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EVALUATION OF THE AMERICAN INTERNATIONAL HEALTH ALLIANCE (AIHA) PARTNERSHIPS PROGRAM

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TABLE OF CONTENTS

ANNEXES

ACRONYM LIST

AIDS	acquired immune deficiency syndrome
AIHA	American International Health Alliance
ALOS	average length of stay
AUPHA	Association of University Programs in Health Administration
CA	cooperative agreement
CDC	Centers for Disease Control
CEE	Central and Eastern Europe
CPR	cardiopulmonary resuscitation
EMS	emergency medical services
ENI	Europe and the New Independent States
FY	fiscal year
ICU	intensive care unit
IREX	International Research and Exchanges Board
MOH	ministry of health
NIS	New Independent States
NMS	new management system
OMB	Office of Management and Budget
PC	personal computer
QIP	quality indicators program
R4	Results Review and Resource Request
SOW	scope of work
STD	sexually transmitted disease
USAID	United States Agency for International Development
WHO	World Health Organization
WWC	women's wellness center

EXECUTIVE SUMMARY

The Cooperative Agreement (CA) between USAID and the American International Health Alliance (AIHA), now in its fifth year, has been successful in meeting its objective of transferring medical knowledge and skills from U.S. to NIS and CEE partner institutions. A sound USAID concept combined with strong AIHA leadership has resulted in a program that has achieved important impact both overseas and in the United States.

Background

The CA with AIHA grew out of USAID's decision to expand into the NIS the hospital partnerships program begun under individual CAs in Eastern Europe. Given that a large number of additional partnerships were anticipated, USAID shifted to an umbrella approach to achieve greater managerial efficiency and programmatic integration. It called together a group of this country's principal hospital-related associations, which formed AIHA and then became its board of directors. Successive agreements brought into the partnerships program additional program initiatives and additional groups of partnerships in both the NIS and CEE.

USAID has committed a total of $78 million to this effort, of which $69 million has been obligated and $45 million disbursed. The evaluation was commissioned to review the accomplishments of the program and to inform decisions about its future direction.

The evaluation was carried out from November 1996 through February 1997. The evaluation team consisted of three core members, who visited partnerships in nine cites in the United States and eight countries, and three specialists, who carried out focused analytical work in the United States. The team interviewed about 250 people. The scope of work was extensive and complex and called for forward-looking comments as well as the traditional retrospective evaluation, but it did not extend to future program design.

The Partnership Model

The partnership model is not unique to AIHA, but the AIHA model does have distinguishing features, including the use of volunteers rather than paid consultants, an institution-to-institution focus, and a structure that encourages collaboration and sharing of information among partners. The AIHA partnership model also differs significantly from typical development projects funded by USAID. While the project was not designed to have direct or major sector-wide policy impact, it did to a degree emphasize sustainability and replicability, although its benefits have in most cases not reached far beyond participating institutions. The idea was to find institutions against which to exert a critical mass of resources, with the prospect that each would bring about change, acquire an energy of its own, and eventually have some impact on the landscape of health care in the NIS.

The model has a number of positive attributes, including a high level of volunteerism and an impressive level of private resources leveraged. The partnerships are built on mutual interest and the thirst of the NIS/CEE partners for knowledge of Western clinical and managerial practice. They

are a politically popular way of delivering foreign assistance. However, the model also has inherent limitations. The cultural and technological gulfs to be bridged and partners' limited international experience made for slow starts in many instances. Further, the respective health care systems are radically different in operation and mentality. There can be disincentives to sharing information among NIS/CEE institutions. U.S. health care professionals may well have less time for volunteer work in the future.

In addition, some of the more successful partnerships have involved privileged institutions in the NIS. Their experiences and achievements will be difficult to disseminate to the vast majority of NIS/CEE health care institutions. Regional activities have faced more challenges in the CEE, where languages and recent history vary more than in the NIS.

The program initially adopted a clinical focus, but managerial constraints rapidly emerged as equally important. As a result, program focus shifted to include health management education partnerships as a complement to the hospital partnerships. In the CEE, the hospital partnerships were to allow students to receive practical experience in applying new management techniques. More recently, initiatives such as healthy communities and community-based health reform partnerships were also added.

Overall Impact

The project has achieved impressive results both overseas and in the U.S. It has moved with agility and effectiveness from clinical practice to broader management issues. In the process it has stimulated the flow of medical knowledge and technology to partner hospitals in the NIS and CEE. It has also shown remarkable success in leveraging outside resources.

Beyond a doubt, the major impact of the project has been changes in the way those involved in the partnerships approach their profession. In almost every interview, NIS and CEE doctors and nurses commented on how their participation in the project had changed their way of thinking. Concepts of management, cost effectiveness, patient education, and continuing education have been quickly embraced by those who have experienced the U.S. health care system in operation. It is very difficult to quantify this change, or to estimate how great the impact will be as those who have participated in the partnerships spread their knowledge to their associates and students.

The project was not designed to stimulate replicability in non-partner hospitals, nor was it designed to be scaled up. Despite this, there has been replicability in some programs (diabetes, EMS, neonatal resucitation) and some scaling up to broader systems (infection control, training, and the role of nurses).

Partners' Program Initiatives

Over time, common themes among partnerships were reflected in cross-cutting initiatives set up by AIHA. They included nursing, emergency medical services, neonatal resuscitation, infection control, and diabetes. Externally inspired initiatives in women's health, breast cancer, health management education, and healthy communities were added.

The *nursing* initiatives have had a strongly positive impact on the nurses involved. They have increased nurses' interest in their profession and have spurred nurses to assume more leadership within hospitals. Nursing conferences have led to the development of national nursing associations in many countries. While the nursing initiatives have yet to have major impact on national-level policy, they have changed the role of nurses in the partner hospitals. In both the NIS and CEE, health sector human resources are out of balance with the needs of the emerging systems, and workforce studies could ensure better use of those resources by coordinating the training of physicians and nurses with projected future requirements.

The *emergency medical services* program has laid the groundwork for a system of training EMS technicians. Using low technology and a carefully crafted curriculum, partners have trained several hundred ambulance attendants, firefighters, police, and others in the basics of EMS in eight centers in the NIS. Compared to the total emergency workforce, relatively few people have been trained, however, and trained EMS workers often lack access to equipment basic to the new skills. Physicians report little change in the condition of patients arriving at their trauma centers. The EMS program has, however, been a pilot that can serve as a model for national-level EMS training centers that would be relatively low cost and could result in a significant reduction in long-term care costs.

The *neonatal resuscitation* program includes nine partnerships that are creating a standard for keeping very young babies alive through the critical first 30 days. By introducing a few simple techniques, the program has shown dramatic and immediate results in NIS partner hospitals. The initiative has the potential to be folded into broader maternal and child health programs and scaled up to the national level.

Infection control has been a topic for concentration in six of the 25 NIS partnerships. With 30 to 40 percent of patients in NIS hospitals contracting hospital-acquired infections, infection control is an important element of efforts to reduce the average length of stay. The infection control program has led to an agreement with the Russian Ministry of Health, and efforts are underway to implement U.S. standards of infection control. Infection control has become part of the philosophy of patient management in some partner hospitals, but protocols have yet to be implemented on a hospitalwide basis, in part because of poor laboratories. Infection control has great potential to improve patient care and reduce the length of stay in hospitals and thereby drive down health care costs. The initiative would have to be scaled up to have broader impact within partner hospitals and to extend to nonpartner hospitals.

The *diabetes* initiative is limited to one partnership in Russia. It is unique in that it embodies a clear strategy for replicating the program in other cities and involves a strong private sector partner, Eli

Lilly and Company. The program is based on patient education and self-care, concepts not widely used in Russia. Results of the pilot project are impressive; the use of insulin has been reduced by 30 percent and the number of diabetes-related hospitalizations by 60 percent. The replication is an important test of whether the model, developed for a small and highly educated city, can be more broadly applied.

Other Results

The achievements of the partnerships are many and diverse. Because the partners themselves identify issues of mutual concern and the program lacks a built-in monitoring system, there is neither a common basis for evaluating the effectiveness of the program nor baseline data from which to work. The program has taken the first steps leading to the development of *quality control* systems within partner hospitals, and one hospital has advanced to the point of joining a U.S. quality indicator project through which it can be judged by U.S. standards.

Partnership hospitals demonstrate an increase in *patient participation*, with more patient education and involvement of patients in decisions about treatment. While data may not be reliable, reports point to dramatic reductions in average length of stay. That hospitals are even thinking along these lines shows that some of the management training is being put into practice. At least two of the partner hospitals have created U.S.-style micro-units that cater to fee-paying patients.

The intent of the model was to change the delivery of health care at selected institutions in the NIS and CEE through exchanges between hospital representatives, thereby stimulating the modernization of clinical practice. Despite the absence of *normal program replication* or *policy impact* objectives in individual partnership design, partner initiatives are being replicated in some nonpartner hospitals, and in some cases protocols and curriculum are becoming part of ministry guidelines and policies. Policy change has been notable in the training and role of nurses, although major obstacles remain in fully implementing these policies both in partner hospitals and at the national level.

AIHA Program Support

AIHA provides four specialized support activities to hospital partnerships: management training by the Association of University Programs in Health Administration (AUPHA), support in information systems hardware and software, a quarterly magazine, and a series of specialized conferences and workshops.

AIHA's subcontract with AUPHA has developed a series of workshops on various *management* topics. In 1996, AUPHA offered 23 courses, for 25 to 30 participants each, for partner hospitals, ministry of health officials, educators, and others. The workshops are well regarded for their content as well as for the participatory, learn-by-doing style that at first made participants uneasy but is now used by participants in their own teaching and presentations. The workshops might be better integrated with other AIHA activities to ensure more follow-up and integration.

The *information systems* initiative is relatively costly but is essential to the sustainability of the partnerships. NIS/CEE partners receive packages of equipment (computers, fax machines, etc.) and associated software that enables them to communicate by e-mail and to tap into the World Wide Web, thus allowing them to keep abreast of AIHA activities and to access a range of medical journals and other material. The initiative is important, but it has yet to achieve its full potential. Most NIS/CEE partners have little experience with computers and are not yet taking full advantage of the resource. AIHA is working to create greater interest in the basic equipment and building the capacity for teleconferencing.

CommonHealth magazine is a quarterly publication that communicates news of partnership activities as well as clinical and management knowledge to hospital administrators, medical staff, researchers, and policy makers. Over time, it has become sophisticated in its layout and content. It is distributed free to partners in the United States (5,000 copies) and overseas (14,000 copies) in both Russian and English. The magazine is particularly welcomed by overseas partners, who are eager for any kind of health information news from other partners; the magazine is of less interest to U.S. partners, who already receive huge amounts of professional information. As little information on health care is available in the NIS/CEE, AIHA should look into adjusting the magazine's content as necessary to build a market for subscriptions and thereby cover costs.

AIHA also arranges technical *workshops, conferences, and seminars* that respond to issues of interest to partners. These activities are frequently initiated by partners or task forces and draw 25 to 500 participants. Over 125 conferences have been held on topics such as nursing, financial management, leadership, and technical issues including laparoscopy, rheumatic fever, neonatology, obstetrics, nosocomial infections, pediatrics, toxicology, hospice care, and cardiovascular treatment. AIHA has also sponsored a limited number of study tours to the United States. With little continuing education in the NIS/CEE, most physicians and nurses have had no training since they completed school. The conferences are of great interest to overseas partners as an opportunity to upgrade their skills and meet with colleagues. The conferences have had important gender-related results in that they have brought physicians and nurses to the same conferences and allowed AIHA to set an example by placing women in visible leadership positions at these events.

USAID Program Initiatives

At the suggestion of USAID, AIHA has undertaken four additional initiatives, including women's health, breast cancer, health management education, and healthy communities.

The *women's health* initiative, with a $1.5 earmark from Congress, is just starting but will include 14 women's wellness centers, each of which is designed to serve 4,000 women in need of family planning, reproductive health, and other preventive services. Women's health services are now offered in various places and departments. The women's wellness centers will deliver services on an out-patient basis and will integrate women's health services into a single facility. Several AIHA partnerships already support women's health activities that could be integrated into this program. Given the strong interest in women's programs, particularly among nurses, this initiative, too early

to evaluate, will likely prove popular. It also fits more closely with USAID's overall health policy than some of the clinical programs.

A *breast cancer* initiative, not yet funded, is planned for the women's wellness centers to allow early detection of breast cancer in three cities affected by the Chernobyl disaster. Originally concieved as a curative program for women suffering from breast cancer, the scope of that program has been scaled back to prevention and early identification of breast cancer with referrals to exisiting facilities for treatment.

Health management education is a CEE program consisting of five partnerships in four CEE countries. These partnerships involve universities and focus on developing new curricula and in-service training for service providers. They address the critical shortage of trained health sector administrators. Because of funding delays and, in some cases, tense relations between partners and AIHA, these partnerships have moved slowly. University faculty generally have little time for volunteer work and receive little support from their administrators, who prefer that faculty work for their university on overhead-generating projects. A reported exception, which the team did not visit, is the program in the Czech Republic, which has produced new curricula and better-trained faculty and reached many students.

The *healthy communities* initiative is underway in two towns in Slovakia and builds on concepts developed by the World Health Organization that target at-risk youth and families. The communities, in one case with a nongovernmental partner, are targeting a range of public education issues such as tobacco and drug use, self-management of chronic diseases, healthy lifestyles, and a city cleanup campaign. Although it is still developing, the healthy communities initiative has considerable potential and fits with USAID health policy objectives. There is clearly a great need for more public education on issues such as drunk driving, smoking, citizen CPR, and the use of seatbelts; this project could be the model for expanded national efforts.

AIHA Management Issues

Partners respect AIHA's leadership and its achievements and are uniformly positive about the program and their experiences. They praise its innovation, its logistical support, and its highly motivated staff. However, many also see the organization as highly centralized, the staff functions and roles as hard to understand, and decisions as partial to favored partners. Partners view the less-than-transparent management style as contributing to difficulty in getting information and decisions and to a sense of continuous crisis management as opposed to stable, clear policies and guidelines. Many believe that AIHA is intentionally vague about funding in order to play partners off against each other and reward favorites.

The uneven flow of USAID funding and absence of budget transparency in AIHA has made it difficult for partners to plan their activities and make the best use of their resources, thus leaving partners frustrated. They complain that AIHA uses too much of its resources for conferences and workshops rather than for individual partnership activities. AIHA's system of allocating costs back

to participating partners without tracking the costs of special initiatives and conferences makes it impossible to determine the costs of the various initiatives and assess their cost-effectiveness.

Partners would like more budget transparency and more control over resources. One solution would be to pass a much greater share of the resources to the partnerships—currently they control about half of the total—and allow them to "buy in" to the central issues they find attractive.

AIHA regional offices provide good logistical support to visitors. Regional office managers have strong management and medical skills but do not play a significant role in program planning or implementation. Decentralization of some decision making to overseas offices would increase efficiency and effectiveness.

The evaluation did not include an in-depth financial review. Some issues merit USAID review in the context of any new CA. Overall, however, AIHA seems to have been a responsible steward of U.S. government funds.

USAID Management Issues

Judged by the results of the CA, USAID should be credited with creating and managing a successful and innovative assistance activity in a complex political and operating environment. The project has, however, consistently suffered from tension between and among USAID, AIHA, and USAID overseas offices. To start, the agency's health policy calls for a focus on preventive and primary health care while the project focuses on tertiary care and hospital-based curative medicine. This issue eased with recognition of the local achievements of the partnerships but has reemerged as resource constraints have forced choices between congressionally mandated partnerships and higher-priority sectoral reform activities and indeed between health care and other strategic sectors.

A series of changes in the structural and operating premises have further complicated management. First, the project was designed to involve significant and ongoing USAID contact, but new USAID guidance on CAs issued mid-course sharply limited the involvement of project officers. This shift has significantly constrained efforts to adjust innovative programs to local conditions and requirements. Second, what began as a relatively straightforward partnership activity has evolved into a much more complex and ambitious menu of initiatives as AIHA built broader cross-cutting initiatives into its program and USAID used the CA to launch additional activities. Finally, the new USAID strategic objectives structure has increased pressure on USAID officers to focus all assistance efforts in the pursuit of agreed country-level objectives. In addition, it holds managers accountable for integrating programs toward that end.

These changes are in many ways contradictory and have created tensions that have been exacerbated by management styles and personalities at both AIHA and USAID. Nonetheless, USAID and AIHA should take pride in what they have accomplished through their collaboration even though the outstanding issues remain a substantial drag on project impact. USAID needs to address these issues at the policy level.

Still, it is hard to imagine a better vehicle for managing the basic hospital partnership process than AIHA. USAID should carefully weigh its position of not considering further noncompetitive agreements for this basic task, as AIHA's predominant capability is strong at the hospital partnership level. As the program moves away from that core expertise, however, AIHA's impact weakens and its predominant capability becomes far harder to argue. Any new agreement should be limited in size and scope to the partnerships and directly related activities. It should also allow for country-level review of annual partnership work plans to avoid inconsistencies with strategic objectives.
USAID should consider a task-order technical assistance core contract, perhaps building in aspects of the partnership approach, for any expanded work on the program's cross-cutting initiatives and for "roll-out" activities appropriate for scaling up to broader application or national-level policy implementation. The core contract should allow for careful integration of these activities into country-level strategic objectives. Although many AIHA activities are noted here as offering potential for scaling up, choices to do so should be consistent with country strategies and funds availability.

Notes of Appreciation

- Literally hundreds of dedicated people involved in the partnerships in the United States and abroad contributed to this evaluation through interviews and comments provided on draft versions. The team appreciates this outpouring of effort and the concern with the project's impact and the future it suggests. We have taken these comments seriously, and although we did not agree with all of them, they have enriched our knowledge and the evaluation itself. AIHA prepared a lengthy response to the revised draft of the report which is included in Annex J. As the evaluation took place over a year and AIHA knew the general findings much before the report was issued, they took steps to remedy many of the problems the evaluation identified. An update on AIHA activities is included in the same annex and demonstrates how seriously they took the evaluation and how quickly they moved to remedy problems.

- USAID asked AIHA to handle logistical arrangements for the evaluation to minimize the burden on USAID and its overseas offices. The team greatly appreciates both the excellent institutional support it received and the truly memorable individual efforts of AIHA staff in Washington and in the field.

- The staff of BHM International's USAID/ENI/DGSR Technical Assistance Project provided the team with logistical and technical support far beyond that normally provided to a consulting team. This support gave the team more time to focus on data collection and issues and we appreciate all their staff has done.

1.0 Background

1.1 History

The American International Health Alliance (AIHA) is a nonprofit organization established with the assistance of the U.S. Agency for International Development (USAID) to create and manage a program of partnerships between U.S. hospitals and universities and partner institutions in the former Soviet Union. The purpose of the partnership project is to improve health care by transferring medical knowledge and technology from the United States to the New Independent States (NIS) and Central and Eastern Europe (CEE).

The concept of a comprehensive cooperative agreement (CA) between USAID and AIHA grew out of the original eight partnerships in CEE, which were managed directly by USAID from Washington. When USAID decided to expand the program into the NIS, it raised concerns about the complexity of managing a large number of additional partnerships with limited staff. In keeping with its desire to provide a higher level of program integration, USAID adopted an umbrella approach. It called together eight of this country's primary hospital-related associations and urged them to form a consortium that would award and manage subgrants to individual partnerships under a single CA and provide supplemental programs and common support. In response, the associations formed AIHA. Representatives of those associations make up the AIHA Board of Directors (see Annex A).

The initial cooperative agreement was signed in June 1992; a series of additional agreements and amendments were subsequently concluded. The follow-on agreements added funds and refined initial program purposes. Later, when USAID decided to create a second series of partnerships in CEE, including those assessing healthy communities and health administration and health management, it brought them into the AIHA framework as well. (See Annex B for a list of the agreements.)

According to the 1995 agreement, the AIHA consortium was formed "to implement the Medical Partnerships component of the NIS Health Care Improvement Project." Its purpose is "to improve the efficiency and effectiveness of health care organization and delivery, to develop and strengthen existing health management development programs and to introduce appropriate responses to problems by creating institutional and professional linkages...."

The total estimated cost of the cooperative agreements between USAID and AIHA for the period 1992 through December 1998 is $78.2 million, of which $69.4 million was obligated as of February 1997. A total of $44.5 million was expended through January 31, 1997. Of the total estimated cost, approximately 64 percent was allocated to NIS programs and 36 percent to CEE programs.

The project started in 1992 with basic hospital-to-hospital partnerships. By 1993, the program began emphasizing common themes across partnerships. AIHA reports that in 1996 about 52 percent of the program budget went to cross-cutting initiatives and 48 percent to partnership exchanges. This trend has been the result of the spontaneous evolution of the partnerships, AIHA's institutional initiative, and program decisions by USAID.

A midterm assessment of the health partnership program carried out in 1994 concluded that the program was well conceived and implemented and was succeeding in transferring skills and models in clinical and administrative areas. It noted AIHA's considerable achievements in mobilizing private resources.

The 1994 assessment also found that the partnerships had achieved limited impact beyond the individual hospital partners' institutions but that, with modifications, the program offered potential for broader developmental impact. The assessment recommended, among other things, that the partners work toward the wider dissemination of lessons learned through, for example, conferences and journals, increased linkages to the priorities of USAID and other donors, and more active shaping and focusing of partners' efforts without undermining the program's volunteer nature. It noted that the role of nursing was poorly developed and appreciated, with consequent negative impact on the efficiency and quality of health care.

AIHA and the U.S. partners responded quickly to several of the directly actionable recommendations by organizing more conferences and disseminating partnership news and lessons learned. For reasons discussed in this evaluation, however, the health partnership mechanism has not responded as effectively as envisioned to many of the broader institutional and national policy issues faced by the NIS and CEE health care sectors.

1.2 Reason for Evaluation

USAID commissioned this fifth-year evaluation of the AIHA cooperative agreement for several reasons. First, the 1994 evaluation was considered an interim exercise, which by design was not comprehensive. Second, after four years of operation, a more in-depth effort to examine results and lessons learned was in order and more likely to produce useful information. Finally, during the evaluation team's background briefings, USAID indicated that it would make no further noncompetitive awards for the health partnerships and thus wanted a thorough look at the AIHA experience to support the subsequent design of a follow-on activity. This evaluation should help inform the future design effort; in fact, the scope of work opens the way for certain forward-looking comments and recommendations. Nonetheless, the document should not be confused with what must clearly be a separate design exercise.

2.0 Methodology

The evaluation methodology followed standard practice for a USAID project. Working from a scope of work, a team of independent consultants carried out interviews, reviewed documents, analyzed data, and made field visits. The team then prepared a draft of the report for review by USAID and AIHA and made revisions based on comments received in meetings and in writing. USAID then solicited comments from the field, with additional revisions made accordingly. Final debriefings will be held with USAID, AIHA, and other interested groups as determined by USAID.

2.1 Scope of Work (SOW)

The SOW was extensive and complex and called for the team to comment on the overall program strategy, including the partnerships and cross-cutting activities such as task forces and workshops. Other SOW issues included the design and implementation of the project, the overall effectiveness of the partnership approach, the achievements of the program in both the NIS and CEE, AIHA organization and management, and USAID project management. USAID was also interested in the team's view on whether the project should be put to competitive bid in the next funding cycle, an issue discussed later under Management Issues (see Annex C for the complete SOW).

2.2 Evaluation Team

The evaluation team was composed of three core members. The team leader is a senior management specialist and former USAID mission director with experience in the NIS and other regions. The senior social scientist is an anthropologist and professional consultant with extensive experience in USAID evaluations. The senior medical specialist has clinical experience as a pediatrician and has served as both the dean of a medical school and a hospital chief executive. Three other team members who provided special studies included an evaluation expert experienced in USAID's new results framework, a financial analyst experienced in USAID audits and inspections, and a research assistant who organized partnership-reported data for team use.

2.3 Evaluation Strategy

The evaluation was carried out between November 1996 and February 1997. Sources of data included interviews, site observations, and written documents.

The evaluation was preceded by the team leader's attendance at the AIHA's NIS conference in Des Moines, Iowa, in October 1996. The core team then carried out interviews with USAID and AIHA staff in Washington, D.C., in November. Members of the core team visited nine partner hospitals, universities, and associations in the United States in November and December. They made two field trips: the first in December to Ukraine, Slovakia, Russia, and Croatia and the second in February to Albania, Romania, Kazakstan, and the Kyrgyz Republic (see Annex D for a list of the 44 partnerships, with those visited by the team noted).

Partner site visits generally lasted for four to eight working hours and included group and individual interviews and tours of hospital facilities. In all, the team interviewed more than 250 persons, including USAID mission staff in all countries visited (see Annex E for a list of persons interviewed). While the core team traveled, the financial analyst carried out a brief, informal review of AIHA's financial systems.

Simultaneously, the evaluation expert and research assistant conducted an extensive study of the voluminous self-reported documentation provided by AIHA (see bibliography at Annex F). Documents included profiles and budgets for each partnership, summaries of various workshops and other activities, quarterly reports submitted to USAID, and a complete set of the publication *CommonHealth*. It was not possible to perform a quantitative evaluation of project results, as the project lacks a baseline as well as a system for monitoring and evaluation. Thus, although the findings of this independent analysis of reported activities supported the conclusions of the evaluation, they cannot be considered conclusive and have not been incorporated into this report. (The analysis, however, will be useful to future project designers interested in what an evaluation system should look like and will be made available informally to those interested. The executive summary is included at Annex G.)

In addition to reports supplied by AIHA, some partners supplied the team with data on impact or quality indicators. The data were reviewed at team meetings and taken into account in formulating findings and recommendations.

AIHA stated that it was unable to provide detailed budget data by individual initiative, since its budgeting system generally records funds by partnership and collects data accordingly. AIHA noted that compilation of budget totals for special individual or cross-cutting initiatives would involve varying groups of partnerships and therefore would require lengthy and expensive manual sorting of financial data. In the absence of useful financial data, the team was unable to provide cost analysis of various programs.

In the absence of a uniform evaluation instrument used by all partners, the evaluation team had to rely for clinical results on data collected by hospitals in their day-to-day operations. The data are described in the appropriate program sections. Many hospitals cited figures for mortality rates and average length of stay in the hospital, but the team was not able to validate the clinical data. The reported rates may not be comparable with published rates from other countries, which may not use the same denominators. For example, hospitals may use newborns over 1,000 grams rather than all newborns as a base for determining child mortality rates. U.S. partners that have worked with their NIS and CEE partners on data collection felt that, for the most part, the latter have not yet achieved reliable data collection systems; however, trends do provide general indicators of the impact of the partnership relationships.

One of the most difficult aspects of the evaluation was simply understanding the complexities of the project. A "partner" is often two or three hospitals in the same town. Each partnership simultaneously addresses several different clinical and management issues. Further, in addition to the activities of each individual partnership, the project includes collaborative cross-cutting activities

undertaken by groups of partnerships with AIHA coordinating support. In addition, the program extends to such supplemental elements as management education courses, information technology support, and thematically based conferences and workshops conducted or subcontracted by AIHA. With each such activity in some way unique, the team found it difficult to generalize. Adding to the confusion were inconsistencies between reports from partners and from AIHA and inconsistent information from AIHA at various points in the evaluation. Therefore, the examples in this report are representative and illustrative rather than comprehensive.

The initial rough draft of the report, dated March 1997, was reviewed by AIHA, which provided extensive clarifications and additional information that was incorporated into the report. The revised first draft, May l997, was sent to all USAID missions with AIHA partnerships. Many USAID/Washington staff, most involved USAID missions, and AIHA provided comments. This final report represents the inclusion of many helpful comments from USAID and AIHA staff.

3.0 Program Issues

This section of the report covers program issues and begins with a brief discussion of the AIHA partnership model as an assistance vehicle. It is followed by descriptions of the special initiatives suggested by the activities of multiple partnerships, activities developed in response to USAID priorities, and the common support and supplemental programs developed by AIHA. The section concludes with a discussion of project results not captured in earlier sections and a brief review of AIHA's monitoring system.

3.1 Partnership Model

The idea of partnerships between U.S. and overseas institutions is not unique to the AIHA project. Many other organizations foster such relationships, including Partners of the Americas, Sister Cities, and IREX. Further, partnerships between and among businesses, governments, universities, and nongovernmental organizations reflect many USAID policies. Common to all partnership programs are exchanges of individuals or groups of peers.

The AIHA program is distinguished by volunteerism, institution-to-institution relationships with a common focus on health care, and a structure that encourages collaboration and the sharing of information among partnerships. This structure has common support areas such as communication and technology that give AIHA an active role in managing the partnerships. The partnerships bring together U.S. hospitals, universities, and health associations with overseas hospitals or university health programs. AIHA arranges the partnerships, which are intended to last three years, with a fourth year for phase out.

It is important to note that the partnership model differs from the standard model for development projects. Clearly, the project is aimed at improving health services. But it did not set out to produce a policy impact any more than it called for sustainability of the partnerships beyond the term of AIHA and for the wide replication of program elements.

Over the course of a partnership, doctors, nurses, administrators, technicians, and others make exchange visits in both directions. While AIHA provides some communications equipment (computers, faxes, modems) and hospitals make some in-kind donations of equipment, the program clearly emphasizes the transfer of knowledge through human resources. For example, the Dubna, Russia-La Crosse, WI, partnership has thus far made 150 trips from La Crosse to Dubna and 155 trips from Dubna to La Crosse. During the initial visits, AIHA assists the partners in identifying topics of mutual interest and developing work plans for visits and technical assistance to further partnership objectives. Subsequent visits and ongoing communication implement that plan.

Why would busy medical personnel take on additional responsibilities as unpaid volunteers under the partnerships? American doctors and nurses say they do it out of professional responsibility and because of a sense of adventure. "This partnership always makes me feel good. It gives me energy and improves everyone's morale," was a typical remark. Many of the Americans involved have not traveled outside the United States before. On the NIS and CEE side, participants demonstrate a great

thirst for information on U.S. technology and management systems. The visits give participants a vision of how the U.S. system works. While the exchanges usually start with clinical issues, within a year most begin to focus as well on such underlying management issues as cost-effectiveness and the role of nurses. The visits to the United States, as one nurse put it, "change the way people think and the questions they ask." According to an AIHA staffer, "What started as a clinical project has become an organizational development project."

3.1.1 Characteristics of the AIHA Partnership Model

The positive aspects of the AIHA partnership model include the following:

- Partner institutions have much in common and are quick to identify mutual interests; AIHA has done a good job of matching partners with common characteristics.

- The level of volunteerism evidenced by busy people is truly impressive. The amount of time volunteered has been much greater than expected.

- The partnerships bring together people in the same town who might otherwise not have talked. "Two guys in Dubna were classmates but hadn't talked to each other in years. Both stayed in our home. It was amazing to see them reunited," reported one host. Another said, "A big change has been between [two rival hospitals in a U.S. city]. We've risen above politics. It is great to spend time with colleagues on trips."

- The basic partnerships are a low-cost way of transferring ideas between U.S. and overseas hospitals. AIHA states that it has leveraged government funds by a factor of three-to-one through volunteered time, in-kind contributions of supplies and equipment, and what it calls "foregone overhead" on the professional services volunteered. Even if the latter is set aside, the leverage factor is still about two-to-one.

- The project is politically popular on both ends of the partnerships. AIHA reports that 60 percent of proposals have received congressional letters of support. Some governors have traveled overseas, and others meet with visiting delegations. When U.S. partners come to Washington, they frequently visit Capitol Hill, and members of Congress follow partnerships through hospital boards. Hillary Clinton was impressed during her visits to partner hospitals in several countries and continues to take an interest in the program. A senior USAID official said, "The U.S. government gets great bang for its buck with this project. It accomplishes a lot out there, especially compared with other programs. Very dedicated people go out. The ones who come here go back changed people."

- The project is built on the exchange of people. While it has also leveraged funds and attracted millions of dollars in donated medical equipment and supplies, it continues to emphasize the transfer of ideas and development of long-term friendships. The international partners are explicit in stressing that in-kind donations only supplement the human element.

- The impact in the United States extends to broader issues of governance, including greater interest in and sophistication about foreign affairs in general and support for foreign assistance in particular.

The model also includes some potential problems as follows:

- The U.S. health care system is not perfect, and the partnerships can occasionally export bad ideas along with good ones, including a thirst for high-cost medicine. "I was in [a U.S. hospital] for three months. Our procedures are the same, you just have a lot more resources. We have much more communication between professionals and more freedom. I saw a lot of defensive medicine and family interference in decisions there," said one visiting doctor.

- The systems are markedly different. The U.S. health care system is fragmented and decentralized while the NIS and CEE systems are highly structured and centralized. "Over there, it's not so different between primary, secondary, and tertiary care; there are lots of hospital-based community and prevention programs; it is a health system. In the U.S., the emphasis is on integrating fragmented systems, a mechanism they [the NIS] already have," remarked one physician. Another said, "They're practicing medicine of the 40s and 50s over there." It is a challenge for the two systems to work together.

- Individual partnerships are limited in what they can achieve. While the changes within one hospital may be impressive, many more hospitals have no access to new information. Several NIS and CEE partner hospitals are atypical, privileged institutions. There is little replication of Western-style management systems or clinical standards in the vast majority of hospitals not included in the project. Where a critical mass of individuals in a single institution is exposed to new thinking, the question arises of how to share the change with other institutions without taking them through the entire partnership experience.

- There can be a disincentive to sharing information. In the current environment, each institution is struggling for survival. Innovations that improve productivity or quality of care can provide a competitive advantage that an institution might be inclined to protect. According to one hospital administrator, as NIS hospitals depend more on private-paying patients, they come to realize that knowledge of the U.S. system is capital they do not want to give away (see Section 3.5.5 on Replication). The partnership model generally does not affect policy beyond the hospital (see Section 3.5.6 on Policy Change).

- When the volunteer partners take ownership of the relationship, they can resent guidance and AIHA- or USAID-mandated reporting requirements. U.S. partners can resent having to ask permission to make adjustments or not being informed about other AIHA activities. There is an inherent tension between volunteers and management about who is in charge.

- The partnership program depends heavily on voluntary contributions from health care institutions and professionals. Hospital administrators and AIHA staff express concern that constraints on the U.S. health care system may limit the future level of volunteerism. This

is particularly true of universities, which experience increased pressure on faculty to generate income from grants and offer fewer professional incentives for volunteerism.

- Some international partners complain of paternalism during the first years of the partnership. Most U.S. volunteers have little experience in working with people from other cultures. They sometimes treat the international partners as if they were much less sophisticated than in fact they are.

- Except for conferences and workshops, the contact among participants outside their own partnerships, either in the United States or overseas, is limited. The project has not created a self-sustaining network that will function as an ongoing resource. AIHA encourages visits between overseas partners, but such visits are rare.

- The partnership model does not incorporate a formal strategy for follow-up with partners at the end of their agreement. The first partnership graduated in fall 1996 and has continued to be active in AIHA activities. Some partnerships are seeking outside funds; others are becoming nongovernmental organizations.

- While AIHA has done an admirable job of providing translation services, language differences limit communication, particularly among CEE participants. Language differences represent a challenge to all forms of foreign technical assistance, but volunteer partnership programs in particular involve many Americans without overseas experience or NIS and CEE language skills. Some partnerships have reached out to their communities to tap the knowledge of ethnic populations.

- Partnerships involving U.S. universities have on occasion been difficult. Universities do not have time for unreimbursed activities and expect overhead. "You can't do university partnerships. They are in financial crisis and can't do volunteer work. Universities can't match in-kind contributions. They are used to 60 to 80 percent overhead. Higher education people are like herding cats, they are not team players. There are problems of academic freedom," as one person put it. Another said, "This will only work in the future if they build in a research component. We need more substantive work to keep the relationship going."

The partnership model represents a departure from the usual community-based programs that characterize other USAID projects. It is not designed for sustainability, replicability, or immediate and direct policy impact. One mission pointed out that it "does not lend itself well to the need for strategies, sectorwide results, and accountability." The partnership approach does broaden the appeal of foreign assistance in the United States by involving hundreds of ordinary citizens in the transfer of information, generates substantial in-kind contributions, and offers an interesting alternative model for infusing new information and technology into the former Soviet system.

Conclusions

- *The partnership model evidences both positive attributes and potential problems. Its strength lies in interaction among individuals. People make lasting friendships and expand their horizons. Partnerships are also an excellent way to transfer technical information at the local level.*

- *The partnership model differs from standard development projects that emphasize sustainability, replicability, and direct policy change and should be judged accordingly. It is an excellent way of changing the way limited groups of people think about health care. It does not lend itself to replication outside targeted hospitals and characteristically does not lead to national-level policy changes in clinical practice or policy.*

Recommendations

- *The basic partnerships should continue. In the absence of strong doubts about future funding, the program should add more hospitals. Those hospitals, however, should be chosen strategically and with advice from local USAID missions.*

- *USAID should broadly interpret the partnership concept as technical assistance built on peer-to-peer personal relationships between practicing health professionals and their institutions, not necessarily as a volunteer effort. Accordingly, USAID should creatively adapt and manage the partnership program to promote sustainable health care reform in the NIS and CEE.*

3.1.2 Types of Partnerships

AIHA partnerships are of three types: hospital partnerships, health management education partnerships, and healthy communities partnerships. Each has its own objectives and types of partners. Of the 44 current partnerships, 36 are hospital partnerships that focus on improving the quality and organization of health care delivery in the hospital and health care provider setting. The 1995 amendment to the CA introduced health management education and healthy community and community-based health reform partnerships funded under the separate Promotion of Health Markets Project.

Hospital partnerships. Partnerships between hospitals (or groups of hospitals in the same town) allow American health care institutions and systems to assist counterparts in addressing significant mortality and morbidity issues, improving health care organization, and introducing market-oriented solutions to hospital and health system delivery and finance problems. In addition to their specific institutional counterparts, hospital partnerships work to a degree with ministries of health, local and regional health system administrations, and schools of public health science.

Health management education partnerships. AIHA's health management education partnerships were first funded under the 1995 CA. The purpose of these partnerships is to develop the capacity in CEE to educate managers in the health care sector, first, by developing undergraduate and

graduate degree programs to create new generations of professional health managers and, second, by offering continuing education for health professionals currently in management positions.

Healthy communities and community-based health reform partnerships. Healthy communities partnerships include a methodology for empowering communities to achieve consensus on problems and the need for change. The methodology involves multiple sectors and is derived from the World Health Organization's model for Healthy Cities. It marks a new direction in partnerships as it is community- rather than hospital- or university-based. The goal is not to achieve a particular level of health but rather to be conscious of health problems and citizens' ability to deal with many of them. Two healthy community partnerships operate in Slovakia.

The evaluation team visited all three partnership types. Hospital partnerships make up the vast share of partnerships and form the core of the project.

3.1.3 Duration of Partnerships

Partnerships are intended to last for three years. In the NIS, partnerships have been funded year to year within only a general time frame; as a result, U.S. partners complain that they experience difficulty in planning. In CEE, USAID funded the partnerships for a specific length of time. Some partnerships are now effectively in their fifth year; Estonia graduated at the end of its three-year agreement in 1996, and the Latvia and Czech Republic partnerships are scheduled to graduate in 1997 as planned. Based on the CA signed in 1995, all partnerships now have an explicit graduation policy.

Most partnerships go through a similar evolution, with the first year focused on getting acquainted, explaining the NIS and CEE systems to the Americans, surmounting cultural barriers, and holding initial discussions of clinical issues and work plans. It is generally not until the second year, when people have visited each others' hospitals and homes, that work begins in earnest. By that time, participants usually recognize that clinical problems cannot be fully resolved until certain management issues such as infection control, the role of nurses, and financial controls have been addressed. By the scheduled end of the partnership, many partnerships have just taken off. Further, as they succeed with their initial activities, they identify other initiatives they want to undertake.

The 1994 evaluation suggested that partnerships should be funded for three years with an additional two-year graduation period. "We will need three to five years more to expand the [U.S.] system throughout this hospital," said one U.S. partnership coordinator. "Three years is not enough if you have a broad goal. More of the money should go to partners to grow their capacity and give them time to learn," said a nurse. A physician at a CEE hospital said, "Our partnership ends in March '98 but we would need at least two more years." Georgia's minister of health said, "We need the partnership until 2001 in Georgia [started 1994]. Then we will come and help you."

