped the people closest to the problems to decide the partnership priorities and implement the program. This method gave the professionals a feeling of empowerment that proved to be powerful and reliable in producing development results. It delivered a high return for USAID's investment, particularly as shown by the early healthy communities initiatives. AIHA successfully adapted the methodology to address problems in institutions.

CEE partners used their enhanced capacity to catalyze policy changes. The partnership facilitated replication by catalyzing increased confidence and motivation of the local partner. The momentum generated by the partnership increased the visibility of the issues and inspired other local groups to mobilize.

The bottom-up collaborative design of the AIHA partnership model can have impact on a systemic level. Illustrative of the remarkable changes that can come from this approach are the elevation of the status of nurses, the elevation of domestic violence to an international level of concern, and recognition of the urgency of addressing health promotion and disease prevention of non-communicable diseases.

4. The partnership model has cross-sectoral application. The development impact of the healthy communities partnerships went well beyond the health sector, making an important contribution to civil society, transparency in local government, and promotion of democratic values. Because the model is generic and not tailored to specific issues in the health sector, it has potential for a range of development sectors. Mission staff who viewed the partnerships only through the lens of their country health strategy missed the opportunity to take credit for the potential contribution of the program to non-health Mission priorities, such as strengthening of democracy, civil society, and local government.

5. Human capacity building leads to institutional capacity building. The partnerships demonstrate that the human mind is the most valuable asset in development. When nurtured and applied to issues in the context of a free and open institution, productivity will increase. Peer-to-peer relationships have a common reference point that breaks down barriers and facilitates knowledge and skills transfer. New thinking becomes the springboard for institutional change. The partnerships demonstrate that human capacity is best built by using new skills and methods in day-to-day work. U.S. partners were collaborators and mentors as the CEE partners practiced their new skills.

The most successful individual partnerships benefited from a visionary and motivated CEE champion who inspired confidence and mobilized colleagues to be open to new ideas and methods.

6. Existing institutions incubated the changes. The partnerships were sustained either being incorporated into an existing organization or by being sponsored and nurtured by an existing organization. For all partnerships, the experience resulted in structural changes to established CEE institutions. The collaborative nature of the partnerships facilitated changes in the culture of the CEE institutions, penetrating deeply into their operations.

The AIHA partnership model can be used to achieve complex changes in complex organizations. The impact of the hospital partnerships was multi-dimensional, changing professional roles and responsibilities, clinical care and hospital management systems that cut across specialties.

7. Evidence of impact was clear even without strong monitoring systems. Even though a M&E system and evaluation criteria were not established at the beginning of the partnership project, it was still possible for the team to see that the partnerships had catalyzed significant change in the partner institutions and to see that in many cases the changes went well beyond the individual institution. The team was also able to make a professional judgment that the CEE partnerships program had significant results. The critical factor that made this possible was that the AIHA partnership model calls for the local counterpart to be an operating entity. Because these entities continue to deliver services, and have institutional memory, it was possible to talk with people who were involved from the beginning and to observe operations.

It takes time for the impact of new methods and new thinking in organizations/communities to take hold. For instance, the healthy communities partnerships were funded for only 18-24 months, health management education partnerships for 3 years and hospital partnerships for 3-4 years, and the impact of these programs on health outcomes will likely not be seen for several years. Rather than using health outcome measures, elements of human and institutional capacity building, such as those used by the team, could serve as predictive measures for sustainable change.

Best Practices

1. The partnership approach produces lasting results.

Exchange visits to the U.S. in particular provided exposure to new technologies, methods and institutions that sparked the imagination of CEE partners. The opportunity to visit U.S. sites, especially prior to 1998, offered CEE partners the opportunity to observe for themselves specific technologies, behaviors, relationships, ideas, and activities that were appropriate to their own settings and could be integrated or initiated in their home institutions. Additionally, on these visits they observed how new technologies and behaviors are applied to real world problems to generate solutions. These observations built confidence that they too could do it.

Local empowerment is the foundation of the partnership approach. By owning the problem and taking responsibility for the solution, the CEE partners were deliberate in how they used the mentoring and other assistance from the US partners. The AIHA capitalized on the success of the SWOT analysis technique and incorporated it into the startup phase of post-1998 partnerships.

The public-private collaboration of the partnerships assured that the assistance to CEE institutions would draw on people and institutions with day-to-day operating experience relative to the focus areas. AIHA was successful in leveraging the USAID investment to achieve impressive in-kind donations through the reliance on partner volunteers for technical assistance, reflecting a remarkable level of private commitment to the modernization of CEE health care.

U.S. partner institutions were adept at achieving the objectives of the program and provided the financial strength to support the volunteer effort. The partnerships provided important access to CEE partners to the international medical community. The sense of acceptance and equality between partners was highly motivating. In many cases these relationships were enhanced and nurtured by a local CEE diaspora eager to establish relations and support linkages with counterparts from their own countries of origin. For example, the Cleveland partnership very successfully courted the Slovak diaspora, which resulted in broad scale community commitment and interest in the success of the program. A Cleveland partner noted that it also resulted in very strong community support and positive attitudes toward USAID.

2. Modern communications technology catalyzed rapid change. AIHA's initiatives to provide CEE partners with modern communications and training enabled them to engage with the global medical community. These initiatives were especially innovative in the early years of the program when web-based communications were only recently widely available even in the U.S. Access to these technologies accelerated the use of evidence-based medicine and quality improvement systems by as much as 10-15 years according to CEE partners.

3. A broad cross-section of professionals was active in the partnerships. Including a cross section of professionals based on gender, age and discipline on the host country partnership team contributed to the ability of CEE partners to achieve buy-in throughout the institution and assured that changes would penetrate daily operations. This inter-disciplinary approach mirrors standard CQI methodologies and serves as a model of best practice in the institution. The cross section of professionals also establishes institutional memory that will be an internal resource for years to come.

Younger colleagues were actively engaged in several individual partnerships (e.g., Bucharest, Slovakia), including exchanges and training opportunities. This foresight created an important next generation of human capacity and opportunity for sustained and expanded program development. Future partnership teams should include a balance of senior and junior professionals and should ensure that the younger generation has access to the professional growth opportunities offered by the partnerships.

4. The volunteerism spawned by the CEE partnerships reflects an important culture change. As a direct result of the example provided in the partnership model, CEE partners in Banska Bystrica, Martin, Vac, Turcianske Teplice, Constanta, and Petrzalka initiated their own volunteer programs that are attracting young people into unpaid community service roles. This reflects a higher acceptance of personal social responsibility than existed under the old regime and serves as a measure of the increased role of civil society organizations in these countries.

Annex 1: Summary of Conclusions, and Recommendations

Partnership Approach and Overall Impact

Conclusions

USAID's investment in the partnerships program has produced important results in the CEE that have had cascading impact in the years since program support ended. There is convincing evidence that the collaborative and participatory approach of the AIHA partnerships model has brought meaningful, lasting changes at the personal, professional, institutional and policy levels in the CEE. As such it has established a track record of success as a tool of foreign assistance. By contributing to the ENI (later the E&E) Bureau goals and strategic objectives, the approach also fulfilled foreign policy goals that have accelerated the movement of the local medical communities, including hospitals, academic institutions and medical service organizations, out of isolation and into the international medical community. Most importantly, it has fostered immeasurable friendship and good will among partners.

Recommendations

USAID should revise its assistance mechanisms to accommodate the unpredictable path of participatory programs. For instance, through the SWOT analysis, the community may find, as in the case of Petrzalka, that there are hidden problems that need immediate attention. If the scope of work for the partnership is too directive, the partners may not have the latitude to organize around the problem that the community believes is their highest priority.

The AIHA partnership model could be adapted for use in resource-poor settings. The model's flexibility and its use of peer-to-peer relationships which fostered positive interactions and much good will would be appropriate in other settings. If applied to a situation such as the roll-out of antiretroviral therapy to address the HIV/AIDS pandemic in Sub-Saharan Africa, the partnership could provide opportunities for mutual benefit which could stimulate US participation. The urgency and compelling nature of the situation as well as the growing cadre of academic institutions involved in international HIV/AIDS care and treatment could provide a solid pool of potential US partners.

However, differences between resource-poor countries and the US would necessitate adaptation of the model for application in these settings. For example, the greater resource disparity between partners might lessen the usefulness of and need for large bi-directional exchange visits. In addition, the urgency of the situation may require more intensive activities geared at more immediate results. A potential obstacle to implementing the partnership model in an African context is the health worker shortage which could limit partnering possibilities. Also, unlike the CEE countries in the early 1990's, most African countries are not politically isolated and in fact their academic elite are already strongly established in, and recognized by, the international community. Furthermore, mobilization of the African-American diaspora could be much more challenging. Lastly, more complicated travel logistics and increased health risks to the US partners could potentially discourage US participation. Many of these challenges could be overcome by careful selection of US partners who have experience working in the chosen resource-poor countries.

The Impact of Each Type of Partnership Established before 1998

Hospital Partnerships

Conclusions

Hospital partnerships set in motion a series of changes at the human and institutional levels that have had lasting impact. Dedicated CEE clinicians working with U.S. partners have led their colleagues and institutions to adopt modern clinical practices guided by the latest published research which has greatly improved the quality of patient care. Exchanges to U.S. partner institutions were important to allow the CEE partners to see the organization of health services in practice. The exchanges in both directions contributed to the change in mindset that allowed adoption and implementation of new approaches and policies. Once the U.S. partners escorted their CEE partners into the global medical community, the CEE clinicians became active participants, seeking out collaborations with other institutions and thriving on the depth and breadth of new knowledge they could access. In the years since USAID/AIHA support ended, the CEE partners' advancement has been limited only by their imagination and their financial resources. In general, they have continued to focus on new approaches to health care delivery and the organization of hospital systems to improve the quality of care. The status of nurses has now been elevated significantly at every hospital partnership visited.

Recommendations

While primary care remains a severely underdeveloped link in the health care system in many places, attention to hospital operations improvements should not be ignored. Cost savings and improved quality of care at this level can have beneficial effects across the health care system. Support for hospital partnerships on a south-to-south basis should be evaluated by USAID as a foreign assistance model.

Health Management Education

Conclusions

Overall, the health management education partnerships helped to establish and strengthen the curricula for health management education programs by promoting modern principles and techniques of health care management education and increasing the availability of information for decision making.

Exchange visits to the U.S. were a critical factor in opening the minds of CEE partners to the realities of U.S. health care systems and management approaches, allowing them to overcome preconceived views and observe firsthand approaches and techniques that could be implemented in their own settings. Unlike visits from external consultants, where the visitor determines what is introduced, these exchanges allowed CEE partners to select for themselves potentially useful practices.

The most successful individual health management education partnerships were those in which the CEE partners had good English language skills that facilitated communication and enabled professional and personal relations to develop between individual partners. Additionally, where CEE partners had already studied abroad or had participated in professional activities abroad, the partnership activities were able to build on existing knowledge of what such a partnership might offer, as well as existing aspirations for obtaining knowledge, skills, and technologies.

Recommendations

Intensive structured training courses of several months duration, such as that implemented through the Bucharest/Chicago partnership, should be included in future health management education programs (rather than short-term training) as a means of ensuring human and institutional capacity development.

Healthy Communities Partnerships

Conclusions

Pre-1998 healthy communities partnerships are effective tools of foreign assistance. They provide powerful evidence that systemic health reforms can be achieved by using a bottom-up, community-based strategy. Many features of the healthy communities model account for these results, but the most important is its emphasis on human capacity building. Strengthened human capacity led to stronger institutional capacity, which brought forth durable change. Three aspects of strengthened human capacity stand out as providing the greatest impetus for other changes. First, the buy-in from stakeholders who are closest to the problem energized and accelerated the change and development process. Citizens took ownership of community problems, experienced participatory democracy and fomented civil society in Slovakia. Whether viewed through the lens of civil society formation, health systems or changes in health status, development impact is evident across the board. Second, the enhanced organizational and advocacy skills nurtured by the U.S. partners were immediately applied to the social problem, giving real time feedback on what would work and allowing for collaboration on course corrections. Third, the new mindset that developed through observation of U.S. models and encouragement from U.S. partners provided inspiration to CEE partners and convinced them that all things were possible.

Recommendations

USAID should incorporate the healthy communities partnership methodology into future partnership programs. Groups of local facilitators should be trained in the SWOT process in order to overcome language barriers that could impede free expression of opinions. Follow-up surveys to measure impact and guide course corrections should be conducted in all partnerships, and funding should be reserved for conducting and analyzing the survey.

The Impact of Each Type of Partnership Established after 1998

Health Care Partnerships and Other Initiatives

Conclusions

The post-1998 health care initiatives gave the evaluation team an opportunity to compare outcomes from partnership activities and more traditional grant programs. Results from grants were generally one-dimensional and buy-in from professionals in the CEE was limited to fewer individuals. Future progress was also largely dependent on their continued involvement. Partnerships, on the other hand, were multi-dimensional, involving people at all levels in the institution and producing durable changes that penetrated the operations of institutions. In addition, they effectively broke through the isolation that the CEE professionals had endured, providing access to a global network of peers and up-to-date information and methods. The HIV/AIDS stigma activity provides an illustration of this difference. While successful in educating the media about HIV/AIDS, the initiative would have benefited from a US or regional partner with media experience to bring an international perspective on these issues into the discussions.

Recommendations

Partnership activities should be utilized when cross-cutting institutional changes are the goal whereas the health care initiative model is recommended for targeted disease control or prevention interventions.

Health Management Education Partnerships

Conclusions

These two post-1998 partnerships built on the expertise developed through the Bucharest/Chicago partnership. Of particular value was a serendipitous challenge faced by the Lexington partners at the time of the partnership, to reopen a closed rural hospital. Over the life of the partnership, the Romanian partners were able to participate in key meetings, activities, and planning sessions and observe firsthand the strategies employed and skills used that led to the reopening of the hospital. Participants felt that the example was similar to problems currently being faced in Romania and that it provided the opportunity to develop practical skills they could put to direct use.

The Tirana/Bucharest partnership provided an excellent opportunity for Bucharest partners to hone their skills as trainers and curriculum developers. The activity is reported to have been well-received by Tirana, perhaps reflecting that the time has come when regional, rather than U.S., partners may be more effective models for development in the region.

Pairing partners who are currently facing similar problems and challenges in their own health care systems was an extremely effective learning opportunity for both sides of the partnership, allowing them to share the experience of addressing and overcoming the same obstacles and enabling them to learn from each other's successes and mistakes.

Recommendations

To optimize the opportunity for learning, partnerships should link institutions that share common real-life problems and concerns that partners can work on simultaneously. In the CEE region, this may increasingly mean intraregional partnerships.

Healthy Communities Partnerships

Conclusions

The post-1998 experience further confirms the usefulness of the healthy communities model for mobilizing communities around health issues and strengthening the role of civil society in emerging democracies. All activities have been sustained and several have already had impact beyond the community level to change national laws and policies, and will likely have greater impact in the future.

Recommendations

Capacity for data collection, analysis, and interpretation should be built into partnerships so that they are better able to participate in and use the information being collected.

Impact of Cross-Partnership Regionwide Initiatives

Conclusions

Overall, the evaluation team found that cross-regional initiatives were more likely to succeed in instances where the AIHA took a strong role in orchestrating and funding successful partnerships and interactions, such as Tirana/Bucharest and the healthy community examples cited above. While the regional meetings and other initiatives with less specific outcome objectives were clearly valued by interviewed CEE partners as a means of showcasing their activities, a strong contribution to enabling individual partnerships to meet program objectives was not clearly demonstrated.

The regionwide nursing initiatives were not as effective at improving the role and status of nurses as the individual partnership training activities and observation of the role of nurses in other settings (during exchange visits). However, they gave the nurses recognition and moral support by providing an opportunity for nurses to feel part of a larger movement within the region. The psychological impact and motivational value of this should not be underestimated. The CEE partnership program has been instrumental in redefining the role of nurses in the former Soviet bloc.

Recommendations

Investment in cross-regional initiatives should be a secondary priority for future programs.

Impact of Intraregional Sharing of Knowledge

Conclusions

In retrospect, AIHA meetings and conferences were not a particularly important method of sharing information or facilitating achievement of individual partnership goals. However, program evaluations conducted while partnerships were still on-going gave the intraregional initiatives high marks for facilitating and encouraging synergies between individual partnership projects, suggesting that the contribution of such meetings may be more easily observed during implementation of the program.

LRCs were a very valuable tool for increasing health professionals' access to data and medical literature, and they contributed significantly to the achievement of partnership goals. Information technology and the Internet had a profound effect on the medical profession in these sites. The LRCs introduced these tools to the CEE partners well ahead of most of their peer institutions. NRCs were less valuable in terms of providing increased access to information, but they did contribute to nurses' enhanced status.

Recommendations

Assuring access by all partners to Internet-based information technologies and communication systems, such as e-mail and learning platforms should be a priority in the future.

Sustainability of the Partnership Relationships

Conclusions

Personal relationships from the partnership program have been more enduring than institutional relationships. However, as one partner pointed out, they have used the Internet to find other organizations that are doing similar work and have developed relationships with them. The partnership program was very

effective in helping to “break the ice” and open the CEE partners to the resources available in the rest of the world.

On-going institutional partnerships were most likely when both sides of the partnership see continued benefits from the relationship, such as the mutually beneficial relationship between Scranton and Slovakia.

Recommendations

Future partnerships’ programs should seek to assist local partners to identify funding sources for necessary hardware, software, service-provider fees, and training once the partnership has ended, so that host country partners will continue to have Internet access and be able to fully utilize the resource.

Sustainability and Replication of Models and Outcomes

Conclusions

Programs introduced by the partnership became sustainable either by being incorporated into the operations of an existing organization or by being sponsored and nurtured by an existing organization.

Partnerships that expanded their reach or program activities had successfully managed to find new means of raising funds and engaging stakeholders.

AIHA encouraged replication through the regionwide meetings, but there was no way for the evaluation team to know whether the examples presented were embraced unless the presenting partnership requested assistance or assumed a leadership role in their field. Replication was clearly apparent in the healthy communities programs that were part of a national and international trade association.

Recommendations

Membership and active participation in local, national, and international trade and professional associations will improve the chances that innovations introduced through the partnerships will be adopted by others. Partnership programs should encourage the formation of such associations where they do not already exist and should encourage participation where they do already exist.

Future partnership programs should assure that partners have strong monitoring and evaluation skills so that they can gather and present data illustrating the extent of problems and the success of interventions at addressing them. Such data is a powerful tool for advocacy and fund-raising.

Future partnership programs should include stronger emphasis on capacity development for partners for increasing community awareness and fund-raising to assure sustainability.

Contribution to USAID Mission Goals and Objectives

Cost Effectiveness

The evaluation team was asked to assess the cost-effectiveness of the overall approach of the Health Partnerships program. Funding for 1994–1998 totaled \$58 million for both CEE and NIS programs, and of that amount, the CEE partnership program received \$24.5 million. For 1999–2005, the CEE partnerships received approximately \$12.8 million primarily as buy-ins from USAID Missions for specific country activities, for a total of \$37.3 million for the partnerships being evaluated. During 1994–2005, the AIHA implemented 30 partnerships and 3 grants. A detailed cost analysis was not possible because AIHA was

unable to provide detailed cost data for the project period prior to 1999. The evolution to collecting better cost data began in 1998, partly in response to USAID's request for partnership and line item information.

Conclusion

It was not possible to determine the cost-effectiveness of the CEE partnerships because of the limited financial data provided to the evaluation team for activities funded prior to 1998. Projects funded after 1998 were less costly than those funded from 1994 to 1998. One explanation for this difference in cost is that post-1998 partnerships involved fewer partner institutions, established fewer LRCs, and involved fewer management inputs.

AIHA's partnership model successfully leveraged extensive private resources to provide technical assistance to the program, however data was not available in a form that would allow analysis of the cost-effectiveness of the model.

Recommendations

USAID should specify a standard cost-tracking system in future partnerships to allow better tracking and analysis of project costs and cost-effectiveness. In particular, a system that allowed for analysis of the costs of managing volunteers would provide valuable information to USAID on the relative cost-effectiveness of such a model.

Annex 2: Scope of Work for the Evaluation

1. Evaluate the developmental impact (legacy) of AIHA’s Health Partnerships program in Central and Eastern Europe, including the partnership approach, individual partnerships and region-wide cross-partnership activities. Given the technical assistance and training focus of the partnerships program, the evaluation team will examine “developmental impact” in terms of the human and institutional capacity the program leaves behind as measured by improved skills and services of individuals and institutions. Of particular interest is capacity building in the following areas: evidence-based medicine, quality improvements, nursing, health care delivery, community mobilization, and health profession education. The evaluation will include findings, conclusions, and recommendations for strengthening the development impact of ongoing and future health partnerships and region-wide activities, both within and outside the E&E region.

Specifically, the evaluation of development impact will address the following questions:

Partnership Approach and Overall Impact:

What are the strengths and weaknesses of the AIHA health partnerships approach in terms of achieving development impact?

To what extent (cite evidence):

- Did the program reorient the focus from hospitals to primary health care?
- Did the program contribute to E&E Bureau goals and objectives?
- Did the program transfer technical knowledge that bridged the gap in clinical practice standards?
- Did the program more closely align personal health and public health efforts?
- Did the program promote modern techniques of health care management and quality in health care practice and education?
- Did the program increase the quality and availability of information for decision-making?
- Did the program promote democratic values and expand civil society?

Individual Partnerships:

To what extent (cite evidence):

- Did the individual partnerships achieve their goals and objectives?
- Did the achievement of partnership objectives contribute to USAID Mission goals?
- Did the partnerships achieve their objectives in a cost-effective manner? Did they use resources efficiently? Were resources well leveraged?
- Did the partnerships improve health care delivery (reduced cost, improved quality)?

Cross-Partnership Region-wide Activities:

To what extent (cite evidence):

- Did AIHA cross-partnerships special initiatives in Nursing, Emergency Medical Services, Women’s Wellness, and Health Management Education facilitate individual partnerships in achieving their goals and objectives?

- Did CEE/NIS and CEE region-wide conferences and workshops facilitate individual partnerships in meeting their goals and objectives?
- Are the Learning Resource Centers effective in advancing the use of evidence-based medicine?
- Are AIHA publications, media relations, and web sites contributing to the achievement of program objectives?

Contractor shall review project documents including the AIHA CEE cooperative agreement and modifications, earlier evaluation studies, partnership close-out reports; the last AIHA Quarterly Report reporting on ongoing partnerships or partnerships recently completed but without close-out reports; briefs prepared by AIHA to update country achievements; and the following AIHA websites:

<http://www.aiha.com/index.jsp?sid=1&id=3531&pid=3531>

<http://www.eurasiahealth.org/index.jsp?sid=1&id=7101&pid=7097>

AIHA will provide these documents to the contractor at the Team Planning Meeting and will provide the contractor additional partnership and technical documentation upon request.

Contractor will e-mail a written questionnaire to U.S. partners, patterned on the questions posed above and below under Work Specifications A2, A3, and A4. The contractor will follow-up the written questionnaire with telephone calls to clarify responses.

Contractor will visit Slovakia, Hungary, Romania, and Croatia to evaluate program impact and will use key informant interviews, focus group interviews (hospitals, health management education, and healthy communities), and site visits to evaluate program impact. The contractor will interview AIHA CEE partners, USAID Mission officers, Ministry of Health personnel involved in the implementation of the partnership. The thematic focus groups will include participants from other countries; e.g., the Bratislava focus group on Health Management Education (HME) will include participants from the Czech Republic as indicated under the section Site #1: Bratislava below. AIHA will identify in-country contacts; organize the focus groups, and will make in-country travel arrangements. The CTO will obtain Mission approval for the country visits. The tentative schedule for the country visits follows:

Monday, October 3 – Bratislava, Slovakia

- Visit Health Management School (Slovakia/Scranton HME partnership) – for partnership institution site visit and to prepare for HME focus group
- Meet with representatives from the Citizens Association of Aid to Children at Risk and other participating community organizations (Petrzalka/Kansas City Healthy Communities partnership)

Tuesday, October 4 – Bratislava, Slovakia

- Conduct Czech and Slovak HME focus group with representatives from the following institutions:
 - Health Management School (Bratislava, Slovakia – host)
 - Trnava University School of Public Health (Trnava, Slovakia)
 - University of Matej Bel School of Economics (Banska Bystrica, Slovakia)
 - South Bohemia University Faculty of Management (Jindrichuv Hradec, Czech Republic – Bohemia/Nevada HME partnership)

- Faculty of Management and Information Technology at the University of Education (Hradec Kralove, Czech Republic – Bohemia/Nevada HME partnership)
- Faculty of Health and Social Care (Ceske Budejovice, Czech Republic – Bohemia/Nevada HME partnership)
- Purkyne Medical Academy (Hradec Kralove, Czech Republic – Bohemia/Nevada HME partnership)
- Postgraduate Medical School (Prague, Czech Republic – Bohemia/Nevada HME partnership)
- Palacky University Faculty of Medicine (Olomouc, Czech Republic – Olomouc/Richmond HME partnership)
- Travel by car or train from Bratislava to Martin

Wednesday, October 5 – Martin, Slovakia

- Visit Martin mayor’s office, hospice foundation, non-smoking promotion center, and other involved community organizations (Banska Bystrica and Martin/Cleveland Health Communities partnership)

Thursday, October 6 – Martin, Slovakia

- Conduct Slovakia Healthy Communities focus group with the following representatives:
 - Martin community representatives (Banska Bystrica and Martin/Cleveland Healthy Communities partnership)
 - Banska Bystrica community representatives (Banska Bystrica and Martin/Cleveland Healthy Communities partnership)
 - Petralka community representatives (Petralka/Kansas City Health Communities partnership)
- Travel by car or train from Martin to Kosice

Friday, October 7 – Kosice, Slovakia

- Visit Faculty Hospital and Polyclinic (Kosice/Providence Hospital Partnership – Neonatology, Perinatal Regionalization)
- Travel over the weekend to Budapest/Vac, Hungary

Monday, October 10 – Vac, Hungary

- Visit Vac Municipal Hospital
- Conduct Hungary Healthy Communities focus group with the following representatives:
 - Vac community representatives (host – Vac/Winston-Salem partnership)
 - Gyor community representatives (Gyor/Pittsburgh Healthy Communities partnership)
 - Hungarian Association of Healthy Cities representatives from Pecs (Pecs/Harrisburg Healthy Communities Network partnership)
- Travel from Budapest to Zagreb, Croatia (evening flight or morning next day)

Tuesday, October 11 – Zagreb, Croatia

- Visit “Sveti Duh” General Hospital (Zagreb/Lebanon hospital partnership)

Wednesday, October 12 – Zagreb, Croatia

- Visit “Dr. Fran Mihaljevic” University Hospital for Infectious Diseases (Zagreb/Lebanon hospital partnership)
- Visit Stampar School of Public Health (healthy cities/communities and HIV/AIDS activities)

Thursday, October 13 – Zagreb, Croatia

- Visit “Srebrnjak” Children’s Hospital for Respiratory Diseases (Zagreb/Lebanon hospital partnership)
- Meet with representatives involved in HIV/AIDS stigma activities:
 - Dr. Stipe Oreskovic (Stampar School)
 - Dr. Josip Begovac (University Hospital for Infectious Diseases)
 - Other members of the working group created at the April 2004 HIV/AIDS stigma meeting in Zagreb (media, NGO representatives, policy-makers, etc.)
- Travel from Zagreb to Split (Croatian Airlines) (if Split included on schedule)

Friday, October 14 – Zagreb OR Split, Croatia

- Visit the Split City Hall, schools which participated in the Project Northland youth alcohol intervention, and other community organizations which participated in partnership activities (Split/New Jersey healthy communities partnership)
- Meet with representatives from Zadar General Hospital and Orthopedic Hospital of Biograd (Zadar/Franciscan Sisters of the Poor hospital partnership) (Optional...the trip by car to Split from Zadar is a couple of hours.)

OR

- Invite Split, Zadar/Biograd partners to Zagreb for meetings
- Travel over the weekend from Zagreb or Split to Bucharest, Romania

Monday, October 17 – Bucharest, Romania

- Visit the Department of Public Health and Management at the “Carol Davila” University of Medicine and Pharmacy (Bucharest/Chicago HME partnership)

Tuesday, October 18 – Bucharest, Romania

- Visit the National Institute for Health Research and Development (formerly the Institute for Health Services Management – Bucharest/Chicago HME partnership and Tirana/Bucharest Intra-CEE HME partnership)

Wednesday, October 19 – Bucharest, Romania

- Meet with representatives from the MOH, the Renasterea Foundation, and others to discuss the radiology quality assurance program
- Travel by car from Bucharest to Constanta

Thursday, October 20 – Constanta, Romania

- Visit the Directorate for Public Health, Constanta City Hall, the Office for Women, and other community organizations and representatives participating in partnership activities (Constanta/Louisville healthy communities partnership)

Friday, October 21 – Return to US

For countries with AIHA programs not visited by the team, the contractor will e-mail a written questionnaire to Mission health program managers, patterned on the questions posed above and below under Work Specifications A2, A3, and A4. The contractor will follow-up with telephone calls to clarify responses. Note, however, that the contractor will have the opportunity to with participants from countries participating in the thematic focus groups, even though the contractor will not be visiting them in their home country. For countries where the USAID officer tasked with managing the partnership activity has been transferred, the contractor will question the transferred mission staff, if possible. AIHA and the CTO will provide the list of contacts.

An illustrative timeframe for producing the impact evaluation follows:

Sep 1	Contractor starts work.
Sep 6	Health Team and Contractor hold Team-Planning Meeting. The meeting will review the background of the evaluation, the Statement of Work, team member's roles and responsibilities, administrative and logistical arrangements, and draft a work plan.
Sep 8	Contractor submits draft work plan.
Sep 14	Contractor submits revised work plan.
Sep 16	E&E Health Team approve revised work plan. The work plan will provide a solid implementation plan for undertaking the evaluation.
Sep 19-30	Contractor collects and reviews information. The information and data collected is reliable and sufficient to meet the needs of the evaluation team.
Sep 26-30	Contractor conducts key informant interviews and/or circulates questionnaires among U.S. partners. The interviews and questionnaires contribute reliable and sufficient information needed to produce sound evaluation findings, conclusions, and recommendations.
Oct 3-21	Contractor undertakes fact finding visits to Slovakia, Hungary, Romania, and Croatia and interviews CEE partners. The interviews and questionnaires contribute reliable and sufficient information needed to produce sound evaluation findings, conclusions, and recommendations.
Nov 15	Contractor completes review and analysis of questionnaires.
Nov 18	Contractor submits first draft of the evaluation report.
Dec 2	Contractor submits second draft of the evaluation report.
Dec 16	Contractor submits final evaluation report.

