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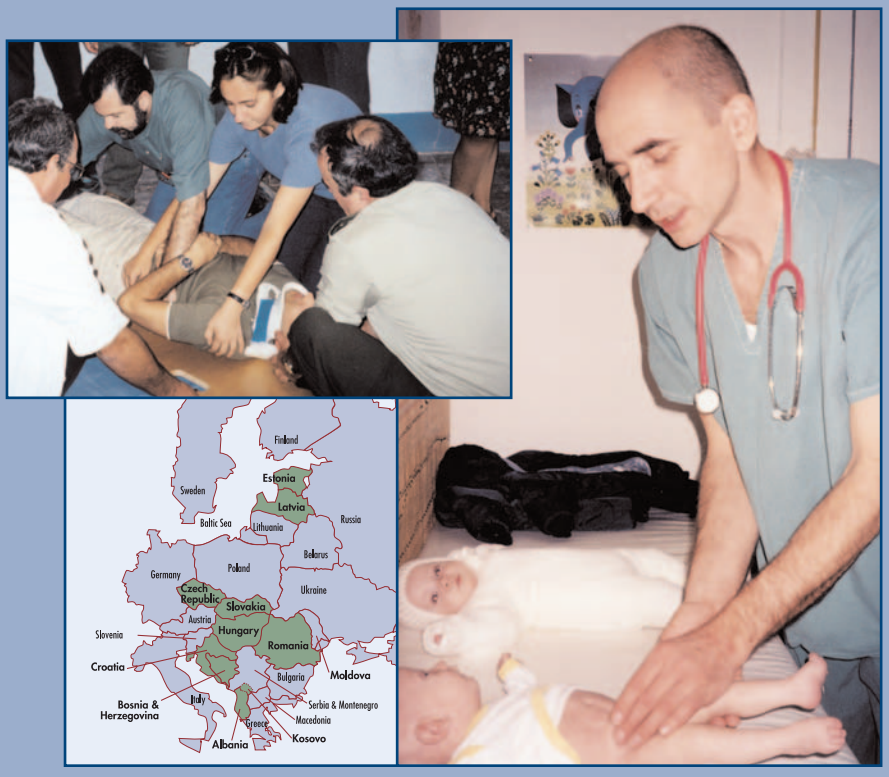
American International Health Alliance

Health Partnership Program
Central and Eastern Europe

1994 – 2006

Final Performance Report



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The American International Health Alliance, Inc. (AIHA) is a 501(c)(3) not-for-profit corporation created by USAID and leading representatives of the US healthcare sector in 1992 to serve as the primary vehicle for mobilizing the volunteer spirit of US healthcare professionals to make significant contributions to the reform of healthcare overseas through partnerships.

PREFACE

This final performance report is a comprehensive overview of AIHA programs in Central and Eastern Europe (CEE) between 1994 and 2006. The report describes AIHA's unique partnership twinning model, the development and evolution of the program in the region, and the main program components funded during this period. The report presents summary results by country (nine plus Kosovo), including details of each partnership and project, together with profiles of selected US and CEE partners, as well as more in-depth success stories. Also included are overviews of results from the perspective of key regional and cross-cutting areas of impact. The conclusions section reflects on the overall legacy and lessons learned.

The report takes into account and incorporates many of the findings from USAID's comprehensive external evaluation conducted during 2005 of AIHA's CEE program. The final evaluation report, produced by Research Triangle Institute (RTI) in January 2006, is cited throughout this report.

The views expressed in this final report do not necessarily reflect those of USAID.

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

ACKNOWLEDGEMENTS

The American International Health Alliance (AIHA) wishes to express its sincerest gratitude to the countless professionals in Central and Eastern Europe and the United States who gave so generously of themselves to the partnership program in Albania, Bosnia and Herzegovina, Croatia, Czech Republic, Estonia, Hungary, Kosovo, Latvia, Romania, and Hungary. The program was successful because these individuals demonstrated the courage and commitment to change; the patience, dedication, and hard work to gain new knowledge and skills; and a generous spirit of trust and collaboration. Together they made significant contributions to improving healthcare services and delivery for thousands of people throughout the region.

