

**ASSESSMENT OF THE AMERICAN
INTERNATIONAL HEALTH ALLIANCE (AIHA)
PROGRAM IN CENTRAL ASIA**

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1. Statement of Work and Assessment Method

a. Schedule and Team

The assessment was commissioned by the USAID Central Asia Regional Mission, under the direction of Jennifer Adams, who is in charge of health and population programs in the region. Two investigators, an independent consultant, Robert Simpson, and an USAID/E&E Bureau senior public health expert, Paul Holmes, were selected to carry out the statement of work. The Mission provided two and a half weeks in the field and about one week for writing the report. Simpson has prior USAID and international health experience. This was Simpson's first visit to Central Asia. The USAID staff member, Holmes, had played a leading role in assessing the first phase of the overall AIHA program and designing the current second phase. Because of family illness, Holmes had to leave the team at the beginning of the trip. Simpson continued the trip, however, and wrote this report. Holmes has reviewed the report.

Representatives from USAID/CAR and AIHA participated in almost all the visits. Mary Skarie, USAID/CAR Project Officer for ZdravPlus, joined Simpson in Kyrgyzstan. Jennifer Adams participated in the visit to Turkmenistan. James Smith, AIHA's Director, or Associate Director Don Harbick participated in most of the field visits. The visit was well organized and administered by USAID and AIHA. All the participants were open and responsive to the assessment. Dr. Zhamilya Nugmanova, the AIHA Regional Director, and Dr. Shulpan Makhmudova, the USAID project officer, were primary and indefatigable resources for the evaluation effort. Their judgments and effective collaboration determine to a large extent the achievements of the AIHA project in Central Asia.

b. Which AIHA partnership activities demonstrate a comparative advantage in a technical field? How can USAID build upon and focus these activities for future, on-going implementation?

The assessment was rapid and the schedule was full, with barely two weeks in mid-May 2001 spent visiting AIHA activities in three Central Asian countries. Visits were made to four current partnerships in Kazakhstan, Kyrgyzstan and Turkmenistan:

- Astana City Family Medicine Center and Mercy Health System in Pittsburgh, Pennsylvania;
- Kazakhstan School of Public Health and the Virginia Commonwealth University (VCU) in Richmond, Virginia;
- Kyrgyz State Medical Academy (KSMA) and the University of Nevada School of Medicine, at Reno, Nevada;
- Turkmenistan Ministry of Health Primary Care Training Center in Ashgabat and the University of North Dakota and North Dakota State Health Department.

The assessment visit also included five completed activities carried out by the Almaty City-Tucson partnership. Activities in Uzbekistan (the National Center for Emergency

Medicine in Tashkent and Ferghana Region and the Grady Health System in Atlanta, Georgia) and Tajikistan (the Republican Education Center for Family Medicine and Boulder Community Hospital in Colorado) were not included in the assessment.

The assessment mainly compares AIHA's program capabilities with USAID's program needs. The key question is not so much whether AIHA did a good job, but whether it was the right job strategically. How well does AIHA contribute to achievement of USAID's Central Asian Strategic Objectives for health? Recognizing that the USAID Strategic Objectives for health have recently been revised, how can AIHA's objectives be brought into closer alignment with the S.O.s? Are the chosen problems and partner situations importantly related to the Strategic Objectives? Are AIHA's capabilities -- as determined by the nature of the AIHA organization, the nature of the partnerships, and the characteristics of the regional activities -- appropriate for the challenges of the USAID/CAR strategy and for health reform in the region. What has been learned from AIHA's activities? How do the results advance health reform in the Central Asian countries?

For example, the most successful partnership activity – measured against the planned objectives for that activity – may be the Toxicology Center in Almaty. The question for this assessment, however, is how this successful activity is contributing to reform of the health sector in Kazakhstan, particularly in line with USAID's Strategic Objectives. There may be a reduction of USAID health funds in the Region soon. Because of limits on USAID funding, whether AIHA activities contribute significantly to health reform in Central Asia is an important question for the CAR Mission. The conclusions of the assessment are intended to inform Mission decisions about the most effective uses of the AIHA program in Central Asia.

- c. How can the local management and administrative capacity of the AIHA regional office, staff and structure, increase its overall effectiveness and efficiency?

AIHA's senior managers in Washington and the Central Asia Regional Office work as a team, so consideration of effectiveness and efficiency must be in terms of the whole team's performance. Nevertheless, the report contains recommendations about how USAID and AIHA managers can interact for greater benefit to the USAID health program. AIHA's relatively long history working in the region has produced a rich network of relationships with health experts and officials in each of the countries. By travelling with the AIHA staff, this assessment provided good opportunities to observe the AIHA team at work with the network of health experts and officials in the region; these interactions were fruitful, producing new insights for AIHA about health reform. Some of the observed interactions were between AIHA managers and USAID staff; these interactions were less fruitful, with relatively limited exchanges of information and few examples of consensus about strategic action. More effort is needed by USAID and AIHA senior managers to achieve productive levels of communication. The opportunities to observe routine AIHA management and administration were limited; judgments in this area must be by inference from interviews and documentation.

2. Characteristics of AIHA's Program in Central Asia

AIHA accounts for about 20% of the USAID budget for health and population activities in Central Asia. AIHA is an important USAID resource for clinically-related service delivery activities and medical education. USAID's main health project, ZdravPlus, concentrates on policy, planning and regulation of health reform, which involves reducing the number of clinical sites and shifting resources towards primary health care. The emphasis of the ZdravPlus consortium led by Abt Associates is at the macro-level, together with extensive service-delivery activities in Kyrgyzstan, in Kazakhstan, and with imminent expansion in Uzbekistan. Project Hope has the lead with tuberculosis control, and the Centers for Disease Control with clinically-based infectious disease control and sexually transmitted diseases.

a. AIHA Partnerships

AIHA Partnerships are formed between Central Asian health institutions and consortia of U.S. health organizations. For example, the Turkmenistan Ministry of Health's Primary Care Training Center is in partnership with five U.S. organizations under the leadership of the University of North Dakota. Sometimes one U.S. consortium will work with multiple Central Asian partners. In Almaty City, the Tucson partnership worked with the Women's Wellness Center, the Toxicology Center, the Kazakhstan Medical Academy, Emergency Medical Services and with Nursing academies. Partnership purposes are well defined, and translated into work plans organized around activities and interactions among the partners – training, curriculum development, workshops – that bring about an exchange of ideas and the professional support for implementing the ideas, usually with some funds for local costs and equipment. About 45% of the AIHA Central Asia planned budget were allocated for Partnership Packages, 31% for management, and 24% for regional and program support activities that are directly managed by AIHA. The financial value of the Partnerships is understated because the salary and related costs of the experts are not included.

The first notable fact about the partnerships is that the U.S. partners commit their institutions with the understanding that the staff time from their organizations is a contribution to the partnerships; the U.S. staff is paid by their U.S. organization without reimbursement from USAID. The U.S. staff members typically report that their personal initiative was an important factor in motivating their employing organization to work in an international, cross-cultural project. Often the Partnership is the first international work experience for them; they are not yet in the ranks of international experts. For the project to be successful, high personal commitment must often compensate for lack of international experience. The volunteers have a steep learning curve, and their motivation enables them to overcome obstacles, often big obstacles such as frustrating bureaucracies. The age and backgrounds of partners suggests that the 'volunteers' are high performers seeking additional challenges. Because the U.S. team is drawn from

U.S. domestic organizations, recruiting specific skills and personality types that will be effective across cultures is not an easy task. The lead U.S. partner's recruitment of consortium organizations and individuals is a key determinant of project success.

A competitive selection process, organized for all partnerships on the same time cycle, allows AIHA headquarters management to select the most appropriate U.S. partner from the group of bidders. To guide the selection process, the AIHA headquarters managers' understanding of the specific requirements for a particular partnership, on both the U.S. and Central Asian sides, is another important determinant of partnership success. The frequent, relatively intimate discussions that AIHA regional and headquarters managers have with Central Asian participants, in the U.S. or in the region, talking about current problems, anticipating future needs, divining trends in both donor and national policies, trying out regional ideas, are important inputs to the partnership brokering process. The fact that these conversations have been going on with the same small team of AIHA managers for almost a decade is obviously a significant asset for AIHA and USAID.