One reason for the partnerships' long startup period, according to U.S. partners, is that AIHA does not provide new partners with a sufficient orientation. To address this shortcoming, several Americans suggested the development of briefing papers on the health care system in the partner

country along with cultural introductions and the sharing of lessons learned from other partnerships. Some suggested that an established partner might mentor new partners to prevent the repetition of mistakes. AIHA feels that much of its work in 1992-1993 was focused on producing material to orient U.S. and NIS partners to the health care systems of their counterparts. In CEE, the orientation process is more difficult and less cost-effective than in the NIS, as each country is different. AIHA says that little useful background material is available and that other NGOs and contractors working in the region use the AIHA-produced material. AIHA feels that established partners do mentor newer ones through annual conferences.

The arbitrary three-year time frame can keep weak partnerships alive, although AIHA's strategy has called for replacing U.S. partners when a relationship is not succeeding. It is a judgment call as to how much effort AIHA should devote to a troubled partnership before terminating it or replacing the nonproductive partner.

Conclusion

- *The duration of partnerships should be based on the pace of accomplishments rather than on an arbitrary period of three years.*

Recommendations

- *Partnerships should start with a two-year budget but continue for up to five years as long as they demonstrate progress. AIHA should undertake a participatory evaluation of each partnership after 18 to 24 months to determine whether to continue, replace, or terminate it.*

- *AIHA should identify partnerships with compelling successes and assist them in locating funding from other sources so that they can become independent of AIHA at the end of project funding.*

3.1.4 Outcomes

The project has had pronounced effects in both the United States and overseas. The most common comment on both sides related to new ways of thinking about patients and health care management. Given that a change in mentality is fundamental to changes in the health care system, the single most difficult challenge to successful transition and transformation is the inculcation of new patterns of thinking.

3.1.4.1 In the United States

The primary outcome of the partnerships on the U.S. side has been the opportunity to visit another country and host international visitors. In addition, the United States has benefited from certain clinical insights, as noted in the various sections.

Partnership participation is a valuable cross-cultural experience for Americans. AIHA reports that its best proposals come from hospitals without international experience. "It's hard to say how this makes you a better American. My kids all want to go into international issues. It has really changed all our lives. I was always interested in alternative medicine, now more so," said a nurse. "I do it for personal growth and opportunities. I do lots of talks around town. I take Russians to meet people who have never met a Russian. I have gotten much more visible in the [state] medical community in my search for wheelchairs. I got a national award I wouldn't have received." "It makes us all better people," said one technician. "It helped us realize that Russians are just like us. We don't have much ethnic exposure here" and "We are all so interested in the news now" were other typical comments.

A nurse remarked on how "we've learned to improvise. I'm much more conscious of waste, more cost-conscious. We can demonstrate that it is possible to do so much more with less. Our people have been able to step back from the way they usually do things." Another nurse noted that "they look at the patient first without technology. In our world it's all technology. It made me go back to the art of nursing and reminded me how important hands are. They are intrigued by our technology, but it's not necessary." Many U.S. participants said they found themselves asking "whether we really need all this stuff." One American nurse said she returned from her visit to Russia and drove into her garage, noted all the recreational equipment and lawn tools, then went to her closet and saw all the clothes and shoes and burst into tears, wondering why she has so many consumer goods when others live so well on so much less.

U.S. participants showed great interest in several NIS and CEE medical procedures. For example, Russian bone-lengthening procedures have been adapted for use in the United States. Mud hydrography programs attracted interest, as did a special bed for high-risk deliveries. Other U.S. partners are learning about radial keratotomy and other types of eye surgery. The Croatians are teaching their partners how to use sonography in early identification of breast and ovarian cancers. Some Americans noted the use of alternative therapies such as massage, hydrotherapy, and aroma-therapy. One U.S. doctor noted that "they are way ahead of us in holistic medicine, acupuncture and so on." At the other extreme, participants noted they were able to observe diseases and conditions that are now rare or nonexistent in the United States.

3.1.4.2 Overseas

Section 3.5 on Other Results describes in greater detail the overseas impact of the partnerships. More generally, the overall impact, which was mentioned in almost every interview, is the changed way of thinking. Some typical comments follow:

- "Our main achievement is a change in mentality," said a Russian hospital administrator.

- "We started with medical problems, but now it's systems thinking and learning. AIHA has allowed us to do this. Now we are facilitating change in partners' thinking, but they are beginning to take ownership of their change. It took us a year to get beyond the shell of politeness. Now they have learned a whole new way of learning," said a U.S. partner.

- "Entering into a market economy was a disaster for most hospitals in Russia, but not so much for us because we had this new approach. It changed the mentality of top people at No. 122. We saw problems being solved in the U.S. It was practical, not theoretical. We saw that we have to deliver high-quality and profitable services."

- "It changed our way of thinking and that's the main effect. We got and appreciate humanitarian assistance, but development is having the greatest effect, as it's laid the roots for a whole new health system in Georgia and probably other NIS countries," said a minister of health.

- "For us, it's a new way of thinking. We have better solutions and we are always looking at better ways to do things. The word 'management' was new to us," was a comment the team heard many times in different versions.

The new way of thinking generally applies to five areas. *First*, it involves a problem-solving orientation with team management and a focus on quality of care. *Second*, the ideas of cost accounting, cost recovery, and income generation represent exciting innovations. *Third*, the concept of patient education and involvement in treatment is new. Some of the most successful activities have been patient self-management of chronic diseases such as alcoholism, diabetes, and asthma. Involving families in childbirth has triggered great interest. As doctors learn about the benefits of patient satisfaction, much more patient education takes place. *Fourth*, the professionalization of nursing has caught the attention not only of nurses but also of hospital managers looking for ways to cut costs (see Section 3.2.1 on NIS Nursing Task Force for more about the nursing initiative). *Fifth*, the idea of routine continuing education is exciting, particularly among nurses. Despite recertification requirements, most doctors and nurses in the NIS and CEE have limited opportunity to keep abreast of new developments after completing school. Until recently, medical societies or professional meetings were virtually unknown; hospitals still do not have libraries. These changes in mentality are pivotal to the achievements of the partnership program.

3.2 Partner Initiatives

AIHA's original program design, confirmed in the 1993 Program Description, called for the support of interpartnership activities that respond to the needs of multiple partners and capitalize on cooperative efforts. Bringing partners together in conferences, workshops, planning meetings, and task forces enables them to share information about their experiences, thus enriching their bilateral efforts. The initiatives also conserve resources by creating economies of scale and developing common models that can represent a step toward systemic impact. The 1994 evaluation encouraged these activities. (The initiatives apply only to the NIS partnerships, with the exception of the CEE nursing initiative.)

In addition to support for bilateral and multilateral activities, AIHA began to work with partnerships or groups of partnerships to try to involve ministries of health and other organizations in their work. An example is the diabetes initiative (described in Section 3.2.6), in which the Dubna-La Crosse partners engaged the Russian MOH and Eli Lilly and Company to elevate the success of an individual partnership to a broader level of replication in other cities.

The costs associated with these joint activities (including travel, meals, and lodging) are budgeted in each individual partnership agreement under a category called interpartnership activities. AIHA incurs the costs of facilitating meetings and workshops, making group equipment purchases, and purchasing (and occasionally publishing) educational materials. USAID estimates that approximately 52 percent of the AIHA budget is allocated to these and other multipartnership activities, but AIHA is unable to provide expenditure figures.

3.2.1 NIS Nursing Task Force

To facilitate a coordinated approach to strengthening the role of nurses as clinicians, managers, and educators, AIHA assembled a task force made up of one U.S. and one NIS representative from each partnership. In April 1995, AIHA's first international nursing conference called *Developing Nursing Leadership* was held in Moscow and attracted over 200 participants. Participants wrote an appeal to health care administrators, nursing leaders, and clinicians that identified the following goals for nursing reform:

- to improve undergraduate and graduate nursing education programs;
- to enhance the professionalism of nurse administrators;
- to create national, regional, and international professional associations; and
- to organize national, regional, and international nursing leadership conferences.

As a result of the conference, nurses from Ukraine, Georgia, and the Kyrgyz Republic formed national nursing associations modeled on the American Nurses Association. In Kyiv, nurses organized a citywide conference and established the Kyiv Nursing Association. In the Kyrgyz Republic, membership has grown to approximately 1,000 nurses. A conference on nursing attracted 110 head nurses from nonpartnership institutions in four other Central Asian republics. Two

partnerships, one in St. Petersburg and the other in Almaty, have developed new four-year nursing curricula that include both didactic and practical training.

The nursing task force supports two activities. The first is annual regionwide meetings that include 200 or more nurses from all 23 NIS partnerships. The AIHA coordinator of the nursing task force has used videos to promote nursing and leverages funds from private sector firms for nursing activities. The conferences provide an opportunity to share experiences and practice new presentation skills. The second annual conference spawned the Society of Nursing Educators will include lawyers, pharmacists, economists, sociologists, physicians, and others, with four representatives from each region of the NIS. In addition, the nursing task force contributes to continuing education courses that address such issues as prehospital care, the patient's first hour in the hospital, and radiation disasters. The task force has also produced a basic nursing handbook.

The second activity supported by the nursing task force is the development of nursing learning resource centers. Recognizing that continuing education is critical to upgrading the role of nurses, the centers will provide faculty, students, and practitioners with a facility that supports alternative forms of learning. The centers will make available books, videos, and other resources for self-learning as well as resources to enhance teaching methods. The centers also serve as meeting sites for nursing associations and a place for collaboration on various nursing issues. Ten centers are already open in Ukraine, the Kyrgyz Republic, and Kazakstan, with ten more planned throughout the NIS. Partner hospitals or universities donate space for the centers and provide a person to staff them. A list of equipment and resources has been developed with the deans of colleges of nursing and directors of education.

A potentially important spinoff of the nursing task force is the Nursing Association of Russia, which now numbers 7,000 members in 17 regional branches. Membership costs $2 a month. The goals of the nursing association are to educate nurses to eliminate pain and to develop a system of accreditation for nursing schools and nurses. The most recent meeting of the association drew 35 chief nurses and their assistants. The association also hopes to influence policies on the role of nurses, the nurse-to-patient ratio, and salaries.

The NIS nursing initiative has been one of AIHA's most successful cross-cutting initiatives. It includes numerous NIS partner hospitals whose nurses are highly interested in improving their skills and enhancing their role as a member of the health management team.

- "Nurses and midwives have a much better role now. AIHA is the prime mover on this. They started a Ukrainian Nurses' Association and the nurses love the informal conversation."

- "The project is important to nurses across Russia. We have improved our self-esteem. We are more than a flower in need of sun, we are a bush that's not afraid of the wind."
- "Nurses and doctors are much more open. Nurses are much more active and interested in their job. They started keeping records on things to justify more resources."

- "The nursing model [used in St. Petersburg] is now a model the MOH is using to train other nurses. We have special teaching teams with lectures on economics, management, and computers. This is the first time nursing has been taught as a profession. Nurses learn to develop didactic materials and work more with MDs."

- "We were the first to bring nurses together from across the NIS. E-mail is a very important way for us to keep in touch. Nurses have done some training on their own. They are very proud of their new skills."

The most successful nursing reform has occurred in Kazakstan and to some extent in the Kyrgyz Republic. New four-year nursing programs have been instituted in 14 medical schools in Kazakstan, with appropriate roles and salaries. A nurse trained in a four-year nursing management program now commands the same salary as a physician, and hospitals offer new positions for nurses at a much more senior level than before. With partner help, a new curriculum has been developed for three levels of nursing skills.

Despite the successful nursing reforms, local regulations that limit the role of nurses, cap nurses' salaries, and specify nurse-to-patient ratios continue to constrain the impact of the nursing initiative. Until such policies are changed, there is a limit to how much nurses can apply their new ideas and skills. A great deal remains to be done before the status of NIS nurses is comparable to that of U.S. nurses. The nursing associations are attracting the attention of policy makers, but they lack experience and do not yet have the clout or the advocacy skills necessary to enter into a policy dialogue with officials**.**

Nevertheless, no individual facet of the partnership program has had a greater impact than the recognition of the greater role nurses can play in the provision of care. This is particularly true in the NIS, where nurses have historically had limited opportunity to demonstrate their capability to assume a partnership role with the physician and others. The exchange of nursing personnel between U.S. and NIS partners has significantly changed the views of both nurses and others who can bring about change. The nursing associations, in conjunction with AIHA, have sponsored a number of seminars addressing nursing leadership and professionalization. The associations act as support groups and potentially as political bodies that seek legislation to enlarge the scope of practice for the nursing profession. The full effects of these changes on the role of nursing will be seen as graduates of the new programs increase in number and governments codify new job descriptions, staffing ratios, and salary levels.

An important issue in health care reform, particularly in the NIS, is matching human resources with country needs. While nursing reform is important for professionalizing the role of nurses and providing patients with much more hands-on care and education, the system currently produces far more physicians than the system can absorb. As a result, many highly (and expensively) trained physicians are being forced into nonmedical jobs; moving nurses into functions now performed by doctors could exacerbate this problem.

Conclusions

- *The NIS nursing initiative has had a strongly favorable impact on the nurses involved. Through conferences and meetings, the initiative has fostered an increased interest among nurses in their profession by providing a collegial forum for the exchange of ideas, strengthening the ideals of professional nursing, and developing a sense of mutual support. Despite its great impact on the lives of the nurses involved in the conferences and exchanges, the nursing initiative has had limited national-level policy impact.*

- *None of the partnerships embodies a program for retraining physicians in the medical system and reforming the role of nursing in the context of an assessment of overall human resource needs and skills at the hospital or system level.*

Recommendations

- *Nursing reform needs to take place in the context of human resource development. An overall study of human resource needs for the health care sector should be conducted to determine the number and type of health professionals that will be needed in the future.*

- *The Russian Nurses' Association and the AIHA nursing task force should combine their efforts to influence policy change. Funds should be provided, even at the expense of other nursing or partnership activities, to deliver technical assistance from organizations experienced in developing nonprofit organizations and advocacy skills.*

3.2.2 CEE Nursing Task Force

The CEE nursing task force formed in September 1995. That CEE countries do not have a common language poses a challenge to interpartnership activities and an even greater challenge to nurses, who are less likely than other health professionals to command English skills. As a testimony to the strong motivation of CEE nurses to interact and learn from each other, the nurses have successfully transcended language barriers through interpreters, enhancing their English language skills, and relying on common third languages and nonverbal communication. The task force has held a number of productive meetings.

The CEE nursing task force began with a steering committee of U.S. partners that met several times to organize the first full task force meeting in April 1996. A counterpart CEE steering committee holds meetings and has its own chair. The two steering committees planned the second task force meeting for April 1997. Nurses have gained experience in organizing and conducting meetings and have developed a structure for continuing post-AIHA activities.

Some of these activities have been particularly effective. One participant reported that "because of the nursing association, nurses and doctors were together at the same conferences for the first time. This changed their attitudes. They have a new attitude toward work. The nurse is not just a cleaner and bather, but a real member of the team. We learned about the changed attitude between the nurse, patient, and doctor. Before, the doctors did not care what the patient or nurse thought."

Although national nursing associations are not directly related to the nursing task force, most of the CEE nurses belong to and are active in national nursing associations. These associations have sponsored more than a dozen conferences and workshops, with participation in each growing as more nurses join. As in the NIS, the impact of the nursing initiative has been constrained by policies in each country that limit the role of nurses. Salaries are low; in some places experiencing a severe shortage of nurses, nurses cannot assume expanded duties. Recognizing these problems, the goals of the task force are based on what is realistic: a focus on sharing information, creating a common foundation of skills in primary areas of nursing, empowering to effect change, and developing collaborative relationships.

While the nursing initiative is not intended to have policy impact, national policy change in CEE can begin at the individual partnership level. For example, nursing partners in the Czech Republic work with the MOH's head nurse and have submitted recommendations regarding the role and responsibilities of nurse managers. At the same time, the role and responsibilities of nurses within individual partnership institutions have been changing such that nurses enjoy a greater role in patient care, stronger teamwork with physicians, and improved self-esteem. AIHA believes that the nursing task force is an integral part of each partnership. It augments partnership-specific activities through opportunities for learning from other partnerships.

One hospital director said, "Nursing reform has a long way to go. There are lots of initiatives but it can't be done because nurses aren't trained. The downside of the partnership is that many good ideas can't be implemented. The nursing task force is as good as possible given the conditions. We would like to see more country-specific task forces...." Another said, "Our main problem is a shortage of nurses, we need 30 percent more." A project coordinator, remarking on the nursing task force as well as on other initiatives, said, "We would put more emphasis on the partnership and less on cross-cutting issues."

The task force recognizes the limits to what a regional task force can accomplish in CEE. Therefore, partners in several countries have held or are planning to hold national nursing workshops and conferences. In addition, through participation in the task force, nurses from different partnerships in the same country or region are able to develop their own groups.

Conclusion

- *Recognizing that partners in different countries speak different languages and work in different health care systems, the CEE nursing initiative has focused on individual countries, placing less emphasis on regional activities. The CEE partnerships depend on the task force primarily as a way of sharing information and getting support.*

Recommendation

- *The CEE nursing initiative should be scaled up to focus on building national nursing associations by assisting with organizational development and training the associations in strategies for policy reform. As in the NIS, funds should be allocated, perhaps at the expense of the overall partnership effort, to strengthening national nursing associations.*

3.2.3 Emergency Medical Services

With eight of the original NIS hospital partnerships identifying emergency medical services or disaster medicine as a clinical area of focus, it was a natural evolution to broaden this interest into a task force. The EMS task force formed in January 1994 with eight partners. Another partner has now joined, and membership will shortly increase to 13 NIS partners. The EMS initiative concentrates on developing emergency medical services training centers that offer a standardized curriculum in prehospital emergency care to police, firefighters, ambulance crews, and hospital staff that provide emergency care.

Typical ambulance staff and public service workers have little training, and accident victims are often injured further in transport. Ambulance arrival time is often measured in hours rather than minutes. Trainees at the EMS centers are taught to make their own splints and other stabilizing equipment from locally available materials but do not have access to the sophisticated equipment used in the training rooms.

At present, eight EMS centers are located in Kazakstan, Moldova, Russia (Moscow and Vladivostok), Armenia, Ukraine, Estonia, and Georgia. They use a common curriculum that combines didactic presentations with practical hands-on skills training in airway management, including intubation for adults and pediatric patients, cardiopulmonary resuscitation (CPR) that incorporates the use of a defibrillator, placement of central venous lines, and splinting and immobilization for transport. Students use mannequins, videotapes, and slides and are expected to demonstrate the successful acquisition of basic skills by the end of the course.

Georgia's minister of health said, "I thought it was important to develop a whole system in the community using the model from Boston-Armenia. We do lots of prehospital services and care so the patient is stabilized before he gets to the hospital. We opened our center last fall and have done four or five courses already, including doctors, nurses, firefighters, and so on."

Kyiv's year-old program has trained 480 physicians and ambulance attendants in the basic curriculum. Trainees are involved in ambulance and prehospital care for that geographic area.

In Moscow, the training center is part of the special Directorate of Biomedical Problems and Disaster Medicine, which has considerable autonomy within the ministry of health and enjoys better space and equipment. The directorate cares for a special population: scientists and workers in the nuclear industry as well as the victims of nuclear disasters and persons involved in space exploration. Even though the directorate covers all of Russia and provides both general and specialized care for 2 million workers, it has no ambulance service, and its EMS trainees staff emergency rooms and clinics.

The EMS center in Almaty, Kazakstan, uses the common curriculum, adapted slightly for local conditions. In addition to training ambulance drivers to assist EMS workers, the center trains its drivers in basic first aid. The basic first aid training was initially somewhat controversial, as drivers had not previously been involved with patients. Now, trained drivers are active members of teams. The Almaty center also trains drivers from embassies in a 40-hour first aid course, charging $100 for each trainee to generate income for the center. The director is actively looking for ways to increase the number of fee-paying trainees.

Reports from other centers record the number of professionals trained. To date, however, no data have been collected to show better clinical outcomes for patients cared for by graduates of the program. Interviews with emergency room physicians and trauma unit surgeons say they see no improvement in the condition of patients arriving at their doors. This may be attributable to three factors. First, few people have been trained; second, those trained are not serving the general public; third, ambulances lack the life-saving equipment needed to improve a patient's chances of survival.

The EMS program is a good example of how partnerships can combine to form a broader initiative. The interest in the program is high because most U.S. partners operate emergency departments that participate in prehospital training of ancillary personnel. Further, the curriculum is focused, and few resources are necessary to conduct a successful program. The fact that AIHA pays for the space at the centers, provides much of the training equipment (some of which is already wearing out), and covers supplemental stipends to local staff who work in the centers raises questions of sustainability.

Conclusion

- *The EMS program relies on relatively low technology and undoubtedly saves lives and prevents further trauma to the few patients fortunate enough to be picked up by trained EMS workers assigned to an ambulance with life-saving equipment. As the program is currently designed, the number of trainees is and will remain low. Those trained in Moscow do not work outside their own hospitals.*

Recommendation

- *The EMS program has laid the groundwork for a system that, with strategic redesign, could begin to have nationwide impact by creating a national training-of-trainers facility. A nationwide EMS program should also be tied in with existing preventive public health*

initiatives and advocacy groups (U.S. and NIS) and should address CPR training, seatbelt laws, antidrunk driving campaigns, and drug abuse prevention.

3.2.4 Neonatal Resuscitation

In recognition of the high infant mortality rates in the NIS, the nine partnerships that initially identified neonatal mortality as a clinical focus now make up the neonatal resuscitation task force. The objective is to create a standard neonatal resuscitation program and to develop neonatal resuscitation training centers for the acquisition of practical skills; centers are to open in Ukraine, Russia, and Uzbekistan in 1997. The task force will also translate and disseminate commonly used data forms for evaluation of resuscitation programs at the NIS institutions. The idea is to develop a cadre of trained nurses and physicians who can serve as a core resource in NIS hospitals.

Skills learned through partnership exchanges can be applied immediately in the delivery room and nursery. Indeed, the program has had an immediate clinical impact. Data from Kyiv show a reduction in neonatal (first 30 days) mortality from 9.4 percent to 4.9 percent. Similar success is reported from Lviv. In Georgia, the task force has sponsored two regional workshops with reported success.

The initiative has potential for wide applicability throughout the NIS and CEE. Basic resuscitation of the newborn can be taught to all midwives, nurses, and physicians. More advanced methods need to be handled at the regional level but may be difficult because of the hierarchical nature of health care in the NIS. Adoption of standardized definitions and reporting would facilitate program evaluation. For example, some hospitals include in the denominator only newborns over 1,000 grams, thus improving neonatal mortality rates. In Russia, Ukraine, and Kazakstan, the neonatal resuscitation task force has become a major part of the national programs for maternal and child health and a model for nationwide replication. In Russia, the MOH is reported to have changed its national guidelines on delivery room assessment and care of the newborn based on the partnership work.

Successful implementation of the neonatal resuscitation program will increase the demand for pediatric services, particularly for infants with disabilities. At least one effort has attempted to coordinate the program with existing programs for the disabled. The Moscow-Norfolk partnership is establishing a coordinated and comprehensive neurodevelopmental follow-up program for infants. The MOH will use this program as a model for others in the Russian Federation. Therefore, the program needs to be coordinated with existing services for disabled children such as social work, rehabilitation, and orthotics.

The 1994 evaluation of AIHA came to a similar conclusion and recommended that neonatal resuscitation should be folded into a general program of maternal and child health. It commended as desirable and cost-effective the initiative for loosening swaddling clothes, keeping newborns with the mother, bringing pediatrics closer to the delivery room, and reducing newborns' exposure to infection. Given the cost of support for children with severe problems, the evaluation noted that resuscitation of the extremely premature was inappropriate.

Clinical Results

Seven institutions in six countries reported a reduction in infant or neonatal mortality. Neonatal mortality is clearly related to the quality of in-hospital care and therefore is a good measure of improvement in a hospital-to-hospital program. Reductions of 49 and 62 percent have been reported in two Ukrainian partnerships. Reductions in infant mortality of 45 percent in Tashkent, 12 percent in Almaty, and 13 percent in Bishkek are other examples of progress toward improved health status.

Infant morbidity measures are less precise and are not reported as frequently. In both Dubna and Kyiv, however, the introduction of contraceptives has led to a marked reduction in abortions. In Tirana, the Caesarean section rate has dropped from 28 to 15 percent, a figure comparable to that in the United States, and introduction of ultrasound into prenatal care has reduced the neonatal asphyxia rate by 71 percent. Although not immediately quantifiable, reductions in mental retardation, cerebral palsy, and other manifestations of intrauterine anoxia have a measurable effect on postnatal morbidity.

The coordination of the neonatal resuscitation initiative with MCH and women's health programs would make it much more effective. It would particularly be important in hospital postdelivery practices such as isolation of the newborn from the mother, glucose feeding, a long length of stay, and other practices.

Conclusion

- *The neonatal resuscitation initiative has shown dramatic and immediate results. In the hospitals visited by the evaluation team, however, neonatal resuscitation is not yet a part of a program of prenatal care and follow-up on nutrition, breast feeding, and family planning.*

Recommendation

- *The neonatal resuscitation initiative needs to be scaled up to the national level and integrated into other maternal and child health programs. If coordinated with the women's health initiative that provides women with better prenatal care, the neonatal resuscitation initiative could be even more effective. A nationwide training-of-trainers program could bring simple life-saving techniques for newborns to a broader range of hospital personnel.*

3.2.5 Infection Control

Six of the 25 NIS partnerships identified infection control as a topic for concentration. Infection control is particularly important as hospitals work to reduce the average length of stay (ALOS). The current length of stay in most NIS and CEE hospitals increases the risk of nosocomial (hospital-acquired) infections. The longer a patient stays in a hospital, the higher is the risk of nosocomial infection, which further prolongs the hospital stay. It is estimated that 30 to 40 percent of patients contract hospital-acquired infections in the NIS. In 1993, the Russia Ministry of Health mandated formal hospital-based infection control programs; subsequently, AIHA and the Russian MOH

entered into an agreement to implement the order. Representatives of the Society of Hospital Epidemiologists of America, the Association for Practitioners in Infection Control, and the American Hospital Association are participating in this effort. There are no CEE members on the infection control task force.

All the U.S. hospital partners visited by the evaluation team emphasized surgery and trauma as priorities but found they could not begin activities directed at surgery without first improving infection control standards. One problem, however, is that current NIS regulations are markedly different from U.S. infection control standards. Developing higher NIS standards as national policy would require retraining all doctors and nurses and establishing all new procedures. Nonetheless, several U.S. partners have been able to introduce their recommended standards to NIS and CEE partners. The Russia, Ukraine, and Kazakstan MOHs are reported to be in the process of revising their infection control standards based on recommendations from U.S. partners.

A nurse in Moscow said, "Infection control was identified as the common dominator. That led us to focus on nursing care and this is the most effective thing—a combination of nursing leadership and nurses' ongoing education. We used to have a 2 percent infection rate of wounds, but since 1995 we have had no postsurgical infection complications for elective surgery." It is clear that those who have visited the United States have become much more conscious of infection control.

Hospitals in the NIS lack trained epidemiologists, uniform data collection systems, and standard terminology to allow comparisons. In response, the infection control task force has focused on a training program that could be used throughout Russia. The strategy is to open two training centers in 1997 in Moscow and Vladivostok to train trainers. Similar centers are planned for Ukraine and Kazakstan.

At this point, it is too early to measure the impact of the infection control program. While some hospitals offered data on rates of nosocomial infections, the data did not appear to be reliable, and definitions of terms vary. The exception is the Central Clinical in Moscow, which seems to have valid data on several quality-of-care indicators and is a participant in the Maryland Quality Indicator Project, through which its data are compared with almost 1,000 member hospitals.

To be effective, hospital infection control principles need to become part of the philosophy of patient management on a hospitalwide basis. Most of the hospitals visited by the evaluation team lack infection control as well as good in-hospital microbiology laboratories, which are an integral part of data collection. Most NIS hospitals employ a staff epidemiologist charged with tracking the rate of infections, but the laboratory directors and nursing staff have not yet developed partnerships that will effect much change. Hospital epidemiologists experience difficulty influencing patterns of care.

The above comments show the change in thinking that characterizes the AIHA partnerships. Doctors, nurses, and hospital administrators now recognize infection control as a core element of every staff member's job. This attitude is not typical in the NIS and represents a change in the way partners think about their work.

As with other specialties, it is becoming increasingly difficult to recruit U.S. hospital epidemiologists as volunteers. For the most part, they are salaried employees who are asked to produce more with fewer resources and have less time to volunteer. AIHA has included the Centers for Disease Control (CDC) in some of its activities by, for example, involving a CDC trainer in an infection control workshop and including CDC in the design of the evaluation study of hospital infection control. Another CDC trainer will be used in a follow-up and the annual conference will involve CDC.

Clinical Results

Nosocomial infections have been a major factor in prolonging hospital stays and contributing to overall morbidity in the NIS. Many institutions have participated in AIHA-organized infection control initiatives long enough to be able to see the results of the training. Individual hospitals report declines in nosocomial infection rates as great as 50 to 60 percent from those previously reported. These rates are still considerably higher than those reported in the United States. They lag changes in both management and the role of nurses and laboratory medicine and change in the physician's role in patient care. Examples of specific reductions in Almaty are associated with catheter complications, which came down from 68 to 12 percent, and a 250 percent decline in serum-transmitted hepatitis.

Conclusion

- *The infection control initiative offers great potential. As health care reform and financing become more important in the NIS, the contributions made by reducing the ALOS and improving quality of care become critical elements in the performance of individual hospitals. Given that all U.S. hospitals operate infection control programs, hospitals are logical places for NIS personnel to develop practical experience.*

Recommendation

- *The infection control initiative needs to be scaled up to have greater impact in nonpartner hospitals. Using the lessons learned from the NIS infection control task force, the initiative might be broadened to nonpartner hospitals to extend impact.*

3.2.6 Diabetes

In 1993, the Dubna-La Crosse partnership identified diabetes as an issue. Unlike other initiatives, which share information between partners, the diabetes initiative—under the auspices of the Moscow Regional Diabetes Initiative—is devoted to replicating this successful project at three other sites in Moscow oblast and at two sites within the Moscow city limits, where 250 additional patients have been trained. The goal of the Dubna program is to serve as a model to facilitate change in diabetes care, improve patient health, reduce costs through shorter hospital stays, and create teams of physicians and nurses trained to manage out-patient diabetes programs.

The diabetes initiative is unique among the AIHA partnership programs in two ways. First, it follows an explicit plan for replication outside partner communities. Second, it involves a U.S. private sector partner, Eli Lilly and Company. Lilly has contributed $2.1 million in insulin and other products while the La Crosse partner has contributed $300,000 in supplies and equipment for the diabetes education center. The program's good record-keeping system demonstrates a decline in hospitalizations, shorter ALOS when patients are admitted, a reduction in the amount of insulin used per patient, and fewer diabetes-related health problems.

The process starts with the formation of a steering committee and two staff training programs of three weeks each in Moscow, followed by two additional weeks in La Crosse. The partners, in cooperation with the Russian Academy of Advanced Medical Studies, developed a 72-hour teaching curriculum that includes modules for clinical training, management, and the financial management of a diabetes education center. The Moscow Academy of Medical Sciences has certified the curriculum. At the time of the evaluation, the Dubna program had trained 400 of the 1,000 diabetics estimated to be in the area to self-manage their care.

A patient education model was developed with assistance from Lilly, Boehringer Manheim, and Russian endocrinologists. Training-of-trainers sessions have been carried out in Dubna for the educators associated with the expansion sites. The program emphasizes a team approach by using physicians, nurses, and patient educators to educate the patient and provide treatment in out-patient settings. Partners are working with WHO/Europe on a patient evaluation system that will allow for the measurement of trends in patient outcomes over time and the comparison of outcomes with similar programs in Europe. Future plans include training doctors from the two Moscow city hospitals and publishing a series of journal articles. New sites will be outfitted with medical and educational equipment. A ten-day study tour of the United States will take place in spring 1997 and include visits to La Crosse, Lilly headquarters in Indianapolis, and Washington, DC.

Clinical Results

The partnership between Dubna and La Crosse has expanded beyond the walls of the hospital to meet community health needs. The diabetes program is an excellent example of how clinical programs can be implemented on an out-patient basis as well as in the hospital. Statistics comparing the use of insulin by diabetic patients before and after participation in a training program show reductions of 30 percent in insulin dose for Type I diabetes and 24.4 percent for Type II diabetes. The improved management of diabetes has many ramifications— 60 percent fewer hospitalizations, fewer complications (cardiovascular, eye, etc.) and, as a result, lower costs.

Conclusion

- *The diabetes project's approach to patient self-management has had a highly positive impact on the health of diabetics while lowering the cost of health care. The program is unique in its emphasis on nonhospital-based patient education and the involvement of Lilly as a partner. It remains to be seen whether the project, developed in a small city with a highly educated population, can be replicated in larger urban settings.*

Recommendation

- *The replication issues and lesson learned should be documented. If successful, the program should be scaled up into a broader initiative to be introduced in many more communities, perhaps as part of a future healthy communities initiative. If the program's cost-effectiveness can be documented, other donors and countries should be interested in replicating the program.*

3.3 USAID Initiatives

This section describes activities involving more than one partnership that have been developed at least in part in response to USAID priorities and encouraged by USAID through separate funding mechanisms. The activities include the women's health initiative, the breast cancer initiative in the NIS, and health management education and healthy communities in CEE.

3.3.1 Women's Health Initiative

The women's health initiative, part of a $1.5 million earmark from Congress, will begin in March 1997 with the opening of four women's wellness centers (WWC), with ten more slated to open in summer and fall 1997. As of March, all centers had completed a site assessment to determine facility, equipment, and training needs.

The objective of the initiative is to meet women's health needs and provide a highly visible model for comprehensive health care services, including promotion, education, early diagnosis, treatment, and follow-up. Each WWC will care for 4,000 women annually and adopt a client-centered approach to women's health over a woman's lifetime. Services will include family planning, perinatal care, STD/AIDS, cancer screening, mental health, substance abuse, chronic disease screening, aging, healthy lifestyle, and adolescent health.

As part of its effort to implement this initiative, AIHA included in its annual meeting program in Des Moines a discussion of an array of issues related to women's health and the establishment of the women's wellness centers.

The women's health initiative is part of a more general interest in women's health. Several partners have initiated programs that target women's health issues even though they are not participating in the initiative. For example, Tirana's mother and child health information center is a resource center for health care professionals in the maternity hospital. In partnership with a local NGO, Tirana has also established a patient information center that publishes prenatal and other health promotion materials for women and children all over Albania. An existing women's health program in Dubna emphasizes family planning and family-centered births.

The women's wellness centers have not been in place long enough to produce measurable results, but some of the other women's health activities have been. In both Dubna and Kyiv, the family planning program has resulted in increased pill use. As a result, abortions are down from three per

live birth to one per live birth. In Tirana, the Caesarean section rate has dropped from 28 to 15 percent, a figure comparable to that in the United States. In addition, the introduction of ultrasound into prenatal care has reduced the neonatal asphyxia rate by 71 percent. Although not immediately quantifiable, reductions in mental retardation, cerebral palsy, and other manifestations of intrauterine anoxia have a measurable effect on postnatal morbidity.

In Dubna, "there is great interest in sex education for young people, as there has been an increase in teen pregnancy and sexually transmitted diseases. They have translated [sex education] materials used in U.S. schools and are using herbal aromatherapy and other alternatives we are looking at," said one U.S. nurse.

Conclusion

- *The women's health initiative is too new to evaluate. At this time, it is not well integrated with the other women's health initiatives already in place in other partnerships.*

3.3.2 Breast Cancer Initiative

The objective of the breast cancer initiative is to develop comfortable and easily accessible out-patient centers that will provide breast cancer screening, including mammography, and a full range of educational materials related to breast cancer prevention, detection, and treatment. Women with cancer will be referred to other facilities for treatment. Sites chosen for the program are women's wellness centers in Kyiv, Lviv, and Odessa in Ukraine. All three cities serve populations affected by the Chernobyl disaster. This initiative has not yet been funded.

3.3.3 Health Management Education

The health management education activity resulted from a 1994 poll of CEE conference attendees who identified the lack of trained health care managers as a leading obstacle to health care reform. The initiative's purpose was to create university-based, degree-oriented programs with formal academic curricula and, ultimately, a new professional career option. As of 1995, the initiative has been funded at over $8 million through the Promotion of Health Markets Project.

Health management education partnerships have been established in Albania, the Czech Republic (two), Romania, and Slovakia and are newer than most of the hospital partnerships. While their objectives are straightforward (design curricula, train faculty, and establish degree programs for health care managers), their contribution is at this point difficult to assess.

The health management partnerships have typically included universities focused on the development of a new curriculum and in-service training programs for service providers. The new curriculum is particularly important for the nursing initiative and the newly created levels of nursing care, with corresponding curricula in clinical and management skills. Startup has been slow because of funding delays and, in some cases, tense relations with AIHA. Given that university staff have

the least time for travel, the use of e-mail and other telecommunication has been particularly important for this type of partnership.

The team notes that it did not visit the health management education initiative's Czech Republic sites, which are reportedly among the most successful. USAID/Czech Republic reports that the seven Czech partners are producing a well-educated cadre of faculty skilled in teaching and management. Students, they report, are applying management theory and practices within the Czech context.

Conclusion

- *The health management education partnerships address a critical link in health care reform by helping build the health management profession. Despite the efforts of some individuals, universities generally seem somewhat less amenable than hospitals to the administrative and financial aspects of the AIHA framework, including the program's central guidance, volunteer structure, and absence of institutional overhead fees.*

3.3.4 Healthy Communities

Healthy communities partnerships are underway in two communities in Slovakia. As noted above, they generally build on the healthy communities concept of the World Health Organization but more specifically on the emerging efforts of large U.S. health care systems that sponsor multi-faceted campaigns to improve quality of life, including health status, in entire communities. The healthy communities activity is also funded under the Health Management Reform project at about $1.1 million.

Turcienske Teplice's healthy communities project includes programs to increase public awareness of the dangers of tobacco and drugs and to encourage self-management of chronic disease. The project also offers an ambulance service, a family stress program, health walks, and a town cleanup campaign. The partner in Petrzalka is a nongovernmental organization called the Aid to Children at Risk Foundation. Turcienske Teplice's healthy communities initiative has been a totally grassroots effort that builds on a network of volunteers who educate youth about the dangers of drug use.

Conclusion

- *While still developing, the healthy communities program has considerable potential. Its preventive and promotive aspects are consistent with USAID's overall health policies. At this time, the program in Turcienske Teplice is performing well because of preexisting momentum and the support of a dynamic mayor.*

Recommendation

- *If subsequent data bear out initial results, the healthy communities initiative could be expanded to include a variety of other public health programs targeted at antidrunk driving,*

seatbelt use, emergency medical services, citizen CPR training, and the treatment of chronic diseases such as asthma, diabetes, and tuberculosis. At some point, nongovernmental advocacy groups supported by USAID grants might be more effective than AIHA in carrying out these initiatives.

3.4 AIHA Program Support Activities

AIHA has provided supporting program activities that supplement, support, or enhance individual partnerships and broader program objectives. These activities, provided either by AIHA directly or through subcontracts, include a series of health management training workshops carried out by the Association of University Programs in Health Administration (AUPHA), other technical workshops focusing on specific issues, support for information systems, the development of a World Wide Web site, and a quarterly publication.

3.4.1 AUPHA Management Training

Of all the areas of focus in the NIS and CEE partnerships, hospital administration and management receive the most frequent mention. This might be expected, as one of the major effects of the breakup of the former Soviet Union and other centrally planned economies was the decentralization of decision making and service provision in response to decreasing state revenues.

Hospitals are routinely headed by physicians who lack training in management or administration. During the first years of the partnerships, individuals from the NIS and CEE who traveled to the United States to visit their partners were intrigued with the concepts of cost accounting, insurance, fee-for-service billing, and the emphasis on cost efficiency. These visits confirmed the supposition in early program descriptions regarding the need for management training of NIS health care professionals.

At the request of USAID, AUPHA became a member of AIHA's Board of Directors specifically to lend its expertise in health management training. AUPHA members include 105 U.S. and Canadian academic health management institutions; they generally maintain close relationships with practitioners.

Under subcontract with AIHA, AUPHA developed a management training course tailored to the needs of the NIS hospital partnerships. The subcontract is AIHA's largest; it started at $200,000 in 1993 when the course was developed and first delivered and increased with the number of partnerships and level of partnership activity to $700,000 in 1996. The goal is to supplement the partnerships' efforts by creating an environment for change through introductory and advanced continuing education in health management for NIS and CEE partners and others in decision-making positions. The curriculum and teaching methods use adult education methods such as case studies. Initially, the workshops were based on U.S. health management cases, but the courses have become more sharply focused on the issues of concern to NIS and CEE health practitioners and now use case studies from partner hospitals.