To be judged acceptable, the evaluation report must document well the developmental impact (legacy) of the AIHA CEE Health Partnerships program and provide findings and recommendations that can be used by other USAID Missions, both within and outside the E&E region.

2. Contractor shall evaluate the sustainability of the partnership relationships.

- Did the partnerships develop professional relationships that continued beyond the period of USAID funding?
- Describe the ways in which these professional relationships continued.

- Where the relationships did not continue, explain why.
- Did the ongoing relationships generate additional resources that helped to build upon the achievements made during the period of USAID funding?

Contractor shall evaluate the sustainability of relationships in the course of undertaking the development impact evaluation described above—through the key informant interviews, focus group interviews, and questionnaires. Contractor will incorporate the findings into the evaluation report.

3. Contractor shall assess the sustainability and replication of the partnership models and outcomes?

“Sustainability” is the capacity of the program to continue successfully in the future after foreign assistance is withdrawn. Sustainability includes financial and institutional dimensions. Financial sustainability refers to the capacity of the CEE partner to replace withdrawn donor funds with funds from other, usually domestic, sources. Institutional sustainability refers to the capacity of the CEE partner, if suitably financed, to assemble and manage the necessary non-financial resources to carry on successfully the program.

“Replication” is the expansion of the AIHA model or targeted interventions such as improved clinical and management practices to other facilities or countries. The contractor will identify both actual and planned replications.

- Is the partnership approach effective as a mechanism for establishing and scaling up community-based demonstration models to regional and national levels?
- Are the partnership models (hospitals, health management education, healthy communities, primary health care) and outcomes (e.g., clinical practice guidelines, publication of health management journals, smoking prevention activities) sustainable?—see definition of sustainability above.
- Are the models replicable?—see definition of replication above.
- Are the Learning Resource Centers sustainable and replicable?
- Did the partnership produce systemic changes in the health system or national policies that continue today? What has been their impact on improving health services or health status?

Contractor shall evaluate the sustainability and replicability of models and outcomes in the course of undertaking the development impact evaluation described above—through the key informant interviews, focus group interviews, and questionnaires. Contractor will incorporate the findings into the evaluation report.

4. Contractor shall identify major “lessons learned” and best practices that other USAID Missions can apply in countries within and outside the Europe and Eurasia region.

What are the 5-10 key lessons learned from the AIHA CEE Health Partnerships experience?

What are the 5-10 best practices demonstrated by the AIHA CEE Health Partnerships experience?

Contractor shall identify the lessons learned and best practices in the course of undertaking the development impact evaluation described above—through the key informant interviews, focus group interviews, and questionnaires. Contractor will incorporate the findings into the evaluation report.

Annex 3: Workplan for the Evaluation

1. Objectives

The objectives of the evaluation are to:

- Document the developmental impact of AIHA’s Health Partnerships program in Central and Eastern Europe—including the partnership approach, the individual partnerships, and region-wide cross-partnership activities;
- Assess the sustainability of the partnership relationships;
- Assess the sustainability and replication of models and outcomes;
- Identify major “lessons learned” and best practices that other USAID Missions can apply in other countries.

2. Workplan

RTI’s evaluation team will evaluate the developmental impact of AIHA’s Health Partnerships program in CEE, including the partnership approach, individual partnerships and region-wide cross-partnership activities. The evaluation team will examine “developmental impact” in terms of the human and institutional capacity the program has left behind as measured by improved skills and services of individuals and institutions, in particular capacity development in the following areas: evidence-based medicine, quality improvements, nursing, health care delivery, community mobilization, and health profession education.

Specifically, the evaluation will address the following questions:

Partnership Approach and Overall Impact:

What are the strengths and weaknesses of the AIHA health partnerships approach in terms of achieving development impact? To what extent:

- Did the program reorient the focus from hospitals to primary health care?
- Did the program contribute to E&E Bureau goals and objectives?
- Did the program transfer technical knowledge that bridged the gap in clinical practice standards?
- Did the program more closely align personal health and public health efforts?
- Did the program promote modern techniques of health care management and quality in health care practice and education?
- Did the program increase the quality and availability of information for decision-making?
- Did the program promote democratic values and expand civil society?

Individual Partnerships:

To what extent:

- Did the individual partnerships achieve their goals and objectives?
- Did the achievement of partnership objectives contribute to USAID Mission goals?

- Did the partnerships achieve their objectives in a cost-effective manner? Did they use resources efficiently? Were resources well leveraged?
- Did the partnerships improve health care delivery (reduced cost, improved quality)?

Cross-Partnership Region-wide Activities:

To what extent:

- Did AIHA cross-partnerships special initiatives in Nursing, Emergency Medical Services, Women's Wellness, and Health Management Education facilitate individual partnerships in achieving their goals and objectives?
- Did CEE/NIS and CEE region-wide conferences and workshops facilitate individual partnerships in meeting their goals and objectives?
- Are the Learning Resource Centers effective in advancing the use of evidence-based medicine?
- Are AIHA publications, media relations, and web sites contributing to the achievement of program objectives?

A team planning meeting was held at AIHA on September 7, 2005, attended by the evaluation team, the USAID CTO and AIHA staff, to discuss the scope of work of the evaluation, travel plans, how to obtain the required documents and necessary contact information, and clarification of evaluation team member roles.

The evaluation team will review project documents including the AIHA CEE cooperative agreement and modifications, earlier evaluation studies; partnership close-out reports; the last AIHA Quarterly Report reporting on ongoing partnerships or partnerships recently completed but without close-out reports; briefs prepared by AIHA to update country achievements.

The team will develop an evaluation framework and appropriate questionnaires for various parties to be interviewed, including: US partner representatives, USAID program managers, and CEE partner representatives. Questionnaire development will include review of tools used by AIHA in the recent evaluation of programs in Latvia and Estonia and tools used in previous evaluations of AIHA's CEE project and other twinning programs.

Prior to visiting the field sites, the team will send out by email the questionnaire for US partners and follow up by telephone to clarify answers. In addition, we will conduct key informant interviews with selected US partners to fine tune the data collection tools for CEE partners and to obtain information about the individual partner programs.

For countries that will not be visited, the evaluation team will send an email questionnaire to USAID Mission health program managers. The evaluation team will follow-up with telephone calls to clarify responses. For countries where the USAID officer tasked with managing the partnership activity has been transferred, the contractor will question the transferred mission staff, if possible. AIHA and the CTO will provide the list of contacts.

Following the field visits the team will analyze the data and prepare a draft report for review by USAID. Comments will be incorporated into a second draft and an oral presentation of key findings will be made at USAID's Ronald Reagan Building. Additional review will be made by USAID and comments will be incorporated into a final evaluation report.

Types and Number of Partnerships by Country					
	Hospital	HME	Healthy Communities	PHC	Other
Albania (5)	Tirana	Tirana (2)	-	Lezha	Tirana WWC
Bosnia & Herzegovina (1)	Tuzla	-	-	-	-
Croatia (3)	Zagreb, Zadar	-	Split	-	HIV/AIDS Stigma
Czech Republic (2)	-	Bohemia, Olomouc	-	-	-
Estonia (1)	Tallinn	-	-	-	-
Hungary (3)	Vac	-	Vac, Gyor, Pecs	-	-
Kosovo (3)				Gjilan	Gjakova WH DOW WWCs
Latvia (2)	Riga	-	-	-	TB Center
Romania (5)	Cluj	Bucharest (2), +contract	Constanta	-	Iasi WWC Breast Health
Slovakia (5)	Kosice	Bratislava/ BB/ Trnava	Petrzalka, Banksa Bystrica/ Martin, Turcianske Teplice	-	

The evaluation team will conduct field site visits to Slovakia, Hungary, Croatia, Romania, and Albania (if possible) to observe first hand the programs' development impact. The proposed travel schedule is as follows:

Saturday/Sunday October 1-2 Travel from US to Bratislava, Slovakia.

(If the budget and logistics allow, Lisa Adams will travel to Tirana, Albania October 3-6 to visit programs, and join the team in Kosice. We are currently reviewing the budget and evaluating the feasibility of this additional visit, so additional details are not yet available).

Monday, October 3 – Bratislava, Slovakia

- Visit Health Management School (Slovakia/Scranton HME partnership) – for partnership institution site visit and to prepare for HME focus group
- Meet with representatives from the Citizens Association of Aid to Children at Risk and other participating community organizations (Petrzalka/Kansas City Healthy Communities partnership)
- Dinner with the partners

Tuesday, October 4 – Bratislava, Slovakia

- Conduct Czech and Slovak HME focus group with representatives from the following institutions (approximately 17-18 participants):
 - Health Management School (Bratislava, Slovakia – host)
 - Trnava University School of Public Health (Trnava, Slovakia)
 - University of Matej Bel School of Economics (Banska Bystrica, Slovakia)
 - South Bohemia University Faculty of Management (Jindrichuv Hradec, Czech Republic – Bohemia/Nevada HME partnership)
 - Faculty of Management and Information Technology at the University of Education (Hradec Kralove, Czech Republic – Bohemia/Nevada HME partnership)

- Faculty of Health and Social Care (Ceske Budejovice, Czech Republic – Bohemia/Nevada HME partnership)
- Purkyne Medical Academy (Hradec Kralove, Czech Republic – Bohemia/Nevada HME partnership)
- Postgraduate Medical School (Prague, Czech Republic – Bohemia/Nevada HME partnership)
- Palacky University Faculty of Medicine (Olomouc, Czech Republic – Olomouc/Richmond HME partnership)

Wednesday, October 5 – Martin, Slovakia

- Travel by train from Bratislava to Martin
- Visit Martin mayor’s office, hospice foundation, non-smoking promotion center, and other involved community organizations (Banksa Bystrica and Martin/Cleveland Healthy Communities partnership)

Thursday, October 6 – Martin, Slovakia

- Conduct Slovakia Healthy Communities focus group with the following representatives (approximately 9-10 participants):
 - Martin community representatives (Banksa Bystrica and Martin/Cleveland Healthy Communities partnership)
 - Banska Bystrica community representatives (Banksa Bystrica and Martin/Cleveland Healthy Communities partnership)
 - Petralka community representatives (Petralka/Kansas City Healthy Communities partnership)
- Travel by train from Martin to Kosice

Friday, October 7 – Kosice, Slovakia

- Visit Faculty Hospital and Polyclinic (Kosice/Providence Hospital Partnership – Neonatology, Perinatal Regionalization)
- Travel on Friday evening or Saturday morning by train to Budapest, Hungary

Monday, October 10 – Vac, Hungary

- Visit Vac Municipal Hospital
- Conduct Hungary Healthy Communities focus group with the following representatives:
 - Vac community representatives (host – Vac/Winston-Salem partnership)
 - Gyor community representatives (Gyor/Pittsburgh Healthy Communities partnership)
 - Hungarian Association of Healthy Cities representatives from Pecs (Pecs/Harrisburg Healthy Communities Network partnership)

Tuesday, October 11 – Zagreb, Croatia

- Travel from Budapest to Zagreb, Croatia

Wednesday, October 12 – Zagreb, Croatia

- Visit “Sveti Duh” General Hospital (Zagreb/Lebanon hospital partnership)

- Visit “Dr. Fran Mihaljevic” University Hospital for Infectious Diseases (Zagreb/Lebanon hospital partnership)
- Diana and Lisa travel from Zagreb to Zadar
- **Thursday, October 13**

Zagreb, Croatia (Mary and Tina)

- Visit “Srebrnjak” Children’s Hospital for Respiratory Diseases (Zagreb/Lebanon hospital partnership)
- Meet with representatives involved in HIV/AIDS stigma activities:
 - Dr. Stipe Oreskovic (Stampar School)
 - Dr. Josip Begovac (University Hospital for Infectious Diseases)
 - Other members of the working group created at the April 2004 HIV/AIDS stigma meeting in Zagreb (media, NGO representatives, policy-makers, etc.)
- Travel from Zagreb to Split (Croatian Airlines)

Zadar, Croatia (Lisa and Diana)

- Visit Zadar General Hospital (Zadar/Franciscan Sisters of the Poor hospital partnership)
- Visit Orthopedic Hospital of Biograd (Zadar/Franciscan Sisters of the Poor hospital partnership)
- Travel from Zadar to Split

Friday, October 14 – Split, Croatia

- Visit the Split City Hall, schools which participated in the Project Northland youth alcohol intervention, and other community organizations which participated in partnership activities (Split/New Jersey healthy communities partnership)
- Travel over the weekend from Split to Bucharest, Romania

Monday, October 17 – Bucharest, Romania

- Visit the Department of Public Health and Management at the “Carol Davila” University of Medicine and Pharmacy (Bucharest/Chicago and Bucharest/Kentucky HME partnerships)
- Visit the National Institute for Health Research and Development (formerly the Institute for Health Services Management – Bucharest/Chicago and Bucharest/Kentucky HME partnerships and Tirana/Bucharest Intra-CEE HME partnership)

Tuesday, October 18 – Bucharest, Romania

- Meet with representatives from the Institute of Public Health, the Inspectorate of Public Health, and/or the Clinic for Occupational Diseases (Cluj/Philadelphia hospital partnership)
- Meet with representatives from The Center for Reproductive Health and Family Planning (Iasi/Minneapolis partnership – Womens Wellness Center)

Wednesday, October 19 – Bucharest, Romania

- Meet with representatives from the MOH, the Renasterea Foundation, and others to discuss the radiology quality assurance program
- Travel by car from Bucharest to Constanta
- Dinner with the Constanta partners

Thursday, October 20 – Constanta, Romania

- Visit the Directorate for Public Health, Constanta City Hall, the Office for Women, and other community organizations and representatives participating in partnership activities (Constanta/Louisville healthy communities partnership)
- Travel by car from Constanta to Bucharest

Friday, October 21 – Return to US

3. REPORTS

1. Team Planning Meeting and Work Plan

The Contractor will hold a team planning meeting with the E&E Health Team and submit a 3-5-page work plan to the CTO within 2 working days after the start date of the Task Order. The work plan will outline the steps the Contractor will take to produce the results; propose an implementation schedule with target dates for accomplishing each task; and will include a rough draft outline for the evaluation report. The Health Team staff will review the proposed work plan at the team planning meeting and the Contractor will revise the work plan, taking into account staff comments, within 1 working day after the team planning meeting. The CTO will approve the final work plan within 1 working day after receipt from the Contractor.

2. First Draft Report

The Evaluation team will submit the first draft report to the CTO on November 18. The report will be circulated within USAID for comment. The CTO will submit written comments to the Contractor within 1 week.

3. Second Draft Report

The Evaluation team will submit the second draft of the evaluation report to the CTO on December 2. The Evaluation team will make an oral presentation within 3 working days after submitting the draft. The CTO will submit comments on the second draft within 1 week of the oral presentation.

4. Final Report

The Evaluation team will submit 50 copies of the final report on December 16, 2005. The final report should be approximately 25 single-spaced pages in length, excluding the executive summary and annexes. The Evaluation team will also send a copy of the report to USAID's Center for Development Information and Evaluation.

Annex 4: List of AIHA Partnerships and Grants, and Period of AIHA Support

1. Bohemia, Czech Republic/Nevada	1996-1997
2. Bucharest, Romania/Chicago, Illinois	1996-1999
3. Bucharest, Romania/Lexington, Kentucky	2001-2004
4. Cluj, Romania/Philadelphia, Pennsylvania	1995-1997
5. Constanta, Romania/Louisville, Kentucky	1998-2002
6. Gjakova/Hanover, New Hampshire	2004- on-going
7. Gjilan, Kosovo/Hanover, New Hampshire	2001-2004
8. Győr, Hungary/Pittsburgh, Pennsylvania	2002-2004
9. Iasi, Romania/Minneapolis, Minnesota	1998-2000
10. Kosice, Slovakia/Providence, Rhode Island	1995-1999
11. Lezha, Albania/Pittsburgh, Pennsylvania	2001-2004
12. Martin/Banska Bystrica, Slovakia/Cleveland, Ohio	1997-1999
13. Olomouc, Czech Republic/Richmond, Virginia	1996-1998
14. Pécs, Hungary/Harrisburg, Pennsylvania	2002-2004
15. Petrzalka, Slovakia/Kansas City, Missouri	1996-1998
16. Riga, Latvia/Little Rock, Arkansas	2001-2004
17. Riga, Latvia/St. Louis, Missouri	1995-1998
18. Slovakia, Slovakia/Scranton, Pennsylvania	1996-1999
19. Split, Croatia/New Jersey	2001-2003
20. Tallinn, Estonia/Washington, District of Columbia	1994-1996
21. Tirana, Albania/Bucharest, Romania (Intra-CEE)	2001-2004
22. Tirana, Albania/Grand Rapids, Michigan	1996-2000
23. Tirana, Albania/New York, NY	1996-1999
24. Tirana, Albania/Providence, Rhode Island	1999-2004
25. Turcianske Teplice, Slovakia/Cleveland, Ohio	1996-1998
26. Tuzla, Bosnia and Herzegovina/Buffalo, New York	1996-1998
27. Vac, Hungary/Winston-Salem, North Carolina	1995-1998
28. Vac, Hungary Healthy Communities Component	1995-1998
29. Zadar, Croatia/Franciscan, New York	1995-1998
30. Zagreb, Croatia/Lebanon, New Hampshire	1994-1998
31. HIV/AIDS Stigma (grant)	2004
32. Breast health (grant)	2003-on-going
33. Doctors of the World/Kosovo (grant)	2002-2005

Annex 5: Evaluation Methodology

The evaluation team focused on “developmental impact” in terms of the human and institutional capacity the program left behind, and measured by improvement in skills and services of individuals and institutions. A list of indicators measuring improved human and institutional development for all three types of partnerships were developed by the evaluation team. These indicators are included as the end of this section.

The evaluation was conducted through interviews by telephone, email, and in person, and site visits to partnerships in Slovakia, Hungary, Croatia and Romania, October 2-21, 2005. The AIHA Partnership program included 30 partnerships and 3 grants. This evaluation focused on substantive evaluation of 18 partnerships and 2 grants, as described in the table below. Each of the three team members focused on one of the partnership types (Hospital, Health Management Education, Healthy Communities), however team members shared responsibility for the interviews and with few exceptions were present for and participated in all field interviews.

Prior to the field visits, the team spent two weeks reviewing documents supplied by USAID and AIHA, developing the final report outline and interview guides and questionnaires for USAID staff, US partners and CEE partners. The team conducted key informant interviews with several US partners, past USAID project officers, and Mission health officers. Interview guidelines and questionnaires for the field interviews were based on project summaries provided by AIHA, however, upon arrival in the field, data collection tools were modified to fit the circumstances of the specific projects visited. A standard series of questions was applied to all sites, where possible. However, the broad range of activities and kinds of partnerships included in the program required that interviews be tailored to each site, and primarily took the form of unstructured interviews. Illustrative interview questionnaires are included in this annex.

Data was compiled by the team in the field and discussed at the end of each day to share findings and impressions. Following the field visits, the team conducted additional interviews with US partners by email and phone, and followed up with individual CEE partners for additional documentation and clarification of information. Where possible, USAID past and present health officers were asked to comment on the summaries of partnership impact which were prepared by the team based on field interviews.

For countries with Partnership program activities that the team did not visit, the evaluation team conducted interviews with selected US partners, and sent an email questionnaire to USAID Mission health program managers.

Limitations of the methodology

Several limitations to the evaluation methodology should be noted.

1. The evaluation team was able to gather first-hand information on 18 of the 30 funded partnerships. Sites visited were selected to facilitate travel in the region and to include countries which had the largest number of activities in order to allow the team to visit as many partnerships as possible.
2. Some partners (particularly US-based partners) could not be contacted as they had left their institutions for new positions and forwarding contact information was not available. In addition, responses to queries about the partnership activities, many of which were completed several years ago, were subject to recall bias.
3. In order to interview as many CEE partners as possible in the short period of the field visits, some CEE partners were required to travel to meet the evaluation team in other sites. For example, Czech partners traveled to Bratislava. This resulted on occasion in partnerships not being well-represented (e.g., Pecs, Hungary partners did not attend the proposed meeting, and several Bohemia/Nevada

key partners did not attend the Bratislava meeting), and inability of the evaluation team to observe all project sites evaluated. In addition, these meetings provided less time for discussion for each individual partnership site. The health management education partnerships in particular, were largely assessed through multi-partnership meetings. The result was uneven data collection, which may have resulted in some partnerships being better represented than others.

4. Due to the design of the evaluation study, visits to sites did not allow for independent data collection or review of records by the evaluation team. This resulted in uneven data collection on the quality of services and lack of verification of program outcomes. In addition, it should be noted that the partnerships for the most part were no longer being funded by AIHA, and the participation of former partners in the evaluation was entirely voluntary. The evaluation team is grateful for the time and effort of all who agreed to provide information to the team, and was mindful of the limitations of what additional data could be demanded beyond what was provided.
5. AIHA headquarter and in-country field staff accompanied the evaluation team on all site visits and attended all interviews except those conducted in Croatia. AIHA's participation allowed the evaluation team the benefit of supplementary clarification and easier access to CEE partners. However, undoubtedly the presence of AIHA staff at the evaluation interviews influenced the CEE partners' responses and the degree to which this caused partners to modify responses cannot be measured. While AIHA made every effort to clarify the purpose of the field visits, on a few occasions, the evaluation team learned that CEE partners had assumed the evaluation team was part of AIHA rather than an independent group.

AIHA CEE Partnership Programs Included in the Evaluation

Date	Type	Country	Partnership	Interviews conducted	Site visited
Funded Pre-1998					
1997-1999	HC	Slovakia	Martin/Banska Bystrica/Cleveland	•	•
1996-1998	HC	Slovakia	Petrzalka/Kansas City	•	•
1996-1998	HC	Slovakia	Turcianske Teplice/Cleveland	•	•
1996-1999	HME	Albania	Tirana/New York		
1996-1997	HME	Czech Rep.	Bohemia/Nevada	•	
1996-1998	HME	Czech Rep	Olomouc/Richmond	•	
1996-1999	HME	Romania	Bucharest/Chicago	•	•
1996-1999	HME	Slovakia	Slovakia/Scranton	•	•
1996-2000	Hospital	Albania	Tirana/Grand Rapids		
1996-1998	Hospital	Bosnia & Herzegovina	Tuzla/Bufalo		
1995-1998	Hospital	Croatia	Zadar/Franciscan	•	•
1994-1998	Hospital	Croatia	Zagreb/Lebanon	•	•
1994-1996	Hospital	Estonia	Tallinn/Washington, DC		
1995-1998	Hospital	Hungary	Vac/Winston-Salem	•	•
1995-1998	Hospital	Latvia	Riga/St. Louis		
1995-1999	Hospital	Slovakia	Kosice/Providence	•	•
1995-1997	Occupational Health	Romania	Cluj/Philadelphia	•	
Funded Post-1998					
1998-2000	Women's Wellness	Romania	Iasi/Minneapolis	•	
2001-2004	HC	Albania	Lezha/Pittsburgh		
2002-2004	HC	Hungary	Győr/Pittsburgh	•	
2002-2004	HC	Hungary	Pécs/Harrisburg		
1998-2002	HC	Romania	Constanta/Louisville	•	•
2004	HIV stigma	Croatia	Stampar SPH	•	•
2001-2004	HME (Intra-CEE)	Albania	Tirana/Bucharest	•	
2001-2004	HME	Romania	Bucharest/Lexington	•	•
2001-2003	HC	Croatia	Split/New Jersey	•	•
2001-2004	PHC	Kosovo	Gjilan/Hanover		
2004-current	Reproductive Health	Kosovo	Gjakova/Hanover		
2001-2004	TB	Latvia	Riga/Little Rock		
1999-2004	Women's Wellness	Albania	Tirana/Providence		
2002-2005	Women's Wellness	Kosovo	DOW/Kosovo		

AIHA CEE Health Partnerships Program Evaluation
List of Indicators to Measure
Human and Institutional Capacity Building
Results of Team Brainstorming

I - Human Capacity: Did the people involved acquire/sustain this capacity?

- training skills
- professional skills in their field or other (IT, Mgt.)
- networking know-how
- fundraising skills
- advocacy skills
- communications skills (e.g., design and production of educational materials, inclusion of strategy for media mass and interpersonal skills)
- needs assessment skills regarding target concerns
- appreciation for usefulness of data in their work
- participation in international forums
- recruit, train & retain volunteers
- identifying & training new stakeholders
- improved professional status (e.g., health managers and nurses)
- mentality of continuous improvement (always looking for ways to improve)
- ability to champion their cause
- ability to motivate staff
- new mindset - 'we can do it'
- ability to adapt models

II - Institutional Capacity: Did the CEE partner institutions acquire/sustain these capacities?

- institutional stability
- ability to absorb incremental costs
- accreditation status
- adoption and implementation of standards, guidelines, protocols
- management skills/structures
- equipment that is relevant
- physical modifications reflecting improved service delivery
- acquiring an ever expanding pool of stakeholders
- involvement of younger generation
- participation in international forums
- use of SWOT analysis/identification of stakeholders
- ability to build upon and expand partnerships
- conduct outreach programs
- evidence-based medicine
- effective use of information technology
- fundraising programs
- promotion and retention of skilled managers, leaders
- financial management skills
- ability to develop curricula and academic programs
- human resource management (grooming and staff development)
- growth in client base, service delivery
- leadership in promoting replications
- on-going development of new services (services more responsive to patient needs and services informed by the latest clinical research)
- more efficient and effective use of human resources
- more efficient and effective use of financial resources

Letter sent by e-mail to U.S. Partners

Dear _____

The American International Health Alliance has given us your name as a “key informant” regarding the partnership between _____ and _____. At the request of USAID, Research Triangle Institute International (RTI) is undertaking an evaluation of the impact of the AIHA Health Partnerships in Central and Eastern Europe (CEE). The purpose of the evaluation is to assess the “legacy” of the partnerships program. The evaluation question is “what were the lasting effects of the partnership collaboration?”

A “legacy” evaluation is an unusual type of evaluation. It attempts to assess the effects of the partnership that are still apparent today even though USAID funding ended several years ago. When the partnership program was designed, USAID hoped the results of the collaboration between partners and the special programs offered to all partners through AIHA’s region-wide initiatives would multiply over time. USAID recognized that these results might be directly related to the topics addressed during the partnership, but that there would likely be changes in many other unanticipated areas.

We would very much appreciate having your thoughts about the impact of the partnerships from your perspective as the U.S. partner. The questions of particular interest to us are

- What changes did you observe in the CEE partner institution since the beginning of your collaboration that you attribute either directly or indirectly to the partnership?
- What changes would you expect to see today if you were to return to the CEE partner institution?
- Have you or other professionals in your institution continued to stay in touch with the CEE partners?
- What were the benefits of the partnership for your institution?

If you could take a few minutes to provide us with this information we would be very grateful. Please “reply to all” when you respond to these questions.

We look forward to hearing from you. Thank you very much for your assistance with this important study.

Sincerely,

The AIHA Partnerships Evaluation Team
Catherine (Tina) Cleland, MBA
Lisa V. Adams, MD
Mary Linehan, MPH

Evaluation of Development Impact of AIHA Partnerships in CEE

Illustrative Interview Guide (Hospital Partnerships)

CEE Partner

A. Background

- What was your position at the institution when the partnerships program began?
- What is your position now?
- What role did you personally have in the formation and implementation of the partnerships program at your institution?
- Did you know any of the US counterparts before the partnership began? When was the last time you were in touch with them? What was the purpose of your communication the last time you were in touch?
- Who were the prime movers (“the champions”) in the establishment and implementation of the partnerships program? How long did they remain involved in the program?
- Can you describe the “state-of-the-art” in clinical care and hospital management at the time the partnerships began? For instance, can you recall how you typically did (something taken from their area of interest)?
- What was the focus of the partnership and how were topics selected as the areas of collaboration? Do you recall what were the original objectives of the partnership?
- Why was that topic important to your institution? Why was it the preferred topic for the partnership (as opposed to all the other areas of need that existed in the institution)?
- Did you travel to the US as part of the partnership program implementation? How often?
- Which individuals from the US partners did you have the most contact with? In what ways did you collaborate with those individuals?
- What were your expectations of the partnership? What did you expect to the “left behind” after the funding ending?
- Was your institution involved in dialogue with the government about policies that could improve the operating environment? What issues were discussed? What was the outcome of those discussions?

B. Implementation of technical assistance and training

- From the achievements noted in the briefing material we received, it appears that the achievements went beyond (or did not match up with, or whatever) the original partnership objectives. Do you recall why the focus changed along the way? What other topics emerged as areas of interest?

- Do you recall what the priority areas for training were? What did people in your institution most want to learn from their US partners. What did they want to teach to the US partners?
- What knowledge was transferred, techniques/procedures demonstrated, etc. during the visits? Do you recall the topics other than those that were the designated focus of the partnership that you learned about?
- Did you attend training programs sponsored by the USA partner? What was the topic of the training? Was the training relevant and practical? Did you use the skills taught? How did it change the way you performed your duties? For instance, how do you now do (something from their area of interest)?
- Did you attend conferences and workshops sponsored by AIHA? What was the primary benefit to your institution of this experience?
- Did you participate in any of the cross partnership special initiatives (nursing, WW, EMS, HME)? Were you able to utilize the knowledge and personal contacts you made in these program at your institution? Can you give some examples?
- Have you used the AIHA website as a reference tool? What has been the usefulness of their publications?
- Has your institution established a website? What kind of information is posted on your website?
- Has your institution used the Learning Resource Centers to identify clinical protocols grounded in evidence based medicine?