The second notable fact about the partnerships is that they are for relatively brief time periods, generally three years, with possible extensions, but only up to a total of five years. Part of the explanation for the short periods is the relatively tight rein that the USAID procurement process imposes. Some of the explanation comes from the short planning time periods common in USAID a decade ago in developing the programs for Eastern Europe and the former Soviet Union, when the AIHA program was designed. Perhaps another factor is the recognition that volunteers and their organizations working in difficult circumstances should not be held to long-term commitments. A significant consequence of the short time periods, in a project where most of the planning process is internal, is tailoring of partnerships to short term results. The information in the balance of this report will indicate that AIHA has been remarkably successful working within the constraints of very short time periods. Given the short time periods, what program objectives are being foregone, or more likely not even considered, because of the pressure for quickly accomplished objectives. Perhaps the longer-term strategic planning that occurs in USAID could compensate for short-term project thinking, by helping AIHA see how their activities fit into USAID's longer-term strategy. The interaction between USAID and AIHA on longer term planning issues has not been substantial nor very fruitful as yet.

The third notable fact about the Partnerships is the relative insulation of the partners themselves from the USAID programming process. The AIHA staff handles interactions with USAID, so the U.S. partners' staff are not drawn into the USAID programming process and diverted from the Partnership activities. Nevertheless, the Partners are developing valuable insights about health reform through their Partnership activities. USAID and AIHA should consider ways to introduce the Partners' insight and experience into the USAID planning process.

b. Regional Activities

About 24% of the planned budget for the Central Asia Health Partnership Program is programmed by the AIHA regional and headquarters offices, rather than by the Partnerships. Of this amount:

- 42% (10% of the CAR total) is for collaborative regional initiatives such as infection control activities and nursing,
- 29% (7% of the CAR total) is for program support activities such as conferences, and
- 29% (7% of the CAR total) is for continuing activities from the prior partnerships such as Sustainability Grants and support for learning resource centers and internet connections.

Nine Central Asian regional initiatives were included in the five-year budget forecast, from FY 1999 through FY 2003, anticipating that one or two initiatives would be emphasized every year, as follows (\$thousands):

Initiative	Emphasis Years in bold					5yr.Budget
	99	00	01	02	03	
Emergency Medical Services	126	9				134
Infection Control/WHONET	25	101	105	15	15	261
Health Professions Education		7	93	20	20	140
Nursing	28		74	50	25	177
Primary Health Care		8	91	100	60	258
Women's Health	22	5	23	25	10	86
Neonatal Resuscitation			12			12

Each of the initiative areas is related to programs at the country level. The work plan does not document well the criteria for selecting these particular initiatives. The AIHA practice is to vet informally and systematically possibilities with host country officials and U.S. Partners and subsequently to propose priorities to USAID. The Emergency Medical Services initiative relates to the Uzbekistan Ferghana Valley activity launched in FY 1999 on a fast track, and to the EMS activity in Almaty under the prior cooperative agreement. The education items correspond to the region-wide interest in reforming the medical and nursing schools, for example, joining with *Zdravplus* to support leadership at the regional Rectors' Council. As rationale for supporting these initiatives, AIHA cites linking country efforts to get regional support, e.g., for regional professional associations which can affiliate with U.S. professional groups. During the assessment, the Rectors' Council and the nursing associations were credited with effectively reinforcing country-specific efforts.

The largest regional initiative, infection control, was addressed through the Almaty/Tucson Partnership, one of the previous set of Partnerships. Although infection control is not prominent in the current partnerships, hospital deaths due to infection are an important issue in the region. To continue this effort, AIHA supports technical contributions from CDC and WHO to reduce infections in hospitals (nosocomial infection). The residual infection control activity in Kazakhstan, supported by the earlier

Tucson partnership, is struggling and needs stronger leadership and support within the bureaucracy.

c. AIHA Program Support Activities

Regional Program Support activities are mainly administered by AIHA staff to supplement resources available through the partnerships, mainly for two purposes: (i.) when centralizing of functions is cost-effective, e.g., for translation of documents, or (ii.) when strategic use of funds by AIHA managers can gain support for the program, e.g., by inviting officials to events that may open their eyes to the benefits of AIHA programs. The largest item, travel costs for conference participants not covered by specific partnerships, accounts for about 6% of AIHA's total budget for Central Asia. USAID country level officers noted the long lists of invitees for AIHA conferences, and expressed difficulty in judging the value of such extensive participation. During the assessment, Central Asian officials cited the trips to U.S. partnership sites and to specific U.S. organizations, such as the U.S. medical school accrediting organization as very valuable. The more general conferences were not cited, perhaps because the purposes were less specific, although still influential. Tracing the developmental benefits of bringing decision-makers to the annual AIHA conference would require extensive detailed analysis. AIHA's senior managers have well-developed, keen judgments about the roles of key decision-makers in Central Asia. Perhaps the questions for USAID are (1.) whether the political capital accrued at these events leads to decisions that are developmentally sound and consistent with the USAID regional and country strategies, and (2.) whether the portion of the budget is reasonable.

Sustainability Grants, about \$324,000 committed in FY 1999 and FY 2000, for completing activities started by the previous set of Partnerships were specifically looked at in this assessment only for the Almaty City - Tucson partnerships.

3. USAID'S Health Sector Reform Program in Central Asia

USAID/Central Asia Strategic Objective 3.2 encompasses a primary outcome of health reform, targeted at Kazakhstan, Kyrgyzstan and Uzbekistan: "Increased utilization of quality primary health care in select populations." The *Zdrav Reform* discussion of transforming primary health care (Conceptual Foundations for Central Asian Republics Health Reform Model, September 1999) outlines the challenge presented in the cities by resistance to Family Group Practices by well-entrenched polyclinic managers. The *Zdravplus* document expresses concern that a lag in improving the quality of primary health care is threatening the restructuring of the delivery system. If the clients lose confidence in the quality of primary care, the support for health reform will erode. The document urges testing of new models of primary care, and notes "The family group practice is the key institutional change needed to accomplish integrated reform of the health financing and delivery system."

During the assessment in each country, the resistance of health professionals to the shift to family medicine was a prominent topic, for example, explaining the lack of momentum for health sector reform in Kazakhstan. In Kyrgyzstan health reform is moving more quickly with strong direction from the Minister of Health, despite ambivalence among senior professionals in the system. Even though policy decisions to pursue health sector reform were made four or five years ago, there is no consensus about a clinical model or example of how to organize health services around family group practices. The problem is mainly in the urban areas. The questions are about quality of care and about use of the existing experts and staff. This lack of momentum for reform, uncertainty about the right clinical model and how to proceed towards it has motivated AIHA to give top priority to supporting the shift towards primary health care. The priority for primary health care was also mandated by USAID's request for applications. ZdravPlus has been supporting pilot service delivery activities in Kyrgyzstan, mainly through STLI. Both ZdravPlus and AIHA are supporting the education and retraining of health professionals to prepare them to deliver primary health care using the family medicine approach. Project Hope is focused on tuberculosis control. Success of future USAID disease control programs, including tuberculosis and AIDS, will depend on the effectiveness of the primary health care system.

AIHA can reasonably argue that its programs are on target, consistent with and supportive of the PHC objective: virtually all of its' partnerships and regional activities are attempting to improve the quality and cost-effectiveness of primary health care, either directly at the service delivery level or indirectly through training and education of health professionals. The emphasis of AIHA activities is on clinical care rather than health financing or macro-level analysis, although health management is an important educational area for AIHA. Partnerships in the previous phase introduced new delivery approaches in special areas of primary care medicine, emergency medicine and toxicology. The current Astana partnership is grappling with delivery of comprehensive family medicine at a community clinic, a more difficult task. Given the breadth and depth of clinical issues surrounding the transformation of the health system, AIHA's emphasis on clinical care is critically needed for the reform effort. (Although the purpose of this report is not to assess the overall USAID health sector program in Central Asia, the comments of interviewees suggest that clinical issues have not received enough attention given their complexity and importance for health reform.)