In addition to the introduction to management course, by 1997 AUPHA had developed and delivered courses covering strategic management, continuous quality improvement, decision making, marketing, and training of trainers. Further, AIHA and AUPHA have collaboratively developed and are teaching courses on financial management of health institutions at both introductory and advanced levels.

In 1996, AUPHA offered 23 courses, each involving 25 to 30 participants. Given that NIS workshops are typically regional in focus, AIHA generally identifies the workshop participants to ensure a mix of partner and country representatives. By contrast, in CEE, where there is no common language and greater disparity among health systems and cultures is the norm, AUPHA has worked with individual partnerships. In some cases, partners have asked AUPHA to conduct the workshops; in others, U.S. partners have served as trainers.

In a typical AUPHA workshop, over half the participants come from partner institutions; other attendees include ministry representatives, educators, and mid- and senior-level hospital managers. AUPHA has found that a critical mass of trainees is a prerequisite to effecting change, largely because health management personnel in the NIS and CEE are usually in their jobs for many years and experience little of the cross-fertilization that is standard in the United States. AUPHA has emphasized the inclusion of women in its workshops and engages women as trainers when possible to reinforce the image of women in leadership positions.

Participants initially found the interactive adult education techniques unconventional, although with experience they have come to embrace the participatory approach and now do much of the training themselves. AUPHA training materials are noticeably user-friendly and include audio-visual aids, case studies, games, and training-of-trainers modules. The introductory courses emphasize subject content but also leadership, problem-solving, and team-building skills. In the training-of-trainers workshops, participants learn to convey management subjects in an interesting way, much in contrast to the Soviet teaching style of long lectures and no practical hands-on experience. AUPHA provides training and accreditation programs for hospital partnerships as well as for the health management education partnerships.

The main criticism of the AUPHA workshops concerns the lack of integration with partners' other activities. Several partners felt that AUPHA was confusing participants by using terminology or concepts that differed from those used in partnership work. AUPHA workshops are said at times to be "dropped in" without adequate preparation, consultation, or follow-up. U.S. partners felt that in some cases the appropriate professionals were not attending the workshops and that participant selections had been political. One mission felt that the AUPHA workshops do not address the management problems that participants have to solve.

One critic said, "AUPHA did a huge conference in [partner city] for ten days on administration, but the timing was bad for us academics, just at the end of the semester. We didn't know [our partners] were invited to those meetings." Another said, "We are an institutional member of AUPHA, and that we haven't worked with them is problematic. We do health management training and so do they. Our people are supposed to be the core health management trainers for [that country]. Our

colleagues are upset over turf issues. It is the opposite of what we have been cultivating there." From yet another, "We wanted the AUPHA course as a training of trainers, but the subjects weren't relevant. They have a very academic management style with a lot of emphasis on leadership, but management is a work process. They didn't include enough on forward thinking."

Conclusion

- *The AUPHA workshops are useful in terms of content and adult education style. They have also succeeded in bringing mixed groups that include women into common learning activities. The workshops, however, might be better integrated with partnership activities.*

Recommendation

- *Each NIS region and CEE country needs an annual plan of all management workshops, conferences, and travel so that busy people can plan for travel and attendance at such events. AUPHA also needs to provide U.S. partners with its training materials so the organization can coordinate its concepts, definitions, and approaches with those used by partners.*

3.4.2 Information Systems Initiative

The medical profession in the former Soviet Union, particularly Russia, has little tradition of continuing education. Some physicians in the CEE countries subscribe to European professional journals and attend meetings in Europe, but few hospitals maintain libraries. Moreover, professional societies as we know them do not exist, and no tort system is in place to keep the societies legitimate. Doctors and nurses work largely with information they learned as students. An important part of the AIHA program has been the creation of self-learning modules that can be accessed individually and the development of associations and continuing education programs. The primary mechanisms for communication are Internet access, distance learning, and teleconferencing.

The information systems initiative is essential to both the cost-effectiveness and future sustainability of the partnerships. The goal of the information component is to build communication capacity and access to technology. AIHA provides hardware and makes available its headquarters Technical Unit, which is made up of one coordinator and two staff. The latter are responsible for teaching and training. Through FY 97, AIHA reported spending close to $900,000 on computer and other equipment.

Each overseas partner is provided with a learning resource center, which includes computers, printers, upgraded telephone lines, and fax machines. There are 92 learning resources centers in place, 59 in the NIS and 33 in CEE. Each resource center is to be staffed for ten to 20 hours a week by an information coordinator who manages the center and maintains databases. Forty-five partner hospitals have their own Web pages. AIHA has obtained OVID—an on-line service that provides full text of many journals—for each of the NIS institutions for a total of $40,000 compared to the commercial price of $6,000 per institution per year. Now that AIHA has laid the groundwork for group purchasing, partners will be able to purchase updates with their own funds.

Use of e-mail is increasing. In June 1993, average use was only 55 minutes per day, but it had nearly doubled to 104 minutes by March 1994. E-mail is still not used for extensive communication on medical or management issues, however; interviews suggest that much of the use relates to planning and coordinating visits. A few doctors have taken a personal interest in computers and use them often. While one nurse said that “the infomatics piece is particularly useful for nurses,” interviews and observations suggest that nurses in fact are making little use of e-mail. With the exception of computers on the two Western-standard micro-units described elsewhere, the computers seemed to be located primarily in the work areas of male physicians. The nursing resource centers have computers and often employ women information coordinators, but these centers are new and, as with much of the AIHA hardware, the computers are not used to their full potential.

Nonetheless, the use of computers has caught on in some of the more progressive hospitals. A hospital in St. Petersburg, for example, started with 12 computers and now has 70 in use for medical and patient information; bookkeeping, planning, and accounting are also part of the integrated network.

Telephone lines are a constraint to the use of e-mail, particularly in Moscow. AIHA is providing upgraded telephone lines for Internet access in most NIS partnership cities where monthly charges for upgraded lines are generally under $100. In Moscow, high-quality telephone lines cost $500 per month. One Moscow participant said that "our problem is poor telephone lines and preventive maintenance of equipment." "We need new phones lines but AIHA can't afford them," another participant said. In a CEE hospital, "there is a problem with the use of computers, especially older doctors don't use them. We have two computers, one in the library and one in the ICU that are never used. We have no computer people aside from a couple of doctors that have a personal interest in it. In the U.S., our people saw the value of computers, but only one uses e-mail. We have lots of PCS but no internal network. It would take us two or three years to get it working. We got some [outside] help, but we need more staff training and hardware." Translation can also be a problem among those who do not speak English and thus find e-mail and the Web of limited use. Overseas partners engage in little e-mail communication among partner institutions.

After the Des Moines conference, AIHA established an Internet-based technology discussion group consisting of information coordinators and others from inside and outside partnerships. NIS and CEE partners have posted questions and suggestions to the list and have made comments, shared information, and consulted on specific clinical cases, including a scanned radiological image from Bishkek.

AIHA maintains a clearinghouse Web site with information on a range of topics, including the activities of other organizations in the NIS and CEE, sources of funding for projects and research, translated educational materials, and contacts in other technical fields. *Connections*, which can be accessed through AIHA's Web site, is a twice-monthly newsletter that keeps partners informed of the latest news and activities.

While the Internet is a potentially rich resource, it remains underused. U.S. partners often have access to sophisticated information systems in their own hospitals and libraries and find the AIHA Web site interesting but marginal. "The Web site doesn't offer anything useful," said one U.S. partner. The potential is far greater overseas, although most physicians and nurses do not yet know how to use the system. When AIHA offered an intensive introduction to the information technology component at the Des Moines NIS conference and made a laboratory continuously available for hands-on practice, attendance was high.

Two NIS cities, Moscow and Dubna, now have teleconferencing facilities that can be used with any U.S. location. Teleconferencing brings together cross-cutting and supplemental activities cost effectively through group and distance learning. La Crosse will provide 100 hours of teleconferencing this year into Dubna while three of 12 planned nursing conferences have been sponsored by U.S. partners (Rochester/Premier, Cleveland, and Detroit) and groups of Russian nurses from Moscow, St. Petersburg, and Dubna. Some teleradiology and joint analysis of CAT and radio scans is planned. U.S. medical staff with less and less time for travel will more easily find an hour for teleconferencing.

AIHA headquarters has been in regular contact with representatives of such organizations as IREX, the Soros Foundation, and the Eurasia Foundation. In cities with connectivity problems, IREX and Soros have helped find solutions. In one partnership city, Soros is the Internet provider for the partnership and others may follow. AIHA headquarters has contacted Soros to tell the foundation about the learning resource center project and inquire about additional possibilities for collaboration. Several partnerships have submitted proposals to the Soros Foundation and the Eurasia Foundation with assistance from AIHA staff.

Many of the NIS and CEE partner hospitals visited by the evaluation team had received equipment donated by the Soros Foundation, which has given computer equipment to many nongovernmental and governmental organizations in the former Soviet Union. The Soros Foundation has regional offices in the same cities as some AIHA regional offices (Zagreb, Cluj, Almaty), yet AIHA regional staff and partner representatives report little coordination with these sources of information and assistance.

Conclusions

- *The information technology initiative has great potential for sustainability of the partnerships but has not yet had much impact. It is new, and AIHA has had to create demand in countries with little tradition of continuing education. Few overseas medical staff have computer experience, and hospitals do not have dedicated computer technicians to help with problems. AIHA is providing hardware, software, and training as usage slowly increases.*

- *While AIHA reports some efforts to coordinate with other organizations and foundations, the effort needs to be stepped up, particularly so that partners will know how to make contacts on their own with local resources.*

Recommendations

- *More training is needed to realize the full benefits of modern information management and the financial investment in hardware and to encourage e-mail communication among participants overseas.*

- *AIHA should publish a hard copy of its Web site directory of participants' e-mail addresses, with a short statement of interests and responsibilities. This may stimulate interest in the use of e-mail by those not yet comfortable with computers.*

- *AIHA should coordinate with the Soros Foundation in each country to see how the technology programs of the two organizations could better complement one another.*

3.4.3 *CommonHealth* Magazine

CommonHealth is AIHA's quarterly bilingual journal. Its purpose is to communicate news of partnership activities and clinical and administrative knowledge to hospital administrators, medical staff, researchers, and policy makers. As the only document everyone receives, it is the major vehicle for information dissemination within AIHA. The journal keeps partners connected and helps reinforce corporate identity and public relations and is useful to partners who want to explain AIHA to others.

CommonHealth costs $384,000 per year to publish, or about $4.50 per issue, including staff salaries and benefits, translation, printing, design, and distribution. It is distributed free overseas (14,000) and in the United States (5,000) in both Russian (8,000) and English (11,000) editions. It was initially published by an outside contractor but is now produced by an in-house staff of three. The main costs are printing, staff time, and distribution by mail, UPS, or DHL. The journal went through a major revamping in 1996 and now incorporates more effective graphs, better proofreading, greater use of color, and a more attractive layout.

By 1994, *CommonHealth*'s articles had evolved from a clinical focus to emphasis on management and administration within and across the partnerships. By spring 1995, it changed from bimonthly to quarterly, with a shift toward health care reform, including finance and administration. Articles cover both partnership achievements and initiatives that cut across partnership boundaries, although since 1995 task forces and cross-cutting initiatives have received more coverage than individual partnerships. The journal has prominently featured the nursing field and nursing leadership, and the fall 1995 issue focused on service quality improvement and methods for measuring quality of care. Issues in 1996 featured healthy communities partnerships and women's health.

CommonHealth can both define prevailing health issues and set the stage for their solution. It reinforces the growing demand in the NIS and CEE for health care service sector reporting. Its evolution from a newsletter to a journal has benefited the partners by providing linkages in the form of news of what others are doing, including announcements of upcoming workshops and conferences; addressing country and regional interests and concerns; and reinforcing the identity of the partnerships.

CommonHealth is also a vehicle for the dissemination of information within and about USAID and has included articles about other USAID health programs in the region. The goal of *CommonHealth* is the widest possible dissemination given available funding.

AIHA believes that selling *CommonHealth* on a subscription basis is unlikely to raise much revenue, as few hospitals or health professionals in the NIS and CEE would opt to spend their limited funds for the journal. Neither are U.S. partners willing to pay for it in its current form. To sell subscriptions outside the partnerships, the magazine would have to expand dramatically its coverage of health issues and activities beyond the scope of the partnerships (and USAID funding). AIHA believes that the magazine would experience difficulty in attracting advertisers given that NIS and CEE partners have little money to spend on equipment, pharmaceuticals, and supplies.

Interviews suggest that *CommonHealth* is particularly welcome among overseas partners proud of their affiliation with AIHA and eager for news and information. It is of less interest to U.S. partners, which already receive an avalanche of literature.

Conclusion

- CommonHealth *is a useful, if fairly high-cost, forum for the exchange of ideas about health practices as well as a means of helping partners become acquainted with each others' work.*

Recommendation

- *AIHA should consider carrying out a market study to test the feasibility of adjusting the format of* CommonHealth *to make it financially self-sustaining through the sale of advertising and subscriptions. The publication could conceivably become the premier periodical on health care reform in the NIS and CEE and achieve full cost recovery.*

3.4.4 Conferences and Specialized Workshops

AIHA sponsors regional conferences in the NIS and CEE as well as annual conferences in the United States for representatives of all partnerships. The conferences have earned acclaim for thematic exchanges of information and expertise. The October 1996 NIS conference in Des Moines, for example, featured communications technology and women's issues but also included workshops and presentations on a broad range of clinical and management topics. U.S. and NIS representatives participated in the presentations equally and, in many cases, jointly. Annual conferences for staff from the NIS and CEE also provide opportunities for sharing experiences and planning new activities.

AIHA also arranges technical workshops, conferences, and seminars to respond to issues of interest to partnerships. These activities, usually initiated by partners or task forces, bring together ministry officials and municipal and regional health administrators. Staff of nonpartner hospitals and educational institutions may also participate. Workshops and conferences range in size from 25 to 500 participants. In all, over 125 conferences and workshops have been held on such topics as nursing, financial management, leadership, and a range of technical issues including laparoscopy, rheumatic fever, natology, obstetrics, nosocomial infections, pediatrics, toxicology, hospice care, and cardiovascular care. A list of these workshops is included at Annex H. AIHA has also sponsored study tours to the United States on issues ranging from health systems management to drug abuse.

Reportedly, conferences are of great interest to participants, as opportunities are few for NIS and CEE health professionals to meet with colleagues to exchange ideas. The use of audio-visual materials has made conference presentations progressively more professional. U.S. partners "teach partners how to do presentations and move away from didactic lectures. We show them how to use overhead transparencies, participatory methods, and so on. We push them to teach others, as we feel they learn more by teaching. It puts pressure on those who come here to learn so they can teach on return," according to one U.S. participant.

Conclusion

- *Conferences are a popular forum for sharing ideas among partnerships; among people not otherwise connected with the project, particularly government officials; and among those teaching the next generation of health care professionals. Conferences also reward those who put in extra time on partnership work.*

Recommendation

- *Conferences should be part of an annual overall regional (NIS) or country (CEE) strategy developed by AIHA field representatives in consultation with partners. Earlier planning of conferences will allow busy professionals to organize their time more productively.*

3.5 Other Results

The results achieved by the hospital partnership program are many and diverse. Because the partners jointly identify the objectives of each partnership, there is neither a common basis for evaluating the effectiveness of the program nor rigorous baseline data. Consequently, the results reported in this section are taken from partners' program descriptions in AIHA quarterly reports and *CommonHealth* and from site visits to partnerships. Despite broad and frequently impressive local impact, there was little evidence of strategic or systemic impact.

3.5.1 Quality Control

Hospitals in the NIS and CEE are beginning to compete with one another as the transformation toward market-oriented health care occurs. Several institutions actively market their services, particularly to foreign companies or insurance companies that will pay full cost. To obtain contracts, each institution stresses those features thought to be most attractive. As cost differentials between institutions evaporate, hospitals must pay more attention to quality control. The Central Clinical Hospital in Moscow has partnered with the Premier Hospital System and, as an affiliate of Premier, has joined the University of Maryland Quality Indicator Project. The project collects data from 912 hospitals and allows comparison with U.S. hospital standards. The comparisons are useful to Central Clinical in identifying areas that need improvement, but the results can also be used to reassure the potential patient or contractor how the quality of care compares to that in the United States.

3.5.2 Patient Participation

The clinical results reported by the partnerships cover a broad array of doctor/patient relationships. In some clinical practice areas, such as laparoscopic surgery, it is clearly the acquisition of new technical skills by the physician that has brought advances measured by decreased ALOS and an earlier return to work. With other chronic illnesses, however, the patient's role is primary and the provider's secondary. For example, the Dubna-La Crosse partnership, which has focused on educating diabetics about self-care, has experienced a reduction in the amount of insulin needed by

patients as well as much better control of blood glucose. This partnership also developed an alcohol treatment program that focuses not on detoxification alone but rather on a participatory 12-step program in which success depends on patient education and the patient's willingness to participate actively in his or her own treatment. These models are potentially valuable in increasing the efficient use of health care resources.

An important outcome of the project is improved health care delivery. Upgraded clinical services and management in partnership hospitals have led to a change in mindset among partner physicians regarding the appropriate use of the various levels of care (community, primary, secondary, and tertiary). Many partnership activities have contributed to the beginning of improved coordination between in-patient and out-patient settings and have led to a shift from in-patient to out-patient service delivery for the ambulatory patient. Such changes will improve the quality of care, cut costs, and help patients become more involved in their own treatment.

In Dubna, the diabetes project is an innovative program that operates at the out-patient and community level. Uzbekistan has integrated high-risk pregnancy with high-risk neonatal care under the maternal and infant care initiative. Women's wellness centers will provide a wide range of preventive and routine curative care for women of all ages.

3.5.3 Reductions in Average Length of Stay (ALOS)

Many of the outcomes achieved by the partnerships result from several elements working together. In general, improved management is the common element that is essential in coordinating the activities of several departments to achieve desired results.

The majority of hospital partnerships that focused on a particular clinical discipline report a reduction in hospitalized patients' ALOS. Several factors are responsible for the reduction. For example, in one hospital the introduction of a new technology such as laparoscopy reduced the ALOS for patients with hernia repair, appendectomy, or gall bladder removal from 17 to 3.2 days. Similarly, the use of endoscopic techniques in caring for patients with prostatic adenoma reduced the ALOS from 21 to 7.5 days. The change in reimbursement from automatically paying for an occupied bed to paying for a fixed number of days for a given procedure has stimulated hospital management to seek ways to shorten the ALOS, avoid losses, or capture the allocated funds. Institutions with lengths of stay greater than 20 days have often been able to achieve 50 percent reductions overall, whereas those with lengths of stay closer to U.S. standards have shown less dramatic reductions.

The program has initiated the trend toward restructuring the delivery of care in in-patient and out-patient settings by modernizing clinical and management services. The use of less invasive techniques such as laparascopic surgery means a shorter recovery time, fewer hospital-acquired infections, and possibly more use of ambulatory techniques. The creation of a hospice in Latvia will promote shorter hospital stays and enable elders to receive the bulk of care at home among family.

3.5.4 Cost Recovery and Finance

The shift in health care funding from a centralized government source to a decentralized multi-payment source has been a major hurdle for many of the partners in the NIS and CEE. The inexperience of hospital financial staff in cost accounting, billing, and collections is reminiscent of the practices of U.S. hospitals when all services were reimbursed on a costs-plus basis. Many NIS and CEE partners have sent financial officers to the United States for hands-on training in partner hospitals. Broader training has occurred through workshops and seminars offered by AIHA, often through AUPHA. Manuals and training materials have been developed and translated.

The early results of these efforts are evident in a few institutions. In Hospital No. 122 in St. Petersburg, for example, the hospital director has combined a polyclinic budget for physicians with the hospital budget and established financial incentives for productivity. The hospital director has also made space available to physicians for their private practices, with physicians retaining 55 percent of revenues and paying the institution 45 percent for occupancy and support costs. A 1995 law made possible the creation of a public charity fund to support nonpatient care activities such as research and education. As a result, Hospital No. 122 is also subsidizing new educational and other programs and operating profitable hotel and catering services for students as a means of maintaining other programs for which funding has been reduced.

The Central Clinical Hospital in Moscow and Hospital No. 122 in St. Petersburg have established Western-style hospital units (micro-hospital units) staffed by nurses whose training allows them to assume responsibilities similar to those of nurses in the United States. Contracts with foreign employers in Moscow and St. Petersburg allow employees to receive care that meets Western standards while the hospital can recover the full cost of care—or more—by charging higher fees. The success of the micro-hospital unit in St. Petersburg has led the hospital to transform an additional nursing unit into a private-room, Western-style micro-hospital.

It should be noted, however, that both the Moscow and St. Petersburg hospitals are privileged organizations that care for elite populations. While they are valuable laboratories for testing new approaches, their substantial advantage in both resources and independence over most NIS health care institutions limits to some extent their usefulness as replicable models.

Conclusion

- *Preliminary data demonstrate improved administration or management of health care systems in specific units of partner hospitals. Individual partnerships report reduced ALOS, establishment of fee-for-service programs, improved pharmacy monitoring of medications, creation of cost-accounting departments, reduction in the number of beds, and a shift from in-patient to out-patient services. As a result, some institutions have been able to improve the quality of service, but no data are yet available to demonstrate the impact on overall costs or improved patient care.*

3.5.5 Replication

The project is not optimally designed to produce an impact beyond the partnerships. When viewed from a distance, the partner hospitals are a small part of an inordinately large system, particularly in the NIS, and the sector policy dimension is not a natural fit. One mission noted that it is difficult to introduce a "spread effect mechanism" after the fact. There is some evidence, however, that some ideas are trickling down to other hospitals. Replication constitutes an intermediate step between pilot programs and their acceptance at the national level. (AIHA's list of initiatives that have spread beyond the partner hospitals is at Annex I.)

Some of those involved in the partnerships are at sufficiently senior levels that they could influence systemwide change. For example, the minister of health in the Republic of Georgia said, "We have negotiated two World Bank loans for $100 million based on our partnership experience. We were the only former Soviet state that approached the bank for reform money." For the most part, however, changes are limited to individual wards or hospital units. Few of the innovations, with the exception of infection control, have even been put in place throughout an entire hospital.

It is clear that NIS and CEE medical personnel are eager to learn about new ideas and new ways of doing things. They particularly enjoy their visits to the United States and the opportunity to see a U.S. system in operation. However, as noted, there are disincentives to sharing information, particularly with hospitals that will be competing for the same private-paying patients. Nonetheless, the two hospitals with model U.S.-style micro-units, No. 122 in St. Petersburg and Central Clinical in Moscow, host frequent visitors from other hospitals who want to see the units. "They are very proud of the micro-unit and do many tours for visitors," said the Louisville partner of No. 122. The Central Clinical hospital is "a reference account for Hewlett-Packard. We train doctors from all over the country."

The diabetes and Alcoholics Anonymous programs in Dubna are slated for replication in nonpartner cities and have the potential for scaling up to much wider application. They appear to embody important cost-cutting strategies as well as effective health care models.

After the evaluation team completed its field work, it learned of other areas of replication. The MOH in Ukraine will replicate the neonatal resuscitation initiatives from Lviv in three additional

sites, add three emergency medical training centers, and develop a regional infection control center, with plans underway to create a Russian Federation regional infection control center.

The main way ideas from the partnerships are replicated is through conferences attended by partners and nonpartners and through the nursing associations in the NIS and the individual CEE countries.

Conclusion

- *The partnership model is not the best approach for achieving replication, but it does provide a mechanism for piloting strategies that can be scaled up for broader impact. The partnerships can be used to pilot test curriculum materials, protocols, and program models that lay the groundwork for a more strategic approach to broader impact.*

3.5.6 Policy Change

The partnerships have not been a particularly strong vehicle for achieving systemwide, sectoral, or national-level policy change. But, then, they were not designed for that purpose; thus, the relative lack of policy impact is not a shortfall.

The one partnership responsible for national-level health policy impact is located in the Republic of Georgia. There, the minister of health, who is particularly active in the partnership, has been able to effect important changes, including changes related to out-patient care, which was not previously known in Georgia. In addition, the country has developed a 24-member hospital association involved in group purchasing. Starting in 1993, Georgia reviewed the existing nursing system and, working with the nursing association, upgraded the role of nurses and created new training systems for both clinical skills and leadership. A central repository for medical information along the lines of the National Library of Medicine is being established, and librarians will be trained for remote access stations all over the country. With sizable World Bank loans in prospect, the minister of health hopes to implement many of these new ideas throughout the country. Georgia's small size and population and limited number of donors in the face of political turmoil have given the partnership added policy-level leverage.

The partnerships have achieved some limited policy impact on Russia's autonomous system of hospitals under the Directorate of Biomedical Problems and Disaster Medicine, which oversees 72 medical centers in 35 Russian regions, all associated with the scientific community. The involvement of the head of the directorate and the privileged position of that system are at least partly responsible for the fact that three of the most successful partnerships are associated with the directorate system. Because of his trips to the United States, the director has placed greater emphasis on continuing education for doctors and nurses and is shifting to a system of productivity-based compensation.

Individual hospitals have pointed to a number of significant policy changes. The most noteworthy is associated with Hospital No. 122 in St. Petersburg, where, as noted earlier, doctors have established private practices in the hospital. They have also embraced the entrepreneurial approach as evidenced by souvenir mugs, cost-conscious management systems, a professional video promoting

the hospital, a hostel that generates income for the nursing school, and a variety of enticements for privately insured employees of foreign companies.

An unintended but almost universal policy change has been the ban on smoking in some or all hospital wards and physicians' offices. In countries where smoking is nearly a given among men and smoke-free areas virtually unknown, these bans are indeed innovative.

Some have argued in the project's defense that policy change has been an important purpose of the project. If we had found strong evidence of this, the evaluation would have been considerably more negative on this point.

Conclusion

- *Hospital partnerships are not a particularly good vehicle for national policy change, although significant local change is possible if the appropriate professionals are brought into the partnership and included in exchanges, conferences, and meetings. The few examples of policy change are limited to situations where senior decision makers have been deeply involved in the partnership.*

Recommendation

- *While partnerships are not designed to have national-level policy impact, they should nevertheless be selected strategically so that senior MOH officials can be included in exchange visits and assume an active role in workshops and conferences.*

3.6 Monitoring and Evaluation

The overall goal of the project is improved health status. In support of this goal, the project has two objectives: to increase medical and technical knowledge and to professionalize the health care sector.

The project has no monitoring and evaluation system; instead, it is monitored largely though partnership reports. Each activity concludes with an "event report" that ideally is prepared by both U.S. and overseas participants before they return to their routine work. AIHA formerly allowed the reports to be written after participants' departure but found it difficult to obtain reports from busy people once they returned home. Trip reports are written in outline form at the beginning of a trip, with both sides contributing to the final product. The report is therefore a useful tool, although volunteers generally want to spend their time working rather than writing reports or gathering monitoring and evaluation data. The partnerships combine the event reports into monthly reports, which AIHA then consolidates into quarterly reports for submission to USAID.

Missions were very critical of the lack of a monitoring and evaluation capacity and framework. One reports that they do not have a full picture of the partnerships and their activities. When it comes to achievements of the partnership, "we can get only filtered information from CommonHealth or

process-oriented data from the quarterly reports. The process tracking information vacuum has always remained a problem..."

While no true baseline exists for the program, sufficient data are available through quarterly reports to reconstruct a *post hoc* baseline. Such a reconstructed baseline has been developed in a separate desk study carried out as part of this evaluation. The executive summary of that study is included at Annex G to show that it is possible, albeit with some effort, to interpret the results for impact.

Conclusion

- *The quarterly reports provide a good overview of activities for the quarter and a useful history of the project. However, the project lacks a standardized method for monitoring progress on objectives, quality-of-care indicators, and management change.*

Recommendation

- *AIHA should adapt USAID's results framework to its evaluation effort and develop a way to monitor progress on partnership results. Routine data could be supplemented with short but substantive case studies showing, for example, how improvements in quality of care are linked to improved management and the changing role of nurses. Graduate students should be encouraged to carry out in-depth studies on special topics.*

4.0 Management Issues

4.1 Background

A central goal of USAID activities in systemic health reform has been to promote a shift from in-patient to out-patient care in an efficient and effective primary care setting. Two major projects address this goal. The ZdravReform program has expanded primary care capacity in pilot sites while the AIHA project improves the quality and delivery of care in hospitals through more professional management. In the former Soviet Union, over 70 percent of all resources for health were directed to the hospital in-patient setting such that patients received the bulk of their care in hospitals. The two programs are viewed as important stepping stones to broad health care reform.

Initially, two sources of tension internal to USAID raised concerns about the cooperative agreement.

- First, in an agency focused largely on preventive and primary health care, many were skeptical about the efficiency of using scarce health care resources at the tertiary level to address issues of hospital-based curative medicine. Over time, however, virtually all participants have come to believe that the project has had substantial impact at the local level, although they would not agree that the partnership approach is the best vehicle for achieving systemic or policy-level impact, particularly at the national level.

- Second, the initial CEE partnership projects were designed to be managed from Washington, although the NIS program assumed greater overseas managerial control. Over time, however, the project has accommodated increased coordination with USAID field offices in both regions while the merger of the two regional programs into the single Bureau for Europe and the NIS (ENI) has brought Eastern Europe closer to the NIS field model.

While these initial problems have diminished, more challenging managerial issues have arisen as a result of basic changes in the project's programmatic and structural operating premises.

- First, revised USAID guidance on CAs has sharply limited the substantive involvement of project officers in the implementation of agreements. Thus, an activity designed with the expectation of significant USAID contact and direction in the form of periodic adjustments and coordination with other evolving health sector efforts must now operate on the basis of one-time annual input.

- Second, AIHA identified common themes among the partnerships as well as opportunities beyond them. It put in place a number of supplemental and cross-cutting initiatives and ventured into policy issues. These efforts probably now consume about half of program resources. Because AIHA does not track the initiatives individually, it cannot determine their costs without extensive manual sorting. Further, these initiatives operate more broadly and require a higher level of coordination with USAID than the basic partnerships. The same is true to a lesser extent of the partnerships' shift from clinical subjects to management issues.

- Third, USAID found AIHA to be a convenient mechanism for implementing its own separate initiatives and dealing with congressional earmarks. Most of these initiatives are more task-oriented and innovative than the core partnerships, less obviously suited to the independent partnership model, and more integrated into country-specific health care sector programs. Indeed, some were initially conceived as contracts.

- Finally, USAID has put in place its new R4 strategic objectives structure that stresses integration of all assistance activities in focused pursuit of key country-level objectives. The structure also makes field office management clearly accountable for the coherent use of all resources spent in-country. The new structure obviously pushes management and project officers toward tighter shaping and monitoring of AIHA programs.

The fact that these changes have occurred midstream in the AIHA project without policy-level reconciliation of the associated issues has further increased managerial tension.

Current Situation

Changes in the partnerships program's managerial environment have resulted in substantial operational problems. Opposing forces are pushing for both more and less involvement of USAID in implementing the project and for both more and less focus of effort within AIHA activities. Further, activities designed for ongoing USAID involvement have suffered as a result of rule changes governing USAID's level of project involvement. One USAID officer noted, "Had we known we would be excluded from efforts to 'cooperate' with AIHA, funds [for an activity] would never have been channeled through this mechanism."

Virtually everyone involved in the project—AIHA and USAID staff in Washington and overseas and U.S. and NIS and CEE partners—feels the resulting pressure and friction. An example of the tension is reflected in the remark of one partner. "I don't know what the problem is between AIHA and USAID, but it's enormously embarrassing." Another adds, "There's a lot of back biting and turfism between AIHA and USAID." There are corresponding if less dramatic tensions between AIHA and the individual partners. The problems vary in nature and depth with the personalities involved but are present even when both sides seem to be trying to accommodate one another.

The problems generally relate more to unresolved managerial issues than to the people involved, although personalities play a part, and the problems are exacerbated by the occasional indifference or negativity of USAID field staff. One partner said, "All they do for us is demand to clear everything." This, combined with the lack of transparency in AIHA headquarters operations and the absence of a clear definition of the role of AIHA staff both in headquarters and overseas, leads to operational friction.

Conclusion

- *Changes in the structure and operation of the AIHA project have created inherent tensions exacerbated by management styles and personalities at both AIHA and USAID.*

Recommendation

- *Many of the tensions could be dealt with through a CA that clearly identifies the roles of USAID/Washington, USAID overseas offices, and AIHA.*

4.2 AIHA Issues

It is clear that AIHA has managed to accomplish a remarkable amount in a short time at the individual partnership level. Whatever AIHA's managerial strengths and weaknesses, the impact of the organization's relentlessly entrepreneurial approach is evident. It has built an excellent record of leveraging voluntary contributions of professional time and in-kind resources. Impacts not only take the form of clinical improvements in partner hospitals in both regions but also relate to the development of a strong political base, thereby leading to greater openness and accountability in some NIS and CEE partners.

Despite the abundant constructive criticism of AIHA that follows, it should be noted that partners were uniformly positive about the overall program and the experience it provided. "We'd do another partnership in a minute," one said. Another offered, "It's one of the best things that ever happened to us."

It is also clear that AIHA's internal management could be improved through broader application of three key management concepts: transparency, clarity of roles, and decentralization. Furthermore, the partnerships' lack of focus on measurable impact has in some ways isolated AIHA from more traditional management of development activities.

4.2.1 Internal Management

AIHA staff is highly motivated and productive. With great confidence in the importance of the partnerships, staff morale is consequently strong. At the same time, both staff and partners note a need for clearer definition of roles and functions. As one person said, "We don't know who's responsible for what." Another felt that "[AIHA] grew too quickly, and they need to improve their processes."

Process improvements extend to a broader sharing of information with partners. "I never know what's going on down there," complained one participant. Partners also strongly recommended decentralization of additional responsibility and decision making to mid-level and junior staff at headquarters and to regional offices in particular. Partners were strongly critical of the highly centralized management and frequently made comments such as "AIHA has to give more decisions to the partners and the field."

Several partners noted that AIHA seems to operate under constantly high pressure. What one perceived as "no orchestration or planning, just a lot of crisis management" another saw as "no transition from startup to steady state."

The regional offices are managed by people whose strong sectoral expertise and good management skills make them capable of contributing far more than logistical support to the partnership effort. Regional offices, which by definition are closer to the NIS and CEE partners and much more knowledgeable of local operating circumstances than headquarters, could take on much of the management of the substance of the partnerships.

Another issue is the considerable turnover among the program analysts, who play a critical operational role and who, in the early years of their careers, tend to show promise as area and language specialists. The turnover results from limited upward mobility; health care specialists generally hold the next-higher positions in the hierarchy. In addition, other career opportunities present themselves. As a result, the project loses the benefit of the program analysts' experience and expertise.

The relative underrepresentation of women at the AIHA senior staff level is striking. Management was aware of the problem and said that efforts had been and will continue to be made to correct the imbalance.

Conclusion

- *AIHA has a highly centralized management style that partners view as contributing to the difficulty in obtaining information and getting decisions and to the sense of continuous crisis management.*

Recommendation

- *AIHA should decentralize decision-making responsibilities from headquarters to regional offices, clearly define the resulting new roles, and communicate the resultant functions internally and externally. Through internal promotions and greater delegation of responsibility, AIHA should also create more incentives for staff to remain with the organization.*

4.2.2 Partnership Management

U.S. partners by and large give AIHA high marks for support, programmatic responsiveness, initiative, and pursuit of the goals of the cooperative agreement. AIHA's handling of airline ticketing, which results in substantial volume discounts, frequently receives both positive and negative reviews. One participant said, "They do a great job on the logistics!" Others, however, complained of circuitous routings to save money, noting that they could get less expensive tickets through their own agents. Partners are also generally frustrated by the lack of transparency in overall

program and budget decisions and the occasional sluggishness in administrative actions. They would like more autonomy in partnership program decisions.

Lack of transparency surfaces as a key element in the responses to questions about AIHA support for the partnerships. Although most of the special and cross-cutting initiatives have grown out of the partnerships, only those partnerships leading an initiative usually feel a full sense of ownership of the initiative. Further, given that some of the funds spent by headquarters are allocated to the partnerships and some of the funds spent by the partners are held in headquarters, few of the partners are confident that they know exactly what their budgets are and how they are to be used. One coordinator said, "We need more equity in the way the money is distributed." Another said, "We're losing money to the cross-cutting initiatives." The comment that "the most money goes to those who make the most noise" expressed a common sentiment.

To be sure, the last comment reflects in part the partners' acceptance of AIHA services and the organization's strong leadership on priorities and funds control and acknowledges the prudent expenditure of funds. The same comment, however, also indicates that AIHA has consciously kept the partnerships less than fully informed, as one staffer admitted, thereby retaining preponderant central control and minimizing what it sees as squabbling over resources. Another said that senior management's husbanding of information was a conscious decision "out of fear of loss of control."

Interestingly, though, AIHA staff also recognizes the benefits of greater transparency. "Generally, the more they know the better," said a staff member. "It would help a lot if they had a better big picture," said another. In fact, the more successful partnerships are those where the U.S. partner has managed to determine the partnership budget and uses it according to the priorities and opportunities identified by the partnership.

Some partners also criticize AIHA for sluggish administrative support and the slow arrival of funds. Some of the latter is AIHA's fault, but some is not. Partners do not generally know, for example, about the funding delays that attended the startup of USAID's new management system (NMS) or the funds rationing systems established by Congress or the Office of Management and Budget (OMB) for certain accounts; they experience these issues as AIHA problems. On the other hand, AIHA admits that certain equally lengthy delays, such as those involved in signing and funding the health management education activities, are largely its fault. One partnership coordinator said, "It took us a year to get a contract and it would have taken longer, but we refused to do anything until the contract was signed."

Sustainability is another concern that frequently arises either directly or indirectly. Neither AIHA nor the individual partnerships have aggressively sought alternative sources of core funding that could keep the partnerships alive after USAID funding ends. Partners would like assistance from AIHA in seeking ongoing support. One person felt that "AIHA should help us with outside funding." Another said that she "lacks information on other projects we might coordinate with." Most partnerships state that they will not be able to continue at anything even approaching current activity levels. Further, many NIS and CEE partners seem to be only minimally aware that funding is not indefinite.

Conclusion

- *The U.S. partners and AIHA share a strong sense of frustration, partly because the vagaries of USAID financial policies are not clear to the partnerships. More important, partners do not understand AIHA's policies and believe that some partners are favored. Partners want AIHA assistance in locating other sources of funding either to sustain their work or expand it in certain areas.*

Recommendation

- *AIHA should create a budget system that provides complete information on budgets (allocations and expenditures) for both individual partnerships and the overall program. Partners should retain ultimate control over use of the funds consistent with overall program guidance. AIHA could provide funds directly to the partnerships, with the exception of AIHA administrative expenses and a contingency fund, and allow the partnerships to "buy in" to those cross-cutting initiatives they found useful.*

4.2.3 AIHA Regional Offices

AIHA has established five regional offices (Almaty, Kyiv, Moscow, Croatia, and Bratislava) and employs country directors in most countries. Each regional office is staffed by one to ten people, including a regional director and, in some cases, computer trainers/technicians, finance specialists, and logistics experts. The regional directors are all impressively trained. The larger offices are staffed by physicians from the region while the smaller offices are usually staffed by Americans with degrees in regional studies and knowledge of the local language. The cost of supporting the regional offices in 1996 totaled about $1.7 million.

The regional offices are primarily responsible for such logistics as making arrangements for visitors (hotels, transportation, and translators) and handling the importation of medical equipment and supplies or computer equipment from AIHA. The regional offices uniformly say they are minimally involved in program planning and often feel uninformed even when visitors are on their way.

Conclusion

- *The AIHA regional offices provide good logistical support to visitors and for the importation of medical supplies. They do not have a significant role in program implementation even though field staff have strong medical and management skills.*

Recommendation

- *The AIHA regional offices should be given a stronger role in program planning and implementation. Definitive and current regional work plans would help coordinate trips and workshops.*

4.2.4 Financial Issues

The evaluation did not include the detail or approach of an audit, but it did look briefly into financial records and management. It appears that AIHA has been a good steward of government resources in support of the partnership program, although it could make improvements in two areas that would benefit the project. At the same time, USAID officials should examine several additional issues in preparation for any new agreement.