C. Impact

- What changes have there been in your institution since the early 90s? For instance:,
 - How is the hospital budget organized?
 - Are there more resources for hospital care? If so, how have these new resources been used?
 - How has the system for hospital reimbursement changed?
- What changes in institutional management can you attribute to the partnerships experience?
 - Have new services been added (home care, prevention programs)?
 - How has length of stay changed since (the early 90s)?
 - How have hospital staffing patterns changed since _____?
 - How has the role of physicians and nurses changed?
 - What system do you have for maintaining an inventory of pharmaceuticals?
 - Is there a system of utilization review?
 - Is there a quality improvement program? Who participates and how does it work?
 - What types of information systems have you implemented? What routine reports are produced?
 - Have there been changes in the way medical records are maintained?
 - How many computers does the hospital own? How old are they? Do all professional staff members have access to the internet?
- Did the partnership contribute to the promotion of democratic values?
 - Who participates in grand rounds?
 - What professionals are considered to be members of the hospital leadership team?

Are there patient education programs?
Is there a patients' bill of rights?
Are there volunteer programs

- Could you see a connection between the partnerships and the economic development of this community or region?
- Were there changes in clinical practice and quality of care that you can attribute to the partnerships? For instance,
Have standards of clinical practice been established?
How are these monitored?
Can I see a few of your medical records?
Has the surgical mortality rate changed since the early 90s? To what do you attribute this?
Have reasons for admission changed? Has the infection rate changed? The complication rate? The readmission rate?
- Impact of policy dialogue sparked by the partnership?
- Impact of partnerships on you personally?
Attendance at international medical meetings?
Do you participate in the physicians'/nurses/whatever professional association?
Publications?
Professional and personal relationships with US clinicians?
Professional and personal relationships with other clinicians in CEE or NIS?
Exposure to alternative approaches from what you knew in early 90s?

D. Opinions about the experience

- How would you summarize the benefits of the partnership to the clinical staff, the patients, the community?
- What were the things that worked particularly well in the partnership program? What did not work well?
- What would you do differently if you had the chance to start over?

USAID Washington

What were the Bureau's health sector goals and objectives during the time you were involved in the partnerships program?

Did the hospital partnerships support the goals and objectives? In what way?

Did you visit any of the partnerships? What was the impact of the partnerships at that time?

USAID Mission

What was your involvement with the partnerships?

Who identified the in-country partners? Why were they chosen?

What were some of the burning issues in the partner institution at the time you were involved?

Did you observe changes (either directly related to the objectives of the partnership or by-products of the partnership) in the partner institution over the time you were monitoring the partnerships?

What did you expect to see in the way of impact of the partnerships?

What questions would you ask about the partnerships if you were to go back now?

How dependent was the program on the original champions of the partnership?

What did you think was the most valuable part of the partnership program?

Do you have knowledge about what they implemented after the program ended that may have germinated from the seeds of the partnership (e.g., JCAHO type survey)?

Did the CEE partner institution become involved in the policy dialogue of the country? In what areas? Do you think their interest in policy change was spurred by the partnership?

What would you say were the keys to the success of the partnership?

How much of the change you saw was not dependent on money?

What was the tone of the relationship between the partners (donor to recipient, peer to peer, etc?)

Did you see ways that democratic values were promoted by the partnership (greater respect between nurses and doctors, patient's rights, rights of family, patient choices)?

How did the partnership promote economic development in the community?

Questionnaire sent by email to past and present USAID Mission Health Program Managers

Dear ----- ,

At the request of USAID/Washington, Research Triangle Institute International (RTI) is evaluating the impact of the American International Health Alliance (AIHA) Health Partnerships in Central and Eastern Europe (CEE). The purpose of the evaluation is to assess the “legacy” of the partnerships program. The evaluation question is “what were the lasting effects of the partnership collaboration?”

A “legacy” evaluation is an unusual type of evaluation. It attempts to assess the effects of the partnership that are still apparent today even though USAID funding ended several years ago. When the partnership program was designed, USAID hoped the results of the collaboration between partners and the special programs offered to all partners through AIHA’s region-wide initiatives would multiply over time. USAID recognized that these results might be directly related to the topics addressed during the partnership, but that there would likely be changes in many other unanticipated areas.

We would very much appreciate having your thoughts about the partnerships from your perspective as the USAID/----- health officer. The questions of particular interest to us are

- What were the strengths and weaknesses of the partnership approach as opposed to the more traditional form of USAID technical assistance provided through a contract?
- Did the partnerships meet Mission goals and objectives?
- Did you attend AIHA conferences or workshops? In your opinion, were these cross-partnership programs beneficial to the partners in your country?
- Would the partnership model be effective in other parts of the world? For what types of development challenges would you recommend use of the partnership approach as an assistance mechanism?

If you could take a few minutes to provide us with this information we would be very grateful. Please “reply to all” in your response to these questions.

We look forward to hearing from you. Thank you very much for your assistance with this important study.

Sincerely,
The AIHA Partnerships Evaluation Team
Catherine (Tina) Cleland, MBA
Lisa V. Adams, MD
Mary Linehan, MPH

Annex 6: Bibliography

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AIHA partnership summary Bucharest, Romania/Lexington, Kentucky 2001-2004

AIHA partnership summary Cluj, Romania/Philadelphia, Pennsylvania 1995-1997

AIHA partnership summary Constanta, Romania/Louisville, Kentucky 1998-2002

AIHA partnership summary Doctors of the World/Kosovo 2002-2005

AIHA partnership summary Gjakova/Hanover, New Hampshire 2004-

AIHA partnership summary Gjilan, Kosovo/Hanover, New Hampshire 2001-2004

AIHA partnership summary Győr, Hungary/Pittsburgh, Pennsylvania 2002-2004

AIHA partnership summary Iasi, Romania/Minneapolis, Minnesota 1998-2000

AIHA partnership summary Kosice, Slovakia/Providence, Rhode Island 1995-1999

AIHA partnership summary Lezha, Albania/Pittsburgh, Pennsylvania 2001-2004

AIHA partnership summary Martin/Banska Bystrica, Slovakia/Cleveland, OH 1997-1999

AIHA partnership summary Olomouc, Czech Republic/Richmond, Virginia 1996-1998

AIHA partnership summary Pécs, Hungary/Harrisburg, Pennsylvania 2002-2004

AIHA partnership summary Petralka, Slovakia/Kansas City, Missouri 1996-1998

AIHA partnership summary Riga, Latvia/Little Rock, Arkansas 2001-2004

AIHA partnership summary Riga, Latvia/St. Louis, Missouri 1995-1998

AIHA partnership summary Slovakia, Slovakia/Scranton, Pennsylvania 1996-1999

AIHA partnership summary Split, Croatia/New Jersey 2001-2003

AIHA partnership summary Tallinn, Estonia/Washington, DC 1994-1996

AIHA partnership summary Tirana, Albania/Bucharest, Romania (Intra-CEE) 2001-2004

AIHA partnership summary Tirana, Albania/Grand Rapids, Michigan 1996-2000

AIHA partnership summary Tirana, Albania/New York, NY 1996-1999

AIHA partnership summary Tirana, Albania/Providence, Rhode Island 1999-2004

AIHA partnership summary Turcianske Teplice, Slovakia/Cleveland, Ohio 1996-1998

AIHA partnership summary Tuzla, Bosnia and Herzegovina/Buffalo, NY 1996-1998

AIHA partnership summary Vac, Hungary/Winston-Salem, North Carolina 1995-1998

AIHA partnership summary Zadar, Croatia/Franciscan, New York 1995-1998

AIHA partnership summary Zagreb, Croatia/Lebanon, New Hampshire 1994-1998

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Hungary FY: 1997, 1998; Romania FY 1997, 1998, 1999, 2004; Croatia FY 1997, 1998

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Annex 7: Persons and Organizations Contacted During the Assessment

Partnership	Institution	CEE Partners contacted	US partners contacted
Bohemia/Nevada	Postgraduate Medical School Prague	<ul style="list-style-type: none"> Ondrej Leseticky (from Jindrichuv Hradec) Eva Lesenkova 	<ul style="list-style-type: none"> Mary Paterson, PhD, Terra P Group
	Faculty of Informatics and Management, University of Hradec Kralove	<ul style="list-style-type: none"> Ladislav Hajek 	
Bucharest/Chicago	Carol Davila University of Medicine and Pharmacy, Department of Public Health and Management	<ul style="list-style-type: none"> Dana Minca, MD – Head of Department Professor Dan Enachescu, MD Adriana Galan, Eng. Bogdan Pana, MD 	
Bucharest/Lexington	Bucharest National Institute for Health Research and Development	<ul style="list-style-type: none"> Florin Sologiu, MD, appointed Director General of the Institute Daniela Valceanu, MD, Chief of Dept. of Training Paul Radu, MD, Scientific Director Valentina Mihaila, PhD, Consultancy, NIRDH Mona Moldovan, MD, Coordinator of Health Management Course Cassandra Butu, Public Health Researcher Cristinel Palas, Chief of Department of Health Services Analysis (DHSA) Daniel Mihai, Database Analyst, DHSA 	<ul style="list-style-type: none"> Tom Samuel, JD, MBA, University of Kentucky, Lexington

Partnership	Institution	CEE Partners contacted	US partners contacted
Cluj/Philadelphia		<ul style="list-style-type: none"> • Sorin Iuonut, 'Iatrika' Foundation, Nursing Resource Center • Eugen S. Gurzau, MD, PhD, Deputy Director, Environmental Health Center, Cluj • Mihaela Sinca, English Teacher • Horațiu Bocșa, Customer Support Executive, S.C. Transart SRL 	
Constanta/Louisville	Constanta community	<ul style="list-style-type: none"> • Daniel Verman, MD, Constanta Community Foundation • Loti Popescu, MD, Executive Director Constanta Community Foundation • Mihaela Dinisov, MD, Deputy Director, Constanta Health Authority • Atena Caranicola, Attorney, Office for Women • Beatrice Bulai, Psychologist, Office for Women • Dr. Catalin Grasa, General manager, Constant County Hospital • Elena Dragomir, Executive Director, Directorate for Labor, Social Solidarity and Family • Mariana Fatu, Head of Domestic Violence Prevention Department, Directorate for Labor, Social Solidarity and Family 	<ul style="list-style-type: none"> • Virginia Kelly Judd, Humana Foundation
DOW/Kosovo			

Partnership	Institution	CEE Partners contacted	US partners contacted
Gjakova/Hanover Gjilan/Hanover			<ul style="list-style-type: none"> Cristina Hammond, Don Kollish, James Strickler, Dartmouth College Ellen Thompson
Győr/Pittsburgh	Gyor Community	<ul style="list-style-type: none"> Mária Miklosiné Bertalanfy, WHO Healthy City Project Coordinator Dr. Peter Schmidt – Deputy Mayor, Győr Horváth Lászlónér – Győr 	<ul style="list-style-type: none"> Kristen Tsapis
Iasi/Minneapolis	Center for Reproductive Health and Family Planning	<ul style="list-style-type: none"> Otila Casian-Botez, Director 	
Kosice/Providence	Kosice Hospital	<ul style="list-style-type: none"> Vladimír Kraus, MD, PhD – Retired, Former Director Peter Krcho, MD, PhD – Director, Neonatal Intensive Care Unit, Medical Faculty Štefan Lukacín, Prof. MUDr, PhD – Head of 1st Gynecology Dept. (original partner leader) Katarína Dianišková, MD – 1st Gynecology Dept. Maria Pisarcikova – PICU, Dept. of Pediatrics Peter Böstörmenyi, MD - 1st Gynecology Dept. Kamila Ilgová, MD – NICU, Head of Nursing Agnesa Hikkerová – NICU, Nurse 	<ul style="list-style-type: none"> David Gagnon, National Perinatal Information Center
Lezha/Pittsburgh			

Partnership	Institution	CEE Partners contacted	US partners contacted
Martin/Banska Bystrica/Cleveland	Martin Community	<ul style="list-style-type: none"> Stanislav Bernát – Mayor Elena Kavcova – Non-Smoking Cessation Center, University and Martin Faculty Hospital Alexander Zacharides – Head of Culture, Regional Development and Foreign Relations Katarina Adamicova – University Teacher in Pathology, Head of Social Commission Henrieta Hudeckova – University Teacher in Epidemiology, Institute of Public Health Olga Potasova, Elementary School Teacher, Non-Smoking Center Danica Sevcovicova, Regional Office of Public Health Miloš Lisý, Student, Martin Katarina Mažáriova, PR Officer, Martin 	<ul style="list-style-type: none"> Mary Jo Keshock, former Cleveland Partner and former AIHA staff member
	Banska Bystrica Community	<ul style="list-style-type: none"> Kuetoslava Koppova – Authority of Public Health, Banska Bystrica Mária Filipová, Municipal Office, Banska Bystrica Janka Dúricová, Authority of Public Health, Banska Bystrica 	
Olomouc/Richmond	Palacky University, Faculty of Medicine	<ul style="list-style-type: none"> Katerina Ivanova Lenka Spirudova Jarmila Potomkova 	<ul style="list-style-type: none"> Yasar Ozcan, PhD Virginia Commonwealth University Thomas Wan, PhD
Pécs/Harrisburg			

Partnership	Institution	CEE Partners contacted	US partners contacted
Petrzalka/Kansas City	Citizens Association of Aid to Children at Risk	<ul style="list-style-type: none"> • Jana Gulova, PhD • Katarina Stefaniciakova • Jana Sturova, Ph.D., Director, Hope Center • Hana Bartova 	<ul style="list-style-type: none"> • Ross Marine, Honorary Consul of the Slovak Republic
Riga/Little Rock			
Riga/St. Louis			<ul style="list-style-type: none"> • Barbara Bogomolov, MS, RNRefugee Health Services, Barnes-Jewish Hospital
Slovakia/Scranton	Slovak Healthcare University, Faculty of Public Health	<ul style="list-style-type: none"> • Vera Rusnakova, MD, PhD, MBA, Head of Medical Informatics Department • Ljuba Bacharova MD, PhD, MBA Elecrocadiologist • Anna Egnerová, MD, PhD, Vice Dean Slovak Medical Center • Suzanna – Student 	<ul style="list-style-type: none"> • Daniel J. West Jr., Ph.D., Professor and Chairman, University of Scranton
	Health Management School	<ul style="list-style-type: none"> • Ingrid Hovorkova • Danka Kaezovicova 	
	Faculty of Economics, UMB, Banska Bystrica	<ul style="list-style-type: none"> • Ján Šebo • Marica Mazurkova 	
	School of Public Health, University of Trnava	<ul style="list-style-type: none"> • Vladimir Krcmery, MD, PhD 	
Split/New Jersey	Split Community	<ul style="list-style-type: none"> • Vesna Zec, Department of Social Welfare and Health Protection • Vedran Mardesic, • Andreja Russo, research partner 	<ul style="list-style-type: none"> • Diane Abatemarco, PhD, MSW, Graduate School of Public Health, Pittsburgh University

Partnership	Institution	CEE Partners contacted	US partners contacted
	Split School "Bol"	<ul style="list-style-type: none"> Inga Golias, school psychologist Sanja Mandic, teacher Ksenija Mardesic, teacher 	
Tallinn/Washington, DC			
Tirana/Bucharest	Bucharest National Institute for Health Research and Development	<ul style="list-style-type: none"> Florin Sologiu, MD, appointed Director General of the Institute Daniela Valceanu, MD, Chief of Dept. of Training Paul Radu, MD, Scientific Director Valentina Mihaila, PhD, Consultancy, NIRDH Mona Moldovan, MD, Coordinator of Health Management Course Cassandra Butu, Public Health Specialist Researcher Cristinel Palas, Chief of Department of Health Services Analysis (DHSA) Daniel Mihai, Database Analyst, DHSA 	
Tirana/Grand Rapids			
Tirana/New York			
Tirana/Providence			

Partnership	Institution	CEE Partners contacted	US partners contacted
Turcianske Teplice/Cleveland	Turcianske Teplice Community	<ul style="list-style-type: none"> • Jozef Turčány – Mayor • Alexander Chvojka – Head of Technical Dept, Mayor’s Office • Alena Chlapíková – Gynecologist, Former Mayor 	<ul style="list-style-type: none"> • Mary Jo Keshock, former Cleveland Partner and former AIHA staff member
Tuzla/Buffalo			
Vac/Winston-Salem	Vac Hospital and Community	<ul style="list-style-type: none"> • Dr. Erős András, General Director • Dr. Szentgyörgyi Ervin, Scientific Director • Dr. Zoltán Kárpáti, Director of Nursing • Dr. Zoltan Romhányi, Economic Director • Dr. Ágnes Katona, Chief Neurologist • Dr. Ilona Csécs, Oncologist • Dr. Gábor Kékesi, Chief Physician, Diabetes • Zsuzsanna Oroszi, Head Nurse • Gyulane Bénik, Cardiology • Dr. Ágnes Kollár, Cardiology • Magdolna Nagy, MD, Coordinator • Laszlo Ujhelyi, Pediatrician, Deputy Coordinator • Maria Boros, Vac H.C. • Bettina Neder, Vac H.C. • Livia Leyer Pethőné, Vac H.C 	<ul style="list-style-type: none"> • Frances Hutchison

Partnership	Institution	CEE Partners contacted	US partners contacted
		•	
Zadar/Franciscan	Zadar General Hospital	<ul style="list-style-type: none"> • Dr. Tlaliija, Infectologist, Hospital of Infection Control • Dr. Jovic, Cardiologist • Dr. Stetic, Assistant Director (at time of partnership) • Dr. Gilic, Chief of Dept. of Psychology • Lydia Buterin, Nurse 	
Zagreb/Lebanon	University Hospital for Infectious Diseases	<ul style="list-style-type: none"> • Josip Begovac • Bruno Barsic • Nensi Brnin • Arjana Pavelic 	
	Sveti Duh General Hospital	<ul style="list-style-type: none"> • Dr. Miroslav Gluhinic 	

Partnership	Institution	CEE Partners contacted	US partners contacted
	Srebrnjak Children's Hospital for Respiratory Diseases	<ul style="list-style-type: none"> • Dr. Sc. Boro Nogalo • Ksenija Marin, Infocoordinator • Dr. Sc. Durdica Milković, Chief Radiology Dept • Dr. Sc. Ivka Zoričić- Letoja Voditey TBO Odeja • Dr. Luvrica Zimić, Voditey/ Spirometriya • Karmen Hengster Mornić, VMS, Bonhoskospiju • Vesna Leškovic, VMS, Dnevna Bolnica • Marisa Vodopisa, VMS Glavno Sestne III Odjels • Vesna Mateu, VMS IMS Koptrola Sluebe • Liubica Mićanović, VMS Poliklinika • Gorcia Vlastić • Sanda Ehrlich Liped, MR, PH Voditey Yekarne • Dr. Slavica Dodig, Voditey Kliničkog Laboratorisa 	
Nursing Task Force	Romanian Nursing Association	<ul style="list-style-type: none"> • Gabriela Bocec – Executive Director, Romanian Nursing Association 	
HIV/AIDS Stigma	Stampar School of Public Health	<ul style="list-style-type: none"> • Luka Voncina, student • Danijela Leso, student • Mario Harapin, Croation Journalists Association • Stipe Oreskovic • Josip Begovac 	

Partnership	Institution	CEE Partners contacted	US partners contacted
Breast Health	Renasterea Foundation	<ul style="list-style-type: none"> • Michaela Geoana • Victoria Asanache, Program Director • Mihai Lesaru, MD, Chief Radiologist 	

Additional contacts:

Forest Duncan, Senior Health Sector Advisor, Project Officer, AIHA Cooperative Agreement
John Capati, Senior Program Associate, AIHA
Sona Strbanova, former Country Coordinator for Czech Republic, , Slovakia and Hungary, AIHA
Sanda Apostolescu, former Country Coordinator for Romania, AIHA
Eun-Joo Chang, Director, Program Performance, Monitoring and Evaluation, AIHA
Dusko Jagodic, Regional Coordinator for ITC Programs in CEE, AIHA
James Smith, Executive Director, AIHA
William Jeffers, Mission Director, USAID/Zagreb
Klara Benko, Project Assistant for democracy and Governance, USAID/Zagreb
Richard Lyons, Second Secretary for Political Affairs, US Embassy Bratislava
Dr. Gabriela Paleru, Health Specialist, USAID/Bucharest
Cate Johnson, Director, Democracy and Social Sector Reform Office, Romania
Mary Ann Micka, MD, former USAID/Romania Health Officer and E&E Health Team Leader
Susan Monaghan, former USAID/Romania Health Officer, now AIDS Sector Advisor at USAID/Tanzania
Susan Kutor, USAID Local Governance and Stability Pact Coordinator, Regional Center, Hungary
Marilynn Schmidt, Director, European Country Affairs Office, USAID/Washington
Anne Convery, Senior Balkans Desk/Croatia Desk Officer, USAID/Washington
Petra Reyes, former Project Officer, AIHA Cooperative Agreement
Hala Azzam, former Project Officer, AIHA Cooperative Agreement
Julia Terry, former Project Officer, AIHA Cooperative Agreement
Dan Blumhagen, MD, Evaluation Team, AIHA Activities in Slovak Republic, USAID/West Bank/Gaza Program Officer
Ross Anthony, PhD, Team Member Continuing Evaluation Panel, Director, International Health, Rand Corp.

Annex 8: Summaries of Field Interviews

Banska Bystrica and Martin, Slovakia – Cleveland, Ohio

Type of Partnership: Healthy Communities

Period of AIHA Partnership Support: 1997 -1999

US Partners:

Initial partners: The MetroHealth System/Case Western Reserve School of Medicine, the Federation for Community Planning, Cleveland-Bratislava Sister Cities

CEE Partner:

Initial partners: Mayors' offices of the cities of Martin and Banska Bystrica (BB).

I. Achievement of Goals and Objectives:

The goals focused on community health and were all met. They were as follows:

- Examine the health and social service needs of the community.
- Develop strategies to improve health and social service planning, coordination and decision-making.
- Reassess relative roles of local government and community-based organizations in developing and influencing health policy.
- Reduce reliance on government funding by developing alternative funding mechanisms and volunteer capacity.
- Mobilize and empower citizens from diverse sectors of the community to focus on health and to effect change.
- Facilitate the establishment of local health councils.

II. Contribution of Partnerships to Achievement of USAID Mission Goals:

The USAID/Slovakia program in Slovakia began in 1992 with the goal of improving the health sector through programs focused on quality, efficiency and sustainability of health services in the categories listed below. The community participation goal was met through the Banska Bystrica and Martin's healthy communities initiatives.

Health Financing System: Assistance to the national insurance fund and Ministry of Health in developing insurance management and new payment systems.

Clinical and Financial Management: Testing of efficient hospital management practices and quality improvement programs in Roosevelt Hospital and Trnava Hospital and development of health management training programs.

Community participation: Fostering cooperation in the health sector between local governments and citizens.

Environmental/Occupational Health: Developing curricula for Matej Bel University and for post-graduate education of general practitioners. (Source: Blumhagen/Aaronson report)

III. Sustainability of Partnership Relationships. (Include Comments from US Partners):

For about 4 years after the partnership ended, the BB partners stayed in touch with their US counterparts. But since that time, the US partners have moved to other positions and they have lost touch. A personal relationship continues between Martin and US partners.

IV. Accomplishments:

A. Contribution to Systemic Change: The 1993 Slovak health reforms called for communities to take responsibility for social care of the population. When the locals assessed what had been included in the social care programs of the past, they realized that they were insufficient to meet the needs of the population, so they had to be expanded and new services had to be added (such as elderly care and drug abuse prevention and treatment programs). The materials from the US helped them design programs and justify their analyses. Local government asked citizens what was most important to them and referendums were held.

In BB, the locals said they needed long term care above all else. The Mayor, who has traveled widely in other parts of the world, was open to new ideas, encouraged others to be open to new thinking and gave his full support to the LTC initiative. The BB partners have finally received approval from the state to build a 16 bed hospice.

The hospice in Martin is not a separate building, but it is housed in a home for the elderly that also has social services.

BB and Martin continue to lobby for hospice care to be covered by insurance. The partners wanted to emphasize that when they visited Cleveland, they saw a hospice for the first time and realized that they needed to provide that type of service for the elderly in their community. The decision as to who would be eligible for the hospice services is the question (e.g., people without families or people who need special services, etc.).

B. Improvements in Health Care Delivery: 1) There were no hospice services in the BB or Martin communities at the beginning of the partnership. There are now full service hospices in both communities. An in-patient hospice facility has been approved. Additional beds have been added to the Geriatric Department of FDR Hospital in BB and to the in-patient nursing care in the retirement home and new playgrounds were set up in the housing estates. 2) Martin has established a website to support people who want to quit smoking and is operating a Center for Smoking Cessation, 3) Many new social services programs (homes for abused women, shelters for the homeless, retirement homes, long term care, etc.) have been established.

C. Improvements in Health Status: 1) With the addition of important social services, the quality of life for elderly patients has improved, 2) *Haemophilus Influenza* vaccinations are now fully covered by insurance as a result of lobbying by Martin, 3) The number of daily smokers has decreased from 36% in 1995 to 29% in 2001. 4) Through their lobbying efforts, in 2004 Parliament passed an Act prohibiting smoking in public buildings. The Minister of Health has stopped smoking.

D. Developmental Impact:

1. Human Capacity Building

Increased capacity is still paying dividends in the following areas:

- **Training skills:** In Cleveland the partners from Martin were trained in the medical aspects of smoking cessation and when they returned they trained the Slovak physicians in the smoking cessation strategies.
- **Professional skills: 1)** In BB, they developed programs to connect health and social services particularly for senior citizens. A survey of the needs of the elderly was conducted. The Matej Bel University is soon to open a health care program which will include training for hospice workers. In Martin, physicians have been trained in how to encourage patients to stop smoking.

2) The Martin professionals were able to use the knowledge gained in the US to enhance their own professional skills and/or establish organizations modeled after some of those they saw in the US. One of the partners indicated that she learned about social medicine, management, hygiene and epidemiology when on an exchange to the US, and she immediately applied them to her work at the Medical University. Another used what she had learned in the US to start the Center for Anti-Smoking Support. Another partner who heads the Social Health Commission in Martin became acquainted with voluntary aspects of providing social services when in the US and put this knowledge into practice by establishing the Foundation.
- **Networking:** Face-to-face networking occurs during conferences and other organized events, otherwise it is too costly to cover transportation. Generally speaking, the partners said that there is still an absence of teamwork and cooperation in Slovakia. However, the Mayor of TT got Martin involved with the partnership. She shared the epidemiological study showing the extent of chronic non-communicable diseases in the area (COPD, emphysema) and the connection to smoking.
- **Fundraising skills:** One of the trips to the US focused on fundraising and grant writing. This training was very helpful. 1) The Martin Hospice Foundation was awarded a \$32,900 grant from EU PHARE. They competed with 50 other organizations to win this first place grant, which at the time was the largest grant they had ever received. 2) There is a community foundation in Martin that support local projects with small awards. One of the BB partners serves as an adviser to the foundation and helps with the evaluation of grant proposals.
- **Advocacy skills and communications:** 1) In Martin the Promotion of Non-Smoking Center was established and since then there has been a 6% decline in daily smoking. In the US they were introduced to the concept of using mass media to communicate about public health and learned how to do it. These skills enabled them to reach the entire Slovak population with their messages in newspapers, radio shows, press conferences. There is a stop smoking day every year and semi-annual press conference on the smoking cessation program. They have established a website which has information about tobacco control and they have a “Quick Line” for people to call who want advice on how to quit. 2) As a result of lobbying by Martin, the *Haemophilus Influenza* is now fully reimbursed by insurance. 3) In 2004 Martin was successful in getting legislation that had been pending for 7 years passed which prohibited smoking in public buildings.
- **Appreciation for usefulness of data in their work:** In BB, the partners conducted and utilized a survey of the elderly to guide their initiatives. They discovered the need for hospice services. In 1998 Martin conducted an epidemiological study using students who went door to door with questionnaires. It showed the extent of chronic non-

communicable diseases and the connection to smoking as well as a high interest in gaining the discipline to stop smoking. They visited the American Cancer Society and learned about effective programs to stop smoking. Since initiating their anti-smoking campaign, they have seen declines in smoking in Martin as well as all of Slovakia.

- **Participation in international forums:** 1) The leaders of the Anti-Smoking campaign have received funding from WHO and the UN to attend international conferences on this topic. Their representatives have collaborated with WHO on global strategies to prevent smoking and encourage smoking cessation, and have learned how to apply evidence based medicine to their treatment of respiratory diseases. 2) The organizers of the hospice program in Martin are collaborating with 5 foreign partner cities to establish hospice programs. West Europeans (Holland, Germany) have visited Martin to observe the operations of their hospice and they are exchanging equipment and information.
- **Recruit, train, and retain volunteers:** Some of the trips of the partnership were dedicated to developing voluntarism. A direct outcome of this was the establishment of the Center for Volunteers within the Community Foundation using materials from the partnership. The Center is affiliated with the University and recruitment of volunteers is focused on students at the Matej Bel University. Institutions request volunteers and the Center matches the volunteers to the organization. They provide handouts to organizations on how to work with volunteers, and there are intermittent short term training programs for volunteer coordinators. They organize a week of volunteering and use this time to inform the public about the volunteer movement and how to get involved. The Center provides volunteers for all kinds of social services. Issues have arisen over volunteerism and they are trying to have legislation passed clarifying the position of volunteers. For instance, injury of volunteers, expenses of volunteers (who may be unemployed and need to have costs of transportation, etc. covered). Some organizations have resolved the issues on their own, but others are afraid that audits will show they have covered volunteer expenses and the costs will be disallowed.
- **Identifying and training new stakeholders:** 1) A representative group from the Mayor's office, the health commission and the health and social services departments participated in the visits to the US. This made it much easier to push through new programs in the city. 2) In Martin, they have established new programs at the medical school to train nurses in "community public health" which covers social health and care for the dying. This is opening up the next generation to a new way of providing services.
- **Continuous improvement:** 1) BB developed its first urban plan under the auspices of the WHO Healthy Cities program. When they became part of the healthy communities program, they undertook a more interactive approach with the citizens and had much greater involvement of all the community stakeholders. Using healthy communities techniques, they revised the city plan in 1998 and they are now reevaluating priorities and have written a new draft plan building on the achievements of the 2nd plan. 2) In both BB and Martin, improvements in the provision of social services has been on-going.
- **New mindset:** 1) There are now about 300 volunteers working through the auspices of the Volunteer Center in BB, but this is still a new concept and society is not yet appreciative of the contribution these people are making in the field of social services. 2) People in Slovakia have expected the government to take care of them, and their perceptions before the partnership were that everything had to be driven by the state.