In the assessment below, the author explores AIHA's contribution towards achieving Strategic Objective 3.2, attempting to determine:

- the extent to which AIHA and USAID have chosen strategically useful activities,
- the extent to which the AIHA project is appropriate for the tasks,
- the extent to which the experience from the AIHA activities will help to resolve important issues about reform,

- the extent to which the education and training institutions supported by AIHA will give health professionals the skills needed to move reform forward.

4. The Context for the AIHA Program: USAID's relationships with AIHA

The cooperative agreement between USAID and AIHA for Central Asia was initially negotiated and approved in Washington based on the USAID/CAR Mission's statement of health sector objectives at that time. This agreement was one of a set of five agreements with the Europe and Eurasia Bureau defining AIHA's role in the New Independent States. The complexity of managing this set of agreements would be a challenge for any organization. Because USAID is a decentralized organization, authority for funding and managing Central Asian programs is delegated to USAID/CAR. In the case of AIHA, however, through definition of the terms of the regional agreements, USAID Washington has retained responsibility for ensuring that various sub-regional agreements reinforced each other and contributed to Eurasian regional objectives. USAID Washington also oversees AIHA's performance in organizing a total effort that meets USAID's needs expressed in the five agreements. Furthermore, the network of U.S. partners, representing many States, comprise an important constituency for USAID/Washington in meeting the needs of the Bureau's many programs. As a result, there is some tension between the Agency's management objectives. Washington created the overall program with the presumption that Missions will use health partnerships to implement the regional and country programs. Missions are accustomed, however, to deciding what organizations will be selected to achieve program objectives, because the Mission provides the funding for field programs. Furthermore, USAID/Washington holds Missions accountable for achievement of regional or country program objectives. Because of Washington's responsibility for overall partnerships program, the Missions are a little unsure of their authority vis-à-vis AIHA. Not surprisingly, therefore, Missions are sensitive to any actions by AIHA that may suggest AIHA does not recognize the Mission as its guide for setting the direction of the program. AIHA, on the other hand, believes that changes in Mission staff can bring abrupt changes in program direction, leaving AIHA's programs at odds with the Mission strategy.

USAID has given to AIHA substantial discretion in directing the program, consistent with the terms of a Cooperative Agreement. Under a cooperative agreement, responsibility for determining the course of action within USAID's broad scopes of work is left with the grantee. Nevertheless, for AIHA, managing the five cooperative agreements involves active, if not day-to-day, relationships with many USAID offices and individuals. In addition, of course, AIHA maintains relationships with many U.S. partners and with the country officials and partner institutions where programs are being implemented. One of the challenging tasks for AIHA's small management team each day, is how to satisfy the needs of so many clients and partners.

Complexities arise when the many USAID clients, in Washington, in Regional Offices such as Almaty, and in the individual countries are all working with AIHA directly and

perhaps concurrently. (In most countries, U.S. Ambassadors are also interested and active clients.) There are bound to be differing, maybe contradictory, ideas about program directions coming from USAID. USAID has considerable experience with this management issue; it is handled by constant effort to communicate horizontally and vertically within the organization.

AIHA has a small, very experienced team of managers at headquarters and in the regions, so communications and coordination within AIHA are more easily handled than in USAID. Moreover, within AIHA authority for most programming and financial decisions is retained at headquarters, so the question of how to deal with USAID on particular matters is mainly determined at AIHA headquarters. There is an incentive for AIHA to limit communication with Missions about program strategy: fear that Missions will raise new and unforeseen demands can arise under the Cooperative Agreement's broad scope of work. To limit this risk, it is not surprising that AIHA concentrates on communications with U.S. and Central Asian partners where AIHA has control over resources and implementation actions.

In addition, when the client -- USAID -- has multiple representatives, it is tempting to choose the most compatible voice among them. That AIHA has not done so, but openly engages with USAID at all levels, is a tribute to the confidence and skill of the organization and its managers. Nevertheless, the fact that this assessment was commissioned suggests that AIHA and the USAID/CAR Mission are not in complete agreement about the strategic and/or programmatic choices in the Central Asian Region. A central purpose of this assessment is to suggest ways that AIHA and USAID/CAR can come to a better understanding about program direction and can sustain that understanding, even if there are changes in staff or shifts in USAID program strategies. **The common ground for USAID and AIHA is a clear and realistic view of the needs for health sector reform in Central Asia.**

Because USAID and AIHA operate very differently, it is difficult to mesh USAID and AIHA at the strategic level. The centralization of authority at AIHA contrasts with decentralization in USAID. In addition, USAID as an organization has an exceptionally complex system of program planning and management, as those involved with defining strategic objectives and results will attest. AIHA has a very informal planning process that occurs in an incremental way, typically in relatively frequent discussions with country officials,. USAID seeks the most effective investment opportunities through macro-level analysis of the health sector. AIHA draws on the experience of government officials whose analysis of the health sector has occurred over a lifetime, seeking energy and vision. USAID also engages these officials, as well as other donors, but relies substantially on quantitative and qualitative information, often analyzed by independent experts. Both USAID and AIHA are trying to understand what is the reality of the development environments in each country, and to develop a vision of what could be. Both organizations know the risks of playing to the local officials, who talk reform but are protecting political interests. USAID must also be mindful that AIHA is part of a Strategic Objective team of implementing organizations that are also potential

competitors, with financial and institutional interests. USAID seeks to be even-handed and promote cooperation.

5. AIHA's strengths and comparative advantages for USAID programs in Central Asia

AIHA has nearly a decade of experience in Central Asia. From the perspective of AIHA's managers, AIHA seeks to capture the energy/combustion of experience and ideas, and to define programs that have "traction", that have prospects for forward movement. AIHA relies on the wisdom of experienced leaders and uses observation visits to the U.S. to enable these leaders to envision change. AIHA seeks situations where there are good prospects for movement in the health system, where determined health professionals can manage change in positive directions. The Almaty Toxicology Center is an example, with copies spreading nationally. Sometimes political interests create momentum and bring support; AIHA is alert to opportunities such as the Health Minister's desire for Emergency Medical Services in the Ferghana Valley in Uzbekistan and an emerging interest in a similar program in adjoining Kyrgyz portion of the Valley. At the same time, AIHA is mindful that countries rather than donors determine the pace of change. In general, AIHA believes health sector reform in Central Asia is going about as fast it can now; sustainable change requires an orderly process.

In the following discussion of AIHA's program, activities are grouped in categories that represent important outcomes of AIHA programs that contribute to health reform. A particular partnership activity may appear in more than one category. A partnership with a Medical Academy could be included in two categories: "better teaching and clinical methods" or "raising professional standards".

The outcomes that AIHA produces with comparative advantage arise from the nature of AIHA's program:

- **Improved health care service delivery:** by seeing delivery of primary health care in the U.S., AIHA partners can select and adapt improvements in health service delivery, such as community outreach;
- **More effective health institutions:** by seeing health organizations in the U.S., AIHA partners can improve the structure and functions of community clinics or teaching institutions as models for national health system reform (however, basic reform or building capacity in complex institutions is beyond the capability of AIHA's limited inputs);
- **Better teaching and clinical methods:** by transferring and adapting curricula, teaching methods and clinical algorithms;
- **Raising standards of health professionals:** by seeing the functions of U.S. workers, new standards or roles can be developed and introduced for physicians and nurses.