Conclusion

- *AIHA has been a responsible steward of government resources in support of the partnership program.*

4.2.4.1 Financial Plan

AIHA's spending projections over given periods have sometimes been at considerable variance from actual expenditures. For example, through the second quarter of FY 96, actuals totaled less than half of projections, with significant divergences in several cost elements. By the first quarter of FY 97, however, actuals were ahead of projections and threatening to overrun them. Part of the variance is undoubtedly related to the "lumpiness" of USAID funding, but part is also the result of a program that has departed from its initial financial plan—an important management device. (It should be emphasized that internal reporting immediately picked up and tracked these variances.) Further, expenditure patterns almost always differ considerably from those initially planned. Other direct charges, staff and consultant travel, and indirect costs are higher than budgeted; other partnership direct support and partnership equipment costs are lower than projected.

Conclusions

- *Because of uneven USAID funding flows and the absence of budget transparency, partners have experienced difficulty in planning their activities and making full use of the money allocated to them.*

- *AIHA's system of allocating back to participating partners costs for the cross-cutting initiatives without tracking the costs of each initiative makes it impossible to assess the cost-effectiveness of the various initiatives.*

Recommendations

- *AIHA should develop a revised financial plan that would give AIHA and USAID a more meaningful basis for monitoring financial performance and judging program effectiveness.*

- *Each partnership should receive a three-year budget, extendable in one-year increments, to use as needed in the implementation of its work plan or with AIHA approval for unplanned activities.*

4.2.4.2 Partner Financial Reporting

AIHA currently reviews voluminous monthly reports submitted by partners to liquidate advances and obtain reimbursement for program costs. This cumbersome process—first undertaken by the administrative office to ensure adequate support and allowability of expenses and then by program staff to review for consistency with work plans—can take a month. A total of three additional finance staff have been hired, and the number of staff reviewing travel and expense reports increased from one to two in 1997.

From the perspective of the partners, who report long lags for reimbursement, the financial reporting system could certainly be improved. As one person complained, "We don't know when we will get paid." Another felt that "the system and processes assume we are thieves." Not being in control of the budget gives U.S. partners a sense of no control over the partnership. Partners perceive that the lack of financial transparency covers for inequities and favoritism on the part of AIHA senior management. This absence of transparency is also a problem for the missions as they never have complete budget information and "can only guess" at the country-level expenditures for cross-cutting initiatives.

Conclusion

- *Partners feel that AIHA uses budgets to manipulate and control partners and their activities.*

Recommendation

- *In the context of the new budgeting system discussed above and any new agreement, AIHA and USAID should examine ways to make the budget process more transparent and more effective as a planning tool.*

4.2.4.3 Other Financial Issues

For clearly stated programmatic reasons, AIHA has contracted on a noncompetitive basis with an organization represented on its board of directors. USAID's Office of Procurement has ruled that such contracts were in accordance with the CA. Nonetheless, a USAID audit pointed out the need for better documentation of AIHA procurement actions, including the specification of a procedural

protocol to be followed. With the level of noncompetitive contracts to related parties now exceeding $2.5 million, the risk of the appearance of conflict of interest is high.

In connection with any future procurement, USAID officials may want to address the following: the compensation packages of AIHA officials; the program contingency fund established with rebates received from airlines as a result of AIHA's high volume of business; inventory controls for equipment provided to foreign partners; and the rising level of indirect costs. Neither the evaluation nor the annual audits identified specific problems, but increases in these areas suggest that USAID should satisfy itself that AIHA is meeting all applicable regulations and guidelines.

4.3 USAID Issues

USAID's management of the AIHA partnership program has been subject to just about every external influence that can be imagined, from strong pressures from the Department of State and Congress, to White House interest, to strong AIHA leadership with its own political power base, to inconsistencies in policy and fractured lines of authority within USAID itself. In terms of the product, USAID's management must obviously be seen as successful. In terms of the frictions and wasted energy needed to produce that product, however, USAID's management has been less successful. To ensure the efficient and effective continuation of the partnership program and its objectives, the future structure of the program must take into account the lessons learned, the problems that have arisen, and the structural sources of friction.

Mission perspectives on the AIHA partnerships ran the gamut from extremely supportive to highly critical, though more tended toward the latter. Missions dealing with particularly sensitive issues and circumstances resent the large USAID investment in the project when they believe that health care sector funds could be used more effectively at the policy level. Most missions also felt it unfair to be held accountable for AIHA results in their countries when they had no control over the project and, in some cases, little information about it. As one mission director said, "The partnerships are nice, but they shouldn't replace economic and political development."

4.3.1 AIHA Cooperative Agreement

Despite the problems of management style indicated above, it would be hard to find a better vehicle for coordinating the basic hospital partnership program and process than AIHA. USAID has stated that it will make no more noncompetitive awards. Even if USAID identified another organization that could do an equal or better job, it would have great difficulty justifying the financial and programmatic costs of the competition and change of management. USAID essentially created AIHA to manage the individual hospital partnerships. AIHA's board is well constituted to support the partnerships, and the organization has done a more than credible job in implementing the partnership aspect of the project.

It is thus not difficult to make the case that AIHA should continue to retain predominant responsibility in the core area of managing the partnerships. Further, most partners would support AIHA's continued participation as program manager. One partner who was generally critical said,

"AIHA should continue to manage the project. There would be no value added by new management." Another said that "if AIHA didn't exist, they would have to invent it." (It should still be noted, however, that several missions nonetheless preferred a competitive approach.)

A better-ensured flow of resources for the partnership program over a period of several years would greatly improve the project's ability to plan and implement activities efficiently. It would, however, weaken the case for sole-sourcing by making it more likely that a new organization could amortize transitional costs and develop AIHA's network and momentum. Nonetheless, given that overall resources for the NIS and CEE are projected to fall and that the health care sector is not among USAID's highest priorities, it is more likely that funding will decline. In short, it will be difficult to project the budget outlook, thus raising questions about whether a more reliable flow of resources can be ensured.

Project duration will be limited by the fact that U.S. partner institutions face increasing pressure to reduce costs. In fact, most partners were quick to say they will experience difficulty in continuing their current level of volunteer participation. Finding new institutions prepared to commit to fixed levels of volunteer and in-kind contributions could help counter these pressures, but the pressures are sectorwide and will without doubt influence the project.

The core partnership program is appropriate for USAID's new guidelines for cooperative agreements. Individual partnerships could be approved at the level of annual work plans at the country level—an important addition to the three levels of substantial involvement specified in the new guidance—and then turned loose to operate without further active USAID involvement. The core partnership program would not, however, include as many current cross-cutting initiatives, health management education activities beyond the hospital level, systemic or policy reform in health policy or finance, or broader public health activities. AIHA's predominant capability in these areas is far from clear. In any case, all these activities require a higher level of continuing coordination with broader country programs than is now allowed under a cooperative agreement.

The communications technology initiative belongs with the partnerships, as it is pivotal to sustainability. As noted earlier, it is an area where AIHA should direct greater overall attention. Indeed, a new cooperative agreement should place a great deal more emphasis on achieving sustainability across the board. That emphasis should be a strong consideration in awarding sub-grants and should be built into subgrantee work plans.

If the future CA were funded for several years, it would both facilitate better planning by partners and stimulate buy-ins from country programs in which additional hospital-level activity is desired. Under a CA, buy-in funds would lose their identity except for overall country-level reporting, they could not be used for purposes beyond core partnership activities, and their uses could not be further directed by USAID. Overseas offices would have the option of reaching separate, freestanding arrangements with AIHA, including contracts that call for specific deliverables and more active involvement.

The AIHA project has accomplished its core mission of creating institutions with technical expertise throughout the NIS and CEE. The institutions have created islands of new thinking, new models, and new methods that over time can contribute to sustained growth and development. Now that these foundation institutions are in place, it is time to review the strategy. At the same time, there is a place for new partnerships to strengthen further the foundation on which the next phase of the project would be based. This would lead to a noncompetitive core contract for AIHA to continue with the basic partnerships and a competitive contract to scale up the activities and bring them more in line with agency health priorities.

A new CA for basic partnerships should be considered, assuming that some reasonable commitment could be made to multiyear funding at no expense to higher-priority systemic reform. If it is not possible to make this commitment, the partnerships could concentrate at a lower funding level on harvesting additional results from the most promising areas addressed by existing partnerships. In either case, a new CA should incorporate a more aggressive stance on focusing activities and cutting off areas of cooperation or entire partnerships that are not producing results at the desired level. The funding level should also take into account the project pipeline, which USAID officials consider to be greater than funds likely to be available for systemic health reform in the region.

Conclusions

- *In implementing the individual hospital partnerships, probably no organization could surpass AIHA over the short term.*

- *The more the project moves away from the hospital partnership core into cross-cutting initiatives, broader health care issues, and systemic reform, the less striking is its impact and the less compelling is the case that AIHA's capability is unique and predominant. And systemic reform should receive the highest priority.*

Recommendation

- *USAID should negotiate a new cooperative agreement with AIHA for the limited purpose of making subgrants to core hospital partnerships. To illustrate simply, such an agreement could fund 25 partnerships at a generous $500,000 each, plus 15 percent for AIHA administration and 10 percent for contingencies, for about $15.5 million over three to four years.*

4.3.2 Competitive Core Contract

It is far harder to argue that AIHA has demonstrated predominant capability for the noncore activities under the partnership program. The independent desk review of reported data in fact suggested that the partnership's impact is diluted as the program moves away from the hospital site (see Annex G). This should not be surprising in that AIHA was created to handle hospital partnerships under a hospital-focused board and cannot be expected to address other areas with equal effectiveness.

Indeed, many cross-cutting initiatives and most health care sector reform efforts "rolling out" of the partnerships could be more effectively carried out under a separate contract or contracts. It is hard, for example, to make the case that hospital partnerships are the most effective way to achieve financial reform of the health care sector. Indeed, financial reform is probably the most promising area for USAID investment in the health care sector. In addition, policy reform and some cross-cutting activities need to be more carefully synchronized with other health care sector activities at the country level and brought firmly within the R4 strategic objectives structure in a way that a cooperative agreement does not allow.

Interestingly, many U.S. partners and most NIS and CEE partners were not interested or excited about systemic impact and said that they were not well positioned to address it. One Russian chief physician, who seemed to have trouble digesting a question about taking good local ideas beyond the hospital level, finally said, "You'd have to find someone who could talk to the ministry." Most USAID personnel and some AIHA field staff believe that specialized consulting organizations have more experience and thus would be more effective in encouraging reform at the systemic level. As an AIHA field staffer noted, "Of course, [a university medical school] or [health policy consulting firm] would be more effective than AIHA in arguing for policy reforms and rolling out good ideas—but we could get to them too, on a nonpartnership basis." In other words, the more experienced people needed to effect change at the policy level would be difficult to engage on a volunteer basis. A technical assistance contract could, however, certainly build in many of the benefits of the partnership concept by ensuring that practitioners and their institutions get together on a peer-to-peer basis. Indeed, demonstrating the benefits of this approach is one of the impacts of the AIHA partnership program.

A core contract with country buy-ins is the best mechanism to take the ideas piloted by partnerships to the regional and national levels. Such a contract at the regional level might organize AIHA non-partnership activities into two categories: preventive health, including community and women's health initiatives; and health management, including health policy reform, continuing medical education, and management with clinical applications. The contract could follow the model of other ENI regional arrangements and provide for buy-ins or draw-downs by task orders from Washington or overseas. It would allow for careful targeting and integration of overall USAID efforts in the health care sector as well as for greater synergy between the various efforts, including the roll out of ideas piloted at the hospital level by AIHA where particular efforts fit country strategies. AIHA could presumably become a significant contender for such a contract, should it choose to compete for it and seek out appropriate allies and subcontractors.

USAID must determine the level of overall resources to be devoted to the health care sector. If resources are constrained, USAID could consider sharply reducing the components included in a core contract and lodging the most promising roll-out activities—best accomplished with technical assistance—under existing project structures. The present evaluation did not review other core contract activities that might accommodate this scaling up and, consequently, can offer no recommendations on this point. In any case, priorities should be set on a demand-pull basis according to sector priorities, not on a supply-push basis simply because AIHA roll-out possibilities are available.

Conclusion

- *As the partnership program moves away from its core expertise in institution-to-institution exchanges, its impact weakens. This suggests that a mechanism other than an institutional partnership program is appropriate for the broader issues of health care sector reform.*

Recommendations

- *USAID should rely on a competitively procured contract for activities currently carried out by AIHA outside the core hospital-to-hospital partnership activities. Such a contract could build in certain beneficial aspects of the partnership concept but should focus more on sustainability.*

- *Any unfunded extension of the current cooperative agreement should be for the limited purpose of partnership activities rather than for the continuation of broader special initiatives and policy efforts.*

4.3.3 Conflicting Signals

As is apparent from the introduction to this section, frictions within the hospital partnership program have resulted at least in part from inconsistent guidance from USAID to AIHA and from USAID's own offices and missions.

The tension resulting from divergent interpretations of two new USAID policies—dramatically less involvement in the implementation of cooperative agreements and dramatically more accountability for the use of funds in support of country objectives—has not been resolved in this project. Some overseas offices have consciously reflected the partnerships in their strategic plans in immediate and direct support of their R4 sectoral strategies. The USAID office for the Central Asian republics, for example, has placed the partnerships squarely in the rubric of social sector reform and hopes to demonstrate that quality of care can be made available on a cost-effective basis. Slovakia has lodged the partnerships under its civil society initiative. Many missions, however, have in effect set aside the partnerships in the "other" category, which essentially means that the partnerships are not part of the identified strategy.

Where partnership objectives were not consistent with USAID country-specific strategic objectives—and in some cases they were decidedly at odds—tensions were predictably higher. Further, many overseas USAID employees, particularly local and contract employees who are usually project managers, seemed unaware that cooperative agreements are to be managed differently from contracts. The problem is also traceable to Washington in that program and procurement offices at times provide AIHA with conflicting guidance.

The tension in the partnership program has also been exacerbated by congressional earmarks. Programmers trying to accommodate both the highest-priority needs of the NIS and CEE health sectors and the requirement of the congressional earmarks have grafted additional initiatives demanding considerable ongoing adjustments and fine-tuning onto a system that is currently

designed to operate relatively independently. AIHA has been willing to try informally to bridge these gaps, again working against current CA guidelines. "It's not really the right way [to do this], but it's the only way we've got" was one USAID explanation.

While the gap is theoretically bridgeable, in practice it has created enormous distances between people and groups that should be collaborators. The result is that AIHA (and, in some cases, the partners) has struggled in some countries against what it perceives as oppressive overmanagement by USAID; in other countries, it has felt ignored. Sometimes one point of contact tells AIHA that it is too accommodating while another alleges that the organization is too independent. Managers of the Health Markets Project, which funded several innovative activities requiring close supervision through AIHA, learned that they could not communicate directly with their implementing agency because of the CA guidance. On top of this, all sides have at times taken unreasonable positions. The Washington regional management model, in which overseas offices are not involved in many decisions related to centrally funded regional activities, has exacerbated the problem.

Clearly, the situation cries out for some overall resolution. It has frequently put mid-level project officers, who have not usually had direct hire authority or close and consistent contact with senior management on these issues, in a difficult position akin to "a crossing guard where everyone's jaywalking." Unfortunately, the confusion is apparent to the partners. Referring to the agency's multiple and inconsistent sources of guidance and the unpredictability of funding, one U.S. participant said, "USAID's just in management gridlock."

Conclusion

- *Tension between the USAID R4 strategic planning system and recent CA guidance is inherent. It is imperative to reach a resolution that respects both the integrity of the cooperating agency and USAID's need to account for results at the country or mission level.*

Recommendation

- *USAID should clarify its guidance to overseas offices regarding the treatment of the cooperative agreement within the R4 strategic framework, uniformly inform employees of the extent of their responsibilities, ensure coordinated representation to AIHA from the various program and procurement officials, and enter into any new cooperative agreement with a full account of the limitations of the new guidance on substantial involvement.*

5.0 Conclusions and Recommendations

The USAID-AIHA cooperative agreement has achieved impressive results both in the NIS and CEE and in the United States. The project has moved with agility and effectiveness from clinical practice to broader management issues and has succeeded in stimulating the flow of medical knowledge and technology to the NIS and CEE partner hospitals. There is widespread agreement that the project has led to totally new ways of thinking on the part of doctors and nurses. It has shown remarkable success in leveraging outside resources.

By its nature, the project has had limited impact on health status, policy reform, and health systems. While neither replicability in nonpartner hospitals nor sustainability beyond the end of USAID funding was part of the design, there is some evidence of replicability of programs (diabetes, EMS, neonatal resuscitation) and scaling up to broader systems (infection control, training and role of nurses). The sustainability of the effort would be greater if AIHA were to assist partners in the search for other sources of support and encourage participants to build outside alliances. USAID should consider how it might use broader concepts of partnership in its priority technical assistance to promote sectorwide reform.

AIHA has benefited from strong entrepreneurial leadership, but the organization should now work to evolve a more transparent and participatory management style that delegates more program and budget responsibility to regional offices and partnerships.

Generally speaking, the NIS partnerships have been more successful than the CEE partnerships, perhaps because the CEE countries are more diverse in language, history, health systems, and challenges and consequently lend themselves less to treatment as a single region. Hospital partners generally seem to have been more successful than university partners.

There is a strong case for moving into another noncompetitive cooperative agreement with AIHA, although any such CA should be limited in scope to hospital-based activities, which are AIHA's predominant strength. The cross-cutting information technology initiative is critical to sustainability and should stay with the partnerships, but more training is needed to realize the initiative's potential.

The cross-cutting initiatives have disseminated lessons learned to all partners and provided important testing of curricula, protocols, and programs, but AIHA has limited technical expertise in scaling these initiatives up to achieve broader systemic impact. The partnerships have been less effective as they have moved beyond the hospital level toward systemic impact and sector reform, although they were not designed for this purpose. Therefore, the broader efforts should be carefully integrated into country-specific strategic objectives through a competitively procured, task order-type contract. Design of the follow-on efforts should include substantial consultation with overseas USAID offices.

USAID must resolve the issues that stem from the tensions between the R4 strategic objectives structure, with its firm requirement for field office accountability in the use of resources, and the new guidance on cooperative agreements, with its sharp limits on Washington and field project officers' involvement in the implementation of the CA with AIHA.

The following list of conclusions and recommendations reached in this evaluation summarizes the findings and recommendations of the report. The background, discussion, and rationale that underlie them is found in body of the evaluation at the sections indicated. The reader is cautioned that relying solely on this list will not provide a full or even totally accurate sense of the evaluation.

Section 3.0 Program Issues

Section 3.1.1 Characteristics of the AIHA Partnership Model (Page 7)

Conclusion

- The partnership model has both positive attributes and potential problems. Its strength lies in interaction among individuals. People make lasting friendships and expand their horizons. Partnerships are also an excellent way to transfer technical information at the local level.

- The partnership model differs from standard development projects that emphasize sustainability, replicability, and policy change and should be judged accordingly. It is an excellent way of changing the way limited groups of people think about health care. It does not lend itself to replication outside targeted hospitals and characteristically does not lead to national-level policy changes in clinical practice or policy.

Recommendations

- The basic partnerships should continue and, unless there are strong doubts about future funding, additional hospitals should be brought into the program. Those hospitals, however, should be chosen strategically and with advice from local USAID missions.

- USAID should separately consider how the partnership concept, interpreted not merely as a volunteer effort but rather as technical assistance built on peer-to-peer personal relationships between practicing health professionals and their institutions, can be more creatively adapted and managed to promote sustainable health care reform in the NIS and CEE.

Section 3.1.3 Duration of Partnerships (Page 11)

Conclusion

- The duration of partnerships should be based on the pace of accomplishments rather than on an arbitrary period of three years.

Recommendations

- Partnerships should start with a two-year budget but continue for up to five years as long as they demonstrate progress. AIHA should undertake a participatory evaluation of each partnership after 18 to 24 months to determine whether to continue, replace, or terminate it.

- AIHA should identify partnerships with compelling successes and assist them in locating funding from other sources so that they can become independent of AIHA at the end of project funding.

Section 3.2.1 NIS Nursing Task Force (Page 15)

Conclusions

- The NIS nursing initiative has had a strongly positive impact on the nurses involved. It has given them increased interest in their profession through conferences and meetings that provide a collegial forum for the exchange of ideas, strengthen the ideals of professional nursing, and generate mutual support. Despite its great impact on the lives of the nurses involved in the conferences and exchanges, the nursing initiative has had limited national-level policy impact.

- None of the partnerships embodies a program for retraining physicians in the medical system and reforming the role of nursing in the context of an assessment of overall human resource needs and skills at the hospital or system level.

Recommendations

- Nursing reform needs to take place in the context of human resource development. An overall study of human resource needs for the health sector should be conducted to determine the number and type of health professionals that will be needed in the future.

- The Russian Nurses' Association and the AIHA nursing task force should combine their efforts to influence policy change. Funds should be provided, even at the expense of other nursing or partnership activities, to deliver technical assistance from organizations experienced in developing nonprofit organizations and advocacy skills.

Section 3.2.2 CEE Nursing Task Force (Page 18)

Conclusion

- Recognizing that partners in different countries speak different languages and work in different health care systems, the CEE nursing initiative has focused on individual countries, placing less emphasis on regional activities. The partners depend on the task force primarily as a way of sharing information and getting support.

Recommendation

- The CEE nursing initiative should be scaled up to focus on building national nursing associations by assisting them with organizational development and training them in strategies for policy reform. As in the NIS, funds should be allocated, perhaps at the expense of the overall partnership effort, to strengthen national nursing associations.

Section 3.2.3 Emergency Medical Services (Page 20)

Conclusion

- The EMS program relies on relatively low technology and undoubtedly saves lives and prevents further trauma to the few patients fortunate enough to be picked up by trained EMS workers assigned to an ambulance with life-saving equipment. As the program is currently designed, the number of trainees is and will remain low while those trained in Moscow do not work outside their own hospitals.

Recommendation

- The EMS program has laid the groundwork for a system that, with strategic redesign, could begin to have nationwide impact by creating a national training-of-trainers facility. A nationwide EMS program should also be tied in with existing preventive public health initiatives and advocacy groups (U.S. and NIS), including CPR training, seatbelt laws, antidrunk driving campaigns, and drug abuse prevention.

Section 3.2.4 Neonatal Resuscitation (Page 22)

Conclusion

- The neonatal resuscitation initiative has shown dramatic and immediate results. In the hospitals visited by the evaluation team, however, neonatal resuscitation is not yet a part of a program of prenatal care and follow-up on nutrition, breast feeding, and family planning.

Recommendation

- The neonatal resuscitation initiative needs to be scaled up to the national level and folded into other maternal and child health programs. If coordinated with the women's health initiative that provides women with better prenatal care, the neonatal resuscitation initiative could be even more effective. A nationwide training-of-trainers program could bring simple life-saving techniques for newborns to a broader range of hospital personnel.

Section 3.2.5 Infection Control (Page 24)

Conclusion

- The infection control initiative offers great potential. As health care reform and financing become more important in the NIS, the contributions made by reducing the ALOS and improving quality of care become critical elements in the performance of individual hospitals. Given that all U.S. hospitals operate infection control programs, they are good places for NIS personnel to develop practical experience.

Recommendation

- The infection control initiative needs to be scaled up to have greater impact in nonpartner hospitals. Using the lessons learned from the NIS infection control task force, the initiative might be broadened to nonpartner hospitals to extend impact.

Section 3.2.6 Diabetes (Page 26)

Conclusion

- The diabetes project's approach to patient self-management has had a highly positive impact on the health of diabetics while lowering the cost of health care. The program is unique in its emphasis on nonhospital-based patient education and the involvement of Lilly as a partner. It remains to be seen whether the project, developed in a small and highly educated city, can be replicated in larger urban settings.

Recommendation

- The replication issues and lessons learned should be documented. If successful, the program should be scaled up into a broader initiative to be used in many more communities, perhaps as part of a future healthy communities initiative. If the program's cost-effectiveness can be documented, other donors and countries should be interested in replicating the program.

Section 3.3.1 Women's Health Initiative (Page 27)

Conclusion

- The women's health initiative is too new to evaluate. At this time, it is not well integrated with the other women's health initiatives already in place in other partnerships.

Section 3.3.3 Health Management Education (Page 29)

Conclusion

- The health management education partnerships address the critical management constraint by building the profession and playing a central role in the overall health care reform effort. Despite the efforts of some individuals involved, universities generally seem somewhat less amenable than hospitals to the administrative and financial aspects of the AIHA framework, including its central guidance, volunteer structure, and absence of institutional overhead fees.

Section 3.3.4 Healthy Communities (Page 29)

Conclusion

- The healthy communities program, while still developing, has considerable potential. The preventive and promotive aspects are consistent with USAID's overall health policies. At this time, the program in Turcienske Teplice is performing well because of preexisting momentum and the support of a dynamic mayor.

Recommendation

- If subsequent data bear out initial results, the healthy communities initiative could be expanded to include a variety of other public health programs such as antidrunk driving, seatbelt use, emergency medical services, citizen CPR training, and the treatment of chronic diseases such as asthma, diabetes, and tuberculosis. At some point, support for nongovernmental advocacy groups might be more effective than relying on AIHA to carry out these initiatives on its own.

Section 3.4.1 AUPHA Management Training (Page 30)

Conclusion

- The AUPHA workshops are useful in terms of content and adult education style. They have also succeeded in bringing mixed groups that include women into common learning activities. The workshops, however, might be better integrated with partnership activities.

Recommendation

- Each NIS region and CEE country needs an annual plan of all management workshops, conferences, and travel so that busy people can plan for travel and attendance at such events. AUPHA also needs to provide U.S. partners with its training materials so the organization can coordinate its concepts, definitions, and approaches with those used by partners.

Section 3.4.2 Information Systems Initiative (Page 33)

Conclusions

- The information technology initiative has great potential for sustainability of the partnerships, but it has not yet had much impact. It is new, and AIHA has had to create demand in countries with little tradition of continuing education. Few overseas medical staff have computer experience, and hospitals do not have dedicated computer technicians to help with problems. AIHA is providing hardware, software, and training as usage slowly increases.

- While AIHA reports some efforts to coordinate with other organizations and foundations, the effort needs to be stepped up, particularly so that partners will know how to make contacts with local resources on their own.

Recommendations

- More training is needed to realize the full benefits of modern information management and the financial investment in hardware and to encourage e-mail communication among overseas participants.

- AIHA should publish a hard copy of its Web site directory of participants' e-mail addresses, with a short statement of interests and responsibilities. The directory may stimulate interest in the use of e-mail by those not yet comfortable with computers.

- AIHA should coordinate with the Soros Foundation in each country to see how the technology programs of the two organizations could better complement one another.

Section 3.4.3 *CommonHealth* Magazine (Page 36)

Conclusion

- *CommonHealth* is a useful, if fairly high-cost, forum for the exchange of ideas about health practices as well as a means of helping partners become acquainted with each others' work.

Recommendation

- AIHA should consider carrying out a market study to test the feasibility of adjusting the format of *CommonHealth* to make it financially self-sustaining through the sale of advertisements and subscriptions. The publication could conceivably become the premier periodical on health care reform in the NIS and CEE and achieve full cost recovery.

Section 3.4.4 Conferences and Specialized Workshops (Page 37)

Conclusion

- Conferences are a popular forum for sharing ideas among partnerships; among people not otherwise connected with the project, particularly government officials; and among those teaching the next generation of health care professionals. Conferences also reward those who put in extra time on partnership work.

Recommendation

- Conferences should be part of an annual overall regional (NIS) or country (CEE) strategy developed by AIHA field representatives in consultation with partners. Earlier planning of conferences will allow busy professionals to organize their time more productively.

Section 3.5.4 Cost Recovery and Finance (Page 40)

Conclusion

- Preliminary data demonstrate improved administration or management of health care systems in specific units of partner hospitals. Individual partnerships report reduced ALOS, establishment of fee-for-service programs, improved pharmacy monitoring of medications, creation of cost-accounting departments, reduction in the number of beds, and a shift from in-patient to out-patient services. As a result, some institutions have been able to improve the quality of service, but no data are yet available to demonstrate the impact on overall costs or improved patient care.

Section 3.5.5 Replication (Page 41)

Conclusion

- The partnership model is not the best approach for achieving replication, but it does provide a mechanism for piloting strategies that can be scaled up for broader impact. The partnerships can be used for pilot testing curriculum materials, protocols, and program models that lay the groundwork for a more strategic approach to broader impact.

Section 3.5.6 Policy Change (Page 42)

Conclusion

- Hospital partnerships are not a particularly good vehicle for national policy change, although significant local change is possible if the appropriate professionals are brought into the partnership and included in exchanges, conferences, and meetings. The few examples of policy

change are limited to situations where senior decision makers have been deeply involved in the partnership.

Recommendation

- While partnerships are not designed to have national policy impact, they should nevertheless be selected strategically so that senior MOH officials can be included in exchange visits and assume an active role in workshops and conferences.

Section 3.6 Monitoring and Evaluation (Page 43)

Conclusion

- The quarterly reports provide a good overview of activities for the quarter and a useful history of the project. However, the project lacks a standardized method for monitoring progress on objectives, quality-of-care indicators, and management change.

Recommendation

- AIHA should adapt USAID's results framework to its evaluation effort and develop a way to monitor progress on partnership results. Routine data could be supplemented with short but substantive case studies showing, for example, how improvements in quality of care are linked to improved management and the changing role of nurses. Graduate students should be encouraged to carry out in-depth studies on special topics.

Section 4.0 Management Issues

Section 4.1 Background (Page 45)

Conclusion

- Changes in the structure and operation of the AIHA project have created inherent tensions that have been exacerbated by management styles and personalities at both AIHA and USAID.

Recommendation

- Many of the tensions could be dealt with through a CA that clearly identifies the roles of USAID/Washington, USAID overseas offices, and AIHA.

Section 4.2.1 Internal Management (Page 47)

Conclusion

- AIHA has a highly centralized management style that partners view as contributing to the difficulty in both obtaining information and getting decisions as well as to the sense of continuous crisis management.

Recommendation

- AIHA should decentralize decision-making responsibilities from headquarters to regional offices, clearly define the resulting new roles, and communicate the new functions internally and externally. Through internal promotions and greater delegation of responsibility, AIHA should also create more incentives for staff to remain with the organization.

Section 4.2.2 Partnership Management (Page 48)

Conclusion

- The U.S. partners and AIHA share a strong sense of frustration, partly because of the vagaries of USAID financial policies. More important, partners do not understand AIHA's policies and believe that some partners are favored. Partners want AIHA assistance in locating other sources of funding either to sustain their work or expand it in certain areas.

Recommendation

- AIHA should create a budget system that provides complete information on budgets (allocations and expenditures) for both individual partnerships and the overall program. Partners should retain ultimate control over use of the funds consistent with overall program guidance. One approach would be to provide funds directly to the partnerships, with the exception of AIHA administrative expenses and a contingency fund, and allow them to "buy in" to those cross-cutting initiatives they found useful.

Section 4.2.3 AIHA Regional Offices (Page 50)

Conclusion

- The AIHA regional offices provide good logistical support to visitors and for the importation of medical supplies. They do not have a significant role in program implementation even though field staff have strong medical and management skills.

Recommendation

- The AIHA regional offices need a stronger role in program planning and implementation. Definitive and current regional work plans would help coordinate trips and workshops.

Section 4.2.4 Financial Issues (Page 51)

Conclusion

- AIHA has been a responsible steward of government resources in support of the partnership program.

Section 4.2.4.1 Financial Plan (Page 51)

Conclusions

- Because of uneven USAID funding flows and the absence of budget transparency, partners have difficulty planning their activities and making full use of the money allocated to them.

- AIHA's system of allocating back to participating partners the costs for the cross-cutting initiatives without tracking the costs of each makes it impossible to assess the cost-effectiveness of various initiatives.

Recommendations

- AIHA should develop a revised financial plan that would give AIHA and USAID a more meaningful basis for monitoring financial performance and judging program effectiveness.

- Each partnership should be given a three-year budget, extendable in one-year increments, to use as needed in the implementation of its work plan or with AIHA approval for unplanned activities.

Section 4.2.4.2 Partner Financial Reporting (Page 52)

Conclusion

- Partners feel that AIHA uses budgets to manipulate and control partners and their activities.

Recommendation

- In the context of the new budgeting system discussed above and any new agreement, AIHA and USAID should examine ways to make the budget process more transparent and more effective as a planning tool.

Section 4.3.1 AIHA Cooperative Agreement (Page 53)

Conclusions

- In implementing the individual hospital partnerships, probably no organization could surpass AIHA over the short term.

- The more the project moves away from the hospital partnership core into cross-cutting initiatives, broader health care issues, and systemic reform, the less striking is its impact and the less compelling is the case that AIHA's capability is unique and predominant. And systemic reform should receive the highest priority.

Recommendation

- USAID should negotiate a new cooperative agreement with AIHA for the limited purpose of making subgrants to core hospital partnerships. By illustration, such an agreement could fund 25 partnerships at a generous $500,000 each, plus 15 percent for AIHA administration and 10 percent for contingencies, for about $15.5 million over three to four years.

Section 4.3.2 Competitive Core Contract (Page 55)

Conclusion

- As the partnership program moves away from its core expertise in hospital matters, its impact weakens and suggests that a mechanism other than a cooperative agreement is more appropriate for the broader issues of health care sector reform.

Recommendations

- USAID should rely on a competitively procured contract for activities currently carried out by AIHA outside the core hospital-to-hospital partnership activities. This could build in certain beneficial aspects of the partnership concept but should focus more on sustainability.

- Any unfunded extension of the current cooperative agreement should be for the limited purpose of partnership activities rather than for the continuation of broader special initiatives and policy efforts.

Section 4.3.3 Conflicting Signals (Page 57)

Conclusion

- Tension between the USAID R4 strategic planning system and recent CA guidance is inherent. It is imperative to reach a resolution that respects both the integrity of the cooperating agency and USAID's need to account for results at the country or mission level.

Recommendation

- USAID should clarify its guidance to overseas offices regarding the treatment of the cooperative agreement within the R4 strategic framework, uniformly inform employees of their resulting responsibilities and limitations, ensure coordinated representations to AIHA from the various program and procurement officials, and enter into any new cooperative agreement with a full account of the limitations of the new guidance on substantial involvement.

ANNEX A

AIHA BOARD OF DIRECTORS

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ANNEX B

LIST OF COOPERATIVE AGREEMENTS

AWARDS & MODIFICATIONS

CCCS-0004-A-00-2017-02

Award or Modification	Effective Date	Total Estimated Agreement Amount	Total Obligation	Description of Award or Modification
Original Award	June 1, 1992	$13,500,000.00	$7,500,000.00	
Amendment 1	May, 1993		$3,500,000.00	Provide incremental funds
Amendment 2	April 6, 1994		$2,500,000.00	Provide incremental funds
Amendment 3	May 6, 1994	$6,500,000.00	$6,500,000.00	Increase the Total Estimated Amount of the agreement and fully obligate the agreement.
Modification 4	September 29, 1994	$5,240,000.00	$4,200,000.00	Increase the Total Estimated Amount of the agreement, of which $3M shall be applied toward the existing Partnerhsip program, and $2.24M for the new Semipalatinsk Program. Increase the obligated amount by $4.2M , of which $3M shall be used to fully fund the 5 months extension to April 30, 1995. The remainder of $1.2M shall partially fund the Semipalatinsk Program.
Modification 5	July 20, 1995		$540,000.00	Provide incremental funds for the Semipalatinsk program.
Modification 6	September 16, 1996		$185,000.00	Provide incremental funds for the Semipalatinsk program.
		$25,240,000.00	**$24,925,000.00**	

24

Award or Modification	Effective Date	Total Estimated Agreement Amount	Total Obligation	Description of Award or Modification
Original Award	December 1, 1993	$8,896,497.00	$2,848,000.00	
Modification 1	August 29, 1994	$153,541.00	$2,500,000.00	Increase the Total Estimated Amount of the agreement and provide incremental funds.
Modification 2 (See Note)	May 1, 1995	$43,913,361.00	$22,156,848.00	(1) Consolidate the NIS and CEE Health Care Partnership Programs; (2) Extend agreeement for 18 months; (3) Increase the Total Estimated Amount of the agreement; (4) Increase the obligation amount.
Modification 3 (See Note)	July 25, 1995		$2,711,000.00	Provide incremental funds for the NIS and CEE programs.
Modification 4	January 24, 1996			Change the Project Officer from Julia Terry to Petra Reyes.
Modification 5	April 10, 1996			Update the country breakdown in modification #2 to delete "Poland 2,000,000" and substitute "Bosnia 2,000,000".
Modification 6 (See Note)	May 17, 1996		$9,470,000.00	Provide incremental funds for the NIS and CEE programs.
Modification 7 (See Note)	August 22, 1996		$2,664,000.00	Provide incremental funds for the NIS and CEE programs.
Modification 8	August 30, 1996			Make administrative changes to the fiscal data specified under the Accounting and Appropriation Data Summary.
Modification 9	September 23, 1996		$2,085,000.00	Provide incremental funds for the NIS and CEE programs.
		$52,963,399.00	**$44,434,848.00**	

TOTAL OBLIGATION TO DATE BY PROGRAM

AMERICAN INTERNATIONAL HEALTH ALLIANCE

Updated: *06-May-97*

PROGRAM	USAID Obligation Program Inception To Date
NIS Program	$19,460,000
CEE Hospital Program	$16,534,848
CEE HME Program	$7,270,000
CEE Healthy Communities	$300,000
CEE Community Based Health Reform	$870,000
TOTAL	**$44,434,848**

ANNEX C

November 22, 1996

SCOPE OF WORK

EVALUATION SCOPE OF WORK

American International Health Alliance (AIHA)
PARTNERSHIPS PROGRAM

I. BACKGROUND

A. Partnership History and Life-line:

Following the grant awards of ten free-standing partnerships for Central and Eastern Europe (CEE) in 1992, USAID recognized the advantage of utilizing an umbrella organization to establish a comparable hospital partnership program for the (New Independent States (NIS). The American International Health Alliance (AIHA), a consortium of hospital associations and health-related organizations, was formed at the request of USAID in 1992, and awarded an agreement to establish nine partnerships in the NIS.

The purpose of the original CEE precursors to the AIHA program was to directly impact health status. As the program evolved to encompass the former Soviet Union under AIHA, the purpose became increasingly to impact the delivery of improved medical care. The basic approach of the program is exchange of medical knowledge and technology. In little more than a year, AIHA developed and was managing twenty NIS hospital partnerships. Based on AIHA's responsiveness and effectiveness in a logistically difficult environment, USAID established a second agreement with AIHA for an additional hospital partnership program in CEE countries.

In 1994 a midterm assessment of the NIS partnerships endorsed program continuation, which enabled USAID to merge and expand the parallel AIHA partnership program efforts during the two years following the Assessment. Following USAID's organizational merger into the Bureau for Europe and the New Independent States (ENI), AIHA's Partnership Program now covers several distinctive program entities operating in 19 countries in Central and Eastern Europe and in the NIS, currently with about 40 partnerships. The structure of the Consortium remains as created in 1992.

Since the establishment of the first AIHA Hospital Partnerships in the NIS in 1992, major changes have taken place in both the donor environments and in the host countries. These unforseen changes, particularly within USAID, have exerted enormous programmatic and management pressures on the AIHA Partnership Program - in many ways contradictory to the strengths and spirit of a volunteer effort - to conform increasingly to the structure and behavior of a more standard contractual development assistance instrument.

AIHA was established at USAID's request at a time of rapid central program deployment through the special authority of the NIS Task Force. Subsequent establishment of a merged Bureau for Europe and the New Independent States (ENI), brought USAID field Missions and USAID Representatives where previously there was no field presence. This organizational expansion was quickly followed by "regularization" and field control of the assistance programs. For example, the relatively uncomplicated exchange of partnership visits - a key element of the volunteer partnership program - was brought to conform to Handbook 10 Participant Training, with additional requirements for planning, and administrative support at all levels, requiring reallocation of partnership program funds to cover higher implementation costs.

Beginning in 1994, USAID Missions have increasingly imposed partnership conformity to USAID country program strategies and focus, and adherence to "USAID development assistance approaches." These at times have been at odds with the U.S. partners' technical approaches to the health/medical areas (e.g., the Partnerships' hospital-based locus versus the Agency's established assistance policy of population-based, preventive primary care- notably in the areas of women's reproductive health and family planning, and pediatric interventions.) Over time, however, the programmatic uniqueness of the medical partnerships, which were tailored for "first world" population structures and disease profiles, did prevail. Yet, noticeably, the Agency's strong public health orientation has encouraged the hospital/medical partnerships out of the original institutional "four walls", into the community, into preventive orientations and more systemic approaches.