They were “amazed” to learn about NGOs and the power of NGOs to influence legislation at the national level. Also, the people believed that the government was responsible for their health and through the partnership they learned about how people take personal responsibility for their health. 3) They had not heard about fundraising before their trip to the US and now they are very actively engaged in fundraising. 4) In Cleveland they learned that businesses donated to local charities. They were unfamiliar with non-governmental social services and the use of volunteers in community service activities. The volunteers are reporting that “it feels good to help others.” 5) For the first time they saw different levels of care for the elderly from independent living to skilled nursing. 6) They saw the value of integrating social and health care, but have been unable to persuade the health insurance agency to reimburse integrated services. Even though they saw these examples 10 years ago, they still use these examples when they teach medical students. 7) They have new programs to train nurses in “community public health” which covers social health and care for the dying. 8) They saw the different role that nurses play in the US health care system and they are pleased that there is now legislation in Slovakia which gives nursing a professional status. There is now a Slovak Chamber of Nurses. The situation is not yet perfect according to the partners in Martin, but it is much improved. There has been “unbelievable” progress for nurses, and these ideas came from the partnership. “It gave us courage because we saw that it could be done.”

- **Ability to adapt models:** 1) There were only 2 or 3 hospices in the country at the time the partnership began and they had very little information about hospice care. On the visits to the US, BB and Martin saw 7 different hospices. Now both communities have model hospice programs. The programs are financed through fund raising efforts using skills learned during the visits to Cleveland. 2) When the locals assessed what had been included in the social care programs of the past, they realized that they were insufficient to meet the needs of the population, so they had to be expanded and new services had to be added (such as elderly care and drug abuse prevention and treatment programs). The materials from the US helped them design programs and justify their analyses. 3) They encouraged the formation of many NGOs after their visits to the US. 4) After observing social services programs in Cleveland they have organized the following resources that are financed by the city of Martin
 - A house for abused women
 - A nice shelter for the homeless
 - “Social apartments” for people who are unable to cope on their own,
 - A Community Center for Retired People.

The city plans to open at least one new facility on a bi-annual basis.

2. Institutional Capacity Building

Institutional capacity is evident in the following areas:

- **Ability to absorb incremental costs (i.e., ability to replace withdrawn donor funds with funds from other sources):** The BB and Martin initiatives are still operating and are financed through municipality budgets and private fund raising.

- **Standards, guidelines and protocols adopted:** The Slovak government did not require Hib immunization, and they conducted a cost-benefit analysis they learned in the US, presented it to the MoH and were successful in having it approved as a required immunization.
- **Expanding group of stakeholders:** The University of Majeh Bej in BB is opening a new faculty of health care and hospice workers will be trained there.
The anti-smoking initiatives started through the partnership in Martin have expanded to regional and national level programs. Physicians have been trained in smoking cessation strategies. New legislation (The Tobacco Control Act) has been passed in Slovakia.
- **Involvement of younger generation:** 1) See new stakeholders above for Martin. 2) There are on-going programs in the schools to inform children about the dangers of smoking, to support them in resisting the temptation to begin smoking and to encourage them to take the message home to their parents.
- **Participation in international forums:** They regularly participate in the WHO Healthy Cities meetings and are involved in a European network of hospices.
- **Strategic Analysis of strengths, weaknesses, opportunities and threats (SWOT)/identification of stakeholders:** All the CEE partners received training in conducting a SWOT analysis. Each city performed its own SWOT analysis and the results were quite different. This gave credibility to the process. A SWOT was also conducted at the end of the partnership. SWOT is now a common method that is used for strategy development in many areas of their work.
- **Ability to build upon and expand the targeted intervention (i.e., replicability):** During the partnership, Martin developed a mobile hospice (The Agape Center) to serve people in their homes. They have now broadened their vision and are planning an inpatient hospice. The land has been secured.
- **Outreach:** The smoking cessation program includes continuous outreach to the community.
- **Fundraising:** See above.
- **Manager/leader:** “Even if the leaders quit, these initiatives will continue without them.”

3. Community Mobilization

See comments regarding system changes above.

Bohemia-Nevada

Type of Partnership: Health Management Education

Period of AIHA Partnership Support: 1996-1998

US Partner:

The University of Nevada's Health Administration program in the College of Business and the School of Medicine

CEE Partners:

The South Bohemia University Faculty of Management in Jindrichuv Hradec; the Faculty of Management and Information Technology at the University of Education in Hradec Kralove; the Faculty of Health and Social Care in Ceske Budejovice, also a part of South Bohemia University; the Purkyne Military Medical Academy, The Postgraduate Medical School in Prague

Interview Limitations: Representatives from 3 of the 5 CEE partners attended (no one from Purkyne Military Medical Academy and from the Faculty of Health and Social Care attended, and according to Mary Paterson, this was one of the most successful elements of the partnership). LRCs were well represented, but not the HME and curriculum development components.

I. Achievement of Goals and Objectives:

Health Management Network

- Create a network of health management professionals within the Czech Republic.
Did not successfully create a network of health management professionals. CEE partners reported that the 3 CEE partners clashed early on regarding interests and objectives, and held a meeting in Prague that resulted in a "divorce". Funds for travel and other resources such as books and technology were split up in order to avoid future conflict. Collaboration among these 3 CEE partners was limited to areas of shared interests (for example the LRCs remained in contact). US partner reported that the LRCs were very separate and the HM activities did not work with them.

Curriculum Development

- Develop a bachelor degree program in health services management at the Faculty of Management in South Bohemia and the Faculty of Management and Information Technology in East Bohemia.
- Offer courses in health services management for students of management, pharmacy, medicine and nursing.
- Develop short courses in health services management for practitioners.
- Develop and test educational materials for use in management education, including theoretical and applied materials.

A program for health managers was developed in Hradec Kralove, Faculty of Management and Information Technology, but it was not accredited and has been moved to the Faculty of Pharmacy. Discussions with the HK rep indicated that basic health management principles were never fully integrated into the economics faculty.

The Institute of Health Care Services Management at the University of Economics, Prague, Faculty of Management, Jindrichuv Hradec developed an undergraduate health management program and have developed masters level studies. The program was accredited.

Management Teaching Skills

- Increase faculty capabilities in teaching methods and techniques in management education.
- Identify and develop faculty with management interests and capabilities to become teachers of health services management.

Unable to assess in this evaluation.

Information Dissemination

- Organize and actively participate in regional, national and multi-national programs to develop and share health service management knowledge and practice.
- Develop a resource center to support the educational needs of faculty and students.

Resource centers were developed; however, due to lack of strong collaboration, there was not active networking among national partners. Prague Postgraduate Medical School's LRC is well-used (20,000 users per year), and support needs of faculty and students, and makes a concerted effort to promote the concept of evidence-based research. However, the HME activity partners reported that they did not use the center.

II. Contribution of Partnerships to Achievement of USAID Mission Goals:

A goal of the Mission (see list of goals in Summary of Banska Bystrica and Martin Partnership, Section II) was to develop health management training programs and this goal was met by the partnership.

III. Sustainability of Partnership Relationships:

No relationship with Nevada continues. CEE partners attribute it to the fact that the key counterparts in Nevada have moved on to other places; Patterson felt that the Czech partners were all too busy to maintain on-going relationships.

IV. Accomplishments:

University of South Bohemia's Faculty of Management moved to the University of Economics in Prague in 1998, causing some delays in graduation of students. In 2000 and 2001 there were 29 and 20 graduates in health management, respectively. In 2003 and 2004, 13 and 7 masters level students, respectively, graduated with a minor specialization in Health Care Management. The focus of training is primarily cost-benefit analysis and financial management of hospitals.

Exchanges were considered valuable for allowing observation of how teaching takes place in the US (unrestricted access to the internet, layout and design of computer rooms to allow collaboration between students) and for obtaining technological skills that allow upgrading of software and hardware without jeopardizing existing systems.

One CEE partner confessed that while in the US, he was less interested in what the exchange offered than the opportunity to establish contact with the university's business school, a partnership which is now supported through the Fulbright program.

Benefits of partnership were described as: obtained information they could apply to their own programs. “We were trained and became trainers.”

The partnership introduced a variety of important technologies that have been adopted, including teleconferencing, e-learning, video-streaming for trainings so they can be disseminated via the internet. Teleconferencing is now widely used.

The HME programs have been sustained at both institutions, with varying degrees of success. CEE partners reported that there has been limited collaboration, and this was limited to the LRCs. LRCs have been well maintained and adapted to meet local information needs.

All partners reported that the technologies that were introduced have become outdated and have been surpassed. Other weaknesses noted:

- They felt they had been grouped with countries with too large a range of technological sophistication (i.e., Albania), which held them back.
- There was no agreement at the outset about what to do with obsolete equipment (who did it belong to? What were they supposed to do with it?)
- The memorandum of agreement did not provide adequate guidance about how they were expected to work.

Breast Health Project In Bucharest, Romania (October 2003– March 2006)

Success Toward Objectives: This activity was funded through a grant. The team did not review the grant agreement, but understood that the objective was limited to improving skills of radiologists in reading mammograms. The program is proceeding and the participating radiologists are receiving on-going evaluations of their readings by an expert.

Human Capacity Development:

Training Skills/Professional Skills

The first course for the original 5 radiology centers was held in April 2004. An evaluation conducted in September 2004 by the US partners was followed by a meeting in October 2004 to discuss the results and future plans. The evaluation yielded favorable results. In April 2005 training in Cluj was held. A two week evaluation completed 4 months later also showed good results. All the trainers in the Cluj training were Romanians who had been trained in the first course.

They plan to adapt sections of the training for incorporation into the medical school curriculum and radiology training.

The radiologist the team spoke with at the center (coordinator of the project) has not traveled to the US and does not think it is necessary or would be useful to him. He did have some advanced training in Geneva some years ago.

Institutional Capacity Development:

Standards, Guidelines and Protocols/Management

They have translated American and European manuals of radiology quality assurance (QA) and these are available at every center that has been trained. Each center also has a QA kit (from the US which includes phantom films). They state that they are aiming for the same quality of radiographic studies as is obtained in the US.

The partners note that while they have felt successful with their public education campaigns on breast health, they have established a good mechanism for informing general practitioners and specialists about appropriate screening guidelines. As a result, they have had many inappropriate referrals. This is an area for future development.

Ability to Build Upon and Expand Partnerships

In 2004, one of the radiologists founded the Breast Imaging Society together with a key US adviser.

Their future plans include introducing a computerized system at all the centers to allow data collection from all the sites in a standardized format as the beginning of a national-level surveillance system.

New Services/Responsive Services

The Radiology Clinic (Renasterea Foundation) is performing between 400-500 mammograms per month; they are approaching their maximum capacity, estimated to be approximately 600 per month. To date they have had more than 6,000 visits since opening in 2003. They estimate approximately 10% of patients are referred for further evaluation. They do not have the capability (yet) to track the outcomes of these patients. They have anecdotal evidence that they are detecting breast cancers earlier in their patients.

They have an (appropriate) clinical intake form, a computerized database. They obtain at least 2 readings of each mammogram (which were noted to be of excellent quality on the site visit). In addition, they have a new ultrasound machine. Fees for services are on a sliding scale and free for those unable to pay.

At present there are 10 centers with a QA system (those that have been trained through the grant) and approximately 60 without.

Ever Expanding Pool of Stakeholders

The Renasterea Foundation's funding comes primarily from various sponsors and private donors (they do not receive any state funding).

Sustainability:

Although this grant is still current, it is apparent that activities will be continued and likely expanded in the coming years.

Replication:

There were 5 original centers that received training in radiographic technique and quality assurance. Staff from these original 5 centers trained an additional 5 centers so there are now a total of 10 centers. In December 2005, they plan to train an additional 4 centers.

Bucharest- Chicago

Type of Partnership: Health Management Education

Period of AIHA Partnership Support: 1996-1999

US Partner:

The Graduate Program in Health Administration and Policy at the University of Chicago

CEE Partners:

The Department of Public Health and Management at “Carol Davila” University of Medicine and Pharmacy, The Institute of Health Services Management

I. Achievement of Goals and Objectives:

The partnership achieved all the goals and objectives in their program. Specifically,

- Established Department of Public Health and Management at the Carol Davila University of Medicine and Pharmacy.
- Established LRC at Institute of Health Research and Development.
- Enhanced knowledge in specific areas of health management, including health economics, communications, human resource management and quality assessment by conducting training at the Univ of Chicago for 3 months for 12 CEE partners.
- Upgraded management skills, including interpersonal communications skills through provisions of training in Romania on organizational management, quality improvement, and social policy formulation in 1998.
- Developed increased capacity of Romanian partner institutions to provide technical assistance in health care management and policy. Romanian partners provided technical assistance for health care management and health policy reform to several countries in the NIS and CEE regions. Materials used in courses are primarily written by Romanian participants in the partnership.

II. Contribution of Partnerships to Achievement of USAID Mission Goals: In the late 90s the Mission’s health sector goals included strengthening linkages between health management education and applications. This goal was met. Graduates of the Masters degree program now hold positions in national and international organizations.

III. Sustainability of Partnership Relationships. (Include Comments from US Partners):

Despite successful partnership activities, contact with Chicago has not continued. Romanian partners noted that “US partners move around a lot.” “The partnership was with the institution, not the individuals.” They did not feel that establishing regional partnerships was an objective of their program. They prefer to establish relationships with partners outside the region where they think they can learn the most.

IV. Accomplishments:

Around 1991, Prof. Dan Enachescu and his team began to develop the idea of creating a school of public health in Romania. Twelve young doctors were sent abroad for training at the London School for Hygiene and Tropical Medicine, University of Montreal and New York University for training of at least 3 months duration. Upon return, these students became trainers, and in partnership with LSHTM, Montreal and

NYU ((LUMNY), they established a masters program in public health, management and continuing education (Institute of Health Services Management). The Institute was abolished by the MOH, however, the Univ. of Medicine continued the courses. Since 1998 an accredited masters degree program has been in place at the Univ. of Medicine.

A school of public health has still not been established, however, in 2003 legislation allowed for several masters level programs in health and social service to be established. Currently there are 3 MS programs in Bucharest (Univ. of Bucharest , School of Economics, and the Univ. of Medicine).

CEE partners reported that prior to the partnership they had strong capability in epidemiology, statistics and demography, and already a clear idea of what they wanted from external partners: skills in communications, health economics and quality improvement.

Prof. Enachescu had a clear vision of how health reform, public health approaches and improved management could improve the standard of health services in Romania. Romanian partners were several years ahead of their CEE counterparts in the AIHA partnership program in being able to integrate and adopt principles of health care management education into their existing programs.

The Bucharest Chicago partnership implemented a 12 week training program at the Univ. of Chicago to provide intensive training for 12 young Romanian doctors on health care management, and teaching tools and methods. The breadth and depth of the training exceeded any training provided in the partnership, and helped establish a cadre of health care management teachers for the Univ. of Medicine. CEE partners reported that the training was very good, and pointed to the case study methodology as an important example: developing Romanian case studies for students to work with made their training more interesting and motivating for their Romanian students. The case study methodology has since been presented to other AIHA partners in the region, including a one-week training in Kazakhstan in 2001, to introduce the Romania experience.

CEE partners reported that the LRC was an important intervention, facilitating a good connection between professors in the region and important access to journals, data and other publications. “As a young student coming in to the program, having all those books was an excellent thing.” The main contribution of the LRC was greater access to on-line research; Romania already had the structure and capacity to use the materials. The LRC is an important tool for evidence-based medicine. The CEE partners stated that access to the internet is essential to their professions.

Contribution of the AIHA partnership:

1. post-graduate teaching training
2. MS degree
3. practical courses for hospital managers
4. accredited short course for people in and outside Bucharest

The partnership has had national and international impact: graduates of the MS program are now in high level positions in the Global Fund, UNFPA, the National Insurance House and OSI. However, the graduates are still at the secondary decision-making level, and not yet in the highest level positions.

The impact of the Chicago partnership has clearly been sustained. When funding ended, they tried to get an extension, but failed. When additional funds were made available by USAID, the Univ. of Kentucky was the US partner organization. This second partnership was funded from 2001-2004. Romanian partners have sustained and built on all aspects of their partnership with Chicago. The MS program has graduated 20-25 students per year since 1998.

Bucharest-Lexington, KY

Type of Partnership: Health Management Education

Period of AIHA Partnership Support: 2001-2004

US Partner:

University of Kentucky School of Public Health

CEE Partners:

The Department of Public Health and Management at “Carol Davila” University of Medicine and Pharmacy; the National Institute of Research and Development in Health

I. Achievement of Goals and Objectives:

The focus of the partnership was developing and implementing health communications and community mobilization strategies essential to the implementation of effective health reform efforts in the region.

Specific Objectives:

- Elaborate and deliver a Communication Campaign
- Knowledge transfer through training spokespersons

Training in communications skills and approaches provided by the Univ. of Kentucky included a broad range of skills, including needs assessment, strategy and design, identification of stakeholders, materials development and evaluation of impact.

II. Contribution of Partnerships to Achievement of USAID Mission Goals: In the late 90s the Mission’s health sector goals included strengthening linkages between health management education and applications. This goal was met.

III. Sustainability of Partnership Relationships: Relationships have been sustained between these two Universities.

IV. Accomplishments:

This partnership built on the Bucharest/Chicago partnership (1996-99). USAID made additional funding available and offered the Univ. of Kentucky as a partner. A new insurance system had been introduced in Romania and the CEE partners recognized the need to educate the community about how to participate in the new system. They knew that the experience and knowledge existed in other countries and had identified this as a priority focus of the partnership.

Prof Enachescu had a clear vision of how health reform, public health approaches and improved management could improve the standard of health services in Romania. Romanian partners were several years ahead of their CEE counterparts in the AIHA partnership program in being able to integrate and adopt principles of health care management education into their existing programs.

By the time this partnership began, Prof Enachescu was joined by a cadre of experienced, knowledgeable and motivated professionals who had been trained in various settings through previous partnerships, and who were also critical to the success of this partnership.

Training was provided by Univ of KY on communication skills and methods. Trainees successfully mastered these skills, implemented several specific health communication and advocacy activities. In addition they have developed a training package for health education and communications.

Romanian partners reported that a key element of the success of this partnership was the opportune real-life event that occurred in Kentucky: efforts to re-open a closed rural hospital. During the partnership the Romanians were able to participate in key meetings, activities and planning sessions over time and observe first hand the strategies, and skills that led to the re-opening of the hospital. Participants felt the example was similar to problems faced in Romania, and provided the opportunity to develop practical skills they could use in Romania.

Additionally, Romanian partners stated that the partnership with KY resulted in the development of the e-learning platform currently in use. A data-base of library's collection has been put on-line, facilitating searches. In addition, the Romanians introduced CD-ROM training courses for distance learning as a result of the partnership.

From the outset this partnership integrated strategies to improve sustainability, including training of a variety of public health professionals at various levels in the health care system in communication skills, training local health authorities, local college of physicians, and the local insurance house. In addition they provided communication training for spokespersons and used their website to provide support.

Communications skills are recognized as an important management tool by the Romanian partners, for a broad range of issues, including improving relations between professionals, educating and engaging patients and communities, promoting patient rights, advocating among policy makers, engaging journalists and other media.

Replication:

This in one of the few activities which has taken the initiative to directly replicate their activities in another setting. The Bucharest-Tirana partnership funded concurrently (2001-2004), saw the Institute transfer the skills learned in their partnership with Kentucky into technical assistance to the Institute of Public Health in Tirana, Albania.

Cluj-Napoca, Romania – Philadelphia, Pennsylvania

Type of Partnership: Hospital

Period of AIHA Partnership Support: 1995-1999

US Partners:

Thomas Jefferson University

CEE Partner:

Institute of Public Health, The Inspectorate of Public Health, and The Clinic for Occupational Diseases

Occupational and Environmental Medicine:

- Identify the major sources of occupational and environmental illness in the Cluj region, including within local industry and health care settings.
- Improve detection and prevention of occupational hazards through education, diagnosis and care of affected individuals.
- Improve health and safety conditions on the factory floor by assessing work sites in the Cluj district, and exchanging information on guidelines for occupational and hazard control.
- Safeguard the health of health care workers by improving the health care setting, including development of protocols for safe handling of radioisotopes, chemical hazards and biological hazards.
- Improve techniques of ambient monitoring and patient surveillance.
- Improve techniques for patient care, case management and rehabilitation.

Pulmonary Medicine:

- Improve the prevention, diagnosis, treatment and research of respiratory diseases resulting from occupational and environmental factors by increasing levels of competency in specific areas of pulmonary medicine.

Nursing:

- Increase role and skills of nurses in the clinical setting and increase interaction between physicians and nurses.

Informatics:

- Develop an Internet-based medical surveillance module that will be accessible to all occupational medicine physicians throughout Romania.

Success Toward Objectives:

The partnership met most but not all of their goals. Since we did not visit Cluj, but rather met with the partners in Bucharest, we were not able to visit the Nursing or Learning Resource Centers.

Human Capacity Development:

Pre-partnership activities and Selection of Partnership Focus

Work with US agencies and partners began in 1993 with a focused collaboration to investigate the high lead concentration in some heavily polluted areas in Transylvania. A successful social marketing

campaign helped lower the measurable blood lead level in children. This early US collaboration led to their participation in the AIHA partnership, spearheaded by Mary Ann Micka at the USAID Mission office.

Areas of focus for the partnership were selected based on the high levels of pollution in the region and the prevalence of respiratory diseases secondary to poor air quality.

Training Skills/Professional Skills

The Cluj partners recognized the need to improve their respiratory diseases curricula.

In the management training, they learned the importance of working in teams and how to use the SWOT analysis (including practicing its implementation). Through all of this, they felt their self-esteem and confidence grow.

The LRC staff received training in communications and medical searches in Kosice and Zadar which they felt greatly increased their knowledge.

Improved Status for Nurses

The Cluj team learned from their US partners how nurses could function. The nurses became more confident and were encouraged by the US partners to work at their maximum potential.

New Mindset

The Cluj team noted that from the exchanges they could observe how a truly democratic institution works which is something they felt they could not learn from movies or books on the US but they had to witness firsthand.

In the training workshop on management for physicians, nurses and lab technicians, they learned that management had to learn to function differently, that they needed to change not just their behavior but their mentality, and that it was really a culture change for them.

The partnership provided a “headstart” to the Cluj institutions in all the selected areas.

Institutional Capacity Development:

Standards, Guidelines and Protocols/Management

Unfortunately, The Prohibition Of Smoking At The Clinic Has Not Been Successfully Enforced And People (Patients And Staff) Continue To Smoke Throughout The Clinic.

Ability to Build Upon and Expand Partnerships

The former LRC director (who now is a fulltime teacher) has established some US – Cluj partnerships between schools. Through a sister city program, she got her school linked to a university in South Carolina and they now have US college students coming to teach high school students in Cluj over the summer.

Evidence-based Medicine (EBM)

They felt the hospital’s role in developing EBM was to establish standards in occupational disease evaluation. One physician would use the US example to drive the changes in their system. They successfully used EBM to develop diagnostic procedures for bronchial asthma. They also use medline for their research purposes.

New Services/Responsive Services

During an exchange to the US, the head nurse saw how the outpatient department worked and began investigating what was necessary for them to establish a similar unit and got the physicians on board to begin organizing it. It is still being organized.

The partners interviewed believed the length of stay for admissions decreased over time but as none of them still worked at the clinic, they could not confirm this.

Ever Expanding Pool of Stakeholders

The Cluj team did involve the labor unions in their occupational health activities. However, this was not done as part of the partnership.

Sustainability:

Many of the programs and policies developed and implemented during the partnership are still in practice today. In addition, the knowledge gained during the partnership is still used today. For example, one of the partners is teaching health management at the nursing school (based on material learned from the partnership) and uses the SWOT analysis. However, as noted above, the no-smoking policy has not been enforced. No legislation from the partnership activities was enacted (although there was legislation passed on lead exposure as a result of the first US collaborative research).

Of note, many of the Cluj partners developed skills (and the self-confidence) in different areas that allowed them to move on to higher paid positions (e.g., teaching, software sales, private consulting firm). While this is a benefit in terms of individual human capacity development, it may have had an overall negative or detrimental impact on the institutional capacity since many of its best workers were lost to other professions and the private sector.

Some of the Cluj partners are still in contact with their US partners but their continued collaboration is mainly in their new positions, some personal contacts, and none with the original partner institutions.

Replication:

The Cluj partners did not replicate or disseminate their activities or models elsewhere. This may have been related to the fact that many of the partners left their original institutions during and after the partnership ended.

Nursing Resource Center (NRC)

In 1998, the NRC was established through funding from AIHA and Soros Foundation/Open Society Institute. Currently, 3 part-time nurses oversee its activities. Initially, despite having funding, they had a difficult time achieving quality training because the physicians did not consider the nurses to be potential partners in providing care and didn't support continuing medical education for nurses. Their Soros Foundation funding was decreased. They began trainings but their certificates were not recognized by any health institutions. Things improved after 2001 when they began collaborating with the Nurses Association. Trainings are now conducted by the Nursing Association and all courses are accredited; topics have included wound management, patient education, and pediatric and surgical nursing standards. Approximately 20-30 hours per month of trainings are held at the NRC. The library portion is still operating and they have 6 computers.

The NRC did not have any links to the nursing school in Cluj though all trainings are open to all nurses in the community.

Learning Resource Center (LRC)

In early 1996, the first computer with internet access in any medical institution was the one set up in the Cluj LRC. The staff recall the first message received from the US partners saying “we are connected” and they felt its broader meaning of “we are connected to the world now”.

Email accounts were set up for all staff. Now they have learned that the LRC should not be a single location but computer/internet access needs to be available everywhere to all.

At the LRC, they created an electronic library using medline. The LRC is now supported by the Institute of Public Health with its own budget line.

Recommendations from the Partners:

- Maintain partnerships for longer time periods.
- Focus more on sustainability and support an ongoing relationship.
- Establish measurable indicators at the start to evaluate the success of the partnership.

Constanta, Romania-Louisville, Kentucky

Type of Partnership: Healthy Communities

Period of AIHA Partnership Support: 1998-2002

US Partners:

Initial partners: The Humana Foundation, The University of Louisville, Jefferson County Health Department

Additional partners who joined the effort after the focus area was identified: Center for Women and Families, police department, public school system, judicial system, emergency hospital, Planned Parenthood, other NGOs

CEE Partner:

Initial partners: County Health Authority departments of health promotion and health education

Additional partners who joined the effort after the focus area was identified: Community of Constanța (i.e., Constanța City Hall, County Police Inspectorate, prosecutor's office, ambulance service, emergency hospital, labor and social protection department, County School Inspectorate, Direction for Labor and Social Protection, World Vision, Youth for Youth and other NGOs)

Achievement of Goals and Objectives:

The original goal of the partnership was to promote community involvement to improve women's health in Constanța. Priorities that were selected through a community engagement process were domestic violence, sexually transmitted infections, family planning issues and smoking cessation. The objectives were numerous and included the following:

- develop a public awareness campaign to reduce the level of acceptance for domestic violence among community members,
- measure and track the level of awareness to determine the effect of the campaign,
- develop an on-going training program for professionals from a variety of disciplines, including medicine, law enforcement, criminal justice and education to recognize and develop effective strategies to prevent and handle incidents of domestic violence,
- establish mechanisms for the ongoing collection and dissemination of community-based information on domestic violence,
- conduct a comprehensive domestic violence assessment to determine the baseline level, and establish standardized reporting measures,
- create a non-governmental Office for Women to advocate on behalf of women and provide a voice in the legislative process, and to support community health promotion activities,
- identify a means to sustain the healthy communities domestic violence programs beyond AIHA grant period,
- develop a health education and promotion campaign to increase awareness of STDs, including HIV, among community members, especially teenagers, in collaboration with local NGOs,

- develop an on-going train-the-trainer program for teenage volunteers to provide information and education to target groups and other key community representatives.

The community developed an integrated approach to responding to the problem of domestic violence. Realizing the need for ongoing coordination of the network that had been developed, the partners saw the need for creation of a Foundation that would be able to continue the initiatives after the ending of the partnership. In 2000, the Constanta-Louisville Healthy Communities Partnership founded the Constanta Community Foundation with a \$10,000 grant from one of the U.S. partners, the Humana Foundation. This was Constanta's first community foundation. The Foundation immediately opened an Office for Women. As a result, the community team that was formed continues to collaborate today.

Developing a program that would have national impact was not part of the original vision for the partnership. However, by meeting the objectives cited above, the local NGO achieved national prominence and leaders from the organization were recruited into national policy making positions. These positions were excellent platforms for influencing development of new legislation to protect victims of domestic violence. The Constanta experience is being used as a model in 6 different counties in Romania and for the MoH National Strategy to monitor, prevent and combat domestic violence. In April 2002, the national strategy on fighting domestic violence was approved. It includes provisions for all levels of government to be active. The law created an interministerial committee of the Departments of Health, Justice, Youth, Police, Education, and Sports, etc. with responsibility for improving the laws to protect victims. It also calls for a National Commission for monitoring and preventing domestic violence and it requires counties to establish an Office for Women and a shelter for victims.

In May 2003 Parliament enhanced laws protecting women and the power of police in domestic violence cases. It also made domestic violence a crime. Unfortunately, bureaucratic responsibility for enforcing this law has not been backed up with budgetary support.

Other examples of impact from the partnership are that more than 900 domestic violence victims have found help through the Center for Women. World Vision has collaborated with the Office for Women in conducting their programs in Romania to increase the self-esteem of women and children.