These transfers from the U.S. to Central Asia are most successful when there is an easily grasped, underlying concept which fits well into the Central Asian Partner's vision

of health reform. It is more difficult to transfer the underlying management principles or strategies that produced the improvements in the U.S., although when the improvements begin to be replicated throughout a national system, this is evidence of more fundamental changes in management thinking.

a. Improved Health Care Service Delivery

The introduction of improved emergency medical services and a toxicology control center in Almaty and the introduction of community outreach for primary health care in Astana are AIHA's most exciting innovations in service delivery. Each innovation appears to provide cost-effective improvements in the quality of health care. All the activities are in Kazakhstan. Unfortunately, AIHA has not documented their lessons in an analytic way, so the results are less useful than they might be at the policy level and with donors. Nevertheless, in each case there is evidence of policy-level influence. Determining the importance of these innovations as contributions to national health sector reform will require careful analysis; however, such effective innovations in primary care are inherently interesting for the architects of health reform. How can improvements in specialized care, for emergency cases, traumas or drug abusers, be incorporated into a reformed health system? Can community outreach that educates families about how to manage chronic diseases reduce need for treatment in hospitals, and thereby reduce overall costs in the health system?

(1.) Emergency Medical Services (EMS) in Almaty

The Tucson partnership introduced an EMS system, an innovation that has been common in AIHA's programs elsewhere. This need was probably identified before health reform was a central topic in the USAID-AIHA discussions. The transfer of ideas, systems and standards has taken root and the changes are being sustained; the management systems for responding to calls, with constant medical monitoring, adherence to performance norms and follow-up supervision are evident. Because an EMS stands apart from the rest of the health system, is less integrated, changing the entire system is easier than reforming a polyclinic. Transferring a self-contained system where management control can be complete may be a relatively safe bet using Partnerships. The EMS service established during the partnership has been expanded substantially by the City with its own resources for equipment and staff, suggesting more than satisfaction with the results. Supplementary funds are being earned: the EMS includes a training team that is successfully charging for its courses. The day that I visited, the team was returning from training at an oil corporation facility paid for by the corporation. As a successful innovation, the EMS stands on its own, and is worthy of some analysis of the results to guide decisions about replication. Comparison with the Uzbek experience in Ferghana Valley would be useful in connection with any planning for Kyrgyzstan. Does an effective EMS become an important contribution to health reform, with what results in terms of reduced costs for the whole system and improved health outcomes for their clients. Interestingly, in-hospital emergency services in Uzbekistan are being linked with the intensive care services. As the Mission thinks about what innovations will further reform, an EMS might not be the first item on the list,

but it may be producing some surprising cost-savings and benefits, including benefits that lend themselves to marketing with the public.

(2.) Toxicology Center in Almaty

This Tucson activity had the most vivid success among the Partnerships visited. Selecting the outstanding manager, who has vision, determination, and discipline was the essential inspiration. The Learning Resource Center is the engine of the system; it is linked to an on-line/hotline emergency information service and to an emergency clinical facility. Although the Center is located in a City Hospital, the information on toxins is provided to requestors from throughout Kazakhstan. Almost half of the calls to the Center request on-line consultations for treatment. An effective laboratory was established under the Partnership to analyze poisons and to identify the chemical structure. A data base on patients with poisoning, that increasingly are alcohol and drug abuse patients as drug trafficking through Kazakhstan increases, already covers two oblasts and is slated for national coverage. Most cases are treated at home – 80%; nevertheless, the number of patients hospitalized has tripled since 1995.

Beyond providing emergency information and treatment, the Center defines its functions as teaching, research and prevention. The Center provides a one-month training course for health professionals – half lectures and half clinical experience – that is the region's alternative to training in Moscow. The training fee is modest. Training staff for replications of the center elsewhere is an important priority. The Almaty Center has taken on the responsibility of creating a national network of Toxicology Centers. Two have been established with the Almaty Center playing the technical assistance role that Tucson used in transferring the system from the Arizona Drug and Poison Information Center. The daily rounds at the clinic for practitioners culminate in a weekly presentation. The mortality rate at the Center and the length of stay have been steadily decreasing. The staff has produced 20 publications, including the Journal of Clinical Toxicology. The Center took the lead in establishing an Association of Toxicologists in Kazakhstan. Prevention is accomplished through public education. The Center has used social marketing concepts to develop broadcast material for television. The Soros Foundation has provided three grants for the prevention program. The Center also monitors labeling of pharmaceutical products for safety.

The Center was established as an Almaty City clinical site; however, it has become a national center. Every document prepared by the Center is sent to the Ministry of Health at the national level for review. The Center drafts national policies and was instrumental in the national directive to establish a network of centers. Support for the Center has been strengthened by good documentation of costs and effectiveness. The energetic Director did his Ph.D. dissertation on the cost savings from fewer admissions and less time in the hospital for admitted patients. The annual savings in the hospital system are double the City's cost for operating the Center. Information about costs and efficacy of treatment methods identified the relative ineffectiveness of expensive hemodialysis. Better training of ambulance service staff allows them to determine that 30% of cases don't require immediate admission.

The Director of the Center cites “understanding and development of *poison control* in Kazakhstan” as the essential ingredient needed for the Center. He credits the Tucson Partnership with transferring and establishing the concept of poison control. The Center is using management methods learned from Tucson, as well as methods for working with media, public officials and staff. The Director states that he can’t implement all his ideas, but Tucson taught him how to realize those ideas that he chooses to implement.

Like EMS, the Almaty Toxicology Center and the emerging national system are relatively self-contained with considerable internal management control of functions and directions for development. The poison control concept has been grafted onto the existing health system without much disruption of that system. The costs and benefits are relatively easily documented. (This is an example of ‘evidence-based’ programming that has persuaded government officials and donors to provide funding for expansion of services and functions.) From the perspective of health sector reform, how can this new system be incorporated into the scheme of primary care? Among the benefits might be growing public confidence in a health system that effectively handles drug abuse and poison emergencies.

(3.) Primary Health Care: Community Outreach

The Astana-Pittsburgh Partnership has adopted aggressive methods of community outreach to improve the health status of the catchment population for the newly opened Family Medicine Center (FMC) supported by the City of Astana. Other aspects of the Astana Partnership are also important and will be discussed below. The purpose of this section is to describe the successful transfer of community outreach strategies from Pittsburgh to Astana. Aggressive community outreach was not envisioned when the Partnership was first formulated. Visits of Astana City officials to Pittsburgh clarified understanding of how health problems are linked to the social environment. Professionals from Astana that are working in the community, notably a visionary school principal and the FMC Director, saw in Pittsburgh and understood how community action outside the clinic can prevent problems that might end up in the clinic.

The incentives underlying the rapid development of community outreach activities in Astana must be powerful because the scope of activity is large and dramatic. For the FMC, capitation payments give the health care provider incentive to keep the entire community of individuals healthy. In a community like Astana or Pittsburgh which experiences economic distress due to unemployment or social disruption due to a migrant labor force, illness and the threat of illness in families moves to a high position on the family agenda of concerns. For a school principal interested in developing leadership skills and preparing the life skills of students, maintaining good health is a strong motivator for introducing student responsibilities and instigating student action in the community.

The Pittsburgh Partnership Coordinator invited to visit Pittsburgh with an Astana team the Principal of the school in the FMC’s catchment area. After observation of school-

based health programs in Pittsburgh, the school activities developed in Astana this year are of two types: promotion of health for students through education and immunizations, and community involvement by teens working with target groups with likely health risks. The school has 2800 students in eleven grades, covering almost the entire catchment area. Health promotion for students done in cooperation with the FMC includes immunizations in the first grade and health exams in the 3rd, 6th and 9th grades. Health education includes a special class on safety, especially traffic safety, and classes under the guidance of the FMC gynecologist on pre- and post-natal care, sexually transmitted diseases and AIDS. (Other Pittsburgh-inspired changes in the school are elections of school leaders with active political campaigns, experience in conflict resolution and introduction of school uniforms.) Teen groups are formed in the 10th grade to work in the community with four high-risk groups: elderly citizens living alone, families with invalid children, single mothers and mothers with many children. Before launching, student leaders received training in the U.S. with conferences in Washington and Philadelphia to learn about teenage problems in the U.S., how they are solved, and who in the community solves them. This experience led to formation of a teenage club for health lifestyles, organized with the help of the FMC pediatrician. The student leaders were also given the skills to carry out community surveys in Astana, gathering information about traumas/accidents, family discord, infectious diseases like TB, sexual deviance and violence. In developing the program for elderly citizens, they solicited help from 40 organizations working with elderly. These initiatives involved education of parents about the value of uncustomary openness with children on topics of family welfare and sexual responsibility.