B. Funding Reductions and Systemic Turbulence:

Beginning in 1994, substantial reductions in overall NIS Congressional appropriations, with year-by-year funding uncertainties for the health sector, have had major direct and indirect impact on the partnerships. Direct impact was first seen in inability by USAID to make 3-year funding commitments for new partnerships. These budget uncertainties combined with Congressional earmarking has encouraged somewhat uncertain year-by-year continuation of ongoing NIS partnerships. Hence, the expected "graduation" and phase-out of partnerships was curtailed, which has directly changed the partnership program plan. Additionally, there has been strong indirect impact of funding reduction on partnerships. As reductions in health funding have limited the availability of alternative health sector assistance instruments for the USAID Missions, they have looked to the partnerships to fill the gap and to help implement their health sector objectives.

Other major organizational changes in the USAID foreground have affected the partnership program. USAID "re-engineering" has sought simultaneously to decentralize programs and "empower" the Missions, and has imposed a strategic results management system. This has system has clashed with the government-wide OMB procurement reform

which has minimized the Government's "substantial involvement" within grant mechanisms. Missions are increasingly turning to the Partnership Program for strategic results.

In the larger context, equally far-reaching economic and political changes have also been taking place in the ENI host countries. As anticipated, bankrupt health sectors have finally forced countries to address health sector reform. The sweeping demand for all forms of health reform assistance - at a time when USAID health sector funding is low and suitable assistance instruments are no longer available - is exerting serious pressure on the volunteer partnerships, to reshape programs.

Volunteer partnering approaches under the AIHA instrument are being used in the CEE to implement an innovative health management education program between academic institutions. They are also being adapted to engineer various community organization/mobilization approaches for social health problems and planning local "reform" of health services.

Though combined into one agreement, the CEE and NIS programs maintain their distinctness, not only in terms of length of program experience, funding levels, but in program focus and content. Both geographic areas are demonstrating some of the anticipated outcomes - in some cases of the longer NIS program, far beyond expectations - in other program aspects perhaps less successful or less quickly successful, than had been anticipated, given the assumptions surrounding the program. The individual partnerships are also showing many surprising and unanticipated results.

II. PURPOSE OF THE EVALUATION

Key issues for 1994 NIS Assessment concerned the criteria and expectations for measuring success of a volunteer program operating in a complex and necessarily changing environment. After four years of highly visible program momentum and substantial USAID investments, the evaluation issues are now also concerned with determining the most meaningful of the many results, their sustainability, and the most efficient and most cost-effective approaches. This external evaluation shall review the AIHA organizational and management structure and the pro-bono services programs in both the NIS and the CEE for cost-effectiveness. It shall make recommendations to USAID for future program directions and approaches, and on future assistance instruments and program management.

Objective 1: To highlight and document major accomplishments and contributions to the ENI through this Volunteer Program: successes, failures, specific impact on health, sustainability, and lessons learned.

Objective 2: To recommend future directions and guidelines for a

follow-on program: in light of lessons learned to date.

Objective 3: To conduct a review of the management of the implementation of the partnerships program and make recommendations for the future.

III. EVALUATION METHODS AND PLAN

A. Methodology

The principal methodologies shall be interviews and review of program materials, and may include focus groups and/or collective meetings with U.S. partners. The evaluation team is expected to revisit selected issues and recommendations posed in the 1994 NIS Assessment and audits, and to review related USAID experiences with other partnerships programs and mechanisms - e.g.,IREX, Partners of the Americas, etc.

USAID/Washington and AIHA shall provide the necessary background information. Team members shall then interview and visit U.S. Partners and make selected NIS/CEE field visits to Partner institutions, USAID, AIHA regional offices, cooperating government officials and others as appropriate. Team members shall also have access to Missions and to AIHA's Regional Offices, and to U.S. and ENI partners through fax and telephone from the U.S.

B. Evaluation Team

The team shall consist of 2-3 core team members, assisted by 2-4 additional resource persons/professionals, who shall have some combinations of the expertise listed below. (It is not expected that each team member will have the precise set of skills an experience outlined, but rather that these skills are in the team) It is anticipated that the core team members shall participate throughout the evaluation, and that the resource persons will participate for shorter time periods, and focused on specific tasks. The team leader shall participate in planning the tasks and timing of the resource persons to complement core team.

1. Senior Management Specialist/Executive (Team Leader)

The management specialist must have extensive experience in the oversight/administration of USAID social sector foreign assistance portfolios, also with direct experience in program evaluation, management, as well as have some familiarity with current U.S. domestic health care issues. Ideally, someone with skills and experience comparable to a USAID Mission Director: familiar with NIS/CEE assistance programming, and experienced with USG assistance modalities and instruments, procurement policies, and USAID organizational issues.

As a senior/executive manager, the team leader should also have knowledge and experience in direct organizational management, and be conversant with management development theory and practice. He/she must be experienced in interviewing senior professionals, must have strong analytic and writing skills, and should be available for six weeks over a ten week period of time, although some of the work may be done at his/her home or place of business. The Team leader is expected to conduct some of the U.S.-based interviews and the preparation of the report, and to be available for various debriefing of USAID Senior Management.

2. Senior Social/Behavioral Scientist: shall address the many cross-cultural, institutional and inter-institutional aspects of the partnership program, including approach to "planned change" and management development. This team member shall have extensive international experience, including NGOs and voluntary organizations, community organization and dynamics, women's issues. He/she shall be familiar with voluntarism and people-to-people programs, including partnership models; familiarity with grassroots mobilization, democratization and implications for civil society programs; shall have some experience in international health, with some understanding of NIS or CEE health sector issues and broader social sector reform issues. He/she must have experience in the areas of cross-cultural collaboration and "transfer" of technology, management systems, and process in the health sector. He/she must also be conversant with organizational behavior and process, team-building and cross-cultural management styles. It is also desirable that this team member (or another) have experience in professional training/education practice, and understanding of academic curriculum development.

Resource Professionals:

3. Senior Medical/Health Care Specialist(s): this set of skills and experience may be found in one specialist, but may also be accessed through two specialists provided that there is an appropriate orientation, briefing and/or consultation between them. In principle this person a recognized senior physician with a public health orientation, with epidemiological skills. The specialist shall also have recognized experience in medical education, secondary/tertiary care and related health care organization and management issues; he/she must be knowledgeable about current U.S. clinical practice and issues in continuing medical and nursing education, inter-professional relationships, clinical team-building and hospital management. International experience and knowledge of non-U.S. health care systems/practice is essential; familiarity with CEE/NIS systems/practice desirable. This resource person(s) should be conversant with the health systems relevance of the following interventions: EMS training, hospital infection control, neonatal resuscitation, women's health, nursing development, QA, hospital administration. The medical specialist must be available full-time for a total period of at least four weeks with extensive travel in the NIS.

4. **Project Financial Analyst:** a senior analyst experienced in USAID project-level analyses will assist the Team Leader/Management Specialist with determining relative project costs of the AIHA program model- for example, the administrative costs of the pro-bono services and in-kind contributions; costs of the multiplier effects, etc. This person must be experienced in performing cost-effectiveness analyses of project allocation of resources, organizational management structures, functions and efficiencies.

5. **Nursing Educator:** an internationally experienced nursing educator conversant with the issues related to the upgrading of nursing skills and practice, development of the nursing profession and nursing educational programs. Must be aware of the inter-professional relationships and team building. It is expected that this team member will conduct interviews mostly with U.S. partners, the AIHA Nursing Task Force, AIHA staff and extended alliance members of the Consortium.

6. **Logistical and/or other** resource persons as determined by BHM and the Team Leader to facilitate the evaluation and the integration of the resource persons' contributions into the Evaluation Report.

IV. EVALUATION ISSUES

Cross-Cutting Questions

- What are the most attractive aspects of the AIHA program? Do four years of program experience suggest changes in criteria and measures of success for AIHA and the individual partnerships?

- Have the respective NIS and CEE partnerships resulted in noteworthy, measurable and sustainable impact in their respective institutions and the broader communities? Which aspects of the AIHA have been most successful, which least successful? What are the lessons learned?

- What is the role of AIHA itself in developing and supporting the projects? What has been its impact on the effectiveness of the institutional partnering?

- What are the strengths, weaknesses and limitations of the AIHA volunteer partnership model? What is its future given funding uncertainties? What has been its relative cost-effectiveness?

- What are the recommended options for future directions of the current partnerships as they shift from USAID support, and what are the options for phase-out of that support?

- What should a follow-on ENI partnership program look like,

programmatically and organizationally? What are the options for assistance instruments, and where should the locus of control for the program be?

Design and Implementation

- How have the original project purpose and design been modified, and how might they be further modified in the future?

- Is the current project purpose and design compatible with the Agency's Strategic Results Framework and decentralization policies? What are the unresolved issues and recommended options?

- What are the benefits and drawbacks of a continued unified region-wide partnership program, as opposed to moving to country-level programs?

- What significant problems, constraints and issues have affected project implementation?

- Have the overall and partnership-specific work plans provided a clear description, time frame, targets, and outcomes of the project? Are there issues concerning work plans as management tools or lessons learned?

Effectiveness of the Partnership Approach

- What are the different results, outcomes and benefits to be expected from the various types of current partnerships -- including hospital, management education, healthy communities, community health reform, and others -- and what combinations do these suggest for the future?

- What is the relative effectiveness and benefits over time of the different approaches to management education in CEE and NIS?

- What are the relative costs of the various types of partnering approaches? What are their respective potentials for leveraging additional resources?

- Compare the scope and relative costs of the "cross-cutting" programs supporting the institution-to-institution partnering base. What are the issues and implications for follow-on project design?

- Are there areas of activity where partnerships are a well-suited which are currently under-utilized? Are any current activities not well-suited to partnerships?

- Comment on AIHA's criteria for "graduating" partnerships from USAID support and its phase-out strategies.

Achievements of NIS and CEE Programs

- After four years of hospital partnership activities in the NIS and a somewhat shorter period in CEE, during which the programs have gained in scope and momentum, what are AIHA's most significant successes?

- What are the most successful initiatives in Hospital Infection Control, Emergency Medical Services, Neonatal Resuscitation, Women's Health, Hospital Management, and Nursing Development?

- What are the most significant clinical and educational accomplishments? Have there been systematic and continuing improvements in-hospital continuing education, in patient care?

- Are there improved institutional management practices and increased efficiencies?

- What is the evidence of active in-country dissemination of lessons learned and of community outreach.

- What generalizations can be made about the impact of the project on the health of the people of the areas involved? What data or anecdotal information exists to measure or illustrate the impact on specific groups or populations or communities? How can impact be better assessed in future projects?

AIHA Organization and Management

- Is the AIHA organizational structure and staffing pattern for this complex program efficient and cost-effective? Does it reflect current operational needs?

- How appropriate are the respective program elements to AIHA's organizational strengths and capabilities?

- How has AIHA maintained technical and managerial competence as the program has expended into new technical areas?

- Comment on the role of the AIHA Board in providing guidance on the expansion of program activities, in oversight of operations, in extending the domestic and international reach of the project, in overseeing AIHA operations.

- What criteria has AIHA used to allocate grants to partners? Have theses criteria proven to be appropriate, equitable, and instrumental in achieving their objectives? What changes should be made in the future?

- Does AIHA successfully support the partners, both in the NIS/CEE and in the US? Are there alternative structures and operations which would make the structure more responsive and effective? How do the US partners perceive their relationship to AIHA and the support they receive?

- Comment on the effectiveness of AIHA's management and dissemination of information within and about the project.

- Have AIHA and the Medical Partnerships Program developed a strong constituency for international development and a positive image of USAID among US participants.?

USAID Management and Organization

- What are the current management issues surrounding the effective implementation of the partnerships program ?

- Based on the partnership program models implemented by AIHA, how can USAID management be most effective ?

- What are the key mechanisms for monitoring and evaluation? How well suited are they to the volunteer partnerships?

V. ASSESSMENT TIMETABLE

The assessment shall be conducted during November 1996 - February 1997. The performance period should encompass November 1996 through May 1997. Exact timing shall be determined based on the availability of the team members.

An initial draft of the assessment report shall be prepared by the Team Leader, who will incorporate the reports of the other team members. He/she shall be assisted by the contractor's designated administrative staff.

The timetable shall be worked out by BHM with the Core Team in consultation with AIHA. To maximize the availability of core team members and key resource persons, the work may be accomplished in phases. There may be an initial phase of several weeks in November for the core team to do detailed planning with AIHA.

VI. RESPONSIBLE PROJECT OFFICER: Dr. Petra Reyes, Partnerships Project Officer, USAID/W will work closely with the Evaluation Team on the evaluation and to prepare an outline for the final report.

ANNEX D

LIST OF AIHA PARTNERSHIPS
(Partnerships Visited by the Evaluation Team Indicated by *Bold Italics*)

Foreign Partner City and Country	Participating Foreign Institution(s)	U.S. Partner City and State	Participating U.S. Institution(s)
Yerevan, Armenia	Emergency Medical Scientific Center	***Boston, MA***	***Boston University Medical Center***
Yerevan, Armenia	Erebuni Medical Center	Los Angeles, CA	UCLA Medical Center
Minsk, Belarus	Children's Hospital No. 4; Radiation Medicine Institute; Minsk Medical Institute	Pittsburgh, PA	Children's Hospital; University of Pittsburgh Schools of Medicine and Nursing
Tbilisi, Georgia	Ministry of Health of the Republic of Georgia; Tbilisi State Medical University; City Hospital No. 2	***Atlanta, GA***	***Emory University School of Medicine; Georgia State University; Grady Memorial Hospital***
Almaty, Kazakstan	***Institute for Pediatrics and Children's Surgery; First Aid Hospital; Almaty Perinatal Center; Almaty Medical College***	Tucson, AZ	Tucson Medical Center; Arizona Health Sciences Center; St. Mary's and St. Joseph's Hospitals; El Dorado and Northwest Hospitals; Veterans Affairs Medical Center; Tucson General Hospital

Foreign Partner City and Country	Participating Foreign Institution(s)	U.S. Partner City and State	Participating U.S. Institution(s)
Semipalatinsk, Kazakstan	***Semipalatinsk Oblast Administration; Oblast Oncology Dispensary; Oblast Clinical Hospital; Oblast Children's Hospital; Semipalatinsk Central City Hospital; Regional Diagnostic Treatment Center (Kurchatov, Kazakstan)***	Houston, TX	The Methodist Hospital; Baylor College of Medicine
Bishkek, Kyrgyz Republic	***Kyrgyz Republic Ministry of Health; Institute of Oncology and Radiology; Institute of Obstetrics and Pediatrics***	Kansas City, KS	University of Kansas Medical School; University of Kansas Hospital
Chisinau, Moldova	City Ambulance Center; Republican Clinical Hospital; Medical University of Moldova; Ministry of Health	Minneapolis, MN	Hennepin County Medical Center
Dubna, Russia	***Hospital No. 9; Central City Hospital; Bolshaya Volga Hospital; Children's Rehabilitation Center***	***La Crosse, WI***	***Lutheran Health System; Franciscan Health System; Gundersen Clinic; Skemp Clinic; La Crosse Visiting Nurses Association***
Moscow, Russia	***EMS Training Center at the Institute of Continuing Education of the Federal Directorate for Biomedical Problems and Disaster Medicine***	Austin, TX	City of Austin Emergency Medical Services Department
Moscow, Russia	***Pirogov First Municipal Hospital***	***Boston, MA***	***Brigham and Women's Hospital***

Foreign Partner City and Country	Participating Foreign Institution(s)	U.S. Partner City and State	Participating U.S. Institution(s)
Moscow, Russia	***Medical Center of the General Management Department of the President of the Russian Federation***	***Chicago, IL***	***Premier, Inc.***
Moscow, Russia	***Ministry of Health and Medical Industry; Institute of Pediatrics and Children's Surgery***	Norfolk, VA	Children's Hospital of the King's Daughters
Moscow, Russia	Savior's Hospital for Peace and Charity; Main Medical Administration for Moscow	Pittsburgh, PA	Magee-Women's Hospital
Murmansk, Russia	Murmansk Regional Hospital; Murmansk City Ambulance Hospital	Jacksonville, FL	[St. Vincent's Medical Center; Memorial Hospital of Jacksonville][1]; Jacksonville Sister Cities Association
Stavropol Krai, Russia	Regional Ministry of Health; Stavropol Regional Hospital; Stavropol City Hospital No. 4	State of Iowa	Iowa Hospital Association
St. Petersburg, Russia	St. Petersburg Medical University in the name of Pavlov	Atlanta, GA	Georgia Baptist Medical Center
St. Petersburg, Russia	***Medical Center of St. Petersburg in the name of Sokolov***	***Louisville, KY***	***Jewish Hospital Health Care Services***

[1] These two hospitals represented the American side of the program from 1992 through June 1996. Effective July 1, 1996, responsibility was transferred to the Jacksonville Sister Cities Association.

Foreign Partner City and Country	Participating Foreign Institution(s)	U.S. Partner City and State	Participating U.S. Institution(s)
Vladivostok, Russia	City Clinical Hospital No. 2; Vladivostok State Medical Institute	Richmond, VA	Medical College of Virginia
Dushanbe, Tajikistan	City Medical Center	Boulder, CO	Boulder Community Hospital
Ashgabat, Turkmenistan	Niyazov Medical Consultative Center	Cleveland, OH	Cleveland Clinic Foundation
Donetsk, Ukraine	Donetsk Oblast Trauma Hospital	Orlando, FL	Orlando Regional Healthcare System
Kyiv, Ukraine	***Left Bank Center for Maternal and Child Health Care***	***Philadelphia, PA***	***University of Pennsylvania School of Medicine; Hospital of the University of Pennsylvania; Children's Hospital***
Kyiv, Ukraine	***EMS Training Center at the EMS Hospital; City of Kyiv***	Coney Island, NY	Coney Island Hospital; New York City Fire Department, EMS Division
Lviv, Ukraine	Lviv Clinical Railway Hospital; Lviv Perinatal Center	Buffalo, NY	Millard Fillmore Health Systems; SUNY Buffalo School of Medicine and Biomedical Sciences
Lviv, Ukraine	Lviv Oblast Clinical Hospital; Lviv Medical Institute	Detroit, MI	Henry Ford Health System; University of Michigan School of Medicine
Odessa, Ukraine	Odessa Oblast Hospital	Coney Island, NY	Coney Island Hospital
Tashkent, Uzbekistan	Second State Medical Institute	Chicago, IL	University of Illinois at Chicago Medical Center

Foreign Partner City and Country	Participating Foreign Institution(s)	U.S. Partner City and State	Participating U.S. Institution(s)
Tirana, Albania	***University Hospital Center of Tirana; University Hospital of Obstetrics and Gynecology; Central Trauma Hospital of Tirana***	Bronx, NY	Jacobi Medical Center
Tuzla, Bosnia	Tuzla Clinical Center	Buffalo, NY	Buffalo General Hospital; Buffalo General Health System
Zadar, Croatia	Zadar General Hospital; Orthopedic Hospital of Biograd	Franciscan Sisters of the Poor Health System, Inc.	Franciscan Sisters of the Poor Health System, Inc. (participating Hospitals in Kentucky, New Jersey, Ohio, and South Carolina)
Zagreb, Croatia	***"Sveti Duh" General Hospital; "Dr. Fran Mihaljevic" University Hospital for Infectious Diseases; "Srebrnjak" Children's Hospital for Respiratory Diseases***	***Lebanon, NH***	***Mary Hitchcock Memorial Hospital***
Tallinn, Estonia	Tallinn Central Hospital; Mustamae Hospital	Washington, DC	The George Washington University
Vac, Hungary	Javorszky Odon Korhaz (Vac Municipal Hospital)	Winston-Salem, NC	Carolina Medicorp, Inc.
Riga, Latvia	Bikur Holim Hospital; Riga Maternity Hospital; the Latvian Medical Academy's Clinical Children's Hospital	St. Louis, MO	Barnes-Jewish Hospital at BJC Health System

Foreign Partner City and Country	Participating Foreign Institution(s)	U.S. Partner City and State	Participating U.S. Institution(s)
Cluj-Napoca, Romania	***Center for Medical Research; Health Services and Management of Cluj; Inspectorate of Public Health; Clinic for Occupational Diseases***	***Philadelphia, PA***	***Thomas Jefferson University***
Kosice, Slovakia	Faculty Hospital and Polyclinic in Kosice	Providence, RI	Women and Infants Hospital of Rhode Island; Hasbro Children's Hospital at the Rhode Island Hospital
Petrzalka, Slovakia	Aid to Children at Risk Foundation; Institute of Preventive and Clinical Medicine	Kansas City, MO	Truman Medical Center Corporation; Missouri Department of Health
Turcianske Teplice, Slovakia	***Office of the Mayor of Turcianske Teplice; Town Health Council***	Cleveland, OH	The MetroHealth System
Tirana, Albania	***University of Tirana; Ministry of Health; National Institute of Public Health***	New York, NY	The Robert F. Wagner Graduate School of Public Service at New York University
Bohemia, Czech Republic	South Bohemia University Faculty of Management; Faculty of Health and Social Care; Faculty of Management and Information Technology at the University of Education; Purkyne Medical Academy; Postgraduate Medical School	Las Vegas, NV	University of Nevada, Las Vegas

Foreign Partner City and Country	Participating Foreign Institution(s)	U.S. Partner City and State	Participating U.S. Institution(s)
Olomouc, Czech Republic	Palacky University Faculty of Medicine	Richmond, VA	Virginia Commonwealth University
Bucharest, Romania	***Department of Public Health and Management at Carol Davila University of Medicine and Pharmacy; Institute of Hygiene, Public Health, Health Services, and Management***	***Chicago, IL***	***Graduate Program in Health Administration Policy at the University of Chicago***
Slovakia	***Trnava University School of Nursing and Social Care (Trnava); Economic Faculty of the University of Matej Bel (Banska Bystrica); Health Management School (Bratislava)***	Scranton, PA	University of Scranton Graduate Program in Health Administration

ANNEX E

LIST OF PEOPLE INTERVIEWED

UNITED STATES

Washington, DC

AIHA
- Donald Harbick, NIS Program Director
- Edward L. Martinez, Associate Director
- Donn Rubin, Program Director, Central and Eastern Europe
- Martin Saggese, Associate Director for Administration and Chief Financial Officer
- Jim Smith, Director
- Kurt Sweezy, Evaluation Officer

AUPHA
- Henry A. Fernandez, JD, President and Chief Executive Officer
- John R. Kress, MHA, Director of Education & Special Projects
- Bernardo Ramirez, MD, Vice President, International Programs

National Association of Public Hospitals & Health Systems
- Bernice Bennett, MPH, Director of Special Projects, AIHA—Partnership Coordinator

State Department
- John B. Post, Special Assistant

USAID
- John Braley, Training Advisor, NET Project, ENI/DGSR/HRDSR
- Catherine F. Cleland, MBA, Project Director, Health Care Reform
- Diana Joan Esposito, Procurement Policy and Evaluation
- Susan A. Matthies, PhD, Senior Economist
- Petra Reyes, PhD, AIHA Program Officer
- Barbara Turner, Deputy Assistant Administrator, AA/ENI

Chicago, IL

Premier Health Alliance
- Janet Roach, Capital Equipment Consultant
- Deborah Simecheek, RD, PhD, Food and Nutrition Consultant
- Alan Weinstein, President
- Sharon Weinstein, RN, Director, Office of International Affairs

University of Chicago
- Edward Lawlor, PhD, Associcate Professor, Irving B. Harris Graduate School of Public Policy

La Crosse, WI

City of La Crosse
- David Allen, Insurance Company
- Doug Mormann, County Health Department
- Patrick Zielke, Mayor

Franciscan Skemp Hospital
- Brian Campion, MD, CEO
- Ray Land

Gundersen Lutheran Hospital and Medical Center
- Jay Choutka, Medical Media and Teleconferencing
- Patrick Connelly, Alcohol Treatment Project
- Mark Gilles, Orthotics Work Group
- J. Michael Hartigan, MD, Neonatologist and Pediatrician
- David Houge, Biomedical Engineering and Equipment
- John Katrana, PhD, CEO
- Sandra McCormick, Vice President for Business Development, Project Director
- Wanda Nelson, RN, Nursing Education
- Kermit Newcomer, MD, Renal Dialysis; Partnership Steering Committee
- Cheri Olson, MD, Women's Health
- Barb Pretasky, Project Coordinator
- Richard Reynertson, MD, Diabetics Program
- Jack Schwem, Retired President of Lutheran Hospital
- Linda Woychik, Administrative Assistant

Louisville, KY

Clark Memorial Hospital
- Irina Bakhtina, MD, Dean, Postgraduate School of Nursing (visiting from Hospital No. 122 in St. Petersburg)
- Sue Cravens-Phillips, Director of Women's Health Services
- Craig Incorvia, Engineering and Productivity
- Susan Mason, Executive Secretary/BCLS Site Coordinator
- Annessa Mitchel, RN
- Victor Titov, MD, President of Charitable Fund (visiting from Hospital No. 122 in St. Petersburg)
- Jane Younger, Senior Vice President, COO, and Project Coordinator

Jewish Hospital
- Doug Shaw, President
- David Witt, Vice President

Atlanta, GA

Emory University School of Medicine
- Carol Burns, National Information Learning Center
- H. Kenneth Walker, MD, Professor of Medicine

Georgia State University
- Judith Lupo Wold, PhD, RN, Director, Nursing Programs

Grady Health Systems
- Gail Anderson, MD, Emergency Medicine
- Susie Butcher, MD, Maternal and Child Health
- Laura Hurt, RN, BSN, MHA, CNAA, Director, Medical-Surgical Nursing
- Paul Klever, Administrative Director, Medical Affairs; Partnership Coordinator
- David Vroon, MD, Director of Clinical Laboratory
- Judy Wold, RN, Nursing

Republic of Georgia
- Avtandil Jorbenadze, Minister of Health
- Nino Vepkhvadze, PhD, Head of the Department of Hygiene, Tbilisi State Medical University

Boston, MA

AIHA
- Elena Bourganskaia, MD, NIS Project Coordinator

Boston University School of Medicine
- Adam Chobanian, MD, Dean

Children's Hospital
- Edward O'Rourke, MD, Director of Infection Control
- Regina Napolitano-Stein, Director of Infection Control (visiting from Coney Island Hospital)

Lebanon, NH

Dartmouth Mary Hitchcock Medical Center
- Jo Ann Kairys, Vice President for Planning and Marketing; Partnership Coordinator
- Steve Kairys, MD, Pediatrician and Team Leader for Clinical Objectives
- Leslie Lenz, Manager of Education Department, Team Leader for Development, Quality Improvement and Critical Care
- Pam Thompson, RN, Vice President of Children's Hospital at Dartmouth, Nursing Team Leader
- Dennis Tobin, PhD, Pharmacy Initiative

Philadelphia, PA

Children's Hospital of Philadelphia
- Trish Dunphy, MSN, RN, Obstetrical/Neonatal Nursing, Hospital of the University of Pennsylvania
- Vivian Lowenstein, CNM, MSN, School of Nursing and Midwifery
- Mary Lou Manning, RN, Infection Control
- William Schwartz, MD, Pediatrician and Project Manager
- Allyson Wesolowsky, Project Coordinator

Thomas Jefferson University
- Kay Arendasky, RN, University of Pennsylvania Hospital
- Fides Gorman, Project Coordinator
- Jussi J. Saukkonen, MD, Dean, College of Graduate Studies
- Lance L. Simpson, PhD, Professor of Medicine, Biochemistry and Molecular Pharmacology, and Director of Jefferson Clinical Center in Occupational and Environmental Medicine
- Ed Tawyea, Academic Information Services and Research (Infomatics)

EUROPE

Kyiv, Ukraine

AIHA
- Dan Borque, AIHA Board Chair and Vice President of VHA
- Oksana Khartonuk, MD, West NIS Regional Director

Center for Maternal and Child Health Care, Left Bank
- Viktor Didichenko, MD, Head Physician

Emergency and Disaster Training Center
- Mikhail Natsiuk, MD, Director

Iowa Council on International Education
- Phil Latessa
- Anne Shodda

Partnership Representatives
- Dmytro Dobriansky, MD, Neonatologist, Lviv Medical University
- Severin Dyba, MD, Head Physician, Lviv Railway Hospital
- Ivan Popil, MD, Head Physician, Lviv Perinatal Center
- Gregory Roschin, MD, Head, Disaster Medicine Department, Academy of Post-Graduate Education of Physicians
- Miroslava Strouk, MD, Partnership Coordinator, Lviv Oblast Clinical Hospital

USAID/Kyiv
- Greg Huger, Mission Director
- David Sprague, Deputy Mission Director

Bratislava, Slovakia

AIHA, Regional Office for Central and Eastern Europe
Mary Jo Keshock, Coordinator, Slovakia Programs
Center for Treatment of Drug Dependencies
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Health Management School
Viera Rusnakova, MD, PhD, Executive Director
Urad Vlady Slovenskej Republiky
Zuzana Panisova, PhD, Director
USAID/Bratislava
Roy J. Grohs, Economic Restructuring Division
Pat Lerner, Mission Director
Hana Mo...iarikova, Project Advisor

Trnava, Slovakia

University of Trnava, School of Public Health
Vladimir Kr...mery, Jr., MD, PhD, FRSH, DrSc, Professor and Dean of the Faculty
Daniel J. West, Jr., PhD, FACHE, Associate Professor and Director, Graduate Health Administration Program, University of Scranton

Turcianske Teplice, Slovakia

Turcianske Teplice City Government
Hildegard Majstrikova, MD, Mayor

Banska Bystrica, Slovakia

Matej Bel University
Juraj Nemec, PhD, Assistant Professor, Department of Public Economics

St. Petersburg, Russia

Sokolov Central Hospital No. 122
Irina Bakhtina, MD, Dean, Postgraduate School of Nursing
Demitri Baklonoff, MD, Invasive Cardiologist
Anatoly Boiko, MD, Associate Dean, Postgraduate School of Nursing
Rimma Grigorieva, MD, Vice President
Olga Makarva, Hotel Director
Olga Marozova, MD, Director of Media and Public Relations
Tatiana Mikheeva, PhD, Director of Continuing Education for Nurses
Yakov A. Nakatis, MD, President and Head Doctor
Galina Orlova, RN, Head Nurse
Sergei Scherstyner, MD, Director of the Ambulatory Surgery Center
Victor Titov, PhD, Chair, Nadezhda Charity Foundation

Valery Yelnsinovsky, MD, Chief of Surgery and Deputy Chief of Medical Staff

Moscow, Russia

AIHA
- Victor Boguslavsky, MD, AIHA Regional Director for NIS
- Elena Frolova, MD, AIHA Translator

Central Clinical Hospital
- Igor N. Denisov, MD, Vice Rector for Academic Studies & Professor of Medicine
- Marianne E. Hess, RN, BSN, CCRN, Clinical Nurse Educator, Premier Health Alliance
- Victor Tarasof, MD, Medical Information Officer
- Yelena Therubina, MD, Obstetrics
- Marina O. Ugryumova, MD, Head of Department; Partnership Coordinator

Eli Lilly and Company CIS
- Alan Lyne, Marketing—CIS

EMS Training Center
- Ludmilla Gizatulina, MD, Director
- David R. Wuertz, Infection Control Officer, City of Austin, Texas

First Municipal Hospital in the name of Pirogov
- Tatiana Krasnova, MD, Deputy Head of Obstetrics/Gynecology, Head Physician for MCH Program
- Andreai Lishanski, MD, Deputy Head Physician; Partnership Coordinator
- Valeri Vershinin, MD, Head Physician

Ministry of Health and Medical Industry of the Russian Federation
- Vladimir D. Reva, MD, CM, Deputy Chief Sanitary Inspector of the State, Federal Department of Medical, Biological, and Emergency Problems

Nursing Task Force Members
- Anna Aoknina, former Head Nurse, Savior's Hospital, Moscow
- Irina Igraghimora, Administrator of Resource Center
- Lidia Modestova, Head Nurse, Central Clinical Hospital, St. Petersburg
- Tatiana Mikheeva, Chair of Task Force, Head Nurse at Hospital No. 122, St. Petersburg
- Galina Otroda, Head Nurse, First City Clinical Hospital in the Name of Pirogov, Moscow
- Rimma Tishenko, Head Nurse, Hospital No. 9, Dubna

USAID/Moscow
- Jane Stanley, Project Management Specialist, OEH
- Terrence Tiffany, Director, Office of Environment and Health
- Natalia V. Voziyanova, PhD, Project Management Specialist, Office of Environment and Health

Dubna, Russia

Central City Hospital No. 9
- Svetlana Bertash, MD, Deputy Head, Moscow Oblast Health Administration

Elena A. Ignatenko, Civil Protection Management, Head of Management
Yuri Komendantov, PhD, Deputy Mayor of Dubna
Irina Makarova, MD, Chief Health Care Specialist; Dubna City and Partnership Administrator
Valery Prokh, PhD, Mayor of Dubna
Sergei Riabov, MD, Head of Health Care Department, Dubna City

Zagreb, Croatia

Srebrnjak Hospital
Sandra Erlich, Pharmacist
Narancik Lyerka, MD, Pediatrician
Maja Medar-Lasic, MD, former Head of the Hospital
Dr. Mirkovic, MD, Head of TB Team
Miljenko Raos, MD
Bozica Vlasic, Head Nurse
Ivka Zori…ic-Letoja, MD, Head of Asthma Team
Sveti Duh General Hospital
Bruno Barsic, MD, PhD, ICU Manager
Dragutin Košuta, MD, Assistant Professor, Surgeon, Head of the Hospital
Mladen Radmilovic, MD, Program Coordinator
University Hospital for Infectious Diseases
Bruno Baršic, MD, PhD, Assistant Professor
Ivan Beus, Director of Hospital
Barbara Brnin, RN, Head Nurse
Tatjana Jeren, MD, PhD, Head of Diagnostics
USAID/Zagreb
Tom Yates, Program Officer

Tirana, Albania

AIHA
Judy Biletnikoff, Coordinator
ARCH/Health for All
Tatiana Daci, Director
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Anduena Vako, Manager, Mother and Child Information Center
Ministry of Health and Environment
Altin Bejko, MSc, Head of Coordination Unit
Zamira Sinoimeri, MD, Deputy Minister
Teodor Todhe, MD, Director
National University Service for Orthopedy and Traumatology
Mehdi Alimehmeti, MD, Vice Director, Pathologist
Pëllumb Karagjozi, MD, Head

University Hospital Center of Tirana
Mehdi Alimehmeti, MD, Vice Director
Saemira Gjipali, DSc, Public Relations
Artan Goda, MD, Professor, Head of the Hospital Medical Commission
Arben Hoxha, Engineer, Chief of Biomedial Department
Mentor Petrela, MD, Professor, General Director
Llesh Rroku, MD, General Vice Director, Cardiologist
Alush Saraci, Chief of Human Resources
Aferdita Tafaj, Economic Vice Director
University Hospital of Obstetrics and Gynecology
Linda Ciu, MD, Pediatrician, Chief of Neonatology Department
Skeinder Kosturi, MD, Vice Director
Gjergji Theodhosi, MD, Head of Obstetrics/Gynecology Department
Zhami Treska, MD, Director
USAID/Tirana
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Cameron L. Pippitt, Project Development Officer

Bucharest, Romania

AIHA
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Silviu R|dulescu, MD
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Institute of Hygiene, Public Health, Health Services, and Management
Irina Dinc|, MD, Specialist in Public Health and Management
Adriana Galan, Engineer
Cristian Havriliuc, MD, PhD, Professor and Deputy Director
Carmen Moga, MD, Public Health Specialist
Silvia Gabriela Scîntee, MD, MSc, Public Health Specialist
USAID/Bucharest
Florin J. Russu, MD, Chief, Health and Population Division
Randal-Joy Thompson, Program Officer
Ekaterina Vasile, Assistant Project Officer

Cluj, Romania

Clinic for Occupational Diseases
Ioan Stelian Bocsan, MD, PhD, Director
Medical Center for Health Services and Management
Aritotel Cocârl|, MD, PhD, Clinic Director

Eugen S. Gurz|u, MD, PhD, Director
Aurelian L. Sinca, PhD, Senior Research Psychologist, Head of Psychology and Sociology of Preventive Behavior Department

Ministry of Health, Department of Occupational Health, Inspectorate of Public Health
Doina Andrassoni, MD, PhD, Director
Gabriela Gansca, MD, Head of Health Promotion Department
Serban R|dulescu, MD, PhD, Medical Director, County of Cluj
Doina Suciy, MD, Occupational Health Physician and Information Coordinator

Almaty, Kazakstan

AIHA Regional Staff
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Janel Lardizabal, Coordinator for Special Projects
Zhamilya Nugmanova, MD, PhD, Director for Central Asia
Iliya Zabolokin, Technical Support and Training Coordinator

Almaty Medical College
Kalkaman Ayapov, MD, MPH, President
Galina S. Beisenova, Director, Vice President, “Emily” Medical Centre

City Health Administration
Orynbai D. Dairbekov, MD, Chief of the Managing Department
Raushan K. Kabykenova, MD, Deputy Chief of Administration

Emergency Medicine Training Center
Dina Bulanbaeva, MD, Director

Hospital for Urgent Medical Care (Emergency Hospital)
Aedil Apsatarov, MD, Head of Surgery and Endoscopy
Eleanora Besebaeva, Information Resource Center, Toxicology Information Center
Amantai B. Birtanov, MD, Head Physician
Elzhan A. Birtanov, MD, Director of Toxicology Information Center
Aidar Isabecov, MD, Laparascopic Surgeon
Rustem Kadirbaev, MD, Chief of Emergency Surgery
Ashim Kuanishbecov, Chief of Endoscopic Surgery
Galina Mirocova, Head Nurse
Galina Podduclnaya, MD, Toxicology Center

Perinatal Hospital
Dr. Amanzholova, MD, Director

Scientific Center of Pediatrics and Children's Surgery
Auken K. Mashkeev, MD, Director
USAID/Almaty
Robert Alexander, Project Officer
Patricia Buckles, Mission Director
Jatinder Cheema, MPH, PhD, Office of Social Transition
Marilynn Schmidt, General Development Officer
Theresa Ware, Kazakstan Desk Officer, USAID/Washington

Semipalatinsk, Kazakstan

Children's Clinical Hospital
Saget Akmetkalizer, MD, Deputy Director
Meiramber Kairamvbayer, MD, Deputy Director
Lyuba Litrinova, Head Nurse
Emergency Care Hospital
Kainulan Musin, MD, Director
Natalya Sukhorukova, Chief Nurse
Goverment of Semipalatinsk Oblast
Galzmzhan Jakianov, Governor
Aldynguzov Kadyr, MD, First Deputy, Health Department
Marina Orazgaliyeva, MD, Director of Medical Insurance Foundation
Bakhyt Tumenova, MD, Head of Social Sphere Department
Gynecology Hospital
Katya Ryadunova, Head Nurse
Galina B. Zhamilya, MD, Director
Medical College of Nursing
Degelen Zhanusov, Principal
Oblast Clinical Hospital
Kurmengelinar Fazylbek, MD, Deputy Director and Chief Surgeon
Askar Makashev, MD, Director
Yesengazi Masalimov, MD, Deputy Director of Medicine
Semipalatinsk Medical Institute
Yuri Prouglo, MD, Chief of Pathological Anatomy
Eizban Zhunusbekov, MD, Director of Regional Pathology Bureau
Semipalatinsk Oneologic Dispensary
Gabdulmanap Abeyev, MD, Doctor in Chief

Bishkek, Kyrgyz Republic

Blood Transfusion Station
Toktogazy S. Kutukeev, MD, Chief Doctor

Institute of Obstetrics and Pediatrics

Galina Cergeeva, Information and Resource Center, AIHA Coordinator
Lyubov Chochlenok, Chief Nurse
Duyshe K. Kudayarov, MD, Professor and Director
Orozaly J. Uzakov, MD, Deputy Director

Kyrgyz Institute of Oncology and Radiology
Zakir P. Kamarli, MD, Professor and Director
Olga Kaplenko, Head Nurse

Kyrgyz State Medical Academy
Tukhvatshin Rustam, MD, Chief of Central Laboratory
Omor T. Kasymov, MD, Vice-Rector

Ministry of Health
Tojgonaly Abraimov, MD, First Deputy Minister
Victor Glienko, MD, Deputy Minister
Akmatgan K. Kaziev, MD, Head Administrator of Education, Science, and Human Resources
Tamara S. Sactanova, Chief Specialist of Nursing; President of the Nursing Association of Kyrgyz Republic

Republic Center of Continuing Education for Medical and Pharmaceutical Personnel
Tulegen Chubakov, MD, PhD, Professor and Director
Damir Ozhanchakov, MD, Director of Nursing Education Program

USAID/Bishkek
CJ Rushin-Bell, USAID Representative

ANNEX F

BIBLIOGRAPHY

American International Health Alliance (AIHA)

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For the Year Ended September 30, 1994
For the Year Ended September 30, 1995

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- Romania

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External Assessment of the AIHA Medical Partnership Program, November 1994.