The TATU (teens against tobacco use) program was designed to use teen trainers of peers to combat the effects of aggressive advertising to youth by tobacco companies. The program continues today in the Constanta schools.

Contribution of Partnerships to Achievement of USAID Mission Goals:

USAID/Romania directed AIHA to create a Healthy Communities Partnership around the topic of women's health. By the end of the partnership in 2002, more than 900 women had received services and support from the Center for Women. The number continues to grow.

Sustainability of Partnership Relationships:

The information received from the Humana Foundation is as follows:

“The Humana Foundation communicates with Drs. Loti Popescu and Daniel Verman several times a month. Our field manager in Bucharest and a native of Constanta, Tudor Trocan, also has periodic contact with them. We also receive quarterly reports from the Office for Women.

Each summer since 1999, Humana has offered summer internships to 2-3 students of Middlebury College in Vermont to spend 4-5 weeks learning firsthand about the health system of Romania. Many of those students visited Constanta and met with Drs. Popescu and Verman who often

arranged for interviews and site visits targeted to the research topic assigned to each student. A few students spent most of their time in Romania in Constanta.

Here are highlights of our involvement since the end of the AIHA/USAID grant period:

- A. In **December 2002**, with a \$500 Humana Foundation grant, the Office for Women distributed food and Christmas gifts to 20 clients, the same type of distribution as in 2001.
- B. In **January 2003**, at the request of Humana, Dr. Verman presented in Zalau the Constanta Healthy Communities model to the Louisville-Salaj Partnership for Health Reform, another USAID-funded grant through World Learning.
- C. In **February 2003**, the Foundation contacted Dr. Agis Tsouros to ask if the WHO Healthy Cities Project Coordinator position for Romania had been filled. He said the position was open, was impressed with Dr. Popescu's work, and asked that she forward her CV. We reviewed her CV before she forwarded it to Dr. Tsouros.
- D. In **July 2003**, the Foundation asked the Office for Women to contact three groups in the community foundation movement in Romania to be sure they were aware of the existence of the CCF: the Association for Community Relations, the Romanian Association for Community Development, and AID-ONG Timisoara.
- E. In **September 2003**, the Foundation forwarded \$50 to the CCF for the second Annual Youth Volunteer Awards in Constanta.
- F. In **October 2003**, at an international WHO Healthy Cities conference in Belfast, Ireland, Drs. Popescu and Verman promoted Constanta's candidacy for the first Healthy City status in Romania, one of only a few European countries not yet participating in the Healthy Cities movement. Humana paid for their lodging and visas.
- G. In **November 2003**, Dr. Verman asked the Humana Foundation if Abbott Laboratories funding for the tobacco-cessation program in Constanta was possible.
- H. As a follow-up to the Belfast Conference, in **November 2003**, we contacted Dr. Agis Tsouros Regional Advisor, WHO's Centre for Urban Health Healthy Cities and Urban Governance Programme in Copenhagen, to nominate Dr. Popescu as candidate to be the first national coordinator for Healthy Cities in Romania. He said funding was the obstacle to establishing such a position, and thought he might find resources in Greece. The Foundation had contacted the Mott Foundation consultant in Romania who said Mott funding was not available.
- I. In **March 2004**, the Humana Foundation contacted Dr. Henry Enck, associate provost at the University of Louisville (UofL) regarding Dr. Popescu's interest in establishing an education center or Master's in Business Administration in Constanta in association with the University of Constanta. Although Dr. Enck said UofL does not establish education centers or master's degrees in business abroad, UofL might be able to offer a degree in human resources or justice administration. We sent the contact information for Dr. Enck to Dr. Popescu.
- J. In **May 2004**, the Humana Foundation forwarded to Drs. Popescu and Verman their requested certificates of completion of the 2000 "Seminar on Coordinated Community Response to Domestic Violence" from the University of Louisville Department of Justice Administration.

- K. In **June 2004**, Humana paid for train fare and lodging so that Dr. Popescu could attend an international conference in Bucharest given by the City University of New York's College of Criminal Justice.
- L. The Board of the CCF had to obtain emergency funding to replace the sudden and unexpected loss in July 2004 of its primary funding source--the Constanta County Council. The challenge was two-fold: (1) begin to establish the constancy of annual funding partners for long-term sustainability, and (2) create the precedent for such support in a society heretofore unaccustomed to funding partnerships of profit and not-for-profit enterprises. In **September 2004**, the CCF Board of Directors developed a fundraising plan and officers visited more than 30 individuals and organizations in Constanta and Bucharest to solicit funds to match a \$2,000 Humana 2:1 challenge grant. In October, the CCF met the Humana challenge with \$1,121 from two local companies and the Constanta County Council. This \$3,121USD funded the Office for Women through 2004.
- M. The Humana Foundation was instrumental in obtaining operational support for the Office for Women in 2005. In **September 2004**, David Popik, director of Best Buy Group A/S in Vamdrup, Denmark, visited the Humana Foundation and offered support for our work in Romania. He agreed to donate \$7,500 to the Office for Women. The Foundation worked with Drs. Popescu and Verman to develop a case for support and a list of prospective funding sources. The Foundation forwarded the case for support in a funding appeal to several international organizations such as The Fund for Women and the Netherlands Foundation, and contacted more than 30 nonprofits. In addition, we gave four referrals to the CCF for possible funding sources, such as Citibank, Embassy of Norway, Rotary Club of Constanta, and Shell Romania.
- N. In **October 2004**, the Humana Foundation gave a \$2,500 challenge grant to a new Louisville foundation, Beta's Blessings, which is now working with Bellarmine University of Louisville, Dr. Popescu and the University of Constanta to develop a national curriculum for training teachers to adjust to the recent mainstreaming of children with special needs into the public school system of Romania. Beta's Blessings is also working to establish a group home in Romania for older orphans including job training.
- O. In **February 2005**, we introduced Avram Schey, Fellow of the Joseph R. Crowley Program in International Human Rights at the Fordham University School of Law in New York City, to Dr. Verman. Mr. Schey is conducting a human rights fact-finding mission in 2005 in Romania, particularly in the area of children's rights.
- P. In **April 2005**, the Humana Foundation forwarded a letter from Foundation Chairman David A. Jones to the Democratic Party Committee in Romania supporting the nomination of Daniel Verman for the position of president of the National Agency for Family Protection.
- Q. The Humana Foundation paid for lodging for Drs. Popescu and Verman to attend the International Union for Health Promotion and Disease Prevention (sponsored by WHO and the European Commission) in Stockholm in **June 2005**, where they presented the Partnership's models at conference workshops. We reviewed their abstracts and made suggested changes. Constanta and Friuli-Venezia Giulia, Italy formed a health partnership as a result of this conference."

Accomplishments:

- **Contribution to systemic change:** The concept that individual health is influenced by both social as well as medical needs was not reflected in the existing community health

care system before the partnership. Victims of domestic violence need medical care, counseling and other support services. Involving local stakeholders was a way of educating opinion leaders in the community about the issue. The vision of a comprehensive health care system that includes social services as well as clinical services was an important change in the way people thought about how the community should respond to the health care needs of the citizens.

- **Improvements in Health Care Delivery:** The partnership gave the Romanians their first experience in finding out the opinion of the population. It was the first step in bringing the community and its citizens closer to the health services. This is now a common feature in the management of the health sector, but has not yet been adopted by other sectors of the city government. In the US they also broadened their view of who the victims of domestic violence were. The victims included the elderly and children. They also learned about centers for women, shelters, security systems to protect victims from aggressors, the need for counseling for victims and aggressors and confidentiality of victims. Plans for the future include the addition of each of the provisions to their program, but several require further legislation and funding. Nonetheless, they are forever changed now that they understand the concept of being victim sensitive in their response to problems. They also learned that they must involve the whole community in health education, and that it is imperative that there be an openness and willingness to share information. Under the old system, power came from holding information and they found that they cannot be effective unless they are able to share information. Through the Foundation's education programs with general practitioners and emergency room physicians, there is now a standard set of questions that are asked of patients presenting with injuries. While in Louisville the CEE partners learned about outreach to underserved populations. They have worked through the leaders of the Roma community to gain acceptance of efforts to talk to women about domestic violence and to educate parents about the need for immunization. This year there has been a marked increase in reports of domestic violence from the Roma community.

There is now more cooperation between specialists and GPs in testing for STIs. When in Kentucky, the partners saw how GPs and specialists integrated their efforts to diagnose and maintain a surveillance system for STIs with the rural population. The value of this approach was immediately apparent to the partners, and was adopted in Constanta. Now collaboration between GPs and specialists has spread to many other areas.

- **Improvements in Health Status:** There is increased public awareness of domestic violence in Constanta and across Romania, which has diminished the isolation victims felt and has offered these women healthier alternatives to staying in an abusive relationship. The number of women requesting counselling and/or legal assistance has steadily increased in the past 5 years.
- **Developmental Impact:**

1. Human Capacity Building

The partnership was successful in building significant human capacity. Increased capacity is still paying dividends in the following areas:

Training skills: The principals (Popescu and Verman) of the partnership continue to perform training of nurses, volunteers, GPs, etc. and to write textbooks and brochures on a broad range of health promotion topics. They created a peer-to-peer training program for high school students that continues to be vibrant.

Professional skills: Both technical and professional skills sets were developed. Original group of CEE partners learned decision-making skills using a combination of a SWOT analysis, focus group interviews, and nominal group techniques. They also developed skills in advocacy, mass media communications, fund raising, integration of social and health issues.

The careers of many who traveled to the US have changed, however, almost without exception, in their new capacities they are using the experience of the partnership. For instance, one member of the original group was on the city council and was a strong supporter of the domestic violence initiative. Now she is a member of Parliament and is continuing to push for legislation to protect the victims of domestic violence.

The Ministry of Labor and Education has approved a national strategy for implementing health education in the schools. In 2002, Dr. Popescu wrote a textbook for high school students on health promotion and education. She has also written training courses for nurses in health promotion and health education and communications in the health system. Thus far, 35 nurses have completed the training.

Networking: The US partner reported that the “Romanian partners developed a network of community partners and several hundred community volunteers, an extraordinary accomplishment for a society developing its first nonprofit sector.” Once the topic of domestic violence was selected, it became clear that the inter-disciplinary nature of the problem required organization and maintenance of a large and diverse network of stakeholders. The police, municipal government, psychologists, attorneys GPs, specialists, ER staff, etc. were all involved in the development of an integrated strategy for launching a response to the problem. In the course of the strategy planning, each of the stakeholder groups became more aware of the issues and community resources are now coordinated to help victims.

More than 40 Romanian government and charitable organizations have collaborated with CCF programs.

Fundraising skills: In September 2002, the Constanta County Council gave the Foundation a \$10,000 grant. In December 2002 after the partnership, one of the principals helped coordinate a national media campaign addressing domestic violence. Phase One was funded by the Ministry of Health and phase two by the US Population Fund.

Humana Foundation encouraged the development of fund raising skills by making several “challenge grants” to the Foundation for the operations of the Women’s Center. While still not able to raise significant amounts, the principals are actively involved in fund raising activities and have been successful in meeting the requirements of the Humana challenge.

The NGO has also developed a model fund raising solicitation that was reviewed by the Humana Foundation. Solicitations have begun, but thus far with limited success.

Advocacy skills and communications: At the beginning of the partnership, domestic violence was viewed as a private matter, and there was little to no support for victims of domestic violence in Romanian society. Before 2001, mass media only paid attention to domestic violence when the victim was killed. The leaders of the Foundation have held important positions in the community and at the national level, and have been successful in raising the visibility of the domestic violence problem and the violation of human rights that it represents in Romania. Dr. Popescu has a weekly call-in television show “Live your Life” where she highlights certain community health issues which include domestic violence

and she answers calls from listeners. Dr. Verman has been in leadership positions at the national level and was instrumental in achieving passage of the legislation. The director of the Women's Center is an attorney. She has successfully documented domestic violence cases and clients have been granted divorces from abusive spouses.

Assessment capacity skills: Through the decision-making process described above, the community leaders involved in the partnership have learned new ways to assess community needs. The Constanta-Louisville initiative was the first such effort of its kind in the Constanta judet. Since then, the local health authority has used the approach in other work.

Appreciation for usefulness of data in their work: The Foundation and Office for Women use scientific methods to identify problems, develop strategies and measure outcomes. They collect data on an on-going basis on the sources of referrals, effectiveness of public information campaigns, the relationship between the victim and the aggressor, number of clients by month of the year and patterns related to victims, such as age, employment, and education.

Participation in international forums: The principals have prepared presentations and addressed AIHA conferences as well as a conference in Stockholm.

Recruit, train, and retain volunteers: The Foundation was at the forefront of developing a meaningful volunteer program in Romania. Prior to 1989 the state required citizens to "volunteer" in various capacities. Volunteerism had negative connotations because it was not viewed as community service, but rather as work without pay. The Foundation has recruited several hundred community volunteers since it was founded in 2000. The Executive Director of the Foundation is a volunteer and many volunteers staff the Center for Women. Volunteer community educators are also used. The partnership initiated the TATU program to train teens to do peer- to-peer training about healthy lifestyles, a program that continues to be active.

Identifying and training new stakeholders: After the identification of domestic violence and the trip to the US, the CEE partners recruited stakeholders who were involved in some way in the response to victims of domestic violence. Besides GPs, specialists, and representatives of local government, many came from outside the health sector, such as attorneys, police, mass media and teachers. According to the US partners, more than 40 Romanian government and charitable organizations have collaborated with the Foundation.

Continuous improvement: The advocates for victims of domestic violence have been successful in getting legislation passed to protect victims. While a very significant achievement, there is still much to be done. The legislation is not being enforced due to lack of funds and does not address the issues in a comprehensive manner. For instance, the role of the Ministry of Labor vs. the NGOs in providing services to victims is still not clear. The Foundation is promoting the use of the same form for reporting domestic violence throughout Romania so that a national data base can be established. Strategies have been developed to continue pushing leaders for change both at the local and national levels. Priorities for strengthening the community capacity to respond to the needs of victims have been identified, such as the opening of a shelter for abused women.

New mindset: There is a Romania proverb that "a woman unbeaten is a woman unloved." The Romanian lexicon did not have a term for "domestic violence." What transpired in the privacy of the home was viewed as a private matter because the interaction between a husband and wife was not a concern of society. Aggressors were not prosecuted unless the victim had greater than a 2 week inpatient stay. A new mindset has emerged from the Foundation's efforts. Domestic violence is no longer viewed by society as

a “private matter,” but rather as an intolerable violation of human rights. Gradually, the Foundation is making headway and the number of victims self-referring to their office has increased 10 fold since 2000 when they began.

A new mindset also developed around the challenge of problem solving. The use of teams to tackle community problems was completely new. As community organizations began to understand their role in stopping domestic violence, the leaders began to understand the concept of stakeholder. The success of the collaborative approach has proved educational for all involved.

The partners learned that they had to reach a critical mass of people (50+1) to achieve change in the society, and this is why change takes time. Particularly with the STI experience, they believe they changed the thinking of the specialists and GPs and succeeded in getting them to collaborate on diagnosis and treatment. This collaborative approach has now moved into other clinical areas..

Ability to adapt models: After observing domestic violence programs in Louisville, CEE partners better understood how to mobilize action against social problems. This opened their eyes to new methods and new ways of thinking about both problems and solutions. The partners identified the challenges that existed in the Romanian culture and developed action plans to change public perceptions and to build a base of support for changes in the Romanian culture.

2. Institutional Capacity Building

The partnership was successful in building institutional capacity. As with any fledgling community non-profit organization, operations continue on a shoestring budget. However, the number of clients served continues to increase and the scope of health promotion programs is expanding as a result of voluntary contributions. Locally elected leaders have demonstrated strong support for the initiative. Institutional capacity is evident in the following areas:

Ability to absorb incremental costs (i.e., ability to replace withdrawn donor funds with funds from other sources): Through fundraising efforts the Foundation continues to operate; however, there is always more to be done if more funds are raised through private individuals or if the government would fund the cost of having a forensic physician certify that the injuries were sustained as a result of domestic violence. The cost of (four color) health promotion materials is being funded by the Ministry of Health.

Standards, guidelines and protocols adopted: A standard form has been adopted to collect data on each report of domestic violence in Constanta judet. The same form is used by the police, the ER, the GPs, etc so that it is now possible to eliminate duplication of reporting and to get complete information on all victims. AIHA computers are used to facilitate communications between these groups; however, we observed that the records all appeared to be written in hand.

Management skills and structures: The Foundation continues to operate as a financially viable NGO. It has provided assistance in the development of NGOs dedicated to fighting domestic violence in six other communities in the Constanta judet. In addition, there is on-going data collection about victims, aggressors, and the effectiveness of the information, education and communication program. The information is used to improve management and to advocate for increased resources from the community council.

Expanding group of stakeholders: See discussion above.

Involvement of younger generation: The Foundation has written a textbook on health promotion for use in the Constanta schools, and books on health promotion for the nurses (one of which was on domestic violence). Youth trainers have been recruited to inform peers about STIs and dangers of tobacco use.

Participation in international forums: See above.

Strategic Analysis of strengths, weaknesses, opportunities and threats (SWOT)/identification of stakeholders: The process followed in the original SWOT analysis impressed all the participants as an effective way to do problem solving. An inter-disciplinary group of stakeholders was identified and has continued to be involved in the NGO's efforts to address the problem of domestic violence.

Ability to build upon and expand the targeted intervention (i.e., replicability): With the help of UNFPA, the CCF has helped spawn 6 other domestic violence NGOs in Constanta judet. In addition, adoption of the standard domestic violence report form (based on the Louisville model) will lead to a national database which can be referenced for policy making. They have also formed a partnership with a community in Italy to assist them in developing a program to stop domestic violence.

Outreach: Through skillful use of mass media (newspapers, TV, radio, press conferences), the NGO has been successful in informing the public about domestic violence. They also have a hotline that operates 24 hours a day though it is staffed only 12 hours a day.

There are many colorful brochures on topics of health promotion that are disseminated by the local branch of the MoH.

Skills have been developed in penetrating the Roma population and bringing them public health messages about childhood immunization and domestic violence.

Fundraising: Abilities have been demonstrated and are continuing. The Healthcare Leadership Foundation, Playboy Foundation, five Romanian companies and an individual donor have also given grants and in-kind contributions to the CCF since its inception. The Foundation has developed a "case for support" which is used as the basis for grant proposals. UNFPA helped the Foundation replicate their model in 6 other communities.

Manager/leader: There are two primary leaders of the domestic violence and health promotion initiatives originated through the partnership. They are both using their personal management skills to keep the Foundation afloat and their salesmanship skills to better inform the government and the public about community health issues.

3. Community Mobilization

Dr. Deborah Wilson, Chair of the University of Louisville department of justice administration says "Constanta's progress on domestic violence from 1999 to 2001 is equivalent to the progress in the US over a 25 year period." A large number of community stakeholders have been organized and are making referrals to the Office for Women. A strong core of volunteers has been recruited, and professionals have been trained to recognize possible cases of domestic violence. The city and judet governments have provided strong public endorsement of the campaign to stop domestic violence. Through mass media, the public is becoming more aware of the problem and victims are coming forward in greater numbers.

Gyor, Hungary – Pittsburgh, Pennsylvania

Type of Partnership: Healthy Communities

Period of AIHA partnership support: 2002-2004

US Partners:

Initial partners: Magee Women's Hospital of the University of Pennsylvania Medical Center Health Systems, the Family Health Council, Ince and the University of Pittsburgh Graduate School of Public Health

Additional partners who joined the effort after the focus area was identified:

CEE Partner:

Initial partners: City of Gyor

Additional partners who joined the effort after the focus area was identified:

I. Achievement of Goals and Objectives:

USAID/Hungary requested a partnership that would focus on improving women's reproductive health.

The goal of the partnership was to assist the Győr community to engage local government and community-based organizations in developing and implementing women's reproductive health intervention services and education programs. Specific objectives were to:

- To increase participation by citizens in the area of women's reproductive healthcare, as evidenced by the development of a community health advisory board.
- To increase awareness of and knowledge about women's reproductive health among targeted, high-risk groups through the development of informational materials and outreach programs.
- To establish one central women's reproductive health resource/education center, two satellite resource/education information stations and eight information points with appropriate educational and informational materials by February 2004.

II. Contribution of Partnerships to Achievement of USAID Mission Goals: This was a women's reproductive health partnership which was aligned with the agency's program strategic objectives.

III. Sustainability of Partnership Relationships. (Include Comments from US Partners):

Personal relationships have been maintained. Do not have strong continued relationship with Pittsburgh, but have long-standing sister city relationships with Finland, France, Germany and Israel, and they feel they get the same kind of access to information through these. Why not US? "Too far"

IV. Accomplishments:

A. Contribution to systemic change: Goodwill in the community about women's health.

B. Improvements in Health Care Delivery: One of the lasting impact of the partnership was a new kind of collaboration between city officials and others in the community. "The partners learned about the breadth of resources available in the community" for health promotion.

C. Developmental Impact:

Elements that made the different

- a. Statistical survey of women's health needs
- b. Collaboration between diverse stakeholders from the city and other community groups to address a specific topic
- c. Learning about how to conduct community education
- d. Clear idea of what they wanted from partnership. Going into the AIHA project they wanted to get: logistic and management tools (to improve patient flow, manage service delivery), and tools to improve community work (focus groups and educational/communication tools).

“We already had the ideas for this, we wanted the tools and resources from US”. They have a prestigious workplace network the health care that has been in place for 30-40 years, and already knew how to develop community outreach services

1. Human Capacity Building

Increased capacity is still paying dividends in the following areas:

- **Training skills:** Provided help to Slovaks and people in NE Hungary in fund raising. Training was conducted for a core group of nurses in focus group techniques. Questions about the health needs of the women of Győr were designed collaboratively by both partners and the analysis was done by both partners.
- **Professional skills:** They learned how to be “community educators.”
- **Networking:** They participate in a regional collaboration with 3 NW countries in Hungary and one county in Austria. Also an informational resource center and communications network was established as part of the project. This facilitates informal dissemination of info and does not require that all health education be conducted through health care institutions.
- **Fundraising skills:** By winning the competition for the AIHA grant, confidence in their fundraising skills increased.
- **Advocacy skills and communications:** They have developed a curriculum on information dissemination and are in the process of being accredited. They learned the important role that the media plays in educating the public. The US and Hungarian partners decided to use local expertise to develop a media campaign. They contracted with a local PR firm to design and carry out several aspects of the “Love Safely” community and media campaign. The campaign included media outreach, webpage development and placement and presentations and educational outreach activities in schools, health centers, at a disco and at informational points around the city.
- **Appreciation for usefulness of data in their work:** The partners relied on the results of a survey to prioritize the reproductive health needs of the women in the community. Focus groups were conducted by nurses with members of the community.
- **Continuous improvement:** They saw many new ways of doing things in the US that were not connected to the partnership. For instance, having appointments for physician visits. This has become one of their priorities for improving their system. The US partners expect continued growth in creative community outreach strategies.
- **New mindset:** This was one of the most important outcomes of the partnership. They realized how important it was to involve the citizens in order to maximize information dissemination.

Partnership gave them a “change of mind set” and “new way of thinking” Specifically:

- At outset conducted community focus groups to determine what the main issues of the community. This was the first time they had included the community in this process
- 1 week training for peer education conducted in Gyor by US partners. All current outreach services have adopted this model (prenatal, in-school health promotion, support for breastfeeding)
- Strengthened materials development capacity—they have developed over 30 flyers, handbooks, & other health promotion materials. (Did not get to see any of these) Materials from the US were translated and modified for the Hungarian context

2. Institutional Capacity Building

Institutional capacity is evident in the following areas:

- **Ability to absorb incremental costs (i.e., ability to replace withdrawn donor funds with funds from other sources):** Deputy Mayor is a pediatrician and has a personal interest in improved management systems, organization and disease prevention. He was clearly supportive of the work of the nurses.
- **Management skills and structures:** All CEE partners acknowledged that Gyor had significant advantages over other parts of Hungary: located between Budapest and Vienna; highly industrialized; low unemployment; urbane population; existing workplace programs; LG with committed health orientation
- **Expanding group of stakeholders:** They were able to get considerable support from the local newspaper, radio, TV.
- **Involvement of younger generation:** The entire “Love Safely” campaign was directed to adolescents. Reusable educational materials for high school students were distributed to all schools for teachers to use continuously in the future.
- **Participation in international forums:** Participated in professional exchanges in Austria.
- **Strategic Analysis of strengths, weaknesses, opportunities and threats (SWOT)/identification of stakeholders:**
- **Ability to build upon and expand the targeted intervention (i.e., replicability):** Their existing program was a significant benefit. Had been a member of the Healthy Cities Association since its outset, and were also a member of the WHO Healthy Cities program. Then USAID announced the AIHA partnership and they submitted a proposal and were selected. Had been very active up to that time (18-19 years at this point), and believe that is why they were selected. **Outreach:** Community social workers have been trained in outreach.
- **Fundraising:** Their skills enabled them to be selected as the Hungarian partner. They applied for the program and were ranked number 1.

3. Community Mobilization

From the partnership they learned “the organizational aspects of how to mobilize the community.” They developed “eye-catching brochures.” Originally, the Gyor partners wanted a project that would focus on women’s health, encompassing all ages of women. However, USAID had requested a project on women’s reproductive health, so the age was narrowed to women 14-45. They also felt that while women’s health was clearly an area of need, there were more pressing community health issues, such as mental health, healthy lifestyles (including physical activity, smoking, drinking and drugs among youth)

Iasi, Romania– Minneapolis, Minnesota

Type of Partnership: Hospital

Period of AIHA Partnership Support: 1998-2000

US Partners:

Hennepin County Medical Center

CEE Partner:

The Center for Reproductive Health and Family Planning

Women's Health:

- Establish a Women's Wellness Center which can serve as a replicable model for extending primary and preventive services on an outpatient basis to women throughout their life cycle.
- Provide a team-based training program for center staff, emphasizing the Women's Wellness philosophy and approach related to the delivery of health promotion, disease prevention and primary care services for women of all ages.
- Develop health education classes for patients and community outreach programs to promote healthy lifestyles.

Success Toward Objectives:

The partnership achieved their stated goals. Since we did not visit Iasi, but rather met with the partners in Bucharest, we were not able to visit the Women's Wellness Center.

Human Capacity Development:

Training Skills/Professional Skills/New Mindset

The design and planning of the WWC was done together with the partners.

They learned from the US partners that they need high quality services. They realized they had to change the mindset of the physicians to encourage them to treat patients more respectfully. For example, they prohibited eating in front of patients and instructed them not to open the door when a patient is in the room being examined. They started discussions about professional behavior with a group of family practitioners and asked if they had ever seen a US physician eating while counseling a patient. They used diplomacy and humor to bring about this change in mindset. Those physicians that went to the US on exchange were able to see how services were delivered.

The clinicians were able to see the differences in experiences for those women that attended birthing classes and those that did not.

They felt the partnership changed many things for them. In the words of the WWC Director, "[the partnership] changed you without your knowing it".

Institutional Capacity Development:

Standards, Guidelines and Protocols/Management

They learned through the partnership what was needed to make the WWC operational. For example, they had wanted to obtain a Doppler ultrasound with money they had raised but the US partners advised that

they purchase an ultrasound with a vaginal probe instead. They followed the advice of the US partners and now appreciate how much more useful the vaginal probe ultrasound is (they use it 30-40 times a day).

Through an agreement with the National Insurance agency, the WWC is funded for 8,000 patients per year. In addition, they have a fee-for-service plan.

Ability to Build Upon and Expand Partnerships

They now work in close collaboration with the National AIDS Control Program for their voluntary counseling and testing service (HIV testing is recommended for all pregnant women). To date they have only had one HIV-infected pregnant woman. They consulted with the US partners regarding her care.

The family practitioners in the area come to the WWC for information and refer their complicated cases there.

The WWC staff also collaborate with various NGOs that are working with street children, the Roma, institutionalized children and HIV-infected populations. They offer their services to these vulnerable groups.

New Services/Responsive Services

The WWC was established in 1999. It provides a full range of services for women including:

- Consultations for breast cancer, cervical cancer and sexually transmitted infections (latter for males also)
- Counseling on the prevention of breast cancer, cervical cancer and sexually transmitted infections (latter for males also)
- Family planning counseling
- Health education classes for teens (females and males) through the Teenagers Club
- Birthing Classes for expectant couples
- Consultations for infertility (for males also)
- Voluntary counseling and testing for HIV
- Domestic violence counseling

Sustainability:

The WWC is still operational today and provides expanded services from when it was originally established. The director is still in contact with some of the US partners. In addition, they continue to share information with the WWC in Moldova.

Replication:

While this WWC may not have been involved in dissemination activities, WWCs have been replicated in other sites.

Kosice, Slovakia - Providence, Rhode Island

Type of Partnership: Hospital

Period of AIHA Partnership Support: 1995-1999

US Partners:

Women and Infants' Hospital of Rhode Island and Hasbro Children's Hospital at the Rhode Island Hospital

CEE Partner:

The Faculty Hospital and Polyclinic

Partnership Objectives:

Neonatal

- Dramatic reductions occurred in mortality for very low birthweight and extremely low birthweight infants
- regionalization of perinatal care accepted by the Ministry of Health and recorded as a legislative edict
- stimulus for further development of referral for both high-risk mothers and infants to Level III (Highest level) centres within Slovakia.
- Significant cost savings of almost \$9,000 USD in just one year for ATB
- The mentioned results were used as a model for other department in the hospital and for other hospitals in CEE and NIS (newly independent states) countries.
- Improved intensive care for critically ill very low birthweight (VLBW) and extremely low birthweight (ELBW) infants by: developing more effective teamwork in the neonatal intensive care unit (NICU); improving transport team skills; and upgrading nursing assessment and technical skills in the NICU.
- Improved infection control procedures in the NICU by: developing protocols for infection control in NICU; training a nurse to be responsible for infection control; and improving strategies for antibiotic therapy.
- Introduce new diagnostic and treatment protocols for infants suffering from intrauterine hypoxia, fetal distress, and intrauterine growth retardation (IUGR).
- Improved diagnosis, treatment, and follow-up of hypoxia by: preparing and disseminating a study guide throughout Slovakia; exploring diagnosis and treatment protocols; and establishing follow-up procedures.
- Improve prematurity prevention programs by: assessing the existing program; reviewing regional initiatives; and implementing a prematurity program.
- Develop a team approach to neonatal intensive care by: assessing the NICU nursing practice; examining interaction of members of the NICU team; designing protocols for team responsibility and team training for nurses and physicians.