Another type of community outreach in Astana originates in the FMC, bringing large groups from the community to the clinic for education and aid with disease management. I observed a meeting of the Cardiology Club. The Director of the FMC is a cardiologist, so the clinic itself happens to have a well-qualified specialist for this program. The Club began in December 2000 to inform cardiac patients how to monitor and manage their heart disease. About 30 middle-aged or elderly citizens attended, 80% women, for a two-hour session. The Club meets on Saturday, a convenient time for the clients. An important incentive was free medicine for cardiac problems. The FMC had received a small grant to look at the question of whether the regular use of free medication would reduce needs for hospitalization (and costs?). Some people came from other catchment areas. A flyer on angina was distributed and explained, to give information about prevention of heart attacks. Blood pressure was checked and monitored in a personal record book, and often health management skills such as massage were taught. Participants with long-term cardiac problems attested that the health management skills learned at the Club had reversed the steady deterioration of their health condition. The FMC objectives for the Club included giving clients more ability to be responsible for their health, to prevent health crises and to reduce hospital admissions for cardiac problems.

The examples of community outreach have only begun, within the last five months, so it is early to judge their value. The important point is that these activities arose directly from the Partnership, and they provide robust examples of disease prevention and

health promotion in the community, in a population-based rather than clinic-based program. Both activities are locally developed and managed, so this kind of opportunity fits well into the Partnership model. Inspiration from the U.S. was a powerful motivator and generated an abundance of ideas which are being applied. Unfortunately the scale of community outreach was not envisioned in setting up the Partnership. There is not yet an organized effort to look at costs, benefits and effectiveness of these programs. Whether or not the Astana FMC becomes a viable model clinic for replication, the community outreach needs analysis to determine its usefulness in health reform. The Director of the Center and a key Partnership member from Pittsburgh thought it would not be too difficult for them to devise a modest data collection effort.

b. Demonstrating/Developing More Effective Health Institutions

Introducing new or redesigning existing institutional models is tricky business and to do so in a complete way is a long-term effort. There is certainly need for long-term institution building in the health sectors of Central Asian countries, but USAID 's current program time-frames don't permit this approach. Is it possible then to improve institutional forms, or introduce new institutional functions in the three-to-five year time frame for AIHA's programs or the standard five-year time-frame of any USAID project? Can such institutional changes contribute significantly to health reform?

In Central Asia, AIHA is working with two basic institutional forms: community organizations/clinics that deliver health services, and schools for health professionals. Service delivery institutions are responsible for the innovations discussed in the previous section. This section will consider institutional and organizational issues of delivery systems, without regard to the particular kind of services (toxicology) being delivered or to any particular aspect of delivery (outreach). In looking at AIHA's partnerships with schools, this section will again look at institutional functions and organization, rather than curriculum or teaching methods that will be discussed later. The question here is whether AIHA is effective in helping institutions structure themselves or in defining new institutional functions in order to significantly benefit health reform.

(1.) Family Medicine Center in Astana

The FMC in Astana is dealing with the Gordian knot of health reform in Central Asia, how to organize clinical services at the community level by using the Family Group Practice model. In this situation, the AIHA Partnership is not restructuring or cutting an existing knot, the Polyclinic; it is creating a new structure beneath the Polyclinic. Is a clinic providing family medicine for a sub-population within a polyclinic's catchment area -- but relatively self-reliant and independent of the polyclinic -- an appropriate model for urban primary health care? A key question for USAID, perhaps not fully analyzed when the Astana partnership was defined, is whether the scale of the FMC and the population it serves is a likely form to be considered in Kazakhstan's health reform. It is not clear. The Abt Concept Paper on health reform argues that family group practices must be formed away from the direct control of Polyclinic managers, like the rural clinics. On the

other hand, there is a strong argument for tackling the reform of Polyclinics directly, accepting that reform may not occur until it happens at the Polyclinic level. All of the structural and functional innovations resulting from the Partnership that are listed below might be used at a Polyclinic level as well as at a sub-clinic like the FMC. How these innovations work, how they play out, however, in a Polyclinic may be quite different from how they work in the FMC.

- Citizen Involvement: FMC Board

The concept of a Community Board to guide and to support the FMC comes from the Partnership. The Board has been functioning since 1999, so it is battle-tested. The Board sees its main purpose as gaining the authorization of the community and giving the community a strong role in guiding the FMC, a clear departure from the top down direction used in the former Soviet Union. Understanding of the community's role came from observing a Community Board in Pittsburgh. The membership noted that the style of management and approach to problem-solving used by the president changed following visits to Pittsburgh. Community institutions, such as the school principal, are active on the Board. Other resources, such as medical institutions and directors of government health programs, are active. The Board's important responsibility to advocate for funding from the Municipal Government has been effective, through facilitation by a Board Member who also sits on the Municipal Governing Council. The Board is prominent in the development of the FMC. This is an innovative organizational structure that has been effectively transferred and adapted through the Partnership.

- Policy-Level Influence

The FMC was resisted at the policy-level in the National Health Agency, and by senior officials in the Municipality. The clinical reforms, based on Family Group Practice, and the community involvement were not supported. Visits to Pittsburgh by Municipal Officials persuaded them that many health problems arise from the society, had their roots in families and the community, and they changed their position. The city decided to use per capita financing to reinforce the preventive/health promotion approach. The Municipal Government support, including financial support and provision of a site, was strong enough to counter the resistance at the National Health Agency. The demonstration effect of the Partnership's sponsored visits allowed the program to get started. Through this process, the Board learned how to be effective at the policy/political level. Both the Board and the City see the real test needed to sustain this support as the satisfaction of the FMC clients from the community. Whether effectiveness in influencing policy by demonstration can be transferred to possible future replications of the FMC or use of a Board, without trips to the U.S., can only be determined by trying to do so. Astana's strong, well-financed Municipal Government is an important factor. On the other hand, a well-documented and carefully analyzed success in Astana might make the advocacy process easier in

the future. Fortuitously because this model is being developed in the national Capitol, a member of the Board works at the national Health Care Agency on primary health care, and the Municipal Director of Health who has become a strong advocate for the FMC and community outreach sits on the National Health Agency Council.

- Importance of Education/Information

The fledgling Learning Resource Center is playing a very effective, surprisingly active role: providing clinical information from the Web for practitioners and clients, preparing educational materials for the patient groups and helping with data collection and processing. The physicians and the nurses see education of families about health care as high priority, as indicated by their interest in information about community/client needs, by the materials they are preparing and by the way they are handling patient visits. The effectiveness of effort in this area is an indication of the high motivation and capability of the staff, who for the most part had been selected through a competitive process. The staff is certainly above average, so their adoption of new concepts will be better than average. Nevertheless, Pittsburgh's efforts in this area have had rapid and promising effect.

- Physician-Nurse Teams

FMC physicians have made radical changes in the use of Nurses, reflecting a substantial upgrading of nursing roles and responsibilities. This change seems to be substantially attributable to the partnership. Nurses are screening patients as the first step in visits, handling routine functions, triaging cases as needed, and advising the physician on the patient's condition. This demonstration of Nurse capabilities seems to be a solid achievement that can reinforce the region-wide Nursing reform effort.

I was not able to review planning, administration and financial management at the FMC to assess the influence of the Partnership. Clearly, the rapid start-up indicates substantial planning, organization and training efforts. All the entire Astana FMC team members are strong, articulate advocates for family medicine. How to generate revenue is at the top of the agenda as a return for high quality care. The Municipality is committed to free health services, reflecting the retrenchment on this issue since the 1998 financial crisis. There are many issues ahead, and it is clear that getting this far has been a tremendous struggle.