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ANNEX G

EXECUTIVE SUMMARY -- A Results-Based Evaluation Assessment of the American International Health Alliance Medical Partnership: A Desk Review of Reported Data

The purpose of this report is to supplement the AIHA field evaluation through a review and analysis of partnership-reported data. Data analyzed as part of this desktop study were derived from AIHA documents, including quarterly reports, publications, and other documentation provided by AIHA. Findings from the analysis closely support the principal field evaluation finding that AIHA has performed well in the hospital partnerships. As the program has moved to broader institutional and policy arenas of health care service reform, however, these same findings suggest that the partnership program's impact has been diluted.

Our approach organizes data along lines of program purposes and stages. A results-based approach provides a way to focus on achievement at a program level while stimulating a dialogue by the partnership about developing a results-based monitoring and reporting plan.

The reported data are found to have little structure, necessitating their organization according to level of impact. The assessment finds that clinical and management organization outcomes are evident in many of the partnerships, indicating positive change in individual hospitals. However, evidence of impact beyond the hospital is often difficult to identify.

An attempt to rank partners by level of impact suggests a correspondence between the number of outcomes and the likelihood of impact. The more outcomes produced, the greater are the chances for impact. Not surprisingly, the longer a program has been in place, the greater is its possibility for impact, though few partnerships exhibit broad, national impact. The Republic of Georgia, a small country by most standards, is an exception that demonstrates clear potential for health care sector reform at the national level.

An assessment is made of the coherence of program elements and the capacity of a partnership to shape those elements into something larger than the sum of their individual parts. Both coherence and the "additive" or incremental quality of program elements are seen as the key to higher-level impact. Five examples are presented to illustrate the positive results that can be achieved in a partnership that pays attention to coherence and the synergy among its parts.

Four selected activity areas outside individual partnerships are reviewed for potential impact: task forces, *CommonHealth* magazine, conferences and other meetings, and electronic communications. Each broadens the possibility for greater communication among partners and contributes to improved medical-technical knowledge and health professional standards.

A review of the relationship between partnership purposes and USAID strategic purposes found that the fit is not tight. An outright contradiction is found between some targeted purposes. However, parallels are noted that could become the basis for a better fit between partnerships and USAID.

Regardless, the report concludes that AIHA should continue its initiative to develop a systematic set of measures and a monitoring plan across the partnerships.

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ADDENDUM

Lessons Learned. Subsequent consideration of the data used in the desk study, following submission of the draft evaluation report to AIHA for its review, suggested even more strongly how, to use its own words, "filtered" those data were. It was known from the start that, by definition, the data were self-reported and to that extent represented what their authors wanted readers to know. Much of the data reviewed, therefore, were intended to focus on success and in that sense are highly self-selective.

Since AIHA does not have a baseline for monitoring and evaluation purposes, it seemed justifiable to use such self-reported data both for the purpose of having available data to work with and to be able to provide AIHA with a model for how results-based data might be coded, analyzed, and interpreted. In this sense, the exercise was intended as a demonstration of the possible shape of a future performance monitoring plan.

It became clear, however, that not only were the data "filtered" but that they were also less than complete. The analysis itself purportedly "missed" some data for some of the partnerships. In addition, there was a strong difference of opinion about what constitutes an input and an output. While this kind of issue is not resolvable in the context of an evaluation exercise, it can only be emphasized that if the input/output distinction is to be used, it must be applied consistently.

Finally, AIHA expressed that it found the methodology helpful as a model for its use in the evolution of its own monitoring and evaluation plan.

ANNEX H

WORKSHOPS AND CONFERENCES SPONSORED BY AIHA

AIHA CONFERENCE AND WORKSHOP SCHEDULE

Pharmaceutical Assessment
Kiev, Ukraine: November 29-December 15, 1992
Representatives from USAID, AIHA and major US pharmaceutical manufacturers traveled to Ukraine to make a comprehensive needs assessment of Ukraine's pharmaceutical industry.

AIHA Annual Partnership Conference
Pittsburgh, Pennsylvania: March 25-26, 1993
US Partners, representatives from USAID and AIHA staff met in Pittsburgh for the First Annual AIHA Partnership Conference to discuss strategies for successful partnership activities.

Clinical Engineers' Workshop
Boston, Massachusetts and Pittsburgh, Pennsylvania: May 8-June 12, 1993
The American College of Clinical Engineering (ACCE) conducted an educational workshop for ten Clinical Engineers from AIHA partner institutions in the NIS.

Advances in Modern Obstetrics Conference
Yerevan, Armenia: May 12-16, 1993
This conference, sponsored by the Erebuni--Beth Israel Partnership, presented lectures on high-risk pregnancy; prenatal, neonatal and pediatric care; and obstetrical nursing to an audience of Armenian health care professionals.

Contemporary Problems in Surgery
Moscow, Russia: June 1-3, 1993
This conference, sponsored by the Pirogov First Municipal hospital and its US partner, Brigham and Women's Hospital, provided a overview of general surgical dilemmas and medical complications to an audience of over 600 Moscow-area physicians.

Japan-Russia Medical Exchange Foundation Conference
Niigata, Japan: June 7-19, 1993
Eleven US physicians from AIHA partner institutions, AIHA Board Members and James P. Smith traveled to Japan to participate in the JRMEF Conference and to coordinate Japanese and American technical assistance efforts to the NIS in the health care sector.

AIHA Health System Administration Workshop
New York, NY; Detroit, MI; Richmond, VA; Washington, DC: July 10-24, 1993
Nine senior health and hospital administrators from AIHA partner institutions in Russia and Ukraine participated in this two-week workshop on health system management in the US.

Woman and Family Education Center Opens
Moscow, Russia: July 26, 1993
As an integral part of their partnership objectives, the Savior's Hospital for Peace and Charity/Magee Women's Hospital Partnership opened the Woman and Family Education Center at Savior's to conduct workshops in Prepared Childbirth, Women's Health, Family Planning and Adolescent Health Issues opened to the general public in Moscow

Issues in Gynecology
Yerevan, Armenia: August 1-5, 1993
Physicians from Beth Israel Hospital, in conjunction with the Ministry of Health of Armenia, conducted workshops in family planning, sexually transmitted diseases, cancer screening, male infertility and cytology for health care professionals in Armenia.

Kiev Dissemination Conference: Neonatal Resuscitation and Surgical Techniques
Kiev, Ukraine: September 17-19, 1993
The AIHA Regional Office in Kiev, together with the four AIHA Ukrainian Partnerships, hosted this three-day conference which aimed to disseminate neonatal resuscitation and surgical techniques learned by Ukrainian physicians through partnership activities to a larger audience of Ukrainian health care professionals.

AIHA Perinatal Micro Hospital Workshop
Samarkand, Uzbekistan: September 27-30, 1993
As part of the Second Universal Health Conference and Exhibition, an 8-member delegation from the University of Illinois at Chicago provided a two-day micro hospital workshop addressing topics such as neonatal resuscitation and care for the premature newborn to an audience which included 25 AIHA delegates from the NIS.

CEE Partnerships in Health Second Annual Conference
Warsaw, Poland: October 2-3, 1993
James Smith, AIHA Executive Director, Miron Fedoriw, AIHA Regional Director in Kiev, and representatives from AIHA Partnerships in Ukraine and Moldova attended this conference which explored the Partnership model and its implementation in Eastern Europe.

AIHA Annual Partnership Conference
Washington, DC: October 21-22, 1993
Over 200 participants attended this conference, including representatives from 18 NIS and all 21 US partnerships. In addition, representatives from USAID and PVOs working in the NIS participated the conference to explore ways the partnerships may be used as "platforms" for other US government technical assistance and private sector development activities. Conference attendees participated in the plenary sessions, breakout forums, as well as informal discussions directed at the examination of partnership successes and dissemination strategies.

AIHA/AUPHA Workshop for Health Services Management Educators
New York, NY; Pittsburgh, PA; and Washington, DC: November 6-17, 1993
Nine educators from the NIS responsible for establishing programs in health services management participated in this in-depth traveling seminar designed to introduce them to health services education in the US.

AUPHA Workshop for Senior Health and Hospital Administrators
L'viv, Ukraine: January 9-23, 1994
Senior administrators from hospital partners in Ukraine and Moldova attended this interactive two-week training program in health administration and management.

Partners in Birth Conference
Moscow, Russia: February 1-2, 1994
The Savior's Hospital for Peace and Charity/Magee Women's Hospital Partnership hosted this conference, designed to inform and update physicians and midwives and other health care professionals interested in family-centered maternity care through shared knowledge, discussion, and active demonstration.

AUPHA Workshop for Senior Health and Hospital Administrators
Moscow, Russia: February 21-March 4, 1994
Senior administrators from hospital partners in Belarus and Russia attended this two-week training program.

National Health Policy Conference
Tbilisi, Georgia: February 28-March 4, 1994
Organized by the Ministry of Health and the government of the Republic of Georgia with the assistance of the US partners from Atlanta, this conference explored issues related to the establishment of a national health care system and outline a health care strategy for the Republic of Georgia.

Murmansk Medical Project Conference
Murmansk, Russia: March 14-15, 1994
The Jacksonville-Murmansk Partnership hosted a conference which included forums and practica in the areas of laparoscopy, ACLS, neurology, nursing, and hospital administration/management.

Invasive Cardiology Conference: Advances in Medical Practice and Nursing Interventions
Moscow, Russia: April 20-21, 1994
The Government Medical Center of the Russian Federation and Premier Health Alliance hosted this conference, which included comprehensive seminars on surgical cardiac procedures and the role of nurses in care of cardiac patients.

AUPHA Workshop for Senior Health and Hospital Administrators
Almaty, Kazakstan: May 10-20, 1994
Senior administrators from hospital partners in the Central Asian and Trans-Caucasian Republics attended this two-week training program.

EMS Basic and Intermediate Course Demonstration
Yerevan, Armenia: May 13-27, 1994
The Yerevan-BUMC partnership presented basic and intermediate courses in EMS, to NIS partners and members of the EMS Task Force, who will be involved in setting up regional EMS training centers.

Neonatal Resuscitation Workshops
Tbilisi, Georgia and vicinity: May 23-31, 1994
In cooperation with the Ministry of Health of the Republic of Georgia, four neonatalogists and pediatricians instructed Georgian clinicians in neonatal resuscitation. After the initial training sessions in Tbilisi, the delegation traveled to Western Georgia to conduct additional courses in this rural area. The Georgian clinicians plan to disseminate this information to additional physicians and mid-wives in Georgia.

Women's and Children's Health Conference
Yerevan, Armenia: May 30-June 1, 1994
The Erebuni Medical Center-Beth Israel Partnership hosted this conference which involved lectures and interactive sessions addressing topics in cytology/colposcopy, family planning, neonatal resuscitation, cervical cancer, obstetrical anesthesia, and prenatal care. (Open to AIHA partner representatives from the Trans-Caucus republics.)

Infection Control Workshop
Moscow, Russia: May 31-June 3, 1994
Representatives from all AIHA Russian partnerships and key city, oblast, regional and Ministry of Health officials participated in this workshop, sponsored by AIHA's Moscow Regional Office, focusing on the management of hospital infection control in compliance with Regulatory Order #220 of the Russian Federation Ministry of Health. The American Society for Hospital Epidemiology is working with AIHA in developing the workshop curriculum.

AIHA/AUPHA Workshop for Health Services Management Educators
Atlanta, GA; Chicago, IL; San Diego, CA: May 31-June 14, 1994
Ten educators from the NIS responsible for establishing programs in health services management participated in this in-depth traveling seminar designed to introduce them to health services education in the US.

Issues in Maternal and Child Health
Kiev, Ukraine: June 2-4, 1994
The Center for Maternal and Child Health Care and the University of Pennsylvania hosted several workshops addressing topics such as family planning, neonatal resuscitation, prenatal assessment and pediatric nutrition workshop for health professionals in Ukraine. (Open to other interested AIHA - NIS partner representatives.)

National Health Policy Conference - Follow-Up
Tbilisi, Georgia: June 6-10, 1994
As a follow-up to the March National Health Policy Conference, participants from the Ministry of Health and the government of the Republic of Georgia re-convened with their US partners to review progress in the establishment of a national health care system.

Symposium in Obstetrics, Gynecology and Neonatology
St. Petersburg, Russia: June 12-22, 1994
The Louisville/Atlanta - St. Petersburg partnership hosted a series of demonstrations and lectures in the management of complicated OB and reconstructive techniques following oncology surgery. *(Open to other interested AIHA - NIS partner representatives.)*

EMS Regional Training Centers "Train the Trainers" Conference
Worcester, Massachusetts: July 16-29, 1994
Representatives of each of the NIS Training Center sites attended a two week training session at the UMass Medical Center, where their American partners taught a course in operating the Centers and how to use the recently developed curriculum.

St. Petersburg - Atlanta Telemedicine Conference
St. Petersburg, Russia and Atlanta, GA: July 26, 1994
Georgia Baptist Medical Center and Hospital no. 122 sponsored a video-conference exchange of medical information, education and surgical procedures during the 1994 Goodwill Games.

Health Insurance Training Seminar
New York, NY; Des Moines, IA; Atlanta, GA; Washington, DC, Baltimore, MD:
August 3 - September 4, 1994
Twenty five health insurance administrators from Russia, Georgia and Armenia participated in this one-month training seminar to assist them in developing health insurance programs in their oblasts and republics.

Infection Control Workshop Planning Session
Washington, DC: August 1, 1994
The US faculty for Infection Control initiatives met at AIHA's offices in Washington, DC to plan for the infection control workshops to be held during AIHA's Second Annual Conference in St. Petersburg, Russia.

Regional Surgical Conference with Emphasis on Infection Control
Odessa, Ukraine: August 29-31, 1994
This conference, presented by the Odessa Oblast Hospital and Coney Island Hospital, explored various surgical topics including laparoscopy, laser surgery for ulcers, and liver resections and endovascular techniques with a special emphasis on infection control. (Open to other interested AIHA - NIS partner representatives.)

Neonatal Resuscitation Seminar
Bishkek, Kyrgyzstan: August 1-5 1994
The Institute of Pediatrics and Obstetrics, in conjunction with Kansas University Medical Center, presented a seminar on neonatal resuscitation to health professionals in Kyrgyzstan. (Selected professionals from AIHA partnership hospitals in Central Asia will be invited.)

Japan-Russia Medical Exchange Foundation Conference
Vladivostok, Russia: September 19-21, 1994
Richmond-Vladivostok partnership representatives attended the second annual JRMEF Conference to continue US-Japan collaboration in the NIS health care sector.

Third National Health Policy Conference
Tbilisi, Georgia: September 19-25, 1994
For the third National Health Policy Conference, participants from the Ministry of Health and the government of the Republic of Georgia reconvened with their US partners to review progress in the establishment of a national health care system. This conference specifically focused on management of human resources in health care.

AIHA Pre-Conference Seminars
St. Petersburg, Russia: September 22-23, 1994
Graduates of AUPHA seminars in L'viv, Moscow and Almaty convened with American faculty to focus on strategies to extend the leadership, team-building and management lessons learned during those seminars.

AIHA Annual Conference
St. Petersburg, Russia: September 24-28, 1994
Second annual meeting of US and NIS partnership representatives.

AIHA Post-Conference Seminar on Epidemiology
St. Petersburg, Russia: September 29, 1994
As a follow-up to the Infection Control Workshop conference in June, representatives from the Ministry of Health, SHEA, AHA, CDC and AIHA as well as partner representatives from the Russian partnerships reconvened to discuss progress in infection control and the spread of the HIV virus and tuberculosis.

AIHA Post-Conference Seminars
St. Petersburg, Russia: September 29, 1994
Concurrent workshops and seminars in selected management and clinical issues.

CEE Partnerships in Health Third Annual Conference
Prague, Czech Republic: September 29-30, 1994
Representatives from health care partnerships in the CEE met to discuss partnership activity.

Neonatal and Perinatal Health Conference
Tashkent, Uzbekistan: October 3-4, 1994
The University of Illinois at Chicago (UIC) will sponsor a conference at TASHMI II on topics in neonatal and perinatal health for the Republic of Uzbekistan. (Open to other interested AIHA - NIS partner representatives.)

Magee Women's - Savior's Obstetrics/Gynecology Conference
Moscow, Russia: October 11-12, 1994
The University of Pittsburgh will sponsor this conference for OB/GYNs from around the world designed to explore new topics and assess trends in the field. (Open to other interested AIHA - NIS partner representatives.)

Continuing Education Conference for Nurses
Nosocomial Infections: Prevention and Control
Moscow, Russia: October 21-22, 1994
Pirogov Hospital will host this conference in cooperation with their US Partner Brigham and Women's Hospital. Presentation will focus on the role of nurses in the prevention and control of infectious diseases. (Open to other interested AIHA - NIS partner representatives.)

AIHA/AUPHA Health Management Workshop
November 2-13, 1994: Borjormi, Georgia
Twenty-Five senior health care managers from Georgia and Armenia attended this two-week training program.

EMS Workshop
Chisinau, Moldova: November 7-18, 1994
The USAID, AIHA sponsored West-NIS EMS Training Center opened for health professionals in Ukraine, Moldova and Belarus.

Postgraduate Course in Pediatrics
Minsk, Belarus: November 7-11, 1994
The Pittsburgh-Minsk partnership hosted this course to disseminate partnership information, improve pediatric care in Belarus and initiate regional continuing medical education. Topics will include toxicology, general diagnostic pediatrics, infectious disease, CPR, thyroid cancer and hospital management.

AIHA/AUPHA Management Trainer Workshop
Moscow, Russia: December 5-10, 1994
Twenty senior representatives of Russian health care institutions will participate in a training program in health care administration and management in Moscow. The goal of the course is to develop a core group of management educators for the Russian Federation.

AIHA Seminar for Nursing Administration
Various cites in the United States: February 1995 (tentative)
Nursing administrators from the NIS will be exposed to an expanding scope of nursing practice during a traveling seminar to various US Partnership institutions. (Open to interested NIS partner representatives.)

Practical Workshop for Nursing
Moscow, Russia: March 29-30, 1995
The Government Medical Center - Premier Health Alliance Partnership will sponsor a conference for 100 nurses. NIS trainers will share clinical and practical skills they have learned through the partnership. (Open to interested NIS partner representatives.)

Emergency Medical Services Conference
Murmansk, Russia: March 1995
In cooperation with the EMS Task Force, the Jacksonville - Murmansk Partnership will develop and host a conference on EMS for participants from the NIS. (Open to interested NIS partner representatives.)

International Nursing Conference
Moscow, Russia: April 3-6, 1995
The AIHA Nursing Task Force has developed a continuing education program for NIS nurses to assist in expanding the scope of nursing practice in the NIS. Topics will include Nursing Management and Administration, the Nursing Process as well as various clinical issues. (Open to interested US and NIS partner representatives.)

Fourth National Health Policy Conference
Tbilisi, Georgia: April 1995 (tentative)
Participants from the Ministry of Health, the government of the Republic of Georgia, outside PVOs and the US partners will reconvene to discuss the progress in establishing a national health care system. This conference will concentrate on educational accreditation, professional licensure and skills certification. (Open to selected observers from AIHA partnerships)

Infection Control Conference
Stavropol, Russia: April 1995 (tentative)
The Iowa - Stavropol Partnership will host a conference on infection control at the Stavropol Krai Hospital. Participants will be exposed to partnership developed epidemiology and bacteriology programs. (Open to interested NIS partner representatives.)

Seminar for Nurses of Kyrgyzstan
Bishkek, Kyrgyzstan: April/May 1995 (tentative)
The Kansas City - Bishkek Partnership will sponsor a conference focusing on nursing management and administration. (Open to interested NIS partner representatives)

Maternal and Child Health Conference
Yerevan, Armenia: April/May 1995 (tentative)
Erebuni Hospital will host their US partners and representatives from other partnerships during a conference on Nursing, Obstetrics, Gynecology and Newborns. (Open to interested NIS partner representatives from the Trans-Caucus Republics.)

EMS Training Center Courses
Vladivostok, Russia; Chisinau, Moldova; Almaty, Kazakstan; Yerevan, Armenia; Tallinn, Estonia; Tbilisi, Georgia; Moscow, Russia; and Kiev, Ukraine: Ongoing
Following the official opening ceremonies in October/November 1994, centers in Vladivostok, Chisinau, Almaty, and Yerevan are now conducting approximately two courses each month. Each course consists of 100 hours of instruction in basic and intermediate pre-hospital emergency care, and includes a disaster response module and practical skills labs. New centers in Tallinn, Tbilisi, Moscow, and Kiev will begin training courses this fall. (Open to interested NIS emergency health professionals. Contact individual center for course schedule and registration.)

AIHA/AUPHA Pre-Conference Leadership Workshop
St. Petersburg, Russia: October 11 - 13, 1995
Graduates of past AIHA/AUPHA seminars and workshops will convene in St. Petersburg, Russia to discuss approaches and techniques toward effective leadership. They will also report on the progress of individual projects and participate in a team-oriented workshop focusing on the role of the leader in the successful implementation of Continuous Quality Improvement.

*AIHA Annual Conference for the NIS: Managing Quality for Healthy Outcomes
St. Petersburg, Russia: October 16 - 19, 1995
U.S. and NIS partnership representatives will convene in St. Petersburg, Russia to reflect on their achievements over the last year and share their objectives as they look to the future. A large educational component of the conference will focus on Continuous Quality Improvement and Health Status Indicators.

Infection Control "Train-the-Trainer" Workshop
St. Petersburg, Russia: October 19 - 21, 1995
The Infection Control Task Force will conduct a "train-the-trainer" workshop at the Clinical Hospital in the name of Sokolov after AIHA's Annual Conference for the NIS. Fifteen to twenty participants who have previously worked with the task force will develop a model curriculum for infection control.

AIHA/AUPHA Introductory Management Skills Workshop
Trakoscan, Croatia: October 22 - November 1, 1995
Thirty senior representatives of Croatian health care institutions and city and national health ministries will participate in a training program in health care administration and management. The workshop will focus on developing management skills in the areas of insurance; health financing; economics; staffing and productivity; the use of information systems to support decision-making; all aspects of planning and development; and quality management.

35th Anniversary Celebration of the School of Nursing at Medical Center
Moscow, Russia: October 25, 1995
Both NIS and US participants will commemorate the contributions to nursing education that the Medical Center of General Management Department of the President of the Russian Federation (MC) has made over the last thirty-five years. The day's activities will include speeches on nursing education and a ceremonial banquet.

*Practical Seminar for Operating Room Nurses
Ashgabat, Turkmenistan: October/November 1995 (dates TBD)
Nurses from Turkmenistan and other NIS partner institutions will receive training at the Cleveland-Ashgabat partnership's model surgery and dialysis center, located at Medical Consultative Center in the Name of President Niyazov.

*AIHA/AUPHA Training-of-trainers Workshop: Faculty Development
Moscow, Russia: November 6 - 19, 1995
This workshop will train promising health care professionals as management educators by exposing participants to essential elements of teaching, including development of visual aids, encouraging student participation, maintaining student interest, and facilitating effective small-group discussion groups. (Open to 15 health care managers and educators from partner hospitals.)

International Conference on Nursing Education
Moscow, Russia: November 30 - December 2, 1995
The Boston-Moscow partnership will host a nursing conference at Pirogov First Municipal Hospital of Moscow to discuss issues related to nursing education, including team collaboration, principles of nursing organization, and leadership models. Presenters will also focus on clinical skill development, nursing management, and nursing assessment and intervention. Open to participants from selected NIS partnerships.

Conference on Obstetrics, Neonatology and Obstetrical Anesthesia
Tirana, Albania: December 4 - 6, 1995
The Bronx - Tirana partnership will sponsor this conference as part of their women's health initiative. American and Albanian physicians, midwives, and nurses will participate in discussions on such topics as the role of midwifery and nursing, the problem of pregnancy induced hypertension, diabetes in pregnancy, and neonatal care of the preterm infant.

*AIHA/AUPHA Introductory Management Skills and Training of Trainers Workshops
Moscow, Russia: December 8 - 20, 1995 (three sessions)
Sixty senior representatives of Moscow health care institutions and city and national health ministries will participate in a training program in health care administration and management. The workshop will focus on developing management skills in the areas of insurance; health financing; economics; staffing and productivity; the use of information systems to support decision-making; all aspects of planning and development; and quality management.

NIS Information Coordinator Workshop
Kiev, Ukraine -- December 4-5, 1995
Moscow, Russia -- December 7-8 & 9-10, 1995
Almaty, Kazakstan -- December 16-17, 1995
Training provided orientation to NIS Information Coordinators responsible for setting up Learning Resource Centers at their institutions. Information coordinators learned how to use various Internet resources and software, including e-mail, gopher, FTP, newsgroups, telnet, and the Web. Also covered topic of grant-proposal writing.

*Moscow Oblast Home Care Conference
Dubna, Russia: January, 1996 (tentative)
This conference, conducted in conjunction with the Moscow Oblast Health Administration, will focus on home care issues, particularly as they relate to the experience of the La Crosse-Dubna partners. (Open to interested health care providers from the Moscow Oblast as well as two representatives from AIHA partner hospitals in this region.)

*AIHA/AUPHA Training of Trainers Workshop
Moscow, Russia: February 7 - 12, 1996
This workshop will be conducted to train NIS educators for the role of facilitators and faculty in introductory management

courses. Participants will be chosen from AIHA and AUPHA partnerships to continue developing the capacity within these institutions to plan and deliver health services management workshops. The ToT sessions are planned in conjunction with, and directly prior to, the 101Russia Workshops in order to provide continued feedback and honing of skills for the NIS faculty/trainees.

*AIHA/AUPHA Introductory Management Skills Workshop and Faculty Training Session
Moscow, Russia: February 10 - March 2, 1996
As with previous introductory workshops, the Introductory Management Workshops will extend the instruction of basic tenets of market driven health management tools and techniques in the context of current regional reform initiatives to organizations not represented in previous NIS training efforts. The continuing NIS initiative will include a variation in the types of professionals trained and will be conducted with larger NIS faculty participation under the monitoring of AUPHA faculty. The course will open with an extended training session for select NIS health managers to prepare them to act as faculty for future workshops and has been developed in association with AUPHA's Partnership Program with Schools Of Health Administration in Russia.

*AIHA/AUPHA Management Skills Workshop
Jurmala, Latvia: February 18 - 24, 1996
This course on "Leadership in a Changing Health Care Environment" is designed to provide Latvian health care leaders with opportunities to gain knowledge and practical skills in areas of leadership, strategic planning, Total Quality Management, team development, staff empowerment, and communication. Representatives from the three Riga partner hospitals, Ministry of Health and USAID will be invited to participate. The course will be co-facilitated by faculty from Barnes-Jewish Hospital of St. Louis, AUPHA and AIHA.

*AIHA/AUPHA Training of Trainers Workshop
Tallinn, Estonia: March 11- 17, 1996
This workshop is designed to train promising executives and educators, many of whom have attended previous AIHA/AUPHA workshops, as trainers in future programs and as resources for their peers in locally generated programs and efforts. It will link health practitioners with academic experts who can jointly present workshops in the future. This training will be conducted together with the World Bank-funded Center for Continuing Education in Tallinn.

*Perinatology Conference
Kosice, Slovakia: March 14-15, 1996
This conference is being organized by the Gynecology and Obstetrics Clinic of the Kosice Faculty Hospital for an audience of Slovakian nationals and colleagues from around Europe. Presenters will include AIHA partners from Women and Infants Hospital of Rhode Island. The conference will focus on the topics of EPH Gestosis and the HELLP Syndrome.

AIHA/AUPHA Introductory Management Skills Workshops

The introductory courses focus on the basic tenets of market-driven health management tools and techniques in the context of current regional reform initiatives. These courses incorporate individual partnership initiatives into AUPHA's didactic, interactive teaching methods. As in previous workshops of this type presented in NIS countries, these will be conducted with AIHA and local faculty participation. In Slovakia, the course will draw participants from the hospital, healthy community and health management education partnerships, and will involve the University of Scranton. Similarly, the Albanian workshop will involve faculty from New York University, the US health management education partner in Albania. Upcoming workshops include:

Ashgabat, Turkmenistan: April 15 - 25, 1996
Vladivostok, Russia: April 23 - 30, 1996
Tirana, Albania: Summer 1996
Bratislava, Slovakia: Summer 1996
Tbilisi, Georgia: Summer 1996
Budapest, Hungary: Fall 1996

Semiannual Continuing Medical Education Conference
Semipalatinsk, Kazakstan
Health care professionals from the Semipalatinsk-Houston hospital partnership will participate in a continuing education conference for medical and nursing staff.

SPRING '96

April
Toxicology Information Center Grand Opening Ceremony and Seminar
Almaty, Kazakstan
April 5-10
On April 5, health care providers from the Almaty-Tucson partnership celebrate the opening of the Toxicology Center at the First Aid Hospital following renovation by the City Health Administration. A three-day seminar from April 8 to 10 serves as an overview for Almaty health care professionals on ways to integrate EMS equipment in the Toxicology Information Center, with a special focus on establishing communications between ambulance teams and receiving departments.

Symposium on Pediatrics
Minsk, Belarus
April 15 - 19
Open to 250 health care professionals from Belarus, this symposium focuses on scientific and clinical issues in pediatric medicine, toxicology, emergency services, diabetes, nephrology and autoimmunity, nuclear medicine and radiology, nursing/nursing education, immunization and screening, and oncology.

Advanced Topics in Women's Health
Tallinn, Estonia
April 21 - 26
Partners from Washington, DC will present the course to an audience of 50 physicians, midwives, and nurses who provide primary care for women throughout Estonia. Topics include family planning and contraception, breast and cervical cancer screening, and treatment of depressive disorders.

Neonatology and Obstetrics Teaching Course
Almaty, Kazakstan
April 22 - 24, 1996
US partners from the University of Arizona will deliver presentations on management of routine and high-risk pregnancies, childbirth techniques and neonatology to Almaty maternity services center providers at the Almaty Postgraduate Retraining Institute.

Update on Laparoscopic and Cardiovascular Surgery, Hemodialysis and EMS
Chisinau, Moldova
April 22 - 25, 1996
At this workshop, the Chisinau-Minneapolis partnership promotes partnership achievements in laparoscopic and cardiovascular surgery and hemodialysis to 100 Moldovan health care professionals. Participants also learn about infection control methodology and advances in diagnosis and EMS treatment.

Moldovan Nursing Conference
Chisinau, Moldova
April 22 - 25, 1996
In collaboration with the Moldovan Ministry of Health, the Chisinau-Minneapolis partnership is hosting a nursing conference to discuss team collaboration, principles of nursing organization and leadership models. Topics include educational and clinical skill development, basic nursing management and nursing assessment and intervention. The role of nurses in infection control will also be addressed. (Open to approximately 100 health care officials and nurses from Moldova.)

Pediatric Infectious Disease Conference
Riga, Latvia
April 24-26, 1996
Physicians, nurses and laboratory professionals will attend this conference to discuss the management of infections in children, prevention of nosocomial and community infections, and the structures and systems necessary to diagnose and treat acute pediatric infectious diseases.

Georgian Nursing Leadership Training Course
Tbilisi, Georgia
April 29 - May 3, 1996
A precursor to the AIHA Nursing Conference in Almaty, this partnership training course emphasizes nursing leadership skills and will be held at the National Resources Learning Center.

Health Management Education Invitational Forum
Budapest, Hungary
April 30, 1996
Prior to AIHA□s CEE Partnership Conference, US partnership representatives, Ministers of Health and of Education, and invited guests will discuss quality control and accreditation issues in the field of health management education.

May

AIHA Conference for Central and Eastern Europe
Budapest, Hungary
May 1-3, 1996
US and CEE representatives from hospital, health management education, and healthy communities partnerships will convene to reflect on their initial achievements, share future work plan strategies, and identify potential areas for inter-partnership collaboration. In addition, conference attendees will participate in educational sessions focusing on such topics as leadership development, continuum of care, community health assessment, and preparation of case studies for health management education.

Second Annual NIS Nursing Conference
Almaty, Kazakstan
May 5 - 9, 1996
Based on the overwhelming success of the first NIS Nursing Conference, this conference will focus on nurse leadership. Attendance will be limited to one US nursing representative and six representatives from each NIS partnership.

AIHA/AUPHA Continuous Quality Improvement Workshop
Central Asia
May 20 - 25, 1996
AIHA and AUPHA will develop a workshop to introduce and explore the role of leadership and managers as the primary agents of change in establishing quality improvement initiatives. The session will also examine approaches to continual improvement of health care through identifying outcomes, understanding and mapping the process of care and designing and conducting tests of change.

Neonatology/Perinatology Conference
L'viv, Ukraine
May 21 - 23, 1996
Sponsored by the Ukrainian Ministry of Health, this conference includes presentations by members of the L'viv-Detroit and L'viv-Buffalo partnerships. Topics of discussion include current issues of primary neonatal resuscitation in Ukraine, applicable US standards of neonatal and perinatal care, neonatal and perinatal infections, and the impact of regionalization of neonatal and perinatal care on western Ukraine. (Open to approximately 150 health care professionals from Ukraine).

First Conference on Nosocomial Infections
Zagreb, Croatia
May 22 - 24, 1996
Hosted by three Croatian partnership institutions with support from their Dartmouth-Hitchcock partners, this conference addresses guidelines for isolation precautions in hospitals, methods and tools for measuring improvement rates of infection, the role of nurses in infection control, and cost-benefit and cost-effectiveness analyses. Representatives from hospital infection control committees throughout Croatia will attend as well as health professionals from other CEE partnerships.

June

Leadership Development Workshop II
Zagreb, Croatia
June 1996
Following on the success of the first workshop held for Zagreb partners in October 1995, faculty from Dartmouth-Hitchcock Medical Center will conduct this workshop for a second group of hospital staff from the three Croatian partner hospitals. This course will be team-taught with Croatians who participated in the earlier program and will focus discussion and activities on development of leadership skills within a quality management framework.

Medicine for You Exposition
Moscow, Russia
June 3 - 9, 1996
At the request of the Russian Ministry of Health, AIHA will share information and training aspects of the partnership program to venders, consumers and health professionals from the international health community. The exposition, which is hosted by the Federal Mandatory Health Insurance Fund, State Sanitary and Epidemiological Committee and other governmental agencies, will provide an overview of national health reform initiatives and advances in Russian and International science, health care services and industry.

Cardiology Conference
Riga, Latvia
June 18-20, 1996
US and Latvian partners will jointly teach current topics in cardiology to physicians and intensive care nurses from Latvia.

Women's and Infants Health Conference
Riga, Latvia
June 25 - 28, 1996
Led by US and Latvian partners, this major national conference on maternal/infant health will provide instruction on prenatal care strategies, risk assessment and response, intranatal management, post-partum complications and response, and neonatology.

Creating Professional Nursing Practice
Dushanbe, Tajikistan
June 24 - 25, 1996
This conference focuses on the nursing process, including patient assessment, problem-solving, team-building, and negotiating a new role for nurses. Open to nurses throughout Tajikistan.
midwives, and nurses who provide primary care for women throughout Estonia. Topics will include family planning and contraception, breast and cervical cancer screening, and treatment of depressive disorders.

SUMMER '96

JULY

AIDS Study Tour
Vancouver, British Columbia; San Francisco, California; Chicago, Illinois; and Washington, DC
July 6-18
Representatives from the Health Ministries of Ukraine and Russia will attend the International Conference on AIDS in Vancouver, British Columbia in Canada and then tour hospitals, community programs and governmental agencies to study US response to AIDS and other blood-borne diseases such as hepatitis B.

EMS Training-of-Trainers Course
Worcester, Massachusetts
July 8-19
Representatives of the four original EMS training centers in Almaty, Kazakstan; Chisinau, Moldova; Vladivostok, Russia; and Yerevan, Armenia will attend the course, which was developed by the University of Massachusetts Medical School. The course will focus on integrating the work of emergency first response teams with that of in-hospital physicians.

FALL '96

SEPTEMBER

Leadership Development Seminar
Zadar, Croatia
September 1-13
About 30 participants will attend the Zadar-Franciscan partnership's first leadership training seminar. Based on similar workshops held by the Zagreb-Lebanon partners, it will focus on developing leadership skills within a quality management framework.

CEE Information Coordinator Workshop
Tallinn, Estonia -- September 2-6, 1996
Training provided orientation to CEE Information Coordinators responsible for setting up Learning Resource Centers at their institutions. Information coordinators learned how to use various Internet resources and software, including e-mail, gopher, FTP, telnet, and the Web. The workshop also covered how to perform medical searches on the Internet, how to provide staff training, and how to design home pages on the Web.

"Fundamentals of e-mail and the Internet for medical organizations staff"
Lviv, Ukraine -- September 2-6; 9-13; & 16-20, 1996
An introduction to basic Internet utilities and resources, including e-mail, gopher, FTP, telnet, and the Web, with a focus on health and medical resources. This workshop was designed for NIS information coordinators who did not attend any of the December 1995 workshops and was conducted by staff at the Lviv Management Institute.

CEE Clinical Engineering Training
Riga, Latvia
September 16-17
This course will offer plenary and breakout sessions on topics pertaining to the physical plant and equipment resources of a health care facility. It will include both technical and administrative sessions.

EMS Conference
Vladivostok, Russia
September 29 - October 2
Representatives of AIHA□s eight EMS training centers in the NIS and CEE will attend the conference, to be held at City Clinical Hospital No. 2. The focus will be on pediatric emergency medicine.

Nursing Leadership for Latvia's Future
St. Louis, Missouri
September 30 - October 8
Twenty-one Latvian nurse leaders will convene to discuss nursing theory and practice, and to discuss strategies for the development of total quality management, project development and fundraising.

NIS Information Coordinator Workshop
Des Moines, Iowa -- September 30 - October 4, 1996
This workshop provided NIS information coordinators with training in HTML editing (Web page design), advanced medical searching on the Internet
(including orientation on the use of Medline and other databases available through Ovid Technologies), grant-proposal writing, and staff training.

120

AIHA Fourth Annual NIS Conference
Des Moines, Iowa
October 7-9
This year's conference will focus on new directions in NIS health care partnerships, with a focus on women's health and informatics, including access to computerized medical resources and management information systems. In addition, there will be various forums for presentation and discussion of common and emerging trends in medical practice, education and management.

Nursing Leadership Course
Riga, Latvia
November 11-15
Latvian nurses will attend an intense course designed to promote leadership skills in a variety of health care settings. The use of individual development plans, patient/staff education materials and total quality improvement methods will be discussed.

Geriatrics/Hospice Conference
Riga, Latvia
November 19-21
A multi-disciplinary program jointly taught by US and Latvian experts on delivery of care to the terminally ill and their families. Topics will include: development of hospice services, the role of pastoral care programs, recruiting and training volunteers, symptom control, psychological support of patient and family, health provider roles and financing mechanisms.

*AIHA/AUPHA Introductory Management Skills Workshop
Budapest, Hungary: Fall, 1996
The introductory courses will focus on the basic tenets of market driven health management tools and techniques in the context of current regional reform initiatives. They will incorporate individual partnership initiatives into AUPHA didactic, interactive teaching methods. As in previous workshops of this type presented in NIS countries, these will be conducted with AIHA and local faculty participation.