Obstetrical

- Improve identification of IUGR by: improving screening and early diagnostic procedures for high risk mothers; refining monitoring of infants in utero using improved invasive and

non-invasive methods; and developing more effective screening methods to identify risk earlier.

- Improve treatment protocols for high risk mothers including intrauterine hypoxia and distress by: improving screening methods; upgrading nursing assessment and patient care management in LDR; and developing a more effective framework in caring for the high risk mother.
- Develop more effective prematurity programs by: developing educational programs for outlying areas in Eastern Slovakia to help identify better referral of high risk mothers; identifying cultural and financial barriers that prevent early identification of risk; and creating nurse training programs throughout Eastern Slovakia for “social nursing” to better serve the high risk population.
- Introduce new diagnostic and treatment protocols for perinatal medicine by: assessing treatment protocols for prostaglandin and examining new techniques to treat IUGR, hypoxia, and related problems.
- Improve infection control procedures by: identifying the role of infection control nurse and developing control protocols.
- Improve care of high risk pregnant women by: developing protocols for OB referral; developing risk indicators; and implementing a regional referral plan for Eastern Slovakia.
- Improve hospital care of diabetic mothers by: assessing present programs and recommending appropriate protocols.
- Explore new techniques in the diagnosis of prematurity by: establishing a physician training program for physicians throughout Eastern Slovakia.

Gynecology

- Improve screening programs for cervical cancer by: assessing problems in screening, diagnosis and treatment of cervical cancer and assessing laboratory protocols in cytology screening.
- Improve delivery of gynecological oncology services by: reviewing present screening for cervical and ovarian cancer and developing, implementing and disseminating regional screening protocols for Eastern Slovakia.

Pediatric

- Reduce hospitalization of children with chronic illness by: examining management of patients with upper respiratory problems and improving treatment for children with renal insufficiency.
- Improve the delivery of emergency and intensive care by: improving infection control in delivery of emergency and intensive care; improving nurse training in these specialized areas; and developing better linkages among pediatric sub-specialties.
- Improve the diagnostic techniques for respiratory illness by: developing treatment protocols to shorten hospitalization; reviewing new diagnostic techniques; and disseminating protocols throughout Eastern Slovakia.
- Improve organizational relationships by: assessing organizational issues and providing recommendations.

- Improve the identification and intervention techniques related to child abuse by: assessing the present program and identifying weaknesses; establishing an in-service training program to assist in the identification effort for hospital professionals; expanding the training program to the Eastern Slovak region; and conducting a regional child abuse conference for the CEE region.
- Improve pediatric intensive care (PIC) by: assessing the present PIC program and identifying deficiencies and developing and implementing program enhancements.
- Improve program in endocrinology and immunology by: exploring the present program design and introducing new advances in the fields.

Administrative (all clinical areas)

- Improve management and fiscal control by: assessing systems deficiencies; preparing, implementing, and monitoring strategies for correcting deficiencies; developing a guide for dissemination nationally; and conducting two conferences on issues related to cost effectiveness and quality of care education.
- Improve nursing education program by: assessing current nursing practice; assessing the existing nursing education program; and developing and monitoring new approaches to nursing education.
- Improve information services by: assessing the present information system and its financial and clinical programs; identifying deficiencies in the system structure and recommend remedies; and developing, monitoring, and implementing a plan for system improvement.
- Improve nurse training by: developing specialty training programs in perinatal clinical care and exploring ways to make program content accepted nationally.
- Improve clinical care model in obstetrics and newborn medicine by: outlining effective clinical path processes; identifying “program champions”; organizing practice team; monitoring progress of clinical path process; and developing guide for dissemination nationally.

Success Toward Objectives:

Overall, the partnership met the general objectives of improving care and services in the partnership areas (see details below).

Human Capacity Development:

Training Skills/Professional Skills

Most of the training that occurred was in the area of infection control (see below under Institutional Capacity for details).

The OB/GYN physicians say they have better communication with the neonatologists, surgeons and other specialists, which was something they observed in Providence.

Champion:

Dr. Peter Krcho, the Director of the Neonatal Intensive Care Unit, is an ambitious and motivated leader who is constantly trying to improve the care provided in his NICU. He is fluent in English and participates in international conferences in his field.

Appreciation for Usefulness of Data

Physicians noted it was easier to argue persuasively for support for the reconstruction of their unit based on their experience of understanding the standard of care from their trips to Providence. Partnership helped with making the renovations to PICU a priority to the hospital leadership (though occurred after partnership ended, unit opened in Feb 2005).

New Mindset

The link to Providence was crucial for countering resistance among thinking such as “our patients are different” and “we can’t do that because...”.

The partnership served as an “impulse” to bring about the changes in infection control. The Kosice staff knew theoretically about nosocomial infections but only after they witnessed how Providence handled these issues were they able to implement the changes.

Improved Status of Nurses

Nurses stated they learned a lot on the exchanges. As a result of the partnership, their authority was increased.

Ability to Build Upon and Expand Partnerships

Kosice staff make their current international contacts at international conferences, esp Salzburg Conference. The NICU team currently has another active partnership with the University of Michigan.

Institutional Capacity Development:

Standards, Guidelines and Protocols/Management

Many infection control principles, Practices and policies that were observed in Providence were developed, adapted and implemented in Kosice Hospital. Kosice physicians and nurses stressed that while it was useful to learn about the concepts updated infection control practices from the US partners, it was essential that they visited the hospital in Providence to visualize and fully understand these concepts in practice. a State they saw how the entire PICU functions in Providence – this was not something they could grasp by simply having it explained to them, they felt they needed to see it “in action”. Examples of the practices incorporated include:

- Laminar flow room for preparation of medications and infusions
- Automatic closing doors
- Increased number of sinks (one per room) with liquid soap dispensers
- Single-use paper towels
- Lay-out of the PICU Unit (central work station with patient rooms surrounding this space)
- Design of rooms to facilitate disinfection
- One infusion pump per patient
- Reservation of a room with negative pressure for isolation
- Creation of a comfortable bedroom and bath where parents from outside Kosice can stay

Some of the same infection control practices from the PICU were also implemented in the NICU. The Director of the NICU also attributes their improved use of antibiotics to the partnership. The partnership resulted in better surveillance of NICU infections and practices to rapidly identify patients with infections

(institution of routine blood cultures on admission). Institution of this revised policy resulted in an immediate cost-savings—which has persisted to today.

They felt it was not a disadvantage that they saw tertiary care in Providence as there were many things they could apply to their facility. In fact some things were cheaper in Slovakia and they garnered the support of their department head—he saw preventing nosocomial infections as a priority so earmarked money for this.

Replication:

They have shared their progress and techniques with other neonatal and pediatric colleagues in Slovakia (unsure if adopted). They have also disseminated their techniques and practices to other departments within their hospital. Also, when visit smaller hospitals in their region, do teaching of these principles. However, the physician partners have not disseminated their changes in management or patient care to other hospitals.

Cross-partnership activities were not as useful to them since they felt the hospital program was so different from the other types of partnerships. They felt similarly about the AIHA meetings in Atlanta and Washington DC.

Sustainability:

All of the programs and policies developed and implemented during the partnership are still in practice today. PICU doctors said they stayed in contact for a few years after the partnership but then lost contact, especially as Providence counterparts left Providence and moved on to other jobs. The NICU Director is still in contact with a few Providence partners.

Recommendations From the Partners:

The Kosice partners recommended investing more resources at the beginning of the partnership to improve the English language ability of the CEE partners. Having English language skills greatly increased the ability of the partners to glean more from the exchanges and trainings.

Petrzalka, Slovakia – Kansas City, Missouri

Type of Partnership: Healthy Communities

Period of AIHA Partnership Support: 1995-1998

US Partners:

Initial partners: Truman Medical Center, Inc., Missouri Department of Health, Missouri Hospital Association

Additional partners who joined the effort after the focus area was identified: Hope House, an anti-domestic violence organization in Kansas City, Missouri

CEE Partner:

Initial partners: Citizen's Association of Aid to Children at Risk. The name was subsequently changed to Citizens Association of Aid to Children at Risk (CAACR).

Additional partners who joined the effort after the focus area was identified:

I. Achievement of Goals and Objectives:

The original goals of the partnership was

- a. To ensure the continuation and further development of the community organization, Aid to Children at Risk Foundation, which was promoting drug/alcohol abuse prevention, intervention strategies and programs among the teenage population in Petrzalka, a Soviet-style concrete village outside of Bratislava.
- b. To mobilize the Petrzalka community for change,
- c. To facilitate an assessment of community health needs,
- d. To empower the community to prioritize and select issues in need of community solutions,
- e. To develop and implement community intervention strategies.

All of the goals were met and in the course of conducting the assessment of community health needs, the partners discovered that domestic violence was a serious community issue that was completely unrecognized. By pursuing the other goals listed above, the CEE partner decided to change its mission from fighting drug abuse in teens to combating domestic violence against women and children. CAACR's drug abuse initiatives which continue to serve the community were spun off to other new community organizations.

II. Contribution of Partnerships to Achievement of USAID Mission Goals:

The USAID/Slovakia program in Slovakia began in 1992 with the goal of improving the health sector through programs focused on quality, efficiency and sustainability of health services in the categories listed below. The community participation goal was met through the Petrzalka healthy communities initiative.

Health Financing System: Assistance to the national insurance fund and Ministry of Health in developing insurance management and new payment systems.

Clinical and Financial Management: Testing of efficient hospital management practices and quality improvement programs in Roosevelt Hospital and Trnava Hospital and development of health management training programs.

Community participation: Fostering cooperation in the health sector between local governments and citizens.

Environmental/Occupational Health: Developing curricula for Matej Bel University and for post-graduate education of general practitioners. (Source: Blumhagen/Aaronson report)

III. Sustainability of Partnership Relationships. (Include Comments from US Partners):

The principals of the US and Slovak partnerships have stayed in touch, but interaction between Truman Medical Center, Hope House and the other US institutions has not continued.

One of the people involved with the US partner, Ross Marine, wrote the following: "As a result of my involvement and participation in the partnership, I was appointed in 2000 as Honorary Consul of the Slovak Republic for the Midwest region of the U.S. by the Slovak government in recognition of my commitment to improving the health and wellness of children in the Slovak Republic. Consequently I continue to be involved currently as well into the future of the Slovak republic. As Honorary Consul of the Slovak Republic I am of the opinion that I am continuing to make a difference."

IV. Accomplishments:

A. Contribution to systemic change: In the first two years of the partnership, CAACR was focused on drug abuse problems among youth. A community coalition of stakeholders was formed and with the help of a local research firm, they initiated a community survey of lifestyle among children and youth in Petržalka which revealed rising rates of drug abuse among teenagers. An unexpected finding of the survey was that domestic violence was also an issue in Petržalka where the unemployment rate was extremely high following the collapse of the old regime. The programs against violence which were supported by the partnership were accepted and within 3 years a wide network of professionals was formed. Petržalka introduced promotional activities and media campaigns to inform the public of these problems and resources available to offer help. Improved laws to combat violence have been passed by the Parliament. A Crisis Hot Line was established and volunteers trained to respond to calls. The CEE partners believe that the attitude of the whole society has changed as a result of their efforts.

B. Improvements in Health Care Delivery: There was no center for abused women in Slovakia in 1997 when they began their work. Since 1998, the Hope Center for silent victims of domestic violence has been the primary focus of the CAACR. They provide counseling for women and children, help women find safe housing, employment and legal assistance. While technically outside of the formal health care system, this program provides a model for the integration of health and social services for victims of violence. Development of a legally authorized NGO to provide these types of social services demonstrates that the society is becoming more responsive to its citizens, particularly victims of violence.

C. Improvements in Health Status: The CEE partner's efforts to inform the public about domestic violence and to offer counseling resources and alternative living arrangements for victims of violence have been successful. As a direct result of their advocacy, there is now national legislation to protect victims of domestic violence. In 2004 the Crisis Hotline received 1850 calls per year and the Hope Center for Battered Women had about 500 clients each year. They were proud to report that in 2001 they had 60 calls, so the increase is a strong testimony to their success. The Center offers family, individual and group therapy and daily counseling services in psychological, social and legal issues surrounding domestic violence. Individual therapy is also offered to offenders.

D. Developmental Impact:

1. What Were the Elements of the Partnership That Catalyzed so Much Progress?

- The SWOT analysis.
- The funding for the demographic survey.
- Assistance in analyzing the survey.
- Having a collaborative, open relationship with the partners. Feeling like they were mutually supportive as colleagues.
- Seeing programs in action.
- “Inspiration” and moral support because they were alone and bucking tradition by taking on a taboo subject.
- Broadening their exposure to many new types of programs and expanding their knowledge about successful methods to accomplish their goals.
- Enhanced their feeling of expertise in their subject area.
- Heightened awareness of the importance of fund raising skills.

2. The Legacy – What is Left Behind

1) Human Capacity Building

Increased human capacity is still paying dividends in the following areas:

- **Champion of the cause:** The founder and leader of the program is Jana Sturova, Ph.D. She started this initiative while an employee of the state counseling service when she began to be concerned about why the children were not having success in school. In December 1994, she organized the founding members of the Foundation, applied for legal status and obtained authorization to hold meetings. She says that the partnership was enormously important to their efforts because they were alone and had no tradition for developing a community service organization. They also did not have funds for the demographic survey that proved pivotal in their formation as a advocate to stop domestic violence. The founding members of the group are all still involved and have benefited from the training and personal and professional development that has evolved over the past 10 years. With this capacity, there is strong back-up to fill leadership positions in the future.
- **Training Skills:** Training programs were established for professionals (social workers, doctors, policemen, teachers) and volunteers in Bratislava/Petrzalka. Volunteers staff the crisis HotLine.
- **Professional skills:** According to the CEE partners, their US partners brought them inspiration, new methods and critical financial support. CEE partners learned skills related to managing a program to aid victims of domestic violence from the US partners. One of the most important lessons from the US was how to cooperate through open communication regarding what was working and not working. Usually communication between Slovaks was characterized by skepticism and fault finding so groups were reluctant to cooperate or to be open about their organizational issues. These skills have enabled the Center to use outside resources much more effectively than they imagined was possible. The curriculum for social workers now includes sections on domestic

violence, and there are seminars on domestic violence for social workers every six weeks and throughout the annual Stop Violence week. Continuing education programs are conducted for social workers employed by the State and municipal governments as well as NGOs. Continuing education for psychiatrist includes sections on domestic violence.

In 2003, the Center held an educational program for teachers on how to recognize child abuse. At first they said there was no child abuse, but in the first week, three teachers called to report suspected cases. In 2004, with the help of other foundations, they trained 200 trained in central and eastern Slovakia.

Numerous volunteers are drawn from the University student body. Several former volunteers have now joined the paid staff and provide psychological counseling and administrative support.

- **Networking:** The CEE partner continues to collaborate with the Counselling Center for Women in Crisis – the League of Human Rights in Brno, Czech Republic, the Women’s Rights Center in Warsaw, Poland and the C.A. Help to Children in Crisis in Zilina, Slovakia, and organizations in the UK, France and the Netherlands. They state that they are now part of an international network to protect women in danger.
- **Fundraising skills:** Prior to the partnership they had received a small grant from the Open Society Institute (OSI) for which they had not made an application. During the partnership exchange to Kansas City they saw many different types of organizations and learned that there are many sources of funding for the issues they were backing, however, they did not have skills in applying for those funds. With the help of a Peace Corps volunteer, the partners developed a marketing/promotion plan to increase awareness of CAACR’s efforts and to be used in fundraising. Since that time they have received funding from the Foundation for Support of Civic Activities, the British Know How Fund, ETP Slovakia, the EU and additional funds from OSI. The EU funds are supporting research about rehabilitation of aggressors. Once this study is completed, they plan to request funding for a program from the government. They also have support from the Equal Program sponsored by the European Social Fund to establish another safe house. The Hope Center is the only center financed by the Mayor of Petrzalka.
- **Advocacy skills and communications:** From 1996-1998 monthly Community Anti-Drug Forums were held to inform local residents about rising rates of drug abuse among teens as well as the prevention and treatment strategies recommended by experts. A community HELPLINE was established to assist residents in their efforts to combat and reduce drug abuse in the community.

Efforts to combat domestic violence resulted in national legislative changes. The CEE partners accomplished this by making presentations in the media and taking their campaign into the streets. Because their work was backed by data from the survey, they had high credibility. They participated in the Ministry of Justice Commission on Violence and worked with the National Association of Women Judges. They called members of Parliament and had a strong media campaign and just prior to elections they sought public statements from candidates to Parliament about their position on violence against “the weakest”. The result was that the new Parliament passed stronger laws to combat violence.

By 1998, the focus of the partnership had shifted to domestic violence.

Dr. Jana Sturova, CAAACR founder and psychologist continues to conduct a special radio talk show two to four times a month, and a special television show on an average of once a month. These are call-in shows aired on local stations. Topics include domestic violence, drug abuse and other social issues. A press conference is held during the Stop Violence week in Slovakia.

This is the most prominent organization in the country on domestic violence.

- **Appreciation for usefulness of data in their work:** Use of a professional research firm to conduct the community research provided valid and reliable data for planning. The entire program was refocused as a result of the information revealed by the data analysis. The CEE partners actually found that the partnership was not sufficiently oriented to data collection and analysis. They thought that evaluation criteria should have been established in the beginning of the collaboration, and that numerical targets should have been set. AIHA did not have an M&E system that they could use to track their progress.
- **Participation in international forums:** In 1997, AIHA sponsored a Health Communities –Healthy Cities dissemination conference in Banska Bystrica where they jointly presented their project with the US partners. In 1998 they participated in the AIHA Child Abuse and Domestic Violence Conference in Kosice in 1998 where their efforts were presented. They are now engaged in on-going communications with counterparts in Western and Central Europe.
- **Recruit, train, and retain volunteers:** A Crisis Hot Line was established and volunteers trained to respond to calls. See involvement of younger generation.
- **Identifying and training new stakeholders:** See teacher training and public education campaign and lobbying of Parliamentarians for changes in the laws. The government has gone from indifference to acceptance of the seriousness of the problem of domestic violence.
- **Continuous improvement:** 1) Most of their clients are women with medium-high to high levels of education. Since they are not seeing the less educated women, they are working with the municipality to identify these women and encourage them to take advantage of the resources they provide. There is also a project underway to work with unemployed women who are victims of domestic violence. 2) Now that abusers are being jailed, the victims are expressed remorse for sending their spouses away. They are asking the Foundation to look into providing some consequences for this crime that would be an alternative to imprisonment. The Center is looking into developing group and individual therapy programs for aggressors. The European Union is financing their experimental work with aggressors.
- **New mindset:** The national philosophy in Slovakia is that the man is the head of the family and what happens at home is not the business of other people. The passage of legislation to make domestic violence a crime signaled a major change in public perception about the rights of the members of the family. In 2003, the Center held an educational program for teachers on how to recognize child abuse. At first they said there was no child abuse, but in the first week, three teachers called to report suspected cases. In 2004, with the help of other foundations, they trained 200 teachers in central and eastern Slovakia.

Before the legislation, the police would send women back to their homes and say they should not talk to the police, but rather to their spouses and solve their problems at home. The education of the police has improved this situation. Also, in the past if a victim could not work for 14 days, the abuse was classified as a crime. Today it is considered a “serious criminal act” and carries a three year prison term.

Now friends, teachers, colleagues, neighbors call the Crisis Hotline on behalf of others and accompany victims to the Center. This type of public support would never have happened before the campaign and passage of the legislation.

- **Ability to adapt models:** 1) The partnership used the Community Health Assessment and Resource team (CHART) developed by the Missouri Department of Health and the Missouri Hospital Association to conduct the community survey. 2) The Hope Center for Battered Women in Petrzalka was modeled after Hope House in Kansas City. The Center still operates today and is a testimony to the success of the adaptation strategy.

2. Institutional Capacity Building

The Hope Center was founded as part of the partnership and as a direct result of the demographic survey that the partnership funded. Sustained institutional capacity is evident in the following areas:

- **Ability to absorb incremental costs (i.e., ability to replace withdrawn donor funds with funds from other sources):** In 1998 CAACR received a grant from EU PHARE and the City of Petrzalka for \$17,200. The grant enabled the Center to hire four full time employees to work on domestic violence issues and the Hope Center’s fundraising and public awareness campaign. In 2002, the Center was accredited by the Ministry for Labor and Social Work to provide social services. With this accreditation they are eligible to apply for grants to fund new
- **Involvement of younger generation:** 1) Every year there is a program on “stop violence” and children do art projects with the theme “These hands are not meant to hurt.” 2) University students now have an interest in community service that did not exist under the old regime. The Center put up billboards to attract university students to volunteer and the recruitment has been successful. They have many university students as volunteers. Many university students are now choosing domestic violence as their thesis topic.
- **Participation in international forums:** The Foundation was holding an international meeting in their offices during the week of our visit. They have many international contacts and have received funding from entities in other countries. They attended the AIHA conferences in Vilnius, Budapest, Bucharest, Kosice and Zagreb.
- **Strategic Analysis of strengths, weaknesses, opportunities and threats (SWOT)/identification of stakeholders:** The first step in the partnership was the completion of a SWOT analysis. It gave the Slovaks a new tool for analysis and planning. They continue to use this technique in their work.
- **Ability to build upon and expand the targeted intervention (i.e., replicability):** 1) About ten years ago they organized an Anti-Drug Forum to mobilize public activity against heroin use by children. Meetings of the Forum are held monthly and provide an opportunity for the public to discuss issues. Parents can talk to specialists and public

officials. They generate income from these meetings which is used to publish pamphlets and books on health promotion. When their interest shifted to domestic violence, other community groups took over responsibility for conducting these meetings, but they have stayed involved. 2) As a result of the partnership, a community based Anti-Drug Forum was established in 1997 in the city of Piestany, Slovakia under the auspices of the CAACR. Piestany is experiencing similar issues and problems in regard to the flow of illegal drugs into the community from outside Slovakia, resulting in significant increases in drug abuse among teens and young adults, sexually transmitted diseases and domestic violence. This group became a separate organization in 2001 and is still operating. They continue to cooperate with CAACR, and the CAACR founder serves on the faculty.

3) In 2001 the Crisis Hotline received 60 calls and in 2004 the volume had increased to 1850 calls per year. The Hope Center for Battered Women had about 250 clients in 2001 and 500 clients in 2004.

4) They were the first social action group in Slovakia. They have helped many civic groups get started around Slovakia.

5) Their training of psychiatrists and social workers in issues surrounding domestic violence can be introduced in other communities.

- **Outreach:** The Center is working with immigrants from Suriname. In addition, volunteers regularly go to schools, shopping centers and other public places to distribute flyers about their program. There is always a surge in phone calls following these efforts to disseminate information.
- **Fundraising:** See above.
- **Manager/leader:** The founding champion has mentored younger colleagues to take on these roles. Several are currently filled positions and are being groomed to take over when Dr. Sturova retires.

3. Community Mobilization

When this group organized to combat drug abuse, they were the only community service organization serving in Petrzalka where there are 130,000 residents and 38% have university degrees. There were only 2 psychiatrists serving Petrzalka and their survey indicated that 20% of the children were suicidal. There were also no laws against selling drugs or using drugs. Their example of what can be accomplished through citizen initiatives was important because today there are 114 NGOs serving Petrzalka.

Scranton-Slovakia Partnership

Type of Partnership: Health Management Education

Period of AIHA Partnership Support: 1996-1999

US Partners:

Initial partners: University of Scranton

CEE Partners:

Initial partners: Trnava University School of Public Health and Nursing, the School of Economics at the University of Matej Bel, Banska Bystrica, and the Health Management School, Bratislava

I. Achievement of Goals and Objectives:

Information Dissemination

- Established a health management resource center in Slovakia at Trnava University.
- Developed and currently publishing a national Journal of Health Management and Public Health (JHMPH) in Slovakia.
- Developed a series of International Health Care Symposiums to share health management information among CEE countries.
- Utilizing videoconferencing capabilities developed by AIHA for use in CEE/HME partnerships.
- Established an LRC primarily serving PhD students who have own keys so non-stop access and can use internet, copier and journals.

Curriculum Development

- Developed and currently offer formalized courses in health management education at TU, UMB and HMS
- Developed educational materials, workshops, seminars and course modules with HMS, TU and UMB in specialized health management areas

Faculty and Student Development

- Did faculty development at UMB, TU, & HMS
- Provide professional activities, in addition to faculty development, that will expand health management knowledge, skills, and experiences for Slovakian partners.
- Created student exchanges to facilitate health management knowledge and learning among Master in Health Administration students from the U.S. and Allied Health students from the Slovak Republic. Currently the exchange between USA and Slovakia is for PhD students.

Accreditation

- Educational standards, competencies and knowledge necessary for professional competence as a health care manager. Several programs in this partnership are now accredited.
- Work with the Minister of Health and the Minister of Education to develop national standards and competencies for health management.

Policy Analysis

- Established an independent Center for Health Policy and Strategy in Banska Bystrica to promote the development, analysis and implementation of health policies and strategies in the Slovak Republic. However this center does not have links to other CEE LRCs.
- Develop a Center for Training and Consulting Skill Development at the Health Management School, Bratislava. ???

Nursing

- Established a Nursing Resource Center (NRC)
- Revised and strengthened nursing knowledge and curriculum development.

Critical to the success of this partnership was the Dean of the School of Public Health in Trnava, Dr. Vladimir Krchmey, a dynamic leader and researcher who served as champion for the program. . He was motivated to continue and build upon the initial partnership activities. Largely due to his initiative, the School of Public Health in Trnava now has institutional relationships with schools in Kenya and Cambodia.

II. Contribution of Partnerships to Achievement of USAID Mission Goals:

Contributed to the USAID mission goal for Clinical and Financial Management: Testing of efficient hospital management practices and quality improvement programs in Roosevelt Hospital and Trnava Hospital and development of health management training programs.

III. Sustainability of Partnership Relationships. (Include Comments from US Partners):

The partnership has continued and flourished. All CEE partners still in contact with Scranton partners, some serving as co-authors on articles and co-sponsoring of conferences (the one to be held in Bratislava next year). Since 2000 the School of Public Health has had an exchange of PhD students with the University in Scranton each year. Each school pays for the transportation of their students to the other country and then the host country school covers the students' living expenses. In addition, they have 1-2 faculty exchanges each year. This exchange is funded through the schools' budgets and not through outside sources.

The legacy of the partnership is seen in their ability to educate students and establish other relationships with other institutions (attribute their involvement in the NISPA to the partnership).

IV. Accomplishments:

1. Human Capacity Building

The partnership was very productive because the CEE partners saw the gaps in their educational background, and the partnership activities helped them fill these gaps. The partnership served as a catalyst for the development of health management education. "The partnership prepared the soil so the seeds sown could flourish."

Some of the partners were involved in exchanges in NIS (Georgia, Ukraine and Moldova) where they were able to immediately use the knowledge they had gained and serve as trainers in health management.

Through the partnership they developed degrees (only advanced degrees or even BA did not exist prior to the partnership?) including a BA, MA and PhD in health management. Now have international students enrolled in their health management programs.

Most partners now members of the NISPA (network of schools in public administration).

2. Institutional Capacity Building

Another success story and legacy of the partnership is the journal that they created during the partnership. The Journal of Public Health and Health Management is a peer-reviewed journal with international contributions and is published quarterly. The partners in Trnava were able find resources to continue the publication of this journal.

In 1999, following the official end of the partnership, Trnava began a partnership with a school in Nairobi for masters degree. Students from Scranton have participated in the exchange with Nairobi through the Trnava school.

Products of the partnership:

- Dissemination of knowledge obtained through the partnership to counterparts in Moldova
- Stronger links between CEE partner institutions were established
- Allowed faculty to serve as consultants and teach in other NIS countries
- They were able to establish the Health Management School as a flexible program with qualified professors who are now able to teach internationally also.
- USA partners now they have access to the Nairobi and Cambodia exchanges through Trnava.

Split, Croatia – New Jersey

Type of Partnership: Healthy Communities

Period of AIHA Partnership Support: 2001-2003

US Partners:

University of Medicine and Dentistry of New Jersey School of Public Health

CEE Partner:

City Government of Split, (Administrative Department for Social Care and Health of Split), NGO-Healthy Cities (a member of WHO Healthy Cities project since 1990)

I. Achievement of Goals and Objectives:

The partnership's overall goal was to assist the Split community in engaging local government and community-based organizations in developing and implementing programs that improve the health of the population. Specific objectives focused on alcohol and youth and were all met. They were to

- Identify the extent of alcohol abuse and factors associated with alcohol abuse among young people ages 12 - 17 in a sample of schools in the city of Split.
- Incorporate appropriate “best practices” in the project activities, including those identified by the Centers for Disease Control and Prevention (CDC) for interventions targeting adolescent alcohol abuse.
- Develop and implement targeted educational, culturally appropriate interventions in specific high-risk schools and the community at large.
- Increase outreach to NGOs and other Healthy Cities projects in Croatia about the problem of adolescent alcohol abuse.
- Through the administration of Project Northland, increase student knowledge about problems associated with alcohol use by 10% by March 2003.
- Increase parental involvement with problems associated with adolescent alcohol use by 10% by March 2003 demonstrated by 80% completion of Project Northland parental score card.
- Increase community knowledge about problems associated with adolescent alcohol use as measured by the number of news stories/articles on Project Northland appearing by March 2003.