The various models of Family Medicine in Pittsburgh had been carefully analyzed, with clear statements about how the Kazakhstan situation is different, leading to judgments about what could not be transferred. This is a micro-level investment, but the lessons, whether it is successful or not, are going to be valuable for decision-makers about health reform. Some achievements, such as Pittsburgh's success in getting a change in the definition of infant mortality, have much broader significance, for the entire health

system, suggesting that some of the achievements at the institutional level of Partnerships need to be carried, by USAID or perhaps AIHA itself, to a higher level in the system.

The main disappointment with this activity is that AIHA's and the partners' achievements are not being documented in analytical, quantitative ways that would allow judgments about cost-effectiveness and cost-benefits for applications elsewhere; **in short there is need for evidence-based programming**. Dr. Akanov, leading the Deputy Prime Minister's Task Force on Health Reform, expressed strong interest in the results from this model. Because this is a very intensive investment by USAID, the marginal cost to measure change may be relatively modest. The Director of the FMC, Dr. Abzalova, expresses personal interest in documenting the experience. A key member of the Pittsburgh Team, Jerry Baron, has the skills and interest to assist. USAID should confer with Abt and AIHA about how to document this experience, especially because there are few efforts dealing with the nitty-gritty issues of family medicine. Because the Partnership is clinically oriented, the concerns about quality of care and clinical cost-effectiveness are appropriately driving the decisions about organizational structure and functions.

(2.) Professional Schools

Two of the four current Partnerships are improving teaching quality at powerful institutions: the Kazakhstan School of Public Health (KSPH) and the Kyrgyzstan State Medical Academy (KSMA). In the U.S. and many countries where Universities and their faculties are involved in teaching, research and extension/application, professional schools play leading roles in debates about policy and in leading reform efforts. The donors (WHO, the World Bank, DFID, USAID) seem to foresee similarly broad roles for these institutions, certainly for KSPH, in the Central Asian Region and in their respective countries. In the former Soviet Union in general, professional medical or health teaching was didactic rather than clinical, university research was basic rather than operational or applied, and involvement in extension or application was limited. These characteristics suggest lack of preparation for a strong policy role. This leads to questions about the expectations for AIHA's Partnerships at these two important institutions.

Both Virginia Commonwealth University and the University of Nevada give first priority to improved teaching, which is in line with USAID's support for "developing and institutionalizing medical/nursing education (LRR 3.2.2.2)". Introducing new curricula and new teaching methods is generally consistent with AIHA's limited resources; these are tangible products that can be incorporated into the teaching programs of existing institutions. I will comment further about training in the following section.

(a.) Kazakhstan School of Public Health

Let me caveat my comments by saying that my opportunity to learn about KSPH was very limited: (i.) a rapid briefing in Almaty, for less than two hours, by the Dean and

faculty chairpersons with the entire faculty present, and (ii.) a telephone conversation prior to my trip with Dr. Ozcan at VCU, that was basically a review of the work plan. My knowledge of KSPH is superficial, so I am loathe to comment about the value and effectiveness of the Partnership program.

KSPH is obviously important to USAID's health reform strategy, as indicated by the Mission's decision to request AIHA to develop a Partnership for KSPH. The School was established only four years ago, in 1997, at the initiative of WHO. It is the first and only School of Public Health in the Region. Funding for faculty and facilities has been meager. Many of the staff are part-time, in addition to full time jobs elsewhere. The Dean is determined and resourceful, seeking financial resources to keep the institution afloat. Tuition for training health professionals in certificate courses is becoming a significant source of revenue.

VCU's Partnership began in 1999. The work plan provides only a modest level of resources given KSPH's financial needs and given the obvious needs in the region for the kinds of teaching, research and application (expert consultancies) anticipated from KSPH. At the same time, the VCU/KSPH work plan is very ambitious, particularly development of new degree programs, including a Ph.D. program in health services research. Many outputs have been achieved, including:

- A new Masters program (Health Administration/Public Health) has been designed. 26 courses are already on the schedule for next year;
- Simultaneously the faculty for these courses have been helped, not only with teaching, but with preparation for research and consulting activities.
- The Learning Resource Center, a professional public health association and a new regional journal on Health Services Research have been established.

Development of the new Ph.D. program is underway, with a curriculum to be designed by September 2001. Dr. Ozcan guesstimates that 70% of the progress towards work plan objectives is achieved by VCU faculty visiting Almaty and the remaining 30% by KSPH faculty visits to Richmond.

Please take into account the superficial assessment of this Partnership, and the author's limited credentials in the development of academic institutions; however, I would urge caution about KSPH capability to pick up these tools and to deliver international quality graduate teaching and research programs. Skepticism about the possibility of achieving substantial improvements in teaching and research capacity does not contradict that VCU faculty have done an outstanding and under-appreciated job, and that the KSPH staff are very determined and able. Their ability to come so far so fast is remarkable. It seems to me that the institutional development task facing this Partnership is daunting. There is no evidence of a multi-donor strategy in the available documents. Perhaps a team of experts representing the donors could be commissioned to review possibilities for supplementary resources. { I am mindful of other USAID projects to build international quality institutions, for example recent

commitments to the American University of Bulgaria (\$35 million).} Alternatively, an independent expert should be asked to look at the quality of the Master's program that is now emerging, and to advise about how to proceed with the further development of the Ph.D. program.

(However this situation is handled, perhaps VCU and AIHA could explore possibilities for fellowships (Muskie?) for graduate training in the U.S., if faculty can be identified who have high probability of returning to work at KSPH. Additionally, there is need for researchers to set up measurement of progress in field projects, such as the Astana FMC and outreach program. Do other projects have small grant funds that would enable KSPH faculty and students to take on this kind of operations research, with technical guidance from VCU?)

(b.) Kyrgyz State Medical Academy

In Bishkek, there was more time to spend with the KSMA leadership and the programs. Mary Skarie joined us for this portion of the assessment.. Subsequent to the trip, Dr. Conoboy at the University of Nevada was interviewed.

The Partnership's work plan concentrates on improving teaching methods and upgrading curriculum content, particularly for family practitioners and nurses at KSMA, emphasizing evidence-based medicine, and for management of health institutions. The KSMA/Reno work plan seems more carefully crafted to avoid overly ambitious tasks. The establishment of a residency program for family medicine is a major step forward. The recent Abt/Reno agreement to deal with disparities between faculties for in-service and KSMA training eliminates a problem and establishes a nice precedent for problem-solving between two USAID activities.

Reviewing the situation at KSMA, USAID's strategic purposes in providing support appears uncertain. In the meeting with Minister Meimanaliev, he gave KSMA high importance. If the purpose is to produce leaders for health sector reform, as Dr. Meimanaliev seem s to desire, a longer term effort will be needed. KSMA is another example of a complex institution that will require long-term assistance in order to function similarly to Western counterparts. At KSMA, there appear to be no Ph.D. graduates from Western universities. USAID's past experience with graduate schools suggests that a combination of (1.) U.S. degree training for young faculty and (2.) long-term assignment of U.S. faculty, to have substantial effect on teaching and research standards and methods, is essential.

The Center for Health Care Research at KSMA made a very effective presentation. This is a very strong team with a clear vision of their objectives. The skills that Reno has given them to do Community Assessments are being put to good use in Southern Kyrgyzstan. The specific research agenda indicates the Center's intention to be useful for policy makers; however, they need additional formal training and education to use their potential. Nevertheless, the progress already made by the team at the Center suggests that they can become the experts that the Minister desires, as leaders of

reform. One of the objectives of Ph.D. programs is to rewire your thinking circuits, so questions about the real world are approached in a disciplined way, different from our intuitive processes. Perhaps the needs of the team for structured Western training can be met through some creative thinking about finding supplementary resources. The Partners in Reno are working on this issue. In the meantime, they could be helpful in documenting lessons from innovative field programs in the region.