*Workshop on Educational Methodologies
Zagreb, Croatia: Fall 1996

*Cost-effectiveness and Quality Improvement Seminar
Bratislava, Slovakia: October 1996

AIHA/AUPHA Introductory Management Skills Workshops

The introductory courses focus on the basic tenets of market-driven health management tools and techniques in the context of current regional reform initiatives. These courses incorporate individual partnership initiatives into AUPHA didactic, interactive teaching methods. As in previous workshops of this type presented in NIS countries, these will be conducted with AIHA and local faculty participation. The workshops in CEE countries will take advantage of AIHA health management education partnerships. In Slovakia, the course will draw participants from the hospital , healthy community and health management education partnerships. A total of 15-20 workshops are planned throughout the NIS over the next year, though dates for these have not yet been determined. Upcoming CEE workshops include:

Tirana, Albania: July 1-5, 1996
Cluj, Romania: December 1996

WINTER '97

Infection Control Workshop
St. Petersburg, Russia
January 13-18
This train-the-trainers course will be attended by future faculty of the Moscow, Vladivostok and St. Petersburg (Russia) Infection Control Training Centers. The course will rely extensively on practical case studies and examples from hospital surveys taken last year in Odessa, Ukraine and Moscow. Hospital surveys at Hospital No. 122 in St. Petersburg and Hospital No. 2 in Vladivostok will immediately follow the course (from January 20 -25). The faculty of the Infection Control Training Centers will be observers at the surveys.

Breast Cancer Study Tour
Boca Raton and Orlando, Florida
January 27-31
Participants in AIHA=s Breast Cancer Initiative in Ukraine will tour hospital sites to learn about breast cancer screening, education and outreach strategies and practices.

121

AIHA/AUPHA Introductory Management Skills Workshops

The introductory courses focus on the basic tenets of market-driven health management tools and techniques in the context of current regional reform initiatives. These courses incorporate individual partnership initiatives into AUPHA didactic, interactive teaching methods. As in previous workshops, these will be conducted with AIHA and local faculty participation.The workshop in Bosnia is expected to involve faculty from the US partner institution. Upcoming NIS and CEE workshops include:
Dubna, Russia: January 14-23, 1997
L'viv, Ukraine: February 14-23, 1997
Tuzla, Bosnia: February (tentative)

AIHA Financial Management Workshops

A new AIHA financial management curriculum for hospital administrators and other health managers was introduced last fall. Developed by Arsen Kubataev, deputy director of AIHA=s Moscow office, and Mary Paterson, partner representative for the Bohemia-Nevada health management education partnership, it focuses on: understanding the relationship between payers and providers of health care, basic financial planning and assessment, forecasting the effects of changes in the health care environment, and cost/benefit assessment. Upcoming workshops include:
Odessa, Ukraine: January 20-25, 1997
Dubna, Russia: January 27-February 1, 1997
Dubna, Russia: February 3-8, 1997
Moscow, Russia: February 10-15, 1997
Moscow, Russia: February 17-22, 1997
Moscow, Russia: February 24-March 1, 1997
Almaty, Kazakstan: March 10-15, 1997
Urgench, Uzbekistan: March 24-28, 1997
Yerevan, Armenia: March 31-April 5, 1997

Central Asia Regional Information Coordinator Workshop I
Almaty, Kazakstan -- Feburary 4-8, 1997
A basic introduction to using Internet resources and software for Central Asia information coordinators that were recently appointed to the Learning Resource Center project. The workshop also provided an overview of skills needed to perform Learning Resource Center Project activities, including Web page design, medical searching techniques organization of bookmarks.

West NIS Regional Information Coordinator Workshop
Lviv, Ukraine -- March 3-7, 1997
An overview of skills needed to perform Learning Resource Center Project activities, including Web page design, monthly reporting, staff training and outreach, organization of bookmarks, medical searching techniques, and grant-proposal writing. Intended to provide necessary training and orientation to NIS information coordinators who could not participate in the Des Moines (October 1996) workshop.

Russia/Transcaucasia Regional Information Coordinator Workshop
Moscow, Russia -- March 3-7, 1997
An overview of skills needed to perform Learning Resource Center Project activities, including Web page design, monthly reporting, staff training and outreach, organization of bookmarks, grant-proposal writing. Intended to provide necessary training and orientation to NIS information coordinators who could not participate in the Des Moines (October 1996) workshop.

Central Asia Regional Information Coordinator Workshop II
Almaty, Kazakstan -- March 24-27, 1997
An overview of skills needed to perform Learning Resource Center Project activities, including Web page design, monthly reporting, staff training and outreach, organization of bookmarks, grant-proposal writing. Intended to provide necessary training and orientation to NIS information coordinators who could not participate in the Des Moines (October 1996) workshop.

ANNEX I

Dissemination of Partnership Initiatives

There are some striking examples of partnership successes that have had an impact far beyond the individual partner institutions, often on a national level. A brief summary of some of these examples of dissemination follows:

1. Magee-Womens (Pittsburgh)/Saviors (Moscow)

a) *Health Education Centers:* In 1993 the partnership established a health education center at the Moscow hospital. The function of this Center was to create a site for comprehensive training in reproductive health, both for professionals and patients. In particular, nurses were trained as primary care givers to women preparing to have a baby, and their husbands. Pre-birth classes were established so that couples could anticipate and prepare for delivery, including participation by the husband—unprecedented in the former Soviet Union.

Magee succeeded in raising additional funds from US corporations, World Learning, and the Soros Foundation to expand this concept beyond Moscow. Today, there are 25 Health Education Centers in 25 cities of the Russian Federation. A national association, the Russian Association for Child Birth (RASPA) has been incorporated as a PVO in Russia. Fundraising has continued with both Russian and US corporations, and these 25 Centers are fully functional and independent of the Magee/Savior's partnership program.

b) *Women's Care Clinic Network:* The partnership pioneered in providing family planning and adolescent health services in Moscow. These services have been expanded to 18 additional oblasts around the Russian Federation. The clinics operate on a fee-for-service basis with funding augmented by contributions from private corporations, the Soros Foundation, and SAVE. In the 19 clinics there are currently 76,000 women who are active users of contraceptives. The Women's Care Clinic Network, spawned by the partnership, has been the model for the AIHA special initiative on Women's Wellness Centers funded by USAID.

2. Tucson/Almaty (Kazakstan)

a) *Neonatal resuscitation:* The partnership trained professors in continuing education in neonatal resuscitation. Working at the Almaty perinatal center and the Kazak Post Graduate Medical Institute, these faculty have incorporated neonatal resuscitation into the curriculum for all pediatricians undergoing their required five-year refresher training. Over 200 physicians from 20 cities around Kazakstan have been trained in these techniques pioneered by the partnership at the one hospital in Almaty.

b) *Nursing Curriculum Reform:* Working with the Almaty Medical College (nursing school), the Tucson/Almaty partnership developed a totally new curriculum for nursing education, not just a

modification of the old curriculum. Agreements were reached with the Ministry of Labor and the Ministry of Education to create a certified nursing position for each year of nursing school completed. Fourth year graduates are paid the same amount as graduates of the medical institutes (first-year physicians). This curriculum has been spread to 11 other nursing schools around the country with a student enrollment of 8,500, completely reforming the way nurses are trained and employed throughout Kazakstan.

c) *Almaty Toxicology Center* (poison control center): This partnership sponsored activity is rapidly moving to become a national center. In recognition of this, the Center was recently awarded a $20,000 grant from the Soros Foundation. The main purposes of the grant are to enable the Center to publish public health education and poison prevention materials, purchase toxicology and statistical programs from WHO, and purchase portable radio transmitters to communicate with ambulances. A problem the Center still faces is that the telephone lines in Kazakstan are not reliable. Further, long distance calls to Almaty from other cities are expensive and hospitals, with very limited budgets, are reluctant to place these calls to the Toxicology Center. There is no equivalent to an "800 number" that could be established at the Center. The Tucson partners continue to work with the Center to address these problems.

3. Kansas/Bishkek (Kyrgyzstan)

a) *Nurse/Managers:* As a pilot project the partnership developed a curriculum for training senior nurses as managers. The Ministry of Health created the new position of nurse/manager and these nurses are employed as hospital administrators. The project now includes one nurse from every oblast in Kyrgyzstan, and the Ministry of Health is monitoring their activities to determine if the positions should be expanded to additional hospitals throughout the republic.

b) *Neonatal Resuscitation:* The neonatal training program, initiated at one partner hospital, was expanded to include pediatricians in two cities, Bishkek and Osh. Over 150 physicians, the overwhelming majority from non-partner hospitals, were trained in this vital service.

4. Coney Island/Odessa (Ukraine)

New techniques in laparascopic surgery, initiated at the Odessa Oblast Hospital, were incorporated into the training of the Medical Institute. Surgeons from throughout the oblast have now been trained in a variety of laparascopic and endoscopic techniques with a commensurate sharp decline in patient length-of-stay.

1. Iowa Hospital Association/Stavropol (Russia)

The Iowa Hospital Association began working with three hospitals. The original plan was to disseminate innovations from within a single department throughout a hospital. In the case of infection control, the new procedures were disseminated from the krai hospital to the city hospital across town.

In the case of women's health, the partners originally planned to work in the city of Esentuki. However, as the krai learned of the innovations there was insistence that the program be shared with the maternity hospital in Stavropol.

The program has now moved above the level of individual hospital administrators and is working with Dr. Nikolai Shipkov, health administrator for Stavropol Krai. He recognizes that it is in his best interest to disseminate innovations as widely as possible and this has become the model for the entire partnership with new techniques adapted in hospitals throughout the krai.

6. Providence/Kosice (Slovakia)

As part of nationwide efforts to rationalize health care delivery in Slovakia, Kosice Faculty Hospital has made exciting progress towards establishing a regional perinatal referral network for eastern Slovakia. As a result of outreach education to providers at secondary and primary care levels, high-risk pregnant women are receiving better care, including timely and appropriate referrals to Kosice Faculty Hospital. Care has been consolidated according to level of competency by hospital, and Kosice Faculty Hospital is now recognized as the tertiary care referral institution supporting area hospitals. As evidence that a regional system is working, in one year, the number of high-risk neonatal referrals transported to Kosice more than doubled, with 39 "in utero" and 66 post-delivery from throughout eastern Slovakia in 1996. At the same time, Kosice's neonatologists have provided training in neonatal resuscitation to staff in outlying hospitals, where the new techniques are being routinely applied. Initial data document an associated decline in the neonatal mortality rate for this region.

7. Winston Salem/Vac (Hungary)

A model diabetes program has been started at Vac Hospital that includes patient education, data collection and evaluation, and a support group united in a Diabetes Club. As a result of the program's early successes, the Ministry of Social Welfare has requested that Vac Hospital help establish national guidelines for diabetes patient education.

8. Lebanon (New Hampshire)/Zagreb (Croatia)

a) *Infection control:* An infection control initiative was started with partner hospitals, in line with a Ministry of Health priority to reduce nosocomial infections. Partners organized a national conference of over 250 participants to assist hospitals from throughout the republic to operationalize improvements in infection control. The partnership is organizing a follow-up conference in the fall of 1997 to enable participants to exchange results achieved in their respective hospitals since the first conference.

b) *Pharmacy reform:* A pilot project at Srebrnjak Hospital has led to a 35% reduction in the cost of pharmaceuticals with no decline in quality of care. One of the physicians involved commented on a recent trip to Dartmouth, "I never realized how big an impact just better administration could have on the care of patients." Srebrnjak's successes have been shared with the other two Zagreb partner hospitals which are implementing similar improvements in pharmacy management. In the fall, this successful model will be presented at a national conference on "The New Role of Hospital Pharmacists in Practice," in response to the Ministry of Health's strong support for disseminating these gains to hospitals throughout the country.

9. St. Louis/Riga (Latvia)

The partners have developed a series of user-friendly protocols for triaging infectious disease patients, making diagnoses, applying appropriate tests, and selecting appropriate treatment. A national conference was convened where these new procedures were presented to health care providers from eight of Latvia's nine districts. Follow-up visits over the next six months observed these protocols being routinely used in non-partner hospitals.

10. Washington, DC/Tallinn (Estonia)

This now "graduated" partnership has supported an initiative to train nurses in quality management and nursing leadership. Even after the partnership has ended, Tallinn Central Hospital continues to support requests from non-partner hospitals for training of nurses in these two important fields.

11. Nevada-Bohemia, Virginia-Moravia (Czech Republic)

The two AIHA health management education partnerships in the Czech Republic have been a key force in establishing a dialogue regarding health management education between educational institutions, practitioners and governmental bodies in the Czech Republic. A consortium of nine partnership institutions from the Nevada-Bohemia and Virginia-Moravia HME partnerships, led by the Purkyne Military Medical Academy, recently won a grant of 2 million Czech Crowns ($80,000) from the Czech Ministry of Health to make recommendations for a nation-wide strategy for the long-term development of health management education. The partners and the Ministry consider this new grant to be a continuation to the foundation built through the partnership program. In awarding the grant, the Czech Ministry of Health has recognized the AIHA partner institutions as national leaders

in health management education. The grant also represents an important step toward consensus between health care providers (the ultimate consumer of health management) and the academic establishment.

ANNEX J

AIHA RESPONSE

Note: The AIHA reposnse dated December 8, 1997 (pages J-35-41 in the hardcopy version) is an original document. Therefore it is not included in the electronic version of the report.

The team received the following "AIHA Response" to the revised May 22, 1997 first draft evaluation report. It is an excellent statement of the AIHA position throughout the evaluation process. It largely contains arguments that we have heard, including many with which we agree entirely and others that we found unpersuasive. As the point of view has been well expressed and taken into account substantially in earlier rounds of drafts and comments, this AIHA response neither prompted major additional adjustments to the text nor markedly changed our thinking on the specifics.

The response is a self-contained document that makes clear the AIHA point of view. Consequently, we believe the readers of this evaluation should have complete access to the arguments, and, for that reason, we have included the response in its entirely as an annex.

The evaluation took place over a year's time and the team briefed AIHA on preliminary findings shortly after the field work was completed. Over the course of the evaluation, AHIA began taking steps to address the problems identified in the evaluation report. Additionally, programs which were found to be successful and effective have been expanded by AIHA. The evaluation report represents a point in time and much has happened since it was written. Following a debriefing with USAID and AIHA, an update on the project was prepared by AIHA and is also included in this Annex. This update, as of December 8, 1997, shows that AIHA has been very responsive to the evaluation findings and has taken productive steps to resolve some of the management problems.

AIHA RESPONSE

TO REVISED (5/22/97) DRAFT EVALUATION OF THE PARTNERSHIPS PROGRAM

INTRODUCTION

We appreciate the opportunity to respond to the USAID-sponsored evaluation of the NIS/CEE Healthcare Partnership Program. At the outset, we would like to express our appreciation for the evaluation team's conscientious effort to get its hands around a large and complex program that is not only non-traditional, organic and decentralized in character, but which has had to change rapidly in response to a dynamic environment. Under the auspices of the Cooperative Agreement, forty partnerships involving hundreds of institutions have been addressing a wide variety of clinical, administrative, and policy issues. Over 5,000 exchanges have taken place as part of the partnership program and over 125 conferences and workshops have been supported through the collaboration of AIHA and the partnerships. In addition, the partnerships have generated a multitude of direct and indirect spin-offs and ripple effects that multiply the effect of their efforts. Evaluating such a large, multi-dimensional program in a meaningful fashion is a significant challenge.

In many respects, the partnership program began as an experiment – in its methodology, in its early focus on the former Socialist countries, and in addressing the health care delivery system rather than more traditional population and primary care subjects. In each instance it has broken new ground, making adjustments as necessary to balance competing interests and meet conflicting demands. As USAID acknowledged in commissioning the evaluation, since its inception the program has been asked to accommodate considerable funding uncertainty and systemic change – in the NIS and CEE host country environments – as well as within the USAID organizational environment. The current evaluation effort was undertaken in an attempt to learn from the collective experience of the past five years with a view toward developing future directions and approaches, both programmatic and within a USAID management context. We offer the following response to the Evaluation Report in a similar spirit of further refining a program that has proven to be highly successful in assisting former socialist societies develop new approaches and practical solutions to their health care problems in a manner especially supportive of our country's desire to promote democratization, decentralization of government, development of market economies, and good will.

In response to an earlier draft of this evaluation, AIHA provided the evaluation team with extensive section-by-section comments and corrections. The revised draft Evaluation Report has incorporated many of the corrections and has adopted many of AIHA's suggestions to better represent the structure of the program. Although we believe errors remain in this latest revision – in some cases because new material has been added – we have not undertaken to list corrections and commentary section-by-section as we did in our

response to the earlier draft. At this point in the process and with a view toward future program design, we feel it is more productive and useful to the Evaluation Report's audience to focus on what AIHA believes to be the few fundamental errors and misapprehensions that remain in this "revised first draft."

Our response to the Evaluation Report consists of two parts. The main section addresses key underlying premises or conclusions to which we take strong exception and which we single out because of their central importance to many of the draft Evaluation Report's recommendations and to future program design. In an Appendix, we address the Evaluation Report's specific recommendations and conclusions highlighted throughout the text of the Evaluation Report and summarized in its Section 5.0.

RESPONSE TO KEY ISSUES

We appreciate the Evaluation Report's central conclusion that the USAID-AIHA cooperative agreement has achieved impressive results both in the NIS and CEE and in the United States through a largely voluntary model. Notwithstanding this overall conclusion, however, we believe that the evaluation contains a number of preconceptions in favor of a top-down rather than a bottom-up policy reform process and greater reliance on paid consultants and contractors rather than volunteer practitioners. These preconceptions are reflected in a series of conclusions and recommendations that we believe could lead to a marginalization of the voluntary partnership methodology and to a pronounced shift toward narrow, top down, off-the-shelf "policy" approaches. The result, in our opinion, would be more predictability and more control on the part of USAID but greater costs, less effective programs, poorer results and significantly less good will, both in the United States and abroad.

Partnership Impact on Health Policy and System Reform; Replication

Notwithstanding the Evaluation Report's overwhelmingly positive assessment of the partnership's impact at the local level and regional levels, the Report described the partnerships as having scant effect on health policy and system reform at the national level. The Report concludes that the program was neither designed nor offers more than limited potential for replication in non-partner hospitals. We strongly disagree with this assessment and conclusion. The Evaluation Report itself cites numerous examples where policy makers are working closely with AIHA and the partnerships in forging significant changes in policy and practice. The practical "bottom-up" approach to the policy process has been successfully applied in areas as diverse as nursing education, infection control, and neonatal resuscitation. This approach has been essential to helping the NIS and CEE countries address their current health care crises, and has advanced the development and nurturing of democratic and market-oriented values necessary to meet long-term goals.

The partnerships operate with an understanding that while health professionals in the US, NIS and CEE may have much to learn from each other, there are few systems or solutions that can be exported wholesale, without significant adaptation and adjustment to local

social, cultural and economic environments. Systemic change must proceed from local change if it is to be successful. This is especially true if it is to promote democratization and a market orientation.

The Evaluation Report suggests "top-down" policy development approaches should receive funding priority. While important components to the US government's assistance strategy, these approaches alone have proven to be ineffective in creating meaningful change. In our own country the policy process is, with very rare exceptions, incremental and evolutionary, reacting to specific problems and exposed deficiencies and building upon successful changes and adaptations at the local level. Rather than leading change, national policy almost always follows change: codifying, legitimizing, and promoting it. While it is true that the state of crisis in the NIS and CEE may require more rapid and radical reforms, to assume that the process of change will be fundamentally different in the NIS or CEE is at best wishful thinking.

If there is a difference in applying this bottom-up policy development scenario in the NIS and CEE, it lies in the additional need to transform the mind-set of health care providers. As in every other sector of their economies, the NIS and CEE countries are undergoing a profound transition in health care from socialist to democratic cultures. The most meaningful reforms have come about, not from the adoption or emulation by national governments of American standards of care, private sector ownership or our unique system of health care financing, but from adaptations created by NIS and CEE health care workers and policymakers who "think" differently: more democratically and more oriented toward patients, markets, services, and results. As the evaluation team found, participants credit the partnership program with having profoundly changed their way of thinking and with having created a "management culture." National and regional ministries of health and other senior governmental officials have strongly endorsed the program because this change in thinking offers them the best and most realistic opportunity to develop solutions to regional health care issues.

The Evaluation Report is wrong in its contention that the partnership program was "not designed" to have major sector-wide policy impact. In fact the program was designed and has been implemented to achieve major impact with a bottom-up approach in mind. In view of the long history of centralized socialist government, USAID was especially concerned in the initial design phase in 1992 and 1993 that partnership efforts be directed at a local and regional level. This decentralized focus was consistent with the reality of shifting responsibilities as Ministries of Health throughout the region were unable to meet their budgetary commitments to the health care sector and burdens shifted to local and regional governments. For example, in the Russian Federation, the design was supportive of the devolution of decision-making and control from Moscow to regional oblast and krai governments. This strategy to support local and regional efforts has been manifested as recently as 1996 in USAID Mission reluctance to have MOHs even participate in the partnership selection process.

<u>Involving Ministries of Health in the Bottom Up Approach to Change</u>

As we describe further in the Appendix, AIHA has tried to achieve a balance by actively encouraging the partnerships to involve Ministries of Health and other governmental as well as non-governmental entities. This has been part of a concerted and planned effort to reduce barriers to change at the local level and to create a receptive audience for the replication and adoption of locally proven solutions at the regional and national level. The Evaluation Report is correct in pointing out that this bottom-up process can often be slow and frustrating, subject to fits and starts in the early stages in particular. It is also correct in pointing out that results may often be difficult to measure and that more adequate partnership assessment and documentation processes are needed.

A thorough evaluation of the impact of a given partnership, or of the partnership program as a whole, ideally should involve non-partner institutions as well as partners in order to capture all the dividends of the partnership process. It is a significant challenge to measure the new ideas generated in other institutions (resulting from information exchange or from competitive pressures created by a more efficient and effective partner institution) or the impact of individuals from other hospitals or ministries of health who are exposed to a Partnership to ultimately lead national and regional reforms.

The partnerships have demonstrated significant systemic achievements in a number of critical areas in relatively short periods of time given the extraordinarily difficult and changing circumstances within which our NIS and CEE colleagues operate, the legacy of socialist thinking, and the need to carefully consider the applicability and relevance of US experiences and technologies. As the evaluation team found, Ministries of Health have reached the same conclusion regarding the value of the partnership approach and have lobbied heavily for the continuation and expansion of the program. While the Evaluation Report regards this support as “political popularity,” we believe that it reflects an accurate assessment of gains achieved on important issues ranging from infection control to women’s health. It also reflects the ministries’ understanding of what it takes to achieve meaningful reform within their own social and economic context and a realization of their changing role consistent with increased democratization and devolution of political power.

Receptivity is key to impact and sustainability. The partnerships have demonstrated that ministry officials are more likely to be receptive if they can point to concrete, positive changes actually occurring in their countries. Their receptivity is nurtured by the ability to influence thinking that comes from personal relationships and follow-through.

Recognizing the importance of creating MOH receptivity to change and with special appreciation for the skills of our NIS and CEE counterparts and their ultimate responsibility for effective, sustainable change, partnerships and AIHA field offices have developed close working relationships with Ministers of Health and their staffs. Because of the wide range of other responsibilities that USAID Missions have and the relatively low priority that health programs receive in the USAID portfolio in the region, more often than not these relationships are much more extensive than those which USAID Missions have developed.

In many instances, AIHA's efforts to work with ministries have filled a void in countries that lacked any specific USAID programs in national health care reform.

While questioning the relevance of some of the United States' specific health-financing experience or policy, AIHA and its partners have consistently argued for more efforts to strengthen Ministerial level capacity to effectively develop, implement, and administer national policy. In the absence of any specific USAID programs funded for this purpose, AIHA and its partnerships have attempted to meet these needs within the partnership programs' objectives. This has included both reaching out to include HHS, CDC, the Veterans Administration and various state, municipal, and private agencies on the US side in the development of workshops, seminars, exchanges and study tours, and the participation of ministerial officials and other influential non-partnership personnel on the NIS/CEE side. USAID has encouraged these efforts and the previous 1994 program assessment urged further emphasis in this area. The Evaluation Report correctly points out that this has often created tensions between AIHA and some of the individual partnerships. Individual partnerships (particularly those who are heavily local in their focus) understandably want to see more resources channeled to their individual partnership objectives. Responding to the demands of both Ministries of Health and USAID to effect broader scale impact and replication, however, AIHA promotes conferences, workshops, and collaborative activities often including organizations and individuals outside of the partnerships. We agree, however, that the dialogue between AIHA and the partnerships could be improved to reduce tension in the program.

The Evaluation Report also questions whether AIHA and/or its partnerships are the best entities to coordinate policy level activity with the Ministries of Health. Our response addresses specific areas of policy in the Appendix, such as neonatal resuscitation, infection control and emergency medicine, in which we believe that the partnership program has clearly demonstrated its success in effecting national policy and practice change. These efforts have been possible in large measure because the partnerships and AIHA enjoy the credibility at the policy level in the NIS and CEE countries which comes from proven local and regional level success. We agree that these efforts could be significantly strengthened and expanded either by AIHA or other entities. We do not believe, however, that support for partnerships at the local or regional level should be "traded-off" for these national level initiatives in the false hope that they offer easier and quicker solutions to complex, difficult challenges.

Regional vs. Country-by-Country

Health care providers, educators and policy makers are facing similar challenges throughout the CEE and NIS. The Evaluation Report suggests that the NIS partnerships, in particular, have achieved greater success because they lend themselves to "treatment as a single region," in light of their common language, history, health system organization, and challenges. AIHA agrees with this conclusion. We are surprised, therefore, with the Evaluation Report's seemingly contrary recommendation that programmatic design be carried out on a country-by-country basis. This approach would surrender an enormous

opportunity to achieve synergistic cross-fertilization and economies of scale that are available when the partnerships are viewed as components of a regional program. Many of the successes that the partnerships have enjoyed are directly attributable to the regional approach that the program has fostered. The success of the pre-hospital EMS training center in any single country, for example, has been largely predicated on its training curriculum and protocol being approved for certification in multiple jurisdictions. The development of the most recent EMS Training Center in Turkmenistan within a six-months time frame was possible because instructors could be trained in other training centers in the NIS and because the certification of the course had already met the approval of officials in the Russian Federation and other NIS countries. Similar examples of the benefits of a regional approach can be noted in virtually every area that the partnerships have pursued including nursing, infection control, diabetes, women's health, breast cancer, and health professions education.

"Seeding" New Partnerships

The Evaluation Report correctly identifies the potential limitations of the partnership model's ability to foster extensive change in other institutions without taking them through the entire partnership experience. Like the Marshall Plan's exchange program 50 years ago, an underlying premise of the partnership program's extensive exchange component is that "seeding" new programmatic models and individuals with broader perspectives will create a critical mass of "new thinkers" who can become critical change agents within the system. The success of the program has been based in part upon its ability to create such a critical mass of "new thinkers" within key institutions by intensely exposing them to the management organization and market-oriented culture of the US health care system. Once this critical mass has been created, further programmatic investments can show relatively quick returns in the form of more specific programmatic outcomes. This dynamic raises a central question regarding the future direction that the program should take. As USAID considers future program design in a more systematic manner, we believe that it should carefully consider the balance between (1) creating more partnerships (i.e., more "seeding") and, (2) more intensely cultivating the existing partnerships. The first permits the creation of more "new thinkers" but may sacrifice the ability to predict and quantify outcomes over the short term; the second
allows more evidence of specific programmatic outcomes and better defined "models" for possible replication but could sacrifice a broader basis and constituency for fundamental change.

In response to the 1994 program assessment AIHA strongly recommended taking a long-term view by starting new partnerships while concurrently funding a limited number of highly specific program initiatives with existing partnerships. Regrettably USAID budget considerations have prevented it from considering this longer-term strategy.

Sustainability

The Evaluation Report also raises questions regarding the "sustainability" of the program. While we also address this important issue more fully in the Appendix, in summary we suggest that the Evaluation Report confuses the sustainability of program outcomes with sustainability of the institutional relationships which have generated the outcomes. This is seriously misleading. USAID and AIHA have always assumed that in only rare cases would the partnerships continue beyond their funding at anywhere near the current level of activity. Federal funding has been and remains critical to enabling US institutions to fulfill the potential of their voluntary commitments. We value the Evaluation Report pointing out that some of the partnerships are looking to AIHA to help them find resources that will sustain their activities after USAID funding and we will work with these partners to determine how to better approach this task.

But continuing partnership activities and exchanges is an inappropriate test of "sustainability" just as it would be if applied to any traditional consultant or contractor; in fact, we know of no USAID consultant who could pass a test that their continued "consulting" activity be sustainable without USAID funding.

The test of sustainability is appropriately applied to programmatic initiatives and interventions. And we believe that partnerships have been designed and implemented so as to produce highly sustainable outcomes. As the Evaluation Report describes, partnerships emphasize the transfer of knowledge. This knowledge has resulted in changes throughout the partner hospitals and, as the evaluation further describes, promoted changes in regional and even national approaches. These changes are all fully sustainable by definition because they represent locally generated solutions and adaptations incorporated into accepted practice.

While the partnerships and AIHA have supported the provision of resources such as computer and training equipment and supplies, which are necessary catalysts to change, a high priority has been placed on minimizing capital and operating cost inputs from the US by ensuring that the NIS and CEE partners assume these burdens from the beginning. In the case of the women's health centers, for example, local partners are providing space, renovations and all operating costs for the centers. While AIHA and the US partners provide a minimal amount of start up equipment and supplies (much of it for patient education programs), most of the US commitment is in the form of training and organizational design.
In those few instances of ongoing training programs where the Evaluation Report correctly points out a potential sustainability problem, we have initiated steps that phase out this support over the next year.

Volunteerism

We take strong exception to the Evaluation Report's relative dismissal of the importance of volunteerism to AIHA's partnership program specifically and to the concept of "partnership" in general. We do not believe that the evaluation team fully understood how key the voluntary nature of the program has been to facilitating the receptivity to change

in the NIS and CEE. Unlike a paid consultancy, an unpaid volunteer is "equal" to his NIS or CEE peer and his or her willingness to sacrifice is an important factor in creating and maintaining credibility and trust. Embracing change is a risky proposition in any society, but especially in those societies that have traditionally not rewarded innovation and reform. We have heard time and again from our NIS and CEE colleagues that they have been empowered to make change because of the personal trust that they have in their US peers and the responsibility they feel toward these same peers who have invested their own time and resources.

When the program was originally conceived in 1992 by USAID and the organizations that make up AIHA's Board of Directors, there were many in the international development community who were skeptical of its ability to attract a voluntary response from enough US health care institutions to make the program work. That skepticism surfaced again in 1995 when USAID asked AIHA to develop partnerships between programs in health management education and between communities involved in developing "healthy communities" approaches. While the Evaluation Report appropriately describes the continued generation of this voluntary component as a challenge, we believe that there is ample evidence that future levels of volunteerism exist to support current and even expanded levels of program activity. Our most recent competitive solicitation for a potential partner for a single hospital partnership in Bosnia generated four solid, fundable proposals from large multi-provider health care delivery systems in the US. AIHA has received numerous expressions of interest by health professions schools and by professional societies to participate in voluntary partnership programs should the opportunity arise. As the program's success has become known, the opportunities for attracting volunteers and institutional commitments may in fact be greater than at the program's inception in 1992.

Achieving a high degree of volunteerism is not easy. The US health care industry is highly competitive and becoming more so every day. We have also learned that the barriers to volunteerism vary among institutions and we appreciate the reminder by the Evaluation Report that we cannot take a large voluntary component for granted. While the Evaluation Report points out a number of meaningful areas for program management improvement, we believe that for the most part the structure that AIHA has developed over the past five years to support the partnerships has been an important factor in successfully generating and focusing this voluntary effort. We know that our systems are far from perfect and we are in the process of instituting a systematic review with partner representatives to effect improvements in management and budget processes. We hope that USAID is similarly careful in its follow-on program design to effect changes that will stimulate and not diminish volunteerism. As is the case in taking on any joint venture partner, a heavy emphasis on the use of volunteerism comes with some trade-offs – largely related to command and control. The benefits of volunteerism to the Federal Budget, to the substantive results of the partnerships in the NIS and CEE, and to the increased global awareness and support for US foreign assistance objectives in communities across America, argue strongly for a concerted effort to foster more, not less, voluntary effort.

Consultants vs. Practitioners

We do not agree with the Evaluation Report's recommendation that the initiatives addressed by the partnerships in a collaborative manner are better implemented through more task-oriented approaches involving traditional consultants or contractors. The Evaluation Report seems to imply that the practitioners involved in the US side of the partnerships are in some way less skilled or less knowledgeable than their "international consultant" colleagues might be when it comes to "scaling up" these efforts. The fact of the matter is that the health care professionals involved in the partnership program are leaders in their respective fields and the health care systems of which they are part are among the most prestigious in the world. Because of their involvement in the program since as early as 1992, as a group they also have a better understanding and far more experience in the NIS and CEE milieu than their consultant counterparts. Over the course of their partnership experience they have developed not only incomparable understanding and expertise but also extensive relationships to senior policy makers without whose support "scaling" up will not occur.

Moreover, one should not mistake a collaborative approach for a lack of rigor in design and implementation. Partnership initiatives are guided by work plans that identify benchmarks for timeliness and deliverables.

The Evaluation Report's suggestion that the partnerships should be relegated to a sort of local "first stage" development process and then turn over replication and policy level activity to a more traditional development organization would also seriously undercut the motivation that currently drives both sides to make a significant impact and difference.

Follow-On Program Design

We believe the partnership model has successfully created a foundation for long-term impact and wide replication. AIHA is eager to work with USAID to refine the partnership model for the next generation of partnerships to strengthen its capacity to respond to USAID's concerns for overall health sector impact. Partnerships have proven to be an effective mechanism to respond to a reform process that is unfolding in a fast-paced and often unpredictable way. Partnerships have an advantage in such an environment over traditional development approaches in that they are not built upon a preordained model of reform and can complement resources that exist in a country at a moment in time. Accordingly, follow-on design should avoid creating artificial boundaries between the partnerships and other health care reform efforts, including "top-down" consulting efforts. The goal should be to synchronize the two.

We continue to believe that the optimal program design would include new partnerships (more "seeding"), while exploiting opportunities to cultivate existing partnerships. Existing partners have built solid relationships based upon trust and collaboration as well as recognized expertise about local and national CEE/NIS health care environments. We

believe these are valuable assets to bring to bear in influencing and supporting efforts to "scale up" and to broaden impact.

A new set of partnerships should continue the positive evolution that has occurred so far under the model and could include projects explicitly focusing on enhancing public management and policy analysis, a direction that some existing AIHA health management education partnerships have taken. New hospital partnerships also could expressly incorporate more policy and management aspects. Development of infrastructure within agencies will be necessary for effective reform. This focus might imply direct partnerships with ministries. National level efforts should continue to be enhanced by the credibility that is provided by successes on a local level. Accordingly, country strategies should consider the advantages of establishing health management education and policy-focused partnerships to coordinate with hospital and/or community health partnerships. Finally, objectives and expectations can and should be clearly defined up front without abandoning the flexibility of the partnership model.

We welcome the opportunity to meet with the USAID team responsible for follow-on program design to flesh out our ideas. We believe our five years of experience implementing program in the NIS/CEE can be constructive to the design process.

CONCLUSION

As we suggested in the Introduction, the partnership program is an experiment of the post-Cold War era. It is an experiment in whether private sector resources can be leveraged in a responsible and cost-effective manner in a time of increased Federal budget constraints. It is an experiment in whether US citizens and communities can be engaged in foreign assistance and in the projection of American interests overseas when many would rather focus our energies more narrowly and here at home. And it is an experiment in whether we can develop new bonds which tie ourselves and our economy with our former adversaries in the Eastern Bloc as they rebuild their economies – bonds of collaboration and cooperation which will benefit our economic and political security. On each of these counts, the partnership experiment has been a success. We are hopeful that USAID will build upon this success and we look forward to a collaboration that will be supportive of the program's strengths and better address its weaknesses.

APPENDIX:

RESPONSE TO CONCLUSIONS & RECOMMENDATIONS

3.1.1* CHARACTERISTICS OF THE AIHA PARTNERSHIP MODEL

There are many approaches to providing technical assistance. As the Evaluation Report notes, these include other "partnership" programs that involve exchanges of individuals or groups of peers. What distinguishes the AIHA program are (1) the dimensions of volunteerism, (2) institution-to-institution relationships with a common focus on health care, (3) a flexible, inclusive approach to objective-setting that relies upon a continuous process of planning and adaptation, and (4) a structure that encourages collaboration, networking, and sharing of information among partnerships and common support areas such as communication and technology. These characteristics are inter-related and mutually reinforcing.

We are pleased that the Evaluation Report recognizes the "truly impressive" level of volunteerism demonstrated by participating institutions and considers this a positive aspect of the AIHA model. As we discussed in the main section of this Response, we believe that volunteerism is an essential condition of an effective partnership. Other "positive aspects" noted by the Evaluation Report include the model's cost-effectiveness and its success in transferring ideas, building bridges among institutions, and raising the level of interest in and support for foreign assistance.

We are concerned, however, that Section 3.1.1 of the Evaluation Report describes challenges that face all types of programs in the NIS and CEE and incorrectly characterizes these as "potential problems" of the AIHA partnership model. As we suggested in comments to an earlier draft of the Evaluation Report, a more useful exercise would address strengths and weaknesses of the AIHA partnership model as compared to alternative models for providing technical assistance. It seems to us less helpful in evaluating one model to list weaknesses of foreign assistance in general or challenges that every model would face in providing technical assistance to the NIS/CEE. Examples include language differences, the risk of counterproductive paternalism, and the highly structured and centralized nature of the health care systems of the NIS and CEE.

The Evaluation Report expresses concern that the partnerships can export bad ideas along with good ones. The Evaluation Report goes on to suggest that the efficacy of partnerships may be limited because our "systems are markedly different." Again, these issues constitute significant challenges to any US technical assistance methodology. We believe that the partnership methodology is less vulnerable to these criticisms than other

* (Refers to section number in Evaluation Report)

methodologies because it provides for an intense level of exchange and interaction among peers over time and because it exposes the participants to a more comprehensive view of both CEE/NIS and US health care systems. This interaction nurtures a mutual understanding that enables partners from both sides to discern differences and weaknesses, thereby permitting the CEE/NIS partners to discriminate in adapting approaches to which they are exposed in the US. Rather than representing a weakness, the Evaluation Report's quote from a doctor regarding aspects of the US health care system demonstrates the program's success in fostering this careful discrimination. Because the systems are different, partnerships have been effective at educating both the CEE/NIS side and the US side. It is a tenet of the partnership philosophy that there is much to be learned on both sides.

We believe that a closer examination of other forms of assistance would demonstrate that the partnerships have overcome more successfully the weaknesses endemic to foreign assistance, such as language barriers and tendencies to paternalism. Rather than being a weakness in this regard, the voluntary nature of the program tends to promote more tolerance and cross-cultural sensitivity than often exists among "international development specialists." It would have been useful if the evaluation team had sought out CEE/NIS participants who had participated in both types of programs – partnerships and more traditional consulting programs – to develop this comparison further. Our own experience suggests that the international development community which has largely derived its experience in the "third world" brings significant baggage as they try to transplant that experience in the NIS and CEE. Partnership program participants (including those who are exposed to the program less extensively and only through workshops or study tours) have almost universally described their experiences more favorably when asked to compare with other programs in which they have been involved.

In this regard, we agree with the Evaluation Report's recommendation regarding the importance of strategically choosing partnership hospitals. With the exception of some of the earliest (1992/93) partnership selections in the NIS which preceded the establishment of USAID missions, USAID missions and the Washington-based USAID project officer have been actively involved in the selection of each of the partnerships. We believe that this participation has been an important aspect of the cooperative agreement and strongly support the Evaluation Report's recommendation that it be continued.

We also agree with the Evaluation Report's identification of the potential limitations of the partnership model's ability to foster extensive change in other institutions without taking them through the entire partnership experience. The program has been remarkably successful in creating the "new thinkers" which are so critical to systemic change. As we discussed in the main section of our Response, we believe that a balance must be achieved in future program funding that will result in additional new partnerships.

Dependence on Voluntary Contributions

While the Evaluation Report cites the voluntary component of the program as being "impressive," it goes on to point out that this could be a potential weakness because the program is heavily dependent upon this volunteerism. As we described in the main section of this Response, we believe that the voluntary component of the program is vital to the partnership methodology and its success and not just an "interesting" or "desirable" component. In this regard, we restate our strong rejection of the Evaluation Report's recommendation that USAID attempt to more broadly interpret and recast the partnership methodology as substantially paid peer-to-peer relationships, presumably with more traditional international development contractors.

Sustainability, Replication and Policy Impact

Finally, the Evaluation Report states in the introduction to this Section, that the partnership model is not designed for sustainability, replication, or policy impact. As we have discussed at length in the main section of our Response, we strongly disagree with the Evaluation Report's contention. We believe that the program is built upon certain assumptions regarding a bottom-up policy process, that in fact are better suited, and have proven more successful, than most of the more traditional programs that USAID has supported in the NIS and CEE.