II. Contribution of Partnerships to Achievement of USAID Mission Goals:

For FY 2000, the report of the mission was as follows. SO 3.4 Mitigation of Adverse Social Conditions and Trends is a new Strategic Objective for USAID/Croatia. Croatia suffers from social problems typical of many transition countries-high unemployment, income inequality, expensive and inefficient health, pension, and social welfare systems, disaffected youth, increase in illegal drug availability and use and declining school enrollment at all levels. This legacy from decades of socialism and the downward spiral of the economy since 1991 have left Croatia facing a critical social ill. USAID will undertake modest and careful interventions aimed at enhancing the public-private dialogue especially in the areas of public education on pension reform and the tripartite initiative on labor issues ...

Based on this summary of Mission objectives, the partnership did meet Mission objectives.

III. Sustainability of Partnership Relationships. (Include Comments from US Partners):

The relationship has been sustained since the partnership ended in 2003. Three of the Split partners traveled to the US the day after our site visit. The US partner wrote that they are “still involved with our partners. In fact, I wrote a grant to a Foundation that funded a formal evaluation of the project. So we have traveled to Croatia and worked with our partnership and project since the USAID funding ended. Additionally, we have funds to supplement our partners travel to the US this month to work on the evaluation analysis and to make a formal presentation at the University of Medicine and Dentistry of New Jersey.”

IV. Accomplishments:

A. Contribution to systemic change: Youth have been impacted significantly by the transitional society they are living in and have turned to alcohol and drugs to escape boredom and feelings of hopelessness. The project made a measurable difference in the schools where it was implemented. With the help of mass media, awareness of the problem of alcohol use among children and youth has increased throughout Split. A specific program has been tested and found effective in educating Croatian youth and teachers about the dangers of alcohol use. It is being implemented in all elementary and secondary schools in Split. Advocacy efforts are now underway to convince the national government to adopt the curriculum in all primary and secondary schools nationwide.

B. Improvements in Health Care Delivery:

C. Improvements in Health Status: The project evaluation concluded that the project had been effective in reducing alcohol use and changing other unhealthy lifestyles among children and youth. As a result, Project Northland will be implemented in Split schools serving 6th to 8th graders. The Croatian partners are seeking approval for nationwide implementation.

D. Developmental Impact:

1. Human Capacity Building

Increased capacity is still paying dividends in the following areas:

- **Training Skills:** Ten 6th grade teachers were trained by the US partners in the Project Northland program, which included innovative methods (use of movies, cartoons, other fun methods) for teaching youth. These methods are now being applied to other programs.
- **Professional skills:** In 1991, the Croatian partners conducted the YRBS survey in the schools. Results were analyzed with the US partners. This type of data analysis was very new to people in Croatia who are not academics.

A cost benefit analysis of Project Northland was included in the project, and it showed that the project was profitable.

The substance abuse experts in Split had never used a curriculum like Project Northland before the partnership. The methodology was completely new and very important. It introduced a “culture of evaluation.” The drug abuse prevention program has been operating since 1996, but they have never had an evaluation of whether it is working.

According to the US partner, “Unquestionably, the partnership was as beneficial to the US partners. I am now at the University of Pittsburgh at the School of Public Health. In my capacity I am using the Healthy Cities framework to talk about public health program

planning. I also feel our students benefited from learning about global public health perspectives from having faculty with first hand experience. Additionally, the project made us more culturally sensitive to adapt ourselves to other global projects we take on.”

The city had a special department working on drug abuse prevention, however, alcohol was not perceived as a dangerous drug. (The survey had shown that elementary school children as young as 8 were drinking alcohol regularly.)

- **Networking:** They presented the project to the Ministry of Education and other stakeholders in the community to get their support, and they explained that all players are important. The local government and the teachers began to work together.
- **Advocacy skills and communications:** The advocates for the program in Split have data to prove the effectiveness of Project Northland in Split. They will be able to rely on this data in their presentations to the MoH and the MoEd.

The Croatians became more aware of the power of the media and how it affects behavior. Even teachers were not aware of the power of the media. According to the US partner, the “use of media for our partnership and our project was outstanding. Our partners use the media to broadcast our project in newspapers, magazines, radio and local and national television.”

The Croatian partners are planning to present the results of the project to the Ministry of Education and the Ministry of Health. They hope to get approval to make Project Northland part of the curriculum throughout Croatia.

A second strategy that will be pursued is to work through the Healthy Cities program in Croatia and urge the 20 members of that organization to implement the project in their schools.

Through the partnership, the youth learned about using mass media to educate the community about the dangers of alcohol. They were on the radio and held discussions with journalists, judges, ministry of law, and the police. They also wrote to the President of Croatia about the project and got a response, which impressed them all.

- **Appreciation for usefulness of data in their work:** In 2000 a needs assessment in the community was conducted through Healthy Cities. It found that there was a decrease in the use of stronger drugs (i.e., heroin), but an increase in the use of drugs by youth. The greatest community problem was unemployment and the influence of unemployment on the health of the community. These findings were consistent with other reported trends in Europe. The partnership team could not decide how to concretize this issue into a project, so alcohol use became the focus. A Youth Behavior Risk Survey (YBRS) created by U.S. CDC found that alcohol use was an unrecognized problem with youth. The survey was used to establish baseline data on the problem of alcoholism among youth. The survey was administered to 1000 youth at 17 schools in mid-2002. The results of the survey indicated that alcoholism use and abuse among adolescents ages 12-17 was a serious problem. Data was analyzed by a team of two people who were not involved in administering the survey: the director of the Healthy Cities Network and a professor from the Stampar School of Public Health in Zagreb.

They surveyed alcohol abuse prevention programs in the US and together with their partners decided that Project Northland would be most effective in Split because it directly involves youth. They decided this approach would be less expensive and effectiveness would be easier to measure than a community-wide

campaign. Also, Project Northland addresses use of marijuana and tobacco in addition to alcohol. The project was implemented in 12 schools, and 12 schools served as controls. Two schools were alternates.

There were annual surveys of the students to determine how the youth were responding to the project. They decided to make changes by starting the program in the 5th grade based on the feedback they received. Analysis of the survey taken at the end of the 3 year project has recently been completed. It shows that there is a statistically significant difference between the control schools and the project schools. This data will be used to lobby the Ministry of Education for implementation of the program in all schools and throughout Slovakia.

The project introduced a “culture of evaluation” that had never existed before. The city government employees regretted that they had not included the Stampar school more heavily in the effort. They need their skills to continue to learn about evaluation methods.

- They presented the project to the Ministry of Education and other stakeholders in the community to get their support, and they explained that all players are important. The local government and the teachers began to work together.
- **Participation in international forums:** In 2003, partners from Split and New Jersey presented the Project Northland and work of the partnership to a Healthy Cities conference in Belfast, Northern Ireland.
- **Identifying and training new stakeholders:** The project calls for a lot of interaction between youth and their parents, including completing homework as a team. This was the first time parents and youth had talked about some delicate issues. The project helped to open communications between parents and youth by providing a “progressive” model for initiating discussions.

During the school visit, the team learned that psychologist does regular workshops for teachers.

Before proceeding with the project, they presented it to the Ministry of Education and other stakeholders in the community to get their support, and they explained that all players are important. The local government and the teachers began to work together.

They organized a meeting of all school principals in the city so that they could assure that youth in both program schools and control schools were motivated (i.e., concerns about the Hawthorne effect).

Parent education programs were conducted to inform them about alcohol use and abuse of adolescents and what could be done to reduce alcohol use in the home.

After the independent evaluation of the data was completed, there was a meeting and discussion among all the stakeholders. However, the city officials recognize that they did not involve academics sufficiently. They want to build a practical alliance with the universities for future efforts.

All became more aware of the influence of media and commercials on the value system of the society.

- **Continuous improvement:** The project used a completely different approach to teaching than they had ever known (e.g., it was creative, relied on cartoons, did not include exams). They are using these techniques now in other workshops. After the training by US partners, the teachers were on their own to implement the project. They reported that students are “difficult” at this age; and when they saw that the students were bored, they would modify the approach. Teachers found that they had to adapt the program on an on-going basis. They now feel capable of training other teachers.

- **New mindset:** They learned about projects and programs of NGOs during their visits to the US, and about survey of youth risk behavior.
- **Ability to adapt models:** Project Northland was selected as the model for the program. It is a multi-tiered, community based alcohol intervention that was launched in 1990 by the National Institute of Alcohol Abuse and Alcoholism of the U.S. National Institutes of Health. The project was pilot tested in Minnesota and implemented in Russia. It incorporates behavioral curricula for use in schools, parental involvement programs, extracurricular peer leadership and community-wide efforts for adolescents in 6th-8th grades. The intervention was evaluated using a randomized community trial. The Project Northland materials were adapted to be culturally appropriate for adolescents in Croatia, translated and reproduced in Split.

They believe the Project Northland effort in Split is a model for use in other Healthy Cities programs.

2. Institutional Capacity Building

Institutional capacity is evident in the following areas:

- **Ability to absorb incremental costs (i.e., ability to replace withdrawn donor funds with funds from other sources):** The partnership provided all the materials and these can be reproduced and used throughout Croatia if approved by the Ministry of Education and the Ministry of Health.

The city government has committed to implementing the program in all the Split schools.

- **Standards, guidelines and protocols adopted:** Project Northland was a proven program with a track record of effectiveness in Minnesota.
- **Use of technology:** From the US partner “the technology that the grant provided in the way of computers, internet access, software such as SPSS provided the partnership with communication and data analysis skills that they did not have prior to the partnership. I see their use of PowerPoint slides with data as a direct result of the resources and skill building.”
- **Expanding group of stakeholders:** The city of Split collaborated with the Stampar School in implementation of the survey and analysis of the data. The partnership brought the public school teachers into the Healthy Cities framework by including them in the project.
- **Involvement of younger generation:** The Croatians surveyed alcohol abuse prevention programs in the US and together with their partners decided that Project Northland would be most effective in Split because it directly targets and involves youth in schools. The program is a three year curriculum focused on 6th–8th graders. They decided this approach would be less expensive and effectiveness would be easier to measure than a community-wide campaign.

The program was interactive, involving peers and parents. The students wrote articles for the school magazine and made presentations to the younger students in their school. Developing skills in resisting peer pressure was an important part of the program. They felt empowered to be able to influence the behavior of their peers.

The youth learned about the impact of media on their values.

- **Participation in international forums:** The partnership published an article in the Journal for Drug Education on the project in Croatia. The US and Split partners made a presentation about the outcome of the project at the medical school in NJ.
- **Strategic Analysis of strengths, weaknesses, opportunities and threats (SWOT)/identification of stakeholders:** They did not conduct a SWOT analysis. Instead they built on previous surveys and decided to do a YBRS.
- **Ability to build upon and expand the targeted intervention (i.e., replicability):** “Healthy Cities NGO began Project Petra, an exciting mentorship program for young people, which not directly related to the work we were doing, was an outgrowth of the partnership.” (US Partner)
- **Manager/leader:** Vesna Zac in the Mayor’s office has been the driving force behind the Project Northland initiative in Split and is seeking approval for implementation of the project in all Split schools and nationwide.

3. Community Mobilization

The community is now more aware of the dangers of alcohol use by children and youth. Selling alcohol to underage youth is now the focus of community education. Parents are more aware of the impact of letting children and youth have access to alcohol at home.

Tirana, Albania/Bucharest, Romania

Type of Partnership: Health Management Education

Period of AIHA Partnership Support: 2001-2004

CEE Partners:

Romania: The Institute for Health Services Management, later called National Institute for Research and Development in Health

The National Institute for Health Research

Albania: The Institute of Public Health in Tirana

I. Achievement of Goals and Objectives:

The partnership's overall goal is to improve the quality of PHC services through institutionalizing health management skills and training for General Practitioners. Specific objectives are to:

- Further develop the advanced training skills of 15 Albanian trainers in developing and delivering management training courses as part of postgraduate education for clinicians by March 2003.
- Increase knowledge of health management techniques for General Practitioners in three targeted sites by providing Health Management training to 60 GPs by June 2003

Tirana partners successfully implemented training for health care management for GPs in several sites in Albania, and formalized a curriculum that was adapted to the Albanian environment.

II. Contribution of Partnerships to Achievement of USAID Mission Goals:

III. Sustainability of Partnership Relationships:

The Institute has established a strong relationship with the Institute of Public Health in Tirana, and the Albanians have indicated to the Romanians that they would like to have continued technical assistance and collaboration.

IV. Accomplishments:

The partnership provided a range of important program implementation skills Specifically:

1. needs assessment
2. identification and working with stakeholders
3. program design and proposal writing
4. training of trainers
5. development and adaptation of curricula
6. development of training materials
7. experience in training
8. assessment of impact

The Romanians said that they developed the course with the Albanians to adapt it to their own reality, as their Kentucky partners had done with them. In addition, the Romanians were able to provide the Albanians with technical assistance regarding health insurance, examples of useful legislation, and health promotion. "Romanian reform started 10 years ago; Albanian reform started 2 years ago." The partners remain in contact and would like to find opportunities to collaborate again. The Romanian partners would like to do more of this kind of technical assistance in the region.

Turcianske Teplice, Slovakia – Cleveland, Ohio

Type of Partnership: Healthy Communities

Period of AIHA Partnership Support: 1996-1998

US Partners:

Initial partners: The MetroHealth System/Case Western Reserve School of Medicine, the Federation for Community Planning, Cleveland-Bratislava Sister Cities

CEE Partner:

Initial partners: Turcianske Teplice Office of the Mayor and Town Health Council

I. Achievement of Goals and Objectives:

The goals of this partnership were all met. The specific initiatives that emerged from the health communities planning process were as follows:

- Using the healthy communities planning process, develop strategies to mobilize the community for change
- Facilitate an assessment of community health needs
- Empower the community to prioritize and select issues in need of community solutions
- Develop and implement community intervention strategies

II. Contribution of Partnerships to Achievement of USAID Mission Goals:

The USAID/Slovakia program in Slovakia began in 1992 with the goal of improving the health sector through programs focused on quality, efficiency and sustainability of health services in the categories listed below. The community participation goal was met through the Turcianske Teplice healthy communities initiative.

Health Financing System: Assistance to the national insurance fund and Ministry of Health in developing insurance management and new payment systems.

Clinical and Financial Management: Testing of efficient hospital management practices and quality improvement programs in Roosevelt Hospital and Trnava Hospital and development of health management training programs.

Community participation: Fostering cooperation in the health sector between local governments and citizens.

Environmental/Occupational Health: Developing curricula for Matej Bel University and for post-graduate education of general practitioners. (Source: Blumhagen/Aaronson report)

III. Sustainability of Partnership Relationships. (Include Comments from US Partners)

The relationships have not been sustained.

IV. Accomplishments:

A. Contribution to systemic change: 1) The CEE partners wanted to focus on lifestyle issues and health promotion and disease prevention. This was a new direction for a municipal government and filled an important need in the community. The programs initiated by the partners continue today and health screening has and improved lifestyles have become accepted aspects of personal health. 2) An ambulance

was purchased during the partnership and now they have a Center for Emergency Services which serves the city and surrounding communities. They believe they were at least 5 years ahead of the rest of the country in establishing emergency rescue services to serve their citizens. Just now, the Ministry of Health is starting a national program on emergency rescue. 3) In the course of raising funds for the ambulance, the community realized the importance of voluntary charitable contributions and changed the tax laws to encourage charitable contributions.

B. Improvements in Health Care Delivery: In 1989, responsibility for health care delivery shifted to the local governments. The leadership of the town realized that they had to teach people to take responsibility for their own health; however, they did not know how to do bring about these changes in thinking. The partners introduced the risk assessment survey. The three parts of the original partnership – emergency rescue, community health center and statistical survey of youth - are still very much alive. Since 1997, the Turcianske Teplice Health Center has been operated and financed by the municipality. The purpose of the center was to make health promotion and disease prevention services accessible to the population at no cost. (The state government had been responsible for disease prevention, but when responsibility was devolved to the municipality, they introduced a health promotion campaign to their efforts.) The center is funded by the municipality and provides hypertension and cholesterol screening, diabetes screening and counseling, education for women in self-breast examination, prenatal education, as well as drug, alcohol and smoking cessation counseling. Originally, the Center was open 5 days a week for four hours a day and was staffed by a part-time physician and a full time nurse. This plan continues except that the scarcity of nurses has left them without nurse coverage during several intervals.

Prior to the partnership, there was no emergency rescue service. Emergencies were handled by walk-ins to the polyclinics. The closest “emergency center” was located in Martin, about 50 km away. As a result of the partnership, the community was able to conduct a local fundraising drive, and was successful in raising \$40,000 for a fully equipped ambulance that serves a wide catchment area (12-20 km). Within 10 minutes everyone within that area can get emergency services.

The youth survey gave them a baseline for measuring changes in drug usage so they could compare themselves to other regions. It gave them a scientific basis for making the case with citizens about the need for community health programs. [They would like to repeat the study since it has been 10 years since the last one.]

Cooperation between NGOs in the community health area was a contribution of the partnership. There was better acceptance of the non-governmental sector by the local government, and the society at large is now more aware of the role of NGOs.

C. Improvements in Health Status: The population of the town is 7000. An average of 450 people are screened each year for hypertension, 181 people for cholesterol, 156 people for diabetes. There are education programs for women on breast self-examination, semi-annual lectures on pre-natal care. An emergency response system has been established which is able to respond to the high number of traffic accidents and other emergency needs. Funds are needed to repeat the statistical survey in order to measure their progress.

D. Developmental Impact:

1. Elements that made the partnership impact last

- Leadership of the town Mayor
- Timing: Devolution of responsibility for disease prevention to the municipalities

- Motivation of the city council to listen to the needs expressed by their community and to use the partnership to respond
- The survey helped the city government become more aware of the community health issues.
- Introduction to community fund raising

“If you want to build a ship, you don’t have to look for a carpenter or a craftsman, but rather a person who is longing for the sea.” Alena Chlapikova, MD, former Mayor, Turcianske Teplice

2. The Legacy

1. Human Capacity Building

Increased capacity is still paying dividends in the following areas:

- **Professional skills:** Emergency medical personnel provide 24 hours staffing of the Emergency Center.
- **Networking:** The partners understand the value of networking, but reported that they have limited opportunity. They are still not comfortable using e-mail to exchange ideas outside of their community.
- **Fundraising skills:** The Slovak partners were unfamiliar with the Western practice of fundraising. They understood the need, but the terms and concepts were new to them. By the end of the partnership they had raised \$40,000 from local contributors for a fully equipped ambulance. In addition, they learned the importance of approaching new donors, establishing a system to recognize contributors and they changed the tax laws to encourage charitable contributions.
- **Advocacy skills and communications:** Through production of brochures and frequent lectures on the subject of health promotion and disease prevention, the public is becoming more pro-active about their health.
- **Appreciation for usefulness of data in their work:** The Family Stress Survey that was conducted gave them a scientific basis for educating the community about the need for changes in lifestyle.
- **Participation in international forums:** The city has hosted visits from other AIHA communities and leaders of the partnership have participated in most AIHA annual conferences and made presentations at other international fora such as the 10 year conference.
- **Identifying and training new stakeholders:** There was a strong resistance to change before the partnership. After the partnership and the purchase of the ambulance, the citizens began to push for more support of a healthy lifestyle. They institutionalized the Center, found a building, hired professional staff and got the services of the Center covered by the national insurance plan. They now are ready to privatize the health center. The Center actively coordinates with the local physicians and the union. With such a dynamic environment, academics became interested in public health.
- **Continuous improvement:** Programs and publications are continuously updated to provide current information. The city is now exploring the feasibility of privatizing the health center.
- **New mindset:** 1) Under the old system, the citizens were used to being “taken care of” by the government, and they did not understand the importance of maintaining a healthy lifestyle. In

addition, there was a strong resistance to change. The leadership of the town realized that they had to teach people to take responsibility for their own health. The citizens are now taking more responsibility for their health and are better organized to bring pressure for what they want to change. 2) At the time of the reforms, the only entity capable of assuming responsibility for functions that the national government was devolving was the local government. Through the partnership they were introduced to NGOs, and they now see how NGOs can fill gaps in government services. The role of NGOs is more obvious to them; so today, NGOs would automatically be involved in community decision-making efforts. 3) The participants said they had a sense that these changes were contributing to a stronger democratic society.

2. Institutional Capacity Building

Institutional capacity is evident in the following areas:

- **Ability to absorb incremental costs (i.e., ability to replace withdrawn donor funds with funds from other sources):** The town of Turcianske Teplice is now covering all the costs of the town Health Center from the town budget.
- **Assumption of responsibility at local level:** Before the old system collapsed, the state had been responsible for public health and preventive health services. But the state health care system deteriorated due to financial shortages, and local health centers no longer got state support. Their Center for Health was the first in Slovakia that was fully controlled and financed by the city.
- **Involvement of younger generation:** On-going health education programs are directed to primary and secondary school children. The initiative has also included development of a sports hall, playgrounds, and other recreational institutions.
- **Participation in international forums:** They have attended the AIHA annual meetings.
- **Strategic Analysis of strengths, weaknesses, opportunities and threats (SWOT)/identification of stakeholders:**
- **Ability to build upon and expand the targeted intervention (i.e., replicability):** 1) They have purchased a second ambulance. 2) They have assisted other sites interested in opening a similar type of health center. Dunajska Streda was an example of a community that has a center modeled after the Center in TT.
- **Outreach:** Lectures in the primary and secondary schools each year on lifestyle, exercise, obesity control, anatomy basics and parenting education
- **Fundraising:** Annual Daffodils Day to benefit cancer treatment; Annual White Pastel to support the Blind Union. Within a year of the beginning of the partnership, the town completed a community fundraising drive to purchase an ambulance by appealing to local civic groups, businesses and schools in the community, as well as to officials across the country. They also enlisted the support of the Cleveland Slovak community through a raffle. Through the process of raising funds, the community learned the importance of approaching new donors, establishing a system to recognize contributors and changed the tax laws to encourage charitable contributions.
- **Manager/leader: The Mayor's support has been instrumental in the success of the partnership.**

3. Community Mobilization

Throughout their initiatives with the US partners, they felt they were strengthening the sense of a democratic society because they were able to get the entire community involved. To raise funds for the ambulance, they mobilized citizens through the Red Cross, the schools and other institutions. There was wide community participation in the effort.

Before the collapse of the old system, the state had been responsible for health education and prevention; but these were devolved to the local level. The principles of volunteering were engaged and the citizens founded many different NGOs connected to the health care system. Now dozens of NGOs cooperate with the city Health Center and they consider the Health Center an important resource.

Vac, Hungary – Winston Salem, North Carolina

Type of Partnership: Healthy Communities

Period of AIHA partnership support: 1998

US Partners:

Initial partners: NovantHealth Triad Region (NHTR)

Additional partners who joined the effort after the focus area was identified:

CEE Partner:

Initial partners: Javorszky Odon Hospital (Vac Municipal Hospital)

Additional partners who joined the effort after the focus area was identified:

I. Achievement of Goals and Objectives:

The general goal of the Vac healthy communities initiative was to improve the community role in and support for the health system. The specific goals were met and have had lasting effects. They were as follows:

- Develop a community health project in Vac to involve different sectors of the Vac community – public and private – in an inclusive process designed to educate the Vac citizenry, especially the community’s youth, on methods to improve their well-being,
- Convene regularly a Health Community Task Force to develop and implement projects to educate the Vac citizenry on pertinent health issues,
- Open a Healthy Community Center in Vac to serve as a venue for community education programs and meeting place for the Healthy Community Task Force,
- Garner the support of municipal government leaders, public health care officials, leading businessmen, and other stakeholders in the community health project.

II. Contribution of Partnerships to Achievement of USAID Mission Goals: USAID’s general objective is to improve health status of the population and the activities of this partnership shared that objective, though the focus was on non-communicable diseases rather than the more traditional USAID focus areas.

III. Sustainability of Partnership Relationships. (Include Comments from US Partners):

“I continue to stay in touch with several of the doctors and nurses (both in the hospital and in the community ...The friendships I established will be long lasting.” (Frances Hutchison, US Partner) The Hungarian partners are on the mailing list of the US partner. Novant granted access to the hospital’s digital library and online medical journals in the years after the partnership ended. The Hungarians receive information that is used in marketing services to the community, as well as information that goes out to employees. This keeps them in touch with what is happening, new services, expansion programs, new building, etc.

IV. Accomplishments:

A. Contributions to systemic change:

B. Improvements in Health Care Delivery: The hospital established an Association for the Health of the Citizens which enables them to avoid paying import duties on donated medical equipment, qualifies

them to apply for charitable funding and to own and operate a building for their activities. The members of the task force that organized the association represented local government, business, public health and schools. A Healthy Community Center was established to promote healthy lifestyles

C. Improvements in Health Status: Establishment of Healthy Corners in grocery stores, and healthy choice sections in school cafeterias. Men's health is the focus of a nationwide program sponsored by the Ministry of Health and the Healthy Cities. The idea originated at Vac at the suggestion of the American Ambassador. The initiative to encourage young boys to get more physical activity has been very successful. The attendance at stop smoking clinics has increased greatly. There is a 20% success rate among those who are receiving psychological support and an 80% success rate for those using biofeedback.

D. Developmental Impact:

1. Elements of the partnership that made the difference

- Hearing about the healthy communities initiatives at an AIHA meeting in Latvia provided the inspiration for the program in Vac
- Personal leadership of Magdona Magy, head of Vac municipal health office and other highly committed individuals,
- The US partner was "open to anything." They wanted to help respond to the community's needs. There was a shotgun approach to the visits to the US- so the Hungarians were exposed to many new ideas. This was very motivating.
- Stakeholders from many different parts of the community were involved in the SWOT

1. Human Capacity Building

Increased capacity is still paying dividends in the following areas:

- **Training Skills:** Peer to peer education on smoking, alcohol and healthy sex as well as teacher-student training is on-going. The Association for the Health of the Citizens of Vac provides educational programs in the schools.
- **Professional skills:** According to the US partner, she observed, Better relationships between all the healthcare workers, more respect for what each contributed, improved teamwork, and a more positive outlook.
- **Networking:** There is now communication between the local government, social organizations and the citizens.
- **Fundraising skills:**
- **Advocacy skills and communications:** Magdona Nagy, Head of the Municipal Health Office, was the original champion of the healthy communities initiatives and continues to hold a leadership position. She was able to convince the head of the Vac hospital to be a sponsor of the program.
- **Appreciation for usefulness of data in their work:**
- **Participation in international forums:**
- **Recruit, train, and retain volunteers:** Health educators are all volunteers. There are about 25 volunteers working for the Association.

- **Identifying and training new stakeholders:** Many stakeholders have become involved in the campaign to improve the health status of the citizens of Vac. The original organizers of the Association included the municipality, schools, local businesses, firemen, police, health professionals, and public health officials.
- **Continuous improvement:** They are continuously expanding their program and taking it to new venues. The biofeedback program to stop smoking is going to be used in factories. This is only available for those who can pay a fee.
- **New mindset:** Many innovations have come about as a result of a shift in their mentality. These innovations were not dependent on money, but rather on motivation and vision.
- **Ability to adapt models:** Vac was the first healthy community in Hungary. They have worked with the Healthy Cities Association to combine the two concepts and there are now many more healthy communities initiatives underway. There is now a network of Associations throughout Hungary that are staffed by volunteers and they collaborate on programs.

2. Institutional Capacity Building

Institutional capacity is evident in the following areas:

- **Ability to absorb incremental costs (i.e., ability to replace withdrawn donor funds with funds from other sources):** The Center and its programs continue to operate through local government support and community fund raising efforts.
- **Standards, guidelines and protocols adopted:**
- **Management skills and structures:** The partners established a legal framework for the program by creating the Vac Citizens for a Healthy Society. The Healthy Community Center opened by the partners serves as a venue for community education programs and as a resource center and meeting place for the Task Force.
- **Expanding group of stakeholders:** Regular meetings of the Vac Healthy Community Task Force bring together the community and municipal policy makers and stakeholders. These meetings demonstrated to the mayor and local policymakers that everyone must share the responsibility for the community's health and well-being.
- **Involvement of younger generation:** The Association for the Health of the Citizens of Vac conducts courses in the city's schools on health education and nutrition. Teachers and health services personnel from the schools participate and share ideas on improving health awareness in the schools and the community. A program for improving school cafeterias has been implemented where healthy food choices are offered. A football competition was organized to encourage young boys to get more physical activity. It has been very successful.
- **Participation in international forums:** Vac has become part of the WHO Healthy Cities organization and participated in meetings where they learned lessons that could be applied to Vac.
- **Strategic Analysis of strengths, weaknesses, opportunities and threats (SWOT)/identification of stakeholders:** A SWOT analysis enabled them to map out the problems in the city. It was conducted at the beginning of the healthy communities initiative and revealed the need to focus on the lifestyles of the young people.

- **Ability to build upon and expand the targeted intervention (i.e., replicability):** The Association for the Health of the Citizens of Vac was created to develop and implement a community health program in Vac and its programs continue. The Healthy Community Center is a place where weekly meetings with teachers and students are held. The project started with a focus on lifestyles of youth, but later expanded to include health screening and health promotion for adults.
- **Outreach:** Adult Health Fairs are held regularly to screen for cholesterol, BMI, high blood pressure, osteoporosis. They have a week devoted to men’s health, and provide screening for prostate cancer (this initiative responds to a request from the US Ambassador)
- **Fundraising:** Local fundraising campaigns support the Healthy Community Center. The partners received funding for production of educational materials.
- **Manager/leader:** The champion of the healthy communities partnership has mentored several young people to fill leadership roles. She is still considered the “Mother” of the healthy communities program in Vac.

2. Community Mobilization

A wide range of groups were represented in the organization of the healthy communities initiative – police, schools, city government, public health officials, hospital, businesses.

Vac – Winston/Salem Partnership Notes 1995-1998

Success Toward Objectives:

The overall long-term objectives of the partnership were to improve the efficiency and quality of health care delivery in the Vac region and to improve the community role in and support for the health system.

Home Care

- Introduce a model home care service; strengthen the primary care system in the region; educate physicians, nurses, and other health care professionals about home care and promote its use.