(c.) The Rectors' Council

The Rectors' Council is a fine example of AIHA's creativity in fashioning a useful solution, an institutional mechanism, to a particular problem, and doing so in a way that will have long-term benefits. The problem was the variation among countries in the region in the educational programs for health professionals: differing curricula, different years of required education, different standards of achievement. Rather than wade into the morass of unifying accreditation rules for curricula and length of education, AIHA with Abt and USAID to devise the Rectors' Council to lead out of the morass with common examination or achievement standards, a topic where agreement could feasibly be reached. Once established, the Rectors' Council is a ready-made continuing vehicle for collaboration on university policy or cooperation among countries in the region.

c. Introducing Better Curricula and Teaching Methods

Training was an important element of every partnership activity. Every U.S. partner had experts to draw upon for curricula development, upgrading teaching methods, skills based training, case simulation for clinical experiential training, or training of trainers. These capabilities have become the bread and butter of programs for health professionals in the U.S. U.S. partners know how to do it, and Central Asian partners all have staff that have become experts for their own countries. This is clearly a growth industry.

The Astana project has trained their own staff and has already planned the training program to pass on their skills to other organizations. KSPH and KSMA are adopting U.S. teaching and training methodologies; however, complete adoption in these organizations may not happen fast. KSPH has the advantage of being a new institution, but the older faculty may nevertheless be resistant. The EMS and Toxicology units have training among their basic skills for propagating their systems of care. The Ashgabat Family Medicine Training Center and the North Dakota Partners have earned the award for overcoming the most daunting obstacles. The Ashgabat training team, even those who hadn't been allowed to travel to North Dakota for training of trainers, did a fine job during the inaugural training demonstration for the assessment team. I was particularly impressed with the nurse/trainer who had grasped the principles so well.

The Ashgabat Family Practice Center has become one of the beachheads for health reform in Turkmenistan, and perhaps as significant, one of the few beachheads for U.S.

development assistance. It was not so clear to me how the Ministry would incorporate the Center into planning for health reform, but the survival skills developed by the Center Director and her staff will undoubtedly enable them to find a way. There was some concern about whether the North Dakota team had made use of other available training materials prepared in Russian, specifically the materials from Tajikistan. AIHA assured me that the Tajik materials had been reviewed to ensure that no duplication of effort occurred. Given the difficulty encountered by the North Dakota team in getting their materials translated in time, I suspect they would have welcomed a ready version from elsewhere.

Training and related functions are clearly within AIHA's comparative advantage category.

d. Raising Professional and Institutional Standards

AIHA has been a catalyst throughout the region in changing the role of nurses, raising their professional opportunities and their educational options. The teaming of doctors and nurses in the Astana Family Medicine Center has been described, where nurses have an important role in handling patients with important judgments to make about responding to the patient's needs. Similar changes were made in Almaty City's Women's Wellness Center. The Tucson Partnership was also instrumental in raising the educational opportunities for nurses, assisting a private nursing college to offer a four year baccalaureate degree to nurses. Perhaps the most significant advances have been made at the Kyrgyz State Medical Academy where a new curriculum has been developed for nurses working in family group practices. Similarly, in Turkmenistan, nurses are full-fledged instructors along with physicians at the Family Medicine Center.

Through the Partnerships' visits to the United States, Central Asian nurses and physicians have observed the professional roles of nurses in management and in clinical care; these observations have been taken back to Central Asia to stimulate reform. AIHA has supported a regional nursing association, reinforcing these changes in attitudes and opportunities for nurses at AIHA sponsored conferences. Similar upgrading of professional standards have occurred for family physicians, toxicologists and emergency medical staff, again stimulated by observing the roles of these professions in the U.S. AIHA's comparative advantage in raising standards arises also from the broad involvement in health institutions where these professions are trained/educated and employed.

The same factors operate to raise standards of care in institutions, for example through observation in the U.S. of client-oriented health services, and standards of infectious disease control in clinical facilities. The quality of care and rapid action by the Almaty Emergency Medical Services is another apt example.

6. AIHA's comparative disadvantages for USAID programs in Central Asia

- a. AIHA Lacks Documented Strategic Analysis for Central Asia that might be utilized in USAID

Both AIHA and USAID do careful strategic planning, but as described above in Section 4, the planning processes are entirely different in nature. The continual incremental strategic planning that occurs within AIHA, usually when AIHA headquarters and regional managers are talking with senior government officials, is dynamic. Options and alternatives are continuously being considered. Problems and needs in the country are being explored for understanding and to identify program opportunities. These informal strategic planning discussions are seldom documented until final program plans emerge, and the underlying fact-finding and reasoning process is relatively invisible. AIHA has a small group of officers at the policy and planning level, so current thinking circulates easily, probably orally for the most part. To draw the obvious contrasts with the USAID bureaucracy, nothing exists as a USAID program until it is in readable text that can be circulated among sometimes distant offices, among reviewers comprised of generalists and technical experts, until consistency between budgets is determined and predictions of program results carefully considered, until a procurement plan is carried out. The strategic thinking in AIHA would be valuable for USAID and the more formal strategic planning carried out by USAID and Abt would enlighten AIHA's thinking. A mechanism or event is needed to link the two planning processes that would not undermine the integrity of either planning system.

- b. The AIHA program has been designed to assist institutions and is not well-suited to address broad strategic problems above the institutional level.

AIHA's programs, particularly the Partnerships, are designed to be effective at the institutional level. Less formally, AIHA managers often operate at the policy level above the Partnerships. At times, because of AIHA's relationships of confidence with policy makers, AIHA can take action to facilitate the policy process. For example, AIHA convened a January 2001 workshop on training and human resource needs in Central Asia by the year 2010. The specter of unemployed medical specialists probably animates much of the resistance to health sector reform. AIHA's initiative created an opportunity for policy makers to begin addressing this problem. Even though AIHA's Partnerships are not directly involved in broad strategic questions, AIHA's access and sometimes long relationships with policy makers could make AIHA an effective participant with USAID in shaping solutions at the policy level. During the assessment, the Kyrgyz Minister of Health asked AIHA to consider convening the donors for a meeting in the Summer of 2001. Devising a response to the Minister could be a useful opportunity for AIHA and USAID to work together in supporting open consideration of policy-level problems in the health sector.

- c. AIHA's short-term inputs are not well-suited for long-term institutional development

The limitations of AIHA's short-term training, short-term visits and short-term technical assistance together with the relatively brief 3 to 5 year project life span allowed by

USAID are most apparent, for example, in considering the long-term institution building tasks ahead for the Kazakhstan School of Public Health, discussed above. USAID and AIHA should take another look at what options are available within USAID's overall project guidance to fashion longer duration assistance where institution building is the objective

7. AIHA's Management and Administrative Capacity and Structure

The functions of the Regional Office addressed in the statement of work for the assessment concern the ability of the small staff to keep on top of the many partnership and AIHA Regional Activities.

- Does the Regional Office have adequate capability to monitor achievement of program objectives, including the technical and programmatic content of the Partnership programs?
- When technical or management problems arise, does the Regional Office communicate effectively to ensure the problems are resolved in a timely and satisfactory way?
- Do the AIHA Regional Activities, such as conferences and workshops, that are organized by the Regional Office detract from the capability of the staff to monitor the Partnership activities?

As noted above, AIHA's senior managers in Washington and the Central Asia Regional Office work as a team, so consideration of effectiveness and efficiency must be in terms of the whole team's performance. The Washington headquarters office is organized for the purposes of program and financial management and administration, and not for technical direction. Because AIHA relies on the U.S. partners for technical leadership, there is no unit for technical program strategy or direction in Washington. AIHA's technical experts are in the Regional Offices, and it is the Regional Office that formulates technical strategies and monitors the technical performance of the Partnerships. The AIHA Regional Office for Central Asia is fortunate to be managed by a senior physician with involvement in AIHA's Central Asian program from the beginning. There are also two health professionals on the staff, a finance manager and a communications technology expert. This is a small team, the smallest among AIHA's Regional Offices.

Decisions at headquarters are made by a small team of management executives: the Executive Director, the Chief Financial Officer and the Associate Director for Partnership Programs. With decision-making authority held within such a small group, administration of the program is vulnerable to bottlenecks at the top. Among the Partnerships, there was some evidence that decisions can be delayed. There are also advantages to centralized decision-making. Communications about what is going on in the field are shared among a fairly small group at headquarters. Perhaps most important, because decisions on programs, finance and procurement are referred to headquarters, the Regional Office is not under direct pressure for approvals or

allocations of resources. The Regional Office can concentrate on coordination of AIHA's activities in the region and on monitoring AIHA programs.