3.1.3 DURATION OF PARTNERSHIPS

We agree with the conclusion that partnerships should be based on accomplishments rather than on an arbitrary period of three years. We also believe, however, that new partnerships are essential to the ongoing "seeding" process. As the Evaluation Report points out, the previous assessment team and AIHA in 1994 identified this tension between (1) continuing to invest in successful partnerships as a basis for regional and national replication of proven program models and (2) the establishment of new partnerships in accordance with the concept of "seeding" as many new change agent institutions as possible. In an attempt to design a program that would respond to both needs, AIHA recommended that partnerships be established for three years with an additional two-year graduation period to focus on replication. AIHA also recommended as part of this strategy, however, that a new cycle of partnerships be established to take the place of graduated partnerships. As we discuss above, we believe that a new round of partnerships that would allow more institutions in the US and in the CEE/NIS to participate in the program would not only "seed" more models of change, but would respond to the demand by more US communities to participate. Maintaining a partnership program, even with new institutions involved, would meet the desire expressed by various Ministers of Health for a continuation of assistance for several more years.

Although partnerships were established for the first time in the CEE, Tajikistan, and eastern Ukraine after 1994, these did not represent a replacement strategy. In the case of the NIS where USAID has been unable to make the longer term funding commitments necessary

to start a new partnership round, funds have gone to existing partnerships on a year-to-year basis, more often than not to meet specific USAID policy objectives in areas such as women's health. While NIS partnerships have carried out these objectives very successfully, as the Evaluation Report indicates, AIHA and the partners have not been able to plan as effectively as they should. This frustration has been further aggravated by long delays in the obligation of funds by USAID once agreed upon by the Agency.

The evaluation team has recommended that AIHA assist the partners in locating funding from other sources for their continuation after USAID funding. AIHA has collaborated with a number of partnerships to help them locate other sources of funding for partnership and replication related activities. These have included conducting workshops for the NIS partners on grant proposal writing, brokering meetings and actively lobbying the public and private sector for the funding of discrete programmatic activities. As a result, a number of partnerships have successfully attracted funds from other USAID programs as well as from the World Bank, Soros Foundation, and WHO. AIHA staff have assisted partners in preparing successful proposals to fund multi-year programs that disseminate successful initiatives, including alcohol treatment, women's health and others. AIHA has also been very active in helping partnerships broker relationships with pharmaceutical and other health products related companies as well as with other NGOs to improve or expand programs. Two such examples are Eli Lilly's and Johnson & Johnson's large-scale disease management replications (like the Moscow Oblast diabetes project) and contracts by several of the partnership EMS centers to provide training to oil and gas companies. These are successful Partnership-AIHA collaborative efforts that broaden the resource base of partnerships with the active participation of the private sector. While the result may not ensure that partnership activities such as exchanges continue beyond the life of USAID funding, these efforts have significantly contributed to program replication and sustainability by the NIS and CEE partners and their countries. Although the first priority of AIHA and the US partners must be given to such programmatic sustainability, we will work with the partners to identify other potential sources of funding for partnership travel and related costs in the future.

3.2.0 PARTNER INITIATIVES

As the Evaluation Report describes, the partnership program provides for collaborative activities involving groups of partnerships. Not only has this proven to be a cost-effective approach but it has also served as an important impetus to replication and to national policy development. These "initiatives" were initially stimulated by the desire of the US partners to work collaboratively with other US partners who were addressing similar issues in the NIS. Collaborative efforts in pre-hospital EMS training, nursing leadership and neonatal resuscitation all arose in this manner. These collaborative activities have grown over the past two years partly in response to recommendations by the 1994 program assessment and to USAID's expressed desire for more targeted programs by the individual partnerships (e.g., women's health). Growth in the initiatives has also resulted from the demands of NIS ministries of health for the replication of programs which they have been successfully developed in other countries by partnerships (e.g., emergency first responder

training and infection control). The biggest impetus for growth, however, has been the opportunities presented to achieve broader scale impact through collaboration.

While the initiatives vary considerably in their actual implementation, they all include a high degree of collaboration by the partners and are generally characterized by meetings, conferences and workshops in which representatives from each partnership participate. In every case, the partners and AIHA have reached out to include other experts who can make a contribution to the effort. In the infection control effort, for example, representatives from the Society for Hospital epidemiology of America (SHEA) and CDC's Hospital Infection Control Branch are active participants. Leadership is generally drawn from partnership representatives in the US and NIS with AIHA providing a supportive role.

Multi-partnership initiatives often overlap with the overall meetings and conferences support that AIHA provides in order to foster partnership sharing and program replication. These include the CEE and NIS annual conferences as well as dissemination conferences or meetings in individual countries. Often, as is the case of the annual conferences where pre-conference meetings and workshops may be held in conjunction to reduce travel costs, several types of "inter-partnership" activities may overlap. In association with the upcoming annual meeting of the NIS partners, for example, AIHA and HHS/CDC will cosponsor week-long training programs for NIS hospital infection control personnel and microbiologists. Separate workshops are being held for the senior infectious disease and control policy makers from each of the NIS Ministries of Health.

As the Evaluation Report has pointed out, poorly defining these collaborative and support activities for budgetary purposes has resulted in some confusion – on the part of the US partners in particular – over funding allocations. AIHA is in the process of convening a working group of the partners to assist in better defining budget allocations in the future.

Although there may be occasional overlap, these multi-partnership initiatives should not be confused with different types of partnerships that USAID has specifically funded through the AIHA Cooperative Agreement. The latter includes the Health Management Education and the Healthy Community Partnerships in the CEE. While they share the elements of the partnership methodology, each is a discrete program with specific budgets, objectives, and partner institutions.

Finally, as the Evaluation Report suggests, the collaborative activities address issues that are exceedingly complex and demand significant changes in organization and mind set in addition to practice. The response of the partnership program has been equally complex involving the active collaboration of a number of governmental and non-governmental organizations such as HHS, CDC, WHO, and professional societies. Readers of the Evaluation Report and this response who wish to more fully understand these "initiatives" are encouraged to seek further information from AIHA.

3.3.1 NIS NURSING TASK FORCE

3.3.2 CEE NURSING TASK FORCE

As the Evaluation Report found, one of the most successful collaborations of the partnerships has been in the promotion of nursing reform. Although the Evaluation Report recognizes the impact that this collaboration has had on the individual participants and even on large groups of nurses in their respective countries, it substantially understates the potential impact of that empowerment on national policy over the long term. For the first time, nurses in the NIS and CEE are organizing as professionals (numerous local, national and regional nursing associations have been developed by the partnerships). Significant changes in education curricula are occurring throughout the NIS and CEE (the successes in Central Asia found by the evaluation team can be found in virtually all of the partnership countries). And nurses are taking on increased responsibilities not only at partnership hospitals, but also in local and regional health administrations. There was considerable evidence in the April 1997 NIS Nursing Conference that the momentum of these results is increasing. The May 1997 meeting of the Council of CIS Ministers of Health specifically cited the importance of the improvement of nursing as a key element supporting improved productivity of the health care systems in the NIS and commended the partnership program for its singular leadership on the issue. These successes are a direct result of the activities of individual partnerships and the commitment of the nurses themselves on both sides of each partnership. As in other initiatives, AIHA has supported and encouraged collaborative and group activities of the partnership nurses in the interest of creating both critical mass and the support networks so essential to creating systemic reform.

We are very proud of the fact that both NIS and CEE nursing task forces have been able to reach out and engage the leading nursing professional and education associations in the United States in their efforts to help their colleagues. The leadership of the American Nurses Association, the League of Nursing, the American Organization of Nurse Executives, and numerous state nursing associations as well as representatives from WHO and the US Department of Health and Human Services have participated extensively in workshops, conferences, study tours and exchanges. This participation has been facilitated by the US partner institutions, which include many of the key nurse educators and elected nurse leaders in the United States. Given this already close involvement and the extraordinary success to date of the nursing organizational effort, we do not believe that the Evaluation Report's recommendation to divert funds from volunteer based partnerships to fund the provision of presumably paid technical assistance by these same organizations is warranted.

Although the CEE partnerships were initiated much more recently, their collaborative activity with respect to nursing is already yielding important results. We agree with the Evaluation Report's observation that the partnerships' influence is beginning to be felt at the national level in many of the CEE countries. The most recent task force meeting held in conjunction with the CEE annual conference in Zagreb, Croatia provided ample evidence of this success and of the potential for the CEE nurse leaders to work together in a regional, policy context. We agree that individual partnerships should be encouraged to further promote the organization of nurses in their respective countries.

We strongly disagree with the Evaluation Report's recommendation that the NIS partnership-based nursing task force be "combined" with the Russian Nursing Association. There are tremendous and obvious differences between the organizations (if one can even call such an ad-hoc task force of partnership related nurse leaders an "organization"), their objectives and their potential roles in nursing reform. Even if it were feasible, we do not understand what purpose would be served by combining the organizations. In support of partnership program "replication" we have encouraged NIS nurse leaders from the partnerships to take an active role in helping to further organize as professionals in each of their respective countries. In this regard, we are very pleased that nurse leaders from a number of the partnerships in the Russian Federation are taking an active role in the Russian Nurses Association.

Workforce and Education Reform

We concur with the Evaluation Report's finding that nursing reform is just one element of overall workforce development and planning. We also agree in principle that workforce development should be a nationally planned, strategic process. Unfortunately, as our own experience in the United States suggests, this is rarely the practice. In fact NIS and CEE countries suffer from most of the same workforce problems as the US does – such as overproduction of physicians and particularly specialists, the maldistribution of health professionals geographically and with respect to need, and the difficulties of maintaining clinical competencies in the face of rapid technological change.

Because many of the US partners have extensive university relationships, the partnerships have been called to the forefront of addressing many of the issues related to professional education and workforce development. While these have not generally been the highest priority focus of any single partnership in accordance with the Cooperative Agreement, with very few exceptions, partnerships in the NIS have addressed medical school curriculum reform as well as nursing school curriculum reform. Regrettably, the Evaluation Report does not describe the significant reforms in education. Examples include significant reductions in entering medical school class sizes, the initiation of a more broad based general education requirement preceding medical studies and the development of residency programs in the last two years of medical school.

In recognition of the expertise that had developed over the past four years in the partnerships, AIHA took the opportunity to address workforce issues in a more systematic manner, by convening a NIS-wide conference in Tashkent, Uzbekistan in May 1997. The Association of Academic Health Centers, an AIHA founding member organization, worked closely with AIHA and the partnerships in developing and conducting the conference and in securing the participation of an extraordinary group of leading US policy makers on a voluntary basis. Over 75 policy makers and leaders in the health professions from the NIS, CEE, Canada and the US participated, as did senior representatives of the World Bank and WHO. Considerable consensus was achieved by the Conference regarding the key issues, including an agreement that there is a significant overproduction of physicians and underproduction of skilled nurses. The group also agreed upon a potential range of

solutions, such as reducing incoming class sizes and regulating the development of private medical and nursing schools. While this does not fully meet the Evaluation Report's recommendation that a study of resource needs for the health care sector be conducted, it represents a critical first step in developing the parameters and objectives of such a study should USAID decide to act on the recommendation. The Conference also had the important benefit of creating substantial interest on the part of leading US health professions schools in future participation in volunteer-based partnership activities.

3.2.2 EMERGENCY MEDICAL SERVICES

As the Evaluation Report suggests, the collaborative activity of eight partnerships over three years has resulted in a new model across the NIS for the training of emergency first responders. This represents a profound shift in practice, not unlike a similar shift that occurred in the 1960's and 70's in the United States. In the United States, the increase in pre-hospital intervention has had a significant impact on morbidity and mortality related to accidents, trauma, and cardiovascular incidents. The development of a trained "first responder" capacity has had the additional effect of creating an essential foundation for improved response to disasters. It has also encouraged the development of greater responsibility for accident prevention and intervention on the part of the community and the average citizen. Everyone involved in this collaborative effort, including the Ministers of Health of each of the six NIS countries involved, believes that the effect will be similarly dramatic in their countries.

Recent requests by the Minister of Health of Belarus and the First Vice-Prime Minister of Uzbekistan for training centers in their respective countries underscore both the high place which this issue holds among national priorities and the relevance of the partnership-developed solution. The interest of WHO in developing similar centers elsewhere in the world and the substantial commitment by the International Atomic Energy Commission in funding a training program for Center instructors related to radiation accident response are additional indicators of success.

We agree with the Evaluation Report's observation that outcome data regarding impact of the training on morbidity and mortality is essential to demonstrate efficacy of the program. This is a high priority of the training centers and the Ministries of Health. Ascertaining impact of an intervention during one discrete segment of the continuum of care in which many changes are occurring is especially complex in the NIS, requiring the development of extensive reporting systems in both the pre-hospital and hospital sectors. Nevertheless, preliminary data from Moldova (where over 65% of pre-hospital providers have been trained) suggest a dramatic reduction in pre-hospital mortality from acute myocardial infarction over the past year. While an important effort is being made to develop outcome data, each EMS Center does conduct extensive student pre-testing and post-testing. While this is an admittedly intermediate indicator of ultimate training impact, it does demonstrate that student skills improve dramatically as a result of the course.

We also agree with potential problems regarding the sustainability of the EMS Centers after USAID funding is terminated. AIHA and its US partners are working with each center to assure adequate funding – whether from private or public sector sources – for the continuation of center operations and training activities beyond 1997. As the Evaluation Report noted, several of the Centers have already demonstrated their success in securing private sector funding. The Centers in Almaty and Moscow both have significant training contracts with oil and gas companies, embassies and airlines. The potential for similar cross subsidies from fee-paying customers exists in other locations. In the case of Moldova, Turkmenistan and other centers, however, the Ministry of Health is committed to supporting training activities with public funds.

We take issue with the Evaluation Report's conclusion that the number of trainees is and will remain low. Collectively the Centers have to date trained 2411 physicians (pre-hospital and hospital), 1395 nurses (pre-hospital and hospital), 1580 feldshers, 424 ambulance drivers, 766 medical students and 1166 other first responders (security service personnel, firefighters, nuclear station personnel, construction workers, and the general public).

While it is true that one or even two centers may be overwhelmed in a country the size of the Russian Federation or Ukraine, several of the Centers are well on their way to having trained a majority of pre-hospital health care providers in their respective countries. As we described above, the Chisinau Center has trained over 1,200 ambulance crewmembers representing approximately 65% of the ambulance forces in Moldova. Each of the other EMS Centers initiated by the partnerships in 1994 in Almaty, Yerevan and Vladivostok have trained in excess of 1,400 individuals. Even the more recently established center in Tbilisi has had a relatively important impact, having trained over 600 individuals since early 1996.

Not only are most of the centers training a critical mass of professionals, but also there is evidence that other equally significant changes are occurring with respect to resource allocation for pre-hospital emergency care. US partners are observing significant improvements in the equipping of ambulances consistent with the improvements to training; several areas, including Primorsky Krai (Vladivostok) and Turkmenistan have seen major purchases of new vehicles and equipment in recent months. As the Evaluation Report recommends, the partnership efforts in many of the countries (most notably Armenia, Moldova, and Far East Russia) include preventive public health components including CPR training, seatbelt laws and other accident prevention programs.

We recognize that challenges exist with respect to increasing the scale of the program in the larger countries of the NIS. The commitment by USAID and the Ministry of Health to seed the development of two additional training centers in Ukraine in 1997 will help address the problem in that country by creating a total of four regional centers capable of training approximately 2,000 professionals annually. By using the existing Kiev center as a basis for developing the instructor cadre for each of the newer centers, the program will be largely responsible for its own replication. The creation of adequate training capacity in the Russian Federation is more problematic. The Russian Federation Ministry of Health

has requested AIHA to support an expansion of the program but funding is simply not available to do so given other priorities.

3.2.3 NEONATAL RESUSCITATION

As the Evaluation Report concluded, the efforts by the partnerships in improving techniques related to newborn resuscitation have shown dramatic and immediate results in the reduction of perinatal morbidity and mortality. The partners recognize that much remains to be done to insure that these resuscitation practices are more universally applied in the NIS and CEE countries and that the practices are part of a more coordinated approach to maternal health. Using a train-the-trainers approach, AIHA partnerships have been working collaboratively with Ministries of Health in Ukraine, Russia, and Uzbekistan to develop national training centers responsible for broadly educating health professionals in these techniques. Using a standard curriculum developed by the partners, several of these Ministerial supported training centers have opened since the evaluation team's visit to the area in late-1996 thus fulfilling much of the Evaluation Report's recommendation.

3.2.4 INFECTION CONTROL

As in the case of neonatal resuscitation, infection control represents an example of how partnerships are in the forefront in successfully "scaling up" and affecting national policy and practice in an area of critical importance. As the Evaluation Report noted, AIHA, the partnerships and outside expert groups, such as CDC and WHO, have been collaborating in the development of training materials and programs. These will be implemented jointly with the Ministries of Health in Russia, Ukraine, and Kazakstan later this year. These collaborative efforts have been ongoing for over two years and build upon the success of individual hospital partnerships in demonstrating sharply reduced nosocomial infection rates. Other NIS ministries of health will join the effort later this year. As the Evaluation Report alludes, the issues involved in infection control are complex and the partnership's response has been
equally complex. Given the importance of this issue globally, we strongly recommend that readers interested in the partnerships' success contact AIHA directly for a more comprehensive and detailed description of the program.

3.2.6 DIABETES

As the Evaluation Report points out, the diabetes "initiative" is less a collaborative activity between partnerships and more an example of a complex replication initiative. The effort was undertaken with the support of USAID-Moscow to demonstrate that the successful diabetes project developed as part of the LaCrosse – Dubna partnership could be implemented elsewhere in the Russian Federation. The replication has the active support of not only the Moscow Oblast, as the Evaluation Report describes, but also the Russian Federation Ministry of Health. The replication project also supports a key US-Russian Federation priority under the Gore-Chernomyrdin Committee. The design of the replication project is exceptionally rigorous and unique because of the extensive involvement of Eli

Lilly and Company. AIHA believes that this coordinated approach to disease management offers an important model for future development programs. Ministries of Health in other countries have expressed interest in similar diabetes projects.

3.3 USAID INITIATIVES

As discussed earlier, the Evaluation Report fails to carefully distinguish between efforts by existing partnerships to address USAID funding and programmatic priorities (women's health and the Ukrainian breast cancer initiative) and the funding by USAID of different types of partnerships (between US and CEE programs in health administration and between US and Slovak healthy communities).

3.3.1 WOMEN'S HEALTH INITIATIVE
3.3.2 BREAST CANCER INITIATIVE

As the Evaluation Report indicates, USAID funding delays of almost 18 months have in turn delayed AIHA and the partnerships in implementing a large scale, collaborative effort to establish over a dozen comprehensive women's health centers in the NIS and three breast wellness programs in Ukraine. Preliminary data from the first two women's centers to open in June 1997 (Moldova and Armenia) suggest that the women's health project will exceed expectations. We believe that the breast cancer initiative in Ukraine will also prove to be very successful and look forward to its implementation before spring 1998. As the Evaluation Report noted, USAID specifically targeted funds in support of developing the women's health component. In those cases where funds were not targeted (Albania, for example), partnerships are not currently involved in the initiative. Program materials developed as part of the initiative will be shared with these other partnerships.

3.3.3 HEALTH MANAGEMENT EDUCATION PARTNERSHIPS

We concur that "the health management education partnerships address a critical link in health care reform by helping to build the health management profession." As the Evaluation Report points out, the health management education partnerships are newer than most of the hospital partnerships. The Evaluation Report's statement that universities "generally seem less amenable than hospitals" to the AIHA voluntary framework is not borne out by experience. This view was held by some during the program's formative stages based, among other things, upon the size of departments that comprise the US partners and the pressures on universities to recover costs.

Like hospitals, US universities are under increasing pressure to be financially accountable. Despite our initial concerns about the relative size of the volunteer pool and the ability of academics to work around teaching schedules, the universities participating in the AIHA project have made truly impressive contributions of the time and expertise of some of the nation's most respected health management educators. The substantial time commitments made by the most active participants is especially noteworthy even in comparison to some of the most energetic hospital partnerships. AIHA in no way feels that the activities and

impact of the partnerships are hindered by a lack of ready volunteers. To the contrary, as with the hospital partnerships, we believe the fact that those performing the training and consulting in the project are volunteers has an undeniably favorable impact on the receptivity of the CEE partners to the ideas offered by their US colleagues.

The Evaluation Report states that the contribution of the health management education partnerships is "at this point difficult to assess." AIHA acknowledges the difficulties in measuring outcomes in the short-term of an educational development program designed to have a very long-term impact on the efficiency and quality of health care delivery. And we are in the midst of implementing an assessment process aimed at capturing the significant short-term outcomes and valuable lessons learned for the longer term. As of late 1996 when the evaluation team conducted site visits, the health management education partnerships had succeeded in establishing or enhancing health management curricula and teaching skills in each of the countries.

The long-term impact on efficiency in health care delivery of these new educational programs and the networks of health care management professionals that they have created can be projected by considering some of the achievements of the partnerships following the visits of the evaluation team in 1996:

- The Czech partners (nine institutions in four Czech cities comprising two AIHA partnerships) have been jointly awarded a grant from their Ministry of Health to increase the exchange of information and expertise among Czech educational institutions in the area of health management education and to develop uniform standards and curriculum requirements for the nation. The application for the grant, which was jointly undertaken by the Czech partners on their own initiative, demonstrates that the HME partnerships have created a network of health management professionals prepared to sustain the development of the profession in the Czech Republic for years to come.

- The academic partners in Romania have begun collaborating with practitioners in developing case studies and have integrated these new materials into an existing executive management course developed by AIHA and AUPHA. At the request of the Ministry of Health, and in support of the decentralization of authority to the district level, the newly adapted curriculum is being used by the Romanian partners to train the district health managers in charge of implementing reform in the forty districts in the country. This effort was initiated in part by two participants in the HME partnership who were recently promoted to the deputy minister level in the Romanian health ministry in charge of implementing the newly adopted national health insurance law and with district health reforms, respectively.

- The Slovakia partners have been invited by their Ministry of Education to develop standards for assuring quality and accrediting health management education in their country. A representative of the Ministry of Education has participated in two of the

partnership exchanges to the US on accreditation issues this year as part of this effort.

The HME partnerships have also demonstrated their potentially significant long-term, region-wide impact on the development of the health management profession in Central and Eastern Europe:

- The Scranton/Slovakia HME partnership published the first regional journal dedicated to the health management profession. The journal, published quarterly in English, includes health management professionals from nine different countries on its editorial board and is distributed to a growing audience in the region.

- South Bohemia University in the Czech Republic, and Trnava University and the University of Matej Bel in Slovakia have laid the groundwork for official university cooperation in health management education designed to standardize curricula, and share educational resources and faculty. This is one of very few instances of voluntary cooperation between Czech and Slovak institutions following the break-up of Czechoslovakia in 1993, and has been fostered through the several regional activities supported through the partnership project since 1996.

These impressive results and the overall progress of the partnerships in the development of faculty and curriculum strongly suggest that USAID consider funding similar health management education partnerships in other CEE and NIS countries.

3.3.4. HEALTHY COMMUNITIES

Although the current draft of the Evaluation Report is more successful than a prior draft in describing the goal of a Healthy Communities partnership, the Report still fails to capture the purpose or goals of the methodology, which empowers a community to achieve consensus and effect change affecting the health of its citizens. The project engages multiple sectors of a community in a democratic process that mobilizes citizens and community leaders to identify and prioritize health problems (including health care delivery problems) and develop solutions.

The items listed in the Evaluation Report as program components – such as “an ambulance service, a family stress program, health walks, and a town cleanup campaign” – are in fact some of the outcomes of a tremendously successful community mobilization process. The most significant outcome of the healthy community partnership is the implementation of the process itself, because it can bring about innumerable improvements in the lives and well being of citizens in the future. The evaluation report even recommends the programs be expanded to promote seatbelt use, CPR training, etc., ignoring that the essence of the project is that the community itself must identify and prioritize needs. The Evaluation Report goes on to recommend that non-governmental advocacy groups supported by USAID grants might be more effective than AIHA in carrying out these recommended initiatives. This language totally misapprehends AIHA’s role as

facilitator in helping the Slovak and American communities use the partnership methodology to initiate and operationalize the healthy communities process. It also fails to credit the U.S. partner communities and institutions of Cleveland and Kansas City. These cities' public hospitals, health departments, and *non-governmental* organizations have played the direct role in both the healthy community planning process and in guiding the interventions that result from the methodology.

Finally, a number of factual errors continue to be contained in the Evaluation Report: the healthy communities partnerships program was funded at $300,000 in total, not $1.1 million. The Evaluation Report also confuses the two healthy communities projects – it is Petrzalka, not Turcianske-Teplice, whose focus is on educating youth about the dangers of drugs.

We believe that the healthy communities program represents an important intersect of health, community development and democratization objectives. The partnership methodology has proven to be extremely successful at promoting the adoption of the healthy community methodology; the Slovak projects appear to be two of the most successful healthy community projects in Europe. We strongly recommend that USAID consider funding additional partnerships directed toward healthy community development as part of its democratization efforts in both the NIS and CEE.

3.4.1 AIHA PROGRAM SUPPORT: AUPHA MANAGEMENT TRAINING

We appreciate the Evaluation Report's recognition of the value of the management education and health administration workshops conducted by the Association of University Programs in Health Administration, an AIHA founding member. The coursework, educational materials and other products developed by AUPHA have been important supplements to the partnerships' nurturing of a management culture in the NIS and CEE, and have made a significant contribution in creating an environment for change. We are also pleased that the Evaluation Report acknowledges the significant contribution of these workshops to removing barriers to the advancement of women in the health professions.

We agree with the Evaluation Report's recommendation that the workshops should be better integrated with partner activities, and training materials should be provided to U.S. partners to ensure better coordination.

3.4.2 AIHA PROGRAM SUPPORT: INFORMATION SYSTEMS

We appreciate the Evaluation Report's strong endorsement of the information technology component of the partnership program. We also concur with the recommendation that more training is needed to help realize the full benefit of the investment in technology. We strongly endorse the team's view that the technology and information sharing efforts are a vital part of any future partnership program.

Since the team completed its work, we have carried out week-long training workshops for approximately 90 hospital information coordinators in NIS and CEE countries. An additional advanced workshop is being planned for 30 NIS coordinators prior to the October 1997 NIS Partnership Conference in Atlanta. We have begun to build the CEE/NIS partner institution's collection of CD-ROM based medical reference and training materials over the course of the past six months as well. Access to the most important medical databases through OVID and other sources is now being provided to CEE hospital and HME partnerships as well as NIS partner institutions. During the summer of 1997, AIHA will complete a redesign and restructuring of the AIHA Website, providing easier access to the growing collection of partner-developed materials and referrals to other quality medical sites on the Internet.

3.4.3 AIHA PROGRAM SUPPORT: COMMONHEALTH MAGAZINE

We appreciate the Evaluation Team's recognition of the improvements we have made in *CommonHealth*, and the observation that *CommonHealth* could be the preeminent journal on healthcare reform in the NIS/CEE.

CommonHealth – along with other more targeted AIHA publications and the various AIHA sponsored websites – is part of a concerted strategic effort to support program replication and to create an awareness and appreciation among policy makers in the NIS/CEE. It is also an important vehicle to increase awareness among other US government agencies, the private sector, and international organizations whose collaboration is essential to achieving the kind of systemic change that we all desire. AIHA believes that attempts to sell *CommonHealth* on a subscription basis as the Evaluation Report suggests is unlikely to raise much revenue as it is currently configured. To sell subscriptions either inside or outside the partnerships, coverage of health issues and activities beyond the scope of the partnerships (and USAID funding) would have to be greatly expanded and the tone and reporting would have to be much more objective. This has the potential, however, of adversely affecting the strategic purpose of the journal to "promote" partnership activities as models for replication and to increase the receptivity to policy change in the NIS and CEE.

3.4.4 AIHA PROGRAM SUPPORT: CONFERENCES AND SPECIALIZED WORKSHOPS

An extensive program of conferences and workshops (well over 125 to date) has been an important element in the partnership program's bottom-up strategy for creating systemic change. It has also been an important vehicle for introducing new clinical and administrative practices to an extended audience beyond the partnerships; thousands of health professionals from non-partnership institutions have participated. While some region-wide conferences and workshops are coordinated by AIHA's Washington office, most are already planned and carried out by AIHA field representatives in collaboration with local partners – as the Evaluation Report recommends. With respect to the Evaluation Report's additional recommendation regarding a lengthier planning time frame, we agree that there is always a benefit from earlier and better planning especially given the

challenges which conference activity in the NIS and CEE can present. The lack of forward funding on the part of USAID and the need to respond quickly to opportunities that the partnerships generate has often resulted in an aggressive and relatively immediate conference and workshop schedule. NIS partners and US have had to make significant sacrifices in order to meet these challenges. Their efforts are reflected in the partnership program's enviable reputation for the very high quality of its conference activity.

3.5.5. REPLICATION
3.5.6. POLICY CHANGE

As we discuss extensively in the main section of the Response, we disagree with the Evaluation Report's contention that the partnerships were not designed with replication or policy change in mind. We also believe that the Evaluation Report's own survey and AIHA's sample list of partnership dissemination and replication activities included at Annex I of the Report shows a range of key issues from hospital infection control to nursing education reform through which the partnerships are making an important contribution to systemic change in the NIS and CEE. The Evaluation Report often minimizes the importance of these changes because they do not represent national regulatory or legislative change or because salaries have not been adjusted or because definitive outcome data is not present. While we agree that such additional indicators of success would be helpful, there is a large body of anecdotal evidence that significant change is occurring and that the fundamental basis for change in the development of "new thinkers" is being created. One of the most important indicators of the value of the bottom-up policy development strategy that the program embodies has been its acceptance by virtually all of the Ministries of Health in the region; in almost every instance, expansion of partnership activity is being actively sought by these policy makers even at the expense of other USAID programs. While the Evaluation Report tends to characterize this support as "popularity," we believe that it reflects a good understanding on the part of policy makers themselves of what it takes to accomplish long-lasting change on a step-by-step basis in the region and recognition that more solid outcome data will be forthcoming.

We agree that the partnership program can be improved. We also believe, along with many of our colleagues at USAID, HHS, WHO, and the international NGO community, that better coordination of assistance is needed so that bottom-up and top-down interventions are mutually supportive and systemic impact more optimally achieved. It would have been helpful if the Evaluation Report could have offered more insight as to how USAID might better accomplish this task.

3.6 MONITORING AND EVALUATION

We agree with the Evaluation Report's observation that the partnership program suffers from the lack of a more organized and standardized method for monitoring progress. AIHA and the partnerships have struggled with the complexity of this task and have tried a variety of solutions in the past. Among the potential solutions looked at and tried was the USAID results-oriented framework. AIHA worked closely with USAID's contractor in 1994 to pilot

the first versions of the results-oriented approach and implementing software. We discarded the approach when we found that it was unable to adequately capture project complexity. Our own assessment of USAID's use of the results-oriented framework suggests that this orientation toward lowest common denominator outcome indicators has not proven to be totally successful in either capturing impact or helping to direct program management.

We are in the process of initiating a collaborative effort with a committee of the US partners to design an improved self-assessment methodology which will better capture outcomes and be useful in its own right as a management tool for our NIS/CEE partner institutions.

4.0 MANAGEMENT ISSUES
4.1 MANAGEMENT ISSUES; BACKGROUND

Anytime that a new, experimental program methodology is being tested, tensions with existing policies and procedures are bound to occur. The partnership program has been the playing field for the resolution of a number of conflicts within USAID over the course of the past five years. Some of these conflicts relate to the relative roles of central office and missions, others relate to reinventing government as a whole, still others relate to the relationship between Government and the private sector. We agree that new program design should help to clarify respective roles and responsibilities so that tensions will be minimized. As the Evaluation Report suggests, however, many of these tensions are related to important questions such as how best to achieve systemic impact, questions for which there may not be a single right answer and over which consensus will be difficult if not impossible to achieve. We believe, however, that progress can be made by establishing clearly defined expectations and benchmarks to measure success. We look forward to working with USAID to improve the program but we recognize that, by its very nature, the partnership program is likely to continue to exhibit some tension.

4.2 AIHA MANAGEMENT
4.2.1 INTERNAL MANAGEMENT

We appreciate the Evaluation Report's acknowledgement that AIHA has "managed to accomplish a remarkable amount in a short period of time." We are especially appreciative of the conclusion that, despite a number of constructive criticisms, our US, NIS and CEE partners were "uniformly positive about the overall program and the experience it provided."

We are in the process of convening a work group of partner representatives to assist us in improving our management processes, especially with respect to those financial management and budgeting systems that impact our partners most directly. In this regard, we will seek out opportunities to further decentralize management decision making within the organization as recommended by the Evaluation Report.

The Evaluation Report also expressed concern regarding the career path for younger staff. We agree that the program analysts play a critical role in our management structure and we have been pleased at our success at attracting some of America's "best and brightest." Turnover at the junior staff level has occurred on average at about 2 years with most going on to graduate programs, medical school or business school after leaving AIHA; a few have sought professional advancement in other fields. AIHA is not only proud of the contribution they have made to the partnership program but also proud of the contribution the organization has made to the development of their careers. In an effort to address the concern raised about upward mobility for junior staff who seek to continue to work in the field, we have recently created the position of Program Associate, which is a promotional track from Program Analyst with a higher salary and higher level of responsibility and autonomy. Three staff has recently been appointed to this new position.

4.2.2 AIHA MANAGEMENT: PARTNERSHIP MANAGEMENT

We agree with the Evaluation Report's conclusion that long delays and unpredictability in USAID funding have complicated the relationship between AIHA and its partners. AIHA has not made it a practice to focus unhappy partners on USAID's administrative problems and uncertainties or on the disparities between the various USAID Mission budgets; the Evaluation Report makes clear that we have paid a price in terms of our own credibility with our partners. The Evaluation Report's recommendation of three-year budgets extended annually is a fine idea. The funding and obligation cycle from USAID has never been predictable enough to allow it in the past, but we concur with the recommendation that any future program should be designed, funded and managed that way.

In amplifying its recommendation in Section 4.3.1, the Evaluation Report goes on to apparently advocate the idea of a pass-through program design which would include the shifting of a substantial burden of USAID financial and management accountability to the individual partnerships and the cessation of most collaborative and regional activities. As the Evaluation Report noted, AIHA receives uniformly high marks for prudent expenditure of funds and as we have discussed at length, the partnership program's collaborative and regional activities have been the source of much of its success. We are prepared to have an extensive discussion with USAID regarding the pros and cons of such an approach. These are fundamental issues that need to be understood and addressed in the context of future program design.

In general, we believe that these related recommendations in this and other sections of the Report suggest an unrealistic view of how cross-cutting initiatives and program support activities, which might attract partner "buy-in," are developed and funded. For example, if AIHA retains only 15% of the funds for "administration" as suggested in Section 4.3.1, then AIHA would only be able to cover little more than its indirect costs such as rent, accountants and financial administration. Virtually all of the staffing costs related to program coordination (including the regional and central office personnel who received high marks in the Evaluation Report) would be unfunded. The same would apply to the shared programmatic activities, such as conferences, *CommonHealth*, technology, and

management training, which the Evaluation Report apparently also supports. The resulting program would not only be substantially different than now exists – the result could be more costly and have significantly less systemic impact in individual countries and in the region as a whole.

4.2.3 AIHA MANAGEMENT: REGIONAL OFFICES

We are very concerned regarding the Evaluation Report's finding that the AIHA regional offices do not have a significant role in program implementation. As we expressed in our response to an earlier draft of the Report, the nature of AIHA's role, in general, is to support the partners' lead role in program implementation. Within that context, the regional office staff has been key in program planning and implementation. As the Evaluation Report found, the Regional Office Directors and senior staff are impressively trained, highly motivated, and highly regarded and respected by Ministers of Health, key policy makers and above all by the partners. They work extremely long hours and are charged with substantial responsibility. In addition to very significant field responsibilities that go well beyond the logistical aspects which the evaluation team observed first hand, regional staff play an important role in identifying ways to broaden the impact of partnership efforts by developing and maintaining relations with USAID, Ministry and other government officials, and other donor organizations. Moreover, several of the Regional Directors have significant responsibilities with respect to managing organization-wide collaborative activities such as the EMS Training Program. As part of our joint effort with partnership representatives to improve internal management processes, we will look at the current role of the regional offices to make sure that we are taking full advantage of this important resource.

4.2.4 FINANCIAL PLAN
FINANCIAL ISSUES
PARTNER FINANCIAL REPORTING

We appreciate the Evaluation Report's conclusion, confirmed by our annual audit reports, that AIHA has been a "good steward" of governmental resources.

As stated earlier, we also agree that uneven and unpredictable USAID funding have created problems for AIHA and the partners to effectively plan. We also agree that AIHA's financial management procedures can be improved to assure quicker turnarounds on reimbursement of funds. It is important to note in this regard, however, that AIHA's financial reporting systems are largely dictated by the need to meet USAID and OMB requirements. These can often appear onerous to the casual observer but are the price of "good stewardship" of taxpayer funds.

The suggestion that AIHA's budget system should track the cost of "cross-cutting initiatives" separately goes back to a fundamental misunderstanding about the nature of the initiatives. The "initiatives" are not so much distinct programmatic entities in themselves; rather they are the collective result of a large number of bilateral or collaboratively planned partner activities. The cumulative result is an "initiative," but from an accounting perspective, they are indistinguishable and often inseparable from other partner activities. For example, if a nurse from a US institution goes to visit her Russian partner hospital, she could easily work with her colleagues on infection control, nursing and neonatology activities. To which "initiative" should the costs of that trip be charged?

While the issues involved are complex, we nevertheless understand the need to clarify the funds allocation process so that partnerships have a better understanding and a higher level of confidence in their ability to plan effectively.

4.3.1 AIHA COOPERATIVE AGREEMENT
4.3.2 COMPETITIVE CORE CONTRACT

We appreciate the Evaluation Report's conclusion that AIHA has implemented the partnership program successfully. As we discussed at length in the main section of our Response and in the Appendix, we believe that the Evaluation Report seriously underestimates the impact of the partnership program in systemic reform. We believe that the multi-faceted partnership program developed by AIHA with its reliance upon individual voluntary partnerships supported by centrally-provided supplemental activities and working within a regional collaborative framework has been a successful approach that warrants continuation and not dismantling. Whether through competitive solicitation or through extension of the current cooperative agreement, USAID should take immediate action to engage in program design and fine-tuning. A failure by USAID to move promptly and assure a smooth programmatic transition will waste significant resources that the US Government and private sector have already invested in the

program and risk reducing the goodwill that USAID has achieved in both the US and overseas through the program. Above all, it will waste the opportunity to take advantage of the significant momentum that has been generated to effect positive change in health care in the NIS and CEE.

4.3.3 CONFLICTING SIGNALS

The Evaluation Report accurately points out that significant tension has resulted from divergent interpretations of USAID policies that dictate "dramatically less involvement in the implementation of cooperative agreements and dramatically more accountability for the use of funds in support of country objectives." We concur with the Evaluation Report that it is imperative for USAID to resolve the inherent tension between its R4 strategic planning system and cooperative agreement. USAID should provide appropriate guidance and better inform its employees, particularly in the field, of the extent of their responsibilities and the limitations on managing cooperative agreements. We cannot overstate the amount of resources AIHA has had to divert from program support in order to respond to and reconcile these "conflicting signals," as the Evaluation Report terms them.

The difficulties have been exacerbated by the nature of the R4 framework and the way in which it was implemented. As we discussed earlier, the framework is overly simplistic and gives little guidance at the operational level. With respect to its implementation, AIHA was never involved in developing the overall framework and, in most cases, was not involved by the Missions in developing country-specific objectives. Given the failure in the process to include AIHA (and presumably other grantees and cooperative agencies) from the start, the result was that USAID missions were left with a challenge akin to forcing a square peg through a very inflexible round hole. This difficulty was exacerbated by the failure of the process to include policy makers in the recipient countries. As AIHA partnerships have developed workplans to respond to Ministerial objectives, the partnerships have had to choose between satisfying local USAID Missions and meeting national priorities as they are encouraged to do as part of the Cooperative Agreement. And, of course, AIHA and the partners have paid the price by having to divert time and resources, and delay partnership exchanges and other program activity.

Finally, the underlying premise of the R4 framework, that the missions are the best arbiters of programmatic decisions, is difficult to reconcile in the context of a regionally designed program, with regional objectives and multi-country involvement in implementation.