Management

- Use the concepts of Continuous Quality Improvement (CQI) to provide hospital and community health leaders with the management and team-building tools they need in order to manage change within Vác Municipal Hospital and its regional health system.
- Develop and improve management processes and enhance management skills of hospital leaders to operate the hospital more effectively and efficiently.
- Improve hospital management and administration, as well as increase efficiency in the clinical areas of diabetes, oncology, one-day surgery, emergency care and acute stroke/rehabilitation.

Clinical Areas

- Reduce length of stay of diabetes patients in Vác Municipal Hospital by improving the diagnosis, treatment and follow-up care of diabetic patients, developing an organizational structure for home care delivery, and developing a comprehensive and intensive diabetes patient education program.
- Reduce length of stay of colostomy patients by improving nurse education for home care of colostomy patients and improving patient education in colostomy management.
- Decrease length of stay of stroke victims in Vác Municipal Hospital through improved nurse and patient education.
- Provide training for clinical personnel in Vác Municipal Hospital and primary care physicians in the Vác region through educational outreach and exchange.

Community Health

- Develop a community health project in Vác to involve different sectors of the Vác community – public and private – in an inclusive process designed to educate the Vác citizenry, especially the community's youth, on methods to improve their well-being.
- Convene regularly a Healthy Community Task Force to develop and implement projects educating the Vác citizenry on pertinent health issues.
- Open a Healthy Community Center in Vác to serve as a venue for community education programs and meeting place for the Healthy Community Task Force.
- Garner the support of municipal government leaders, public health care officials, leading businessmen, and other stakeholders in the community health project.

Champion:

There was no identified overall partnership champion. Many of the physicians we met, including the hospital director, were not working there at the time of the partnership. Nonetheless, Dr. Agnes Katona (coordinator of the partnership) was involved in the partnership from the beginning and was a consistent advocate of and participant in the partnership.

Human Capacity Development:

Prior to the partnership, there were no professional diabetes nurses. With strengthening of nurses' skills and self-esteem through the partnership, the nurses now provide most of the care to patients on the Diabetes Unit.

Ostomy Therapy Nurses were trained by an outside medical supplier of ostomy products in inpatient and outpatient ostomy care.

Institutional Capacity Development:

In the Oncology Department, there were three main accomplishments from the partnership:

- 1) An outpatient treatment unit was established in 1992. This increased the number of outpatient rooms from 3 to 14 and added 2 hospital rooms. Both chemotherapy and palliative care are delivered in this unit. In 2004, 486 patients were treated as outpatients. Prior to the partnership, cancer patients had to go to Budapest for inpatient chemotherapy.
- 2) Oncology Teams were formed including oncologists, pathologists, radiologists ??and nurses?? To ensure smooth working relationships and improved patient care among all the specialists involved in cancer treatment.

Now performing mammography screening for breast cancer and doing pre-op diagnostic procedures for patients. Had recently formed teams for pre-op diagnosis for colorectal cancer. They would like to set up plans for optimal pre-op diagnosis, surgery and follow-up radiation therapy. The exchange team (comprised of a colorectal surgeon, chemotherapy specialist, oostomy specialist, and an oncologist) observed the clinical care teams at Winston-Salem "in action" and this was felt to be extremely useful. Other practices that they observed included breast cancer screening, post-op procedures, and use of home care including hospice.

Hospice care is being established in Vac; currently only 2 other cities in Hungary have hospice care.

Currently clinical care teams only exist for breast cancer and colorectal cancer but the plan is to expand to other cancers groups.

- 3) Establishment of cancer registry which joined the national cancer registry four years ago. They now report quarterly to the national registry. While on exchange, the Hungarian partners observed the use of the national cancer registry.

The Oncology Department has no current contact with the Winston-Salem partners.

Others still in contact with the USA partners. The hospital has had access to Noventhealth's (??) digital library for past 2 years has been very useful.

Diabetes Unit

The unit was recently accredited by the National Diabetes Mellitus Association. The number of patients receiving care in the unit has increased dramatically—from 600 patients in 1996 to >3,000 patients today.

Prior to the partnership, there were no programs for diabetes education for patients. They found the educational materials from the USA very useful. However, there were other items from the diabetes care

program in the USA that they were not able to implement in Hungary; they felt some aspects were not compatible with the Hungarian program so in those instances would use the local approach. Diabetes is treated on an outpatient basis.

Colorectal Cancer Group

The Ostomy Club was formed before the partnership (in 1991). However, the group has grown more than quadrupled in size (from 25 members to 120 members).

Without the partnership, the medical team in Vac commented that they'd have "a poorer experience" today. They remarked that in the USA they were able to see what could be accomplished when resources are made available. Since fundraising is not possible for them (hospital staff are prohibited from fundraising as all needs are to be addressed by the government budget).

Neurology/Stroke Unit

This team's goal was to reduce length of hospital stay for stroke patients. Through the partnership they developed clinical pathways for stroke patients and these became part of their routine care protocols. Pre-partnership the average LOS was 10 days, and in 2004 it had decreased to 7.2 days. This decrease in LOS is largely due to the designation of a Social Care Nurse (a discharge planning nurse) for the unit that assists with earlier transfer of patients to a rehabilitation unit. Prior to the partnership there was one Social Care Nurse for the entire hospital, now the Neurology Unit has its own. The physicians identify patients with social or placement needs and refer them to the Social Care Nurse.

In addition, the unit has created a Stroke Rehabilitation Team that consists of neurologist, rehabilitation physician, a nurse and physical therapist. The neurology unit Director feels that this team approach also has improved care and shortened hospital stay.

Home Care

This service was established in December 1997 as a result of the partnership. Home care had been in the early stages of development but the partnership helped speed along its establishment. The Vac program was one of the first home care services in Hungary. The partnership helped establish the center and train the nurses. This model has received national acclaim.

Nursing Resource Center

The NRC was opened in Dec 1999. Approximately 95% of educators for NRC trainings are nurses or nurse assistants. They seek topics from the nurses. Nurses are also required to obtain CME credits and NRC offers some accredited courses (e.g., ACLS). Sessions are open to nurses from outside the hospital/the community. The computer equipment is no longer used or maintained since computer (with internet) access is available in each department. The partnership sped the development of the NRC and provided high quality equipment.

It was observed that the few books in the NRC were all in English, published in 1996-98, and it did not appear that they had been used. Only one training session per month is held at the NRC currently, but they are hoping to increase that in the coming year.

Nurses are now members of the management team for patient care. Management training is provided to all management team members.

Specialization for nurses began during the partnership and is now universal.

Continuous Quality Improvement (CQI)

The partners were trained in CQI and their hospital QA system has been certified by an independent agency (Hungarian Standards Institute). As the topic was just being introduced into health care in Hungary, they were ahead of their time. The hospital mission statement contains wording on quality.

Emergency Medicine

Established in 1998, this was the first unit in the country to combine care for emergencies and accidents/trauma. They based their documentation procedures on the USA model observed on exchange. They were able to rebuild the ER when their application to the government was funded. Renovation was completed June 1998 (still looks in excellent shape).

General

While the diabetes clubs for adults and children were not initiated as a result of the partnership (were actually founded by patients prior to the partnership), the physician and nurse involved with these clubs (as advisor and guest speaker) think that these clubs were improved by the partnership. In the USA, the team observed support groups and how providers are more open and provide more detailed information to patients and their families. They also adopted the practice of giving awards to patients for surviving cancer-free for a certain number of years.

The medical team estimates that the partnership resulted in at least a 25% reduction in hospital stays in all three departments (endocrinology, colorectal surgery, and neurology).

On the exchanges the partners saw “patient-focused care” (versus science being the main focus). While the team felt that their hospital was fairly patient-focused, they did not have the cooperation between departments or between the physicians and nurses. This was something the team saw on exchanges that seemed to change their attitudes and approach. From the partnership, they realized the role of the nurse is more important, especially in the care of stroke patients. Since the partnership, they have instituted regular trainings for the nurses.

The partnership was a stimulus for the establishment of their CME program; the partnership helped with the implementation of their CME program and donated some equipment.

“The partnership helped us reshape our thinking and focus on competence.”

English language ability helpful but not essential. The development of personal relationships was critical to the partnership success.

Sustainability:

Certain programs/activities continue today. For example, the diabetes mellitus training program has now been accredited and all hospital staff are trained in this aspect.

Some of the original team is still in contact with the Winston-Salem partners and they exchange medical literature and the partners have access to the digital library [of whom???]. Those not in touch include those from colorectal, oncology and Diabetes departments.

They felt dissemination was not stressed enough during the partnership. In response to query about what would have facilitated dissemination, partners replied that a strengthened connection with the MOH; the DM program was accredited after it was visited by the MOH (with USAID and AIHA partners in attendance also)

Replication:

The various medical subspecialty teams have presented the changes in their delivery of care (including the care team approach) and their results at national and international conferences. In addition, they have disseminated their partnership achievements through the Hospital Association journal. They have not, however, transferred this model to another facility nor are they aware of any specific sites where their model has been adapted.

They had established another partnership with a hospital in a Southern Slovakian town (based on proximity and patient referrals as I could understand), no other partnership involvement.

AIHA conferences

They found it interesting to see how other countries solved their problems in a general sense but did not take anything concrete away from these experiences.

History of Partnership

1988 Voluntary Hospitals of America came to Hungary, identified Vac as the best hospital, had a very positive response to this involvement. VHA promised to select USA partner. In 1992, Winston-Salem delegation visited and asked what they could help with. 1993 Vac team visited Winston-Salem, 2nd visit in 1995 for 6-week hospital management course. Met with AIHA on that trip, told them “we already have a partnership”, just need to formalize it. The Vac team tried to find areas where services were strongest in the USA and where they could learn the most. In Sept 1995 a planning mission was conducted. Felt the USA offered better organization of programs and better utilization of resources, felt the technical level was different (higher in the USA) but the professional level (knowledge) was similar.

Partnership served as a catalyst. The same developments would have happened but more slowly. EU membership has not been a catalyst in the same way.

Zadar/Biograd, Croatia – Franciscan Sisters of the Poor

Type of Partnership: Hospital

Period of AIHA Partnership Support: 1995-1998

US Partners:

Franciscan Sisters of the Poor Health System, Inc; Franciscan institutions most directly involved in the partnership included: The Franciscan Health System of the Ohio Valley in Cincinnati and Dayton, Ohio; The Franciscan at St. Leonard in Dayton, Ohio; Our Lady of Bellefonte Hospital in Ashland, Kentucky; St. Francis Health System in Greenville, South Carolina; and St. Mary's Community Mental Health Clinic in Hoboken, New Jersey

CEE Partner:

Zadar General Hospital and Orthopedic Hospital of Biograd (located twenty miles south of Zadar)

Objectives:

Cardiovascular Disease

- Improve knowledge and skills related to the prevention and diagnosis of cardiovascular disease.

Nursing

Introduce a theoretical framework for collaborative practice and improve the management skills of nurse leaders within the partnership institutions and other national-level nursing organizations in Croatia.

Oncology

- Improve knowledge and skills related to the prevention, screening and diagnosis of cancer.

Total Quality Management (TQM)

- Introduce tools and techniques of TQM and improve management knowledge, skills and practices.

Post Traumatic Stress Disorder (PTSD) in Children

- Increase recognition of PTSD and improve related diagnosis and treatment modalities.

Fundraising and Development

- Create a fundraising program within the partner institutions, and increase awareness of and community support for hospitals.

Orthopedics

- Increase the knowledge and skills of clinicians in the treatment of orthopedic conditions related to osteomyelitis and reconstructive surgery

Gerontology

- Develop a theoretical framework and policy alternatives for the care of the elderly population in Croatia.

Infection Control

- Introduce standard policies and procedures to reduce the rate of nosocomial infection in partner institutions.

Success Toward Objectives:

The partnership appeared to meet most of the stated objectives (see below for details). In some instances, the objectives were tailored to better meet the needs of the partners. We did not meet with anyone from the Oncology Service so were not able to assess that component.

Human Capacity Development:

Training Skills/Professional Skills

Infection Control nurses from Zadar attended extensive trainings in Zagreb. The head nurse now trains new nurses in infection control policies.

In the US, the partners from the Psychiatry Department were able to visit renowned sites and meet with international experts in the field of PTSD.

The number of physicians trained to perform cardiac catheterizations increased during the partnership.

Improved Status for Nurses

They learned from US nurses that came to Zadar and from those nurses that traveled to the US that nurses were being asked to do many “non-nursing” jobs. They learned that it is the nurse that has the closest relationship with the patient and they should be burdened with administrative tasks that will take them away from patient care. The nurses now delegate administrative duties such as retrieving lab results to assistants (these positions were created as a result of the partnership). Older nurses are trying to transfer this approach to the new nurses. The nurses that participated in the partnership developed a greater self-confidence and skills. They also learned how to have better nursing documentation including a nurse discharge note which has been very helpful to patients’ families and caretakers. Even though a nurse did not travel to the US, she was able to listen and learn from the nurses that did.

The partnership started a nursing educational program of monthly meetings/trainings held at the university.

CQI

The LRC director was trained in the use of CQI. It is still used today for problem-solving.

New Mindset

The LRC director succinctly stated “the IT horizon is changing so fast, it is good to always be looking ahead – and that’s why the partnership was useful. We saw a different system.” He also said “if you don’t talk to others and see how they are doing things, you can’t grow or move forward”.

Regarding acceptance of new infection control practices by the staff, the physicians were more resistant to change than the nurses and felt like they were being policed; now the physicians seek out the head of Infection Control and use him as a consultant. The head of Infection Control felt they gained a lot from the partnership because “we were not ashamed to learn”.

Others felt it was useful to see where they were in relation to the US, and they learned that their quality was not far from that achieved in the US.

In the US it was helpful for the psychiatrists to see that the psychiatry departments were not in separate buildings but integrated into the outpatient care sites (helping to lessen stigma).

It was useful for the cardiology nurses to see how the cardiology service was organized in the US.

Institutional Capacity Development:

Standards, Guidelines and Protocols/Management

Hospital Director saw the partnership gave them an opportunity to see how things were done in hospitals in other parts of the world; they felt there was no need to recreate the wheel.

Prior to the partnership, the Infection Control staff was not well organized. The head of Infection Control said “infection control existed on paper but was not practiced...we knew the theory but not the practice.” From the partnership they adapted Ohio’s protocols for use in their facility. They learned first that they needed protocols then how to implement them. Prior to the partnership, they were not tracking nosocomial infection rate or the development of antibiotic resistance. The guidelines for evaluating nosocomial infection rates are based on those from the Centers for Disease Control and Prevention; they are updated each year.

The ICU provides the best example of successful infection control: in the past, cases of MRSA (a resistant bacteria) infection had increased and not there are nearly none.

Evidence-based Medicine

Trainings were done on how to do medline searches (the LRC director knew how to do these, did not need to be taught through the partnership).

Most medline searches that are done are for preparation for a PowerPoint presentation and not for patient care. However, they are waiting until they can get the right tools to do evidence-based medicine and then will do training in it.

New Services/Responsive Services

Some new policies were put into effect such as allowing fathers to be present at births. It is unclear if this was DUE TO the partnership since UNICEF and other organizations and factors played significant roles, but they felt that the partnership was probably a contributing factor.

While some grant writing seminars were held, they felt more could have been done in this area since it is so complex. Fundraising was a new area for them – collecting funds was not a typical way to raise money for the hospital prior to the partnership. The Croatian Children and Family Association was created to raise money for the hospital in New York and in Croatia. It was successful in NY but donations were more modest in Croatia. Nonetheless, they were able to purchase a new CAT scanner and now have been seeking funds for a new MRI. The Association no longer exists but donations can be made directly to the hospital.

Some of the greatest successes were achieved in the Cardiology Service due to the young and brilliant physicians on that service – which the US partners immediately realized.

In the Psychiatry Department, there was much collaboration on developing programs for children suffering from PTSD and for psychotherapy for victims of the war. The psychiatrist from Zadar is a specialist in leading Ballant Groups and he was able to train the US partners in this technique. An outpatient unit for children and adults for psychotherapy was initiated by the partnership.

The number of cardiac catheterizations has continued to increase (680 in 2004, 460 so far in 2005). An angiogram machine was donated by the Franciscan Sisters. The catheterization lab was moved to the Cardiology Department and also renovated. They felt initially the partners focused on training that was too basic and instead their needs were for equipment and materials (since they were at the same skill and knowledge level).

A Geriatric Unit that was created at Biograd Hospital. However, this unit was dissolved and integrated into the Orthopedic and Rehabilitation Units after legislation on this issue was passed.

Arthroscopy was introduced at Biograd Hospital and is practiced today. The original equipment donated by the US partners has already had to be replaced 3 times. Arthroscopy remains same day surgery.

Sustainability:

Most of the new practices and approaches are still in practice today. The notable exception is Biograd Hospital where all partnership activities ended when the hospital director died suddenly in 2000. They had plans for continued exchanges of orthopedists from Zadar traveling to Greenville, SC but there was no one to take over the partnership on the Biograd side. However, arthroscopic surgery is still performed at Biograd Hospital (by 4 out of 7 orthopedists) and adequate training of new physicians in this technique can be done at there.

Some maintain contact with the US partners. The spectrum ranges from continued collaboration on scholarly research (child psychiatry) to occasional professional exchanges by email to purely social exchanges around the holidays. The partners in psychiatry in particular have remained collaborators on a number of presentations and articles.

Replication:

The LRC director has served as a trainer to other AIHA LRC sites including Kazakhstan (2001), Russia (2001) and Kosovo (2004).

The Infection Control staff have shared and transferred their experience to the Biograd Hospital and a psychiatric hospital on a nearby island.

Recommendations From the Partners:

- English language classes since “knowledge of English was important to the success of the partnership”
- Evaluate partners individually. They felt that AIHA considered the level of health care to be the same as in the NIS and therefore made the program at the same level whereas they expected a higher level program and did not need to be taught the basics.
- The success of the partnership depends on the people involved – it is important to find motivated people.

LRC

Due to hospital budget limitations, they were not able to implement all they saw.

The head of the LRC traveled to US in 2000 to visit hospital libraries and attend congress on medical informatics.

The LRC started with 3 computers but realized that was not a great model since physicians and nurses are busy and found it frustrating to make time to go to the LRC to find the computers occupied – goal is make the whole hospital an LRC with PCs in every work space (they already have 300 computers now,

plan to add another 50 to reach their target of covering every work space). They are also developing a hospital information system. Access for nurses will be limited to head nurse.

Trainings were done on how to do medline searches (the LRC director knew how to do these, did not need to be taught through the partnership).

The LRC director uses the AIHA website for distant courses and posts questions and responses on the open forum on bioinformatics.

NRC

The NRC opened in 1998 but closed in 2000 during hospital renovation. They hope to reopen it (in a new location) when the renovations are completed. The nurses must find available rooms in the departments for their educational activities. There is limited interest and available time for nurses to visit the library and use the internet.

Zagreb-Lebanon

Type of Partnership: Hospital

Period of AIHA Partnership Support: 1994-1998

US Partners:

Dartmouth-Hitchcock Medical Center

CEE Partner:

“Sveti Duh” General Hospital, “Dr. Fran Mihaljevic” University Hospital for Infectious Diseases and “Srebrnjak” Children’s Hospital for Respiratory Diseases.

The partnership focused on targeted, measurable improvements in the quality of care, clinical outcomes, functional status, and patient satisfaction in a variety of clinical areas, according to individual hospital needs. Concepts of continuous quality improvement, leadership development, infection control, nursing, pharmacy management, and critical care medicine were also introduced across all partner institutions. Specific objectives by area and partner institution are listed below.

Management, Leadership, and Continuous Quality Improvement (CQI):

- Develop capacity for long-term change in thinking about work in the following areas: clinical, operations, finance, management, teams, and planning.
- Plan and implement improvement cycles with specific results measured, in many cases, by statistical process control charts and survey instruments.

Infection Control:

- Develop interdisciplinary, comprehensive infection control programs in each partner hospital, applying measures of quality outcome criteria.
- Develop country-wide standards for laboratory protocols.
- Design and implement a national infection control conference to disseminate learning, methodologies and tools gained through partnership.

Nursing:

- Improve nursing management and leadership by increasing nurses’ skills in these areas.
- Implement a human resource model for nursing practice at Srebrnjak Hospital as a pilot for dissemination to other hospitals.
- Disseminate partnership nursing lessons learned and activities to nurses throughout Croatia.
- Develop a Nursing Resource Center (NRC) in Zagreb, Croatia.

Pharmacy Management:

- Improve pharmacy services at all three partner hospitals by developing specific improvement projects at each hospital. For example, establish unit-dose distribution system at Srebrnjak Hospital.

Critical Care Medicine:

- Establish measures of quality outcome criteria for critical care medicine.

- Develop and establish a collaborative practice model for critical care practitioners.
- Develop methods for assessing and responding to issues of “burnout” in critical care providers.
- Develop a core faculty of critical care providers to act as resources and educators to continue improvement work in the area of critical care medicine.

Asthma and Tuberculosis (Srebrnjak Hospital):

- Implement a comprehensive asthma program (CAP) at Srebrnjak Hospital by assessing clinical capabilities, understanding US outpatient management of asthma, developing clinical skills, and developing patient/family education activities.
- Establish a TB referral center at Srebrnjak Hospital by assessing TB clinical capabilities, providing in-depth training in diagnostics and treatment of TB, and developing additional resources.
- Disseminate partnership work in asthma and TB to wider health care community in Croatia.

Hepatitis (University Hospital for Infectious Diseases):

- Develop a Hepatitis Reference Center and increase early identification and outpatient management for Hepatitis B and C.

Chronic Renal Disease (Sveti Duh Hospital):

- Develop an interdisciplinary team approach to management of dialysis patients with a goal to improve the functional status of the patients.

Women and Infants Health (Sveti Duh Hospital):

- Improve the clinical management of low birthweight babies in the neonatal intensive care unit.
- Improve methodology for in-vitro fertilization procedures.
- Improve the organization of delivery service for obstetrics.

Success Toward Objectives:

Overall, the partnership met their goals in these varied areas (see details below). We were not able to assess the contribution to pharmacy management as we were unable to meet with a pharmacy representative.

Human Capacity Development:

Training Skills/Professional Skills

One physician was able to confirm that her molecular lab is functioning at a high standard by visiting a similar lab at the US partner institution. She also saw some practices she didn't like and felt was able to learn from the mistakes made by the US partners. Observation of the organization of the lab in the US and the computerization and integration of data was useful as the Croatian partners re-organized and planned for computerization.

Appreciation for Usefulness of Data

One physician claimed he was the only one promoting universal precautions and the partnership added credibility to his cause and got other physicians on board.

Improved Status for Nurses

Unanimously, the greatest benefit from the partnership was an improvement in the status and role of the nurses in patient care and decision-making. The management training the Zagreb partners received was useful in promoting different ways of thinking including a less dictatorial relationship between physicians and nurses and more of a collaborative, participatory problem-solving approach.

Specific benefits to the nurses cited were:

- Role of nurses better appreciated
- Nurses more actively involved in providing patient care
- Nurses considered members of the clinical team (partnership helped establish these teams)
- Nurse opinions sought in decision-making, especially in the critical care unit
- Nurses learned how to argue persuasively and make “their case”, which allowed them to effectively change the thinking of those around them (in addition to changing their own thinking)
- Nurses were able to relate to nurses from the US as peers, which helped build their confidence
- The study of decubiti care was the first collaboration of its kind between nurses and doctors, now nurses are in charge of managing decubiti
- A 4-year university-level degree program was created for nurses (previously only a 2-3 year post-high school program was the highest degree available)

CQI

The partners used a CQI technique to monitor nursing time spent transporting patients to other hospitals for CAT scans (since a nurse must accompany each transfer). The results of this evaluation led to the hospital administration deciding to buy its own CAT scan machine. Another CQI project aimed at improving patient food quality resulted in a renovation of the kitchen facilities and revised food transport system.

New Mindset

The partners felt the major lasting change from the partnership is in the way they approach patient care, including parental involvement and access to their hospitalized children. It was “an attitude change” that shifted the focus of care to the patient (rather than to the providers). They observed how care is delivered in the US during the exchanges and jointly decided to make these changes in care delivery. Some of these changes required hospital policy changes as well (e.g., rules and regulations for parent visitation and rooming-in with their children).

In the US, the partners also observed a different management approach that used more inclusive decision-making.

Seeing how HIV/AIDS patients are cared for in the US helped lessen the anxiety of the Croatian nurses providing care to and drawing blood from HIV-infected patients.

They learned “a different way of thinking”. It was good to “feel someone cares about us after the war”.

Institutional Capacity Development:

Standards, Guidelines and Protocols/Management

Numerous nursing protocols were created through the work of the partnership. Examples include: care of decubitus ulcers, insertion and care of foley catheters, obtaining and handling blood cultures, bathing patients, and care of dying patients.

They felt the management and leadership training as well as seeing how hospitals were organized was useful. However, there are some management and care practices that they have been unable to fully implement in the CCU due to lack of time. They also did a survey of CCU staff to assess “burn-out” and found that their staff are not “burned out”.

The partnership “accelerated but didn’t transform” them.

Equipment

Some equipment was donated through the partnership to the microbiology laboratory, the Neonatal Intensive Care Unit, the LRC and the NRC. However, it was noted that the NICU equipment already needs replacement.

Ability to Build Upon and Expand Partnerships

The nurses talked about the partnership whenever possible and invited outside nurses to their workshops; some of those nurses later became the leadership of the Nurses Association, therefore they suppose that the partnership may have indirectly led to the formation of the Nurses Association.

The partnership helped them to build and strengthen other USA links. Especially important to Sveti Duh Hospital is the relationship between the microbiology department and the Centers for Disease Control and Prevention.

At Infectious Disease Hospital, they have established a collaborative relationship with UCSF through some joint HIV research activities (NIH-supported).

Evidence-based Medicine

To equip the LRC, AIHA provided: a computer, a scanner, CD-ROMS and individual email accounts. Now the hospital has its own LAN and each physician and nurse has their own email account. Now each department has its own computers for use in common areas.

The first time the head of the LRC heard the term “evidence-based medicine” was from the US partners. Medline searches used to be done only by librarians but they have now trained physicians and nurses to do them. In 1998, the LRC was the first site to have access to Ovid (a medical search tool) in addition to medline and the Cochrane Database.

The head of the LRC attended workshops in IT and medical searches, web page creation and trainer of trainer methodology. The LRC now functions much like a technology/medical informatics help desk.

The partnership made clear to them that they need some unified medical information system – previously they had one system for each department. Now they have a team for computerization of the hospital information system – 3 of the 5 members of this team were involved in the partnership.

The LRC staff use the AIHA website to locate some educational materials, mostly training materials, and downloaded their brochure.

The nurses are becoming more interested in resources available in the LRC, though they have less time due to their patient care responsibilities.

Medical literature searches are now done for research, clinical decision-making, and the development of guidelines (the latter are reassessed and updated regularly). At the Infectious Disease Hospital, they conducted a study of care of decubiti (the idea to do this evaluation came from the partnership).

New Services/Responsive Services

- Changes in pediatric visitation and rooming-in policies for parents (more family-centered policies)
- Pediatric day hospital for walk-in/urgent care and scheduled day treatments or procedures (e.g., IV antibiotic therapy), opened in 2002 – resulting in fewer pediatric admissions (estimated decreased by 30%)
- Improved infection control practices (already had a committee which monitored nosocomial infection rates and had some policies in place but these were expanded)
- Changes in critical care visitation policies (did a study which showed they didn't need to prohibit visitors to the critical care unit by tracking the nosocomial infection rate)
- Flexible wards and staff (that can be contracted and expanded as needed) were implemented
- Established care teams in the Critical Care Unit and Renal service

It was noted that some ideas/programs/procedures observed in the US were not applicable or desirable for their setting (i.e., partners acknowledged that everything in the US was not necessarily “better” or “preferable” to what the Croatians had established). For example, the US partners showed how they had decreased spending on drugs, but when Sveti Duh Hospital did the same evaluation, they determined they could not achieve the same savings.

Sustainability:

Many of the programs and policies developed and implemented during the partnership are still in practice today. For example, patient satisfaction surveys are still in use as well as clinical teams on the critical care and renal services. In addition, the emphasis on training for nurses has continued after the partnership.

Replication:

The physician partners have not disseminated their changes in management or patient care to other hospitals. However, at least one nurse presented the results of their decubiti study to nurses in Split. While most found the AIHA conferences enjoyable, they did not establish any contacts with other potential partners or colleagues. They felt they gave their talk and that was the end of it. They felt it most useful when the conference was held in Zagreb and open to non-partnership Croatian institutions as they were able to relate and establish linkages with their other Croatian colleagues.

They have had professional visitations to the HIV/AIDS ward so suspect others are taking away information on universal precautions.

Nursing Resource Center

It is still functioning and trainings occur there approximately 4 times a month. It is used at least one day by nurses or students. The computer is not functioning and needs to be replaced. The NRC was the first place in the hospital for the nurses to have access to the internet. Beginning in 2005, nursing trainings will

be accredited by the RN Chamber Association. The Chamber, established in 2003, has adopted many of the protocols and job descriptions prepared through the partnership.

Recommendations From the Partners:

- English language classes would have been useful
- Do not use a “one-size-fits-all” approach – not having done a true assessment the partnership started off with training that was too basic for them

HIV/AIDS Stigma and Discrimination

Type of Partnership: Grant

Period of AIHA Partnership Support: 2004

CEE Partner: Stampar School of Public Health

The AIDS Stigma initiative in Croatia with the Stampar School of Public Health focused on the language used in the media to portray those afflicted with HIV/AIDS. Croatia is in the early stages of responding to the serious issue of HIV/AIDS stigma and discrimination. The process of identifying and involving key stakeholders in a discussion of the topic and targeting the media for education about the issue was an important first step toward raising the awareness about the right to privacy and the human rights of the people with HIV/AIDS. However, the product of the meeting, a booklet on HIV/AIDS was a very basic document that did not incorporate international state-of-the-art knowledge, information or thinking about how to deal with stigma. This activity would have benefited greatly from a partner (US or regional) with experience in dealing with HIV/AIDS, to assure a more substantive discussion of the issues. Funded as grant in 2004, it is too early to tell what the lasting impact of the effort will be.