During the assessment, it was possible to observe in detail only the work of the Regional Office Director, and not the staff. (The administration of the assessment itself was shared by the USAID Mission and by the AIHA Regional Office. Despite some problems caused by canceling of flights, the assessment occurred smoothly and efficiently, giving evidence that the USAID and AIHA staffs worked effectively together.) Throughout the assessment, it was clear that Dr. Nugmanova had a keen appreciation of all the technical and managerial aspects of the AIHA program. Moreover, she has a clear vision of the problems and the potential of health reform in Central Asia that guides the strategic thinking of AIHA's Executive team. She is clear and constructive in identifying problems and communicating them to AIHA's Executive team. She is a skilful diplomat and problem-solver. Because of her excellent judgment and experience, she is able to contribute usefully to the USAID strategic planning process.

The Regional Office provides technical support for communications technology, a service designed for the Learning Resource Centers. This assessment has identified another area where technical support might benefit the Partnership programs: evidence-based programming, i.e., design of program evaluation systems that would collect baseline and follow-up data. The main purpose would be to learn about the costs, the benefits, and the effectiveness of programs, particularly service delivery programs, in order to provide evidence of the outcomes for policy makers. The technical capability for design of program evaluation systems could be provided from medical school faculties, such as KSPH and KSMA, perhaps through small contracts from the AIHA Regional Office or from the Partnerships. Having this kind of capability available under Dr. Nugmanova's guidance would greatly strengthen the program monitoring capability of the AIHA Regional Office. Involvement of the Regional Office in this new approach to program evaluation may require augmentation of administrative capability in the office.

8. Recommendations to USAID and AIHA

With some trepidation, because of the superficial nature of the assessment, this report will make some recommendations about how the USAID and AIHA organizations can mesh more effectively at the level of strategic decisions.

- a. The main recommendation to USAID and AIHA is to seek an appropriate way to link the strategic planning processes between the two organizations.**

The following two suggestions are intended to stimulate the search for linking mechanisms:

- AIHA should make more effort to document the choices for future partnerships in a strategic way, identifying the significance of a proposed partnership for health reform, outlining how the partnership can move health reform forward. This will

happen most effectively if USAID and AIHA are in continuing dialogue about the health reform process, exchanging observations and ideas. When AIHA is approaching the point of proposing partnerships, special effort should be made to engage USAID in the thinking process. The earlier the better. The thinking should also be documented, with reference to health reform, so that future changes in staff or strategies in either organization will have as a reference the strategic rationale for selection of partnerships.

- USAID should consider establishing a forum for its implementing projects (Abt, AIHA, Project Hope, etc.) to engage in strategic discussion about health reform in Central Asia. For example, a semi-annual meeting with an agenda of one or two issues related to health reform would give all USAID's implementing partners a way to share their insights and wisdom about health reform. Responsibility for organizing the meeting could be taken by USAID or rotated among the implementing partners. USAID should discuss with AIHA the possibility of inviting one representative from each of the current U.S. Partnerships. Hopefully, the semi-annual meetings would stimulate more frequent informal strategic discussions about health reform between USAID and individual implementing partners.

b. With regard to AIHA's areas of comparative advantage, USAID should consider the following steps to increase the usefulness of AIHA programs for health sector reform:

- **Improved health care service delivery**

USAID should request AIHA to develop capability for evidence-based programming, to document for policy makers and donors the cost-effectiveness and cost-benefit ratios of AIHA partners' improvements in health service delivery, such as community outreach. With capability for evidence-based programming, innovations in health care service delivery could be given higher priority in selecting future partnerships.

- **More effective health institutions**

For development or reform of complex institutions such as medical schools or schools of public health, USAID should undertake careful evaluation of the effectiveness of AIHA's partnerships programs, with their relatively limited short-term inputs, especially where the expectations of donors are for these institutions to play leadership roles in reform of the health sector through a combination of teaching, research and extension. Creative supplementation of Partnership inputs, for example with long-term fellowships for U.S. academic training or faculty sabbatical exchanges, should be explored.

For less complex institutions, including teaching institutions without research and application functions, or single-purpose organizations such as emergency

services, USAID and AIHA should analyze more carefully the contributions these institutions can make to health reform, especially to understand how these institutions will fit into a system emphasizing primary health care. Partnerships have been more successful with organizations which are somewhat independent in the health system, such as the toxicology centers, and less successful with organizations embedded in complex bureaucracies, such as the no-socomial infection control unit in Almaty.

- **Better teaching and clinical methods**
- **Raising standards of health professionals**

USAID can confidently support partnerships that have these purposes. U.S. partners are highly skilled in transferring teaching methods and use of improved clinical algorithms. By seeing the functions of U.S. workers, Central Asian partners can be inspired to adapt and introduce new standards or roles health professionals. At this stage, change is occurring slowly; for example only a small portion of Kazakhstan's 100,000 nurses have been affected by Partnership programs.

Nevertheless, USAID and AIHA have to consider carefully the contribution these improvements will make to health sector reform. For example, there seems to have been no clear analysis or strategy for effectively using the over-supply of health specialists on government payrolls. Without overall plans for reducing government payrolls, changing roles within health professions may exacerbate the overall problem of oversupply.

c. With regard to AIHA's areas of comparative disadvantage, USAID should consider the following steps to increase the usefulness of AIHA programs for health sector reform:

- lack of documented strategic analysis

USAID should request AIHA to do a better job of making AIHA's strategic analyses accessible to USAID/CAR and to other USAID-funded organizations pursuing the same Strategic Objectives. By documenting these strategic analyses for discussion with USAID, AIHA may reduce the risk of USAID changing program priorities without regard to AIHA's continuing programs.

- difficulty of using AIHA's institutional-level partnerships for broader systemic changes

Both USAID and AIHA should make greater effort to select partnerships that directly contribute to health sector reform, situating the partnerships so results are accessible to policy makers and documenting results so achievements can be considered for broader applications.

AIHA's regional programs have often been very effective in promoting reforms at the policy level; the annual conferences in Washington are useful forums for this purpose. AIHA should make greater effort to engage USAID/CAR and other USAID-funded organizations in orchestrating these kinds of events to move forward USAID's health reform efforts.

- difficulty of pursuing long-term development objectives with USAID's short project time-frames and AIHA's short-term inputs

Despite the short project time-frames and short-term inputs, USAID should engage AIHA in considering long-term health reform objectives and in analyzing how the long-term objectives can be achieved with the AIHA program's limitations.

d. To enable AIHA management to be more effective in supporting health sector reform in the region, USAID/CAR and AIHA should consider the following possibilities:

- a common agenda of health reform issues, developed by AIHA based on the continuing dialogue with health officials in the region.

The AIHA Regional Office, in consultation with AIHA headquarters, should develop an agenda of issues important for health reform. The agenda should be used with USAID/CAR as a guide for continuing, periodic dialogue between USAID and AIHA about obstacles to health sector reform. AIHA should modify the agenda as the reform process unfolds, scheduling regular (bi-monthly?) discussions with USAID. AIHA headquarters staff should arrange to participate in these meetings during their normal visits. (This suggestion is separate from the recommendation at the beginning of this section for AIHA's participation in USAID's strategic planning. The objective here is to put the agenda for regular meetings with USAID staff in the hands of AIHA's Regional Office.)

- allocation of additional staff and financial resources to the AIHA Regional Office in order to organize evidence-based programming in Partnership programs.

The AIHA Regional Office should be given the resources to mobilize an evidence-based programming capability, i.e., the technical expertise from the region that can help AIHA partners document their achievements, including quantitative information about cost-effectiveness and cost-benefits of AIHA innovations. The technical experts could be hired as AIHA Regional Office staff or acquired through small contracts with medical schools or KSPH. U.S. Partners could provide their own experts to contribute to this endeavor.

Attachment: Schedule of Meetings with Contacts