AIHA is also grateful to the many partners who participated in interviews (phone and on-site) during the USAID evaluation and AIHA's site visits, and who responded to surveys and other requests for information. AIHA also acknowledges the valuable contributions of the RTI evaluation team and the findings contained in their report.

AIHA also thanks the United States Agency for International Development (USAID) for the opportunity and privilege of working in the CEE region and for its steadfast support of the partnership program.

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

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ACRONYMS AND ABBREVIATIONS

AIHA	American International Health Alliance
CA	Cooperative Agreement
CEE	Central and Eastern Europe
CPG	Clinical Practice Guidelines
CQI	Continuous Quality Improvement
EBP	Evidence-Based Practice
EMS	Emergency Medical Services
EMSTC	Emergency Medical Services Training Center
ETCH	East Tallinn Central Hospital
FMC	Family Medicine Center
HC	Healthy Communities
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HME	Health Management Education
ICT	Information and Communications Technology
IMSS	Institute of Health Services Management
INLI	International Nursing Leadership Institute
LRC	Learning Resource Center
MOH	Ministry of Health
MOHF	Ministry of Health and Family (Romania)
NIRDH	National Institute for Research and Development in Health (formerly Institute of Health Services Management)
NGO	Non-Governmental Organization
NIS	Newly Independent States of the Former Soviet Union
NRC	Nursing Resource Center
PHC	Primary Health Care
RTI	Research Triangle Institute
STI	Sexually Transmitted Infection
TB	Tuberculosis
TOT	Training-of-Trainers
UN	United Nations
USAID	United States Agency for International Development
WHO	World Health Organization
WWC	Women's Wellness Center

EXECUTIVE SUMMARY

"USAID's investment in the partnerships program has produced important results in the CEE that have had cascading impact in the years since program support ended. The collaborative and participatory approach of the AIHA model has brought meaningful, lasting changes at the personal, professional, institutional and policy levels in the CEE. By contributing to USAID Bureau goals and strategic objectives, the approach also fulfilled foreign policy goals that have accelerated the movement of the local medical communities, including hospitals, academic institutions and social service organizations, out of isolation and into the international medical community. Most importantly, it has fostered widespread friendship and good will among partners." *– USAID/RTI Evaluation, 2006*[1]

Between 1994 and 2006, the American International Health Alliance (AIHA) collaborated with the United States Agency for International Development (USAID) in the development and implementation of a unique healthcare twinning partnership program that linked American healthcare professionals with their counterparts in Central and Eastern Europe (CEE). Building on the successful application of its distinctive voluntary partnership methodology applied in the 12 newly independent states (NIS) of the former Soviet Union since 1992, AIHA established and managed a total of 30 twinning partnerships and four special projects in nine CEE countries – Albania, Bosnia & Herzegovina, Croatia, Czech Republic, Estonia, Hungary, Latvia, Romania, Slovakia – and the United Nations-administered region of Kosovo. These partnerships and projects were designed to improve the quality and accessibility of health-related programs and services in the region while at the same time building bridges between communities in the US and CEE.

The first eight partnerships established in the initial years of the program focused on improving the quality and efficiency of hospital-based care where the majority of healthcare resources were being consumed. With continued funding through USAID cooperative agreements, AIHA adapted its program to meet the changing healthcare reform priorities in the region. In addition to the eventual total of nine hospital-to-hospital partnerships, AIHA initiated four other types of partnerships that focused on building educational capacity in health management (seven), that focused on community mobilization strategies to build healthier communities (seven), that introduced a model for comprehensive women's wellness services (three), and that strengthened primary healthcare services (two). AIHA also created a "partnership-of-partnerships" that brought partners together for supplemental training, networking and information sharing activities.

During the program's 12 years, more than a thousand volunteers from over 60 US hospitals and health systems, medical schools and university programs, community-based organizations, and public health departments in 31 cities participated. They worked with hundreds of their counterparts in a similar number of institutions in 32 CEE communities. The CEE healthcare professionals benefited not only from the knowledge and technical skills their American counterparts shared, but also from the collaborative learning process that drives partnership activities. Together, the dedicated efforts of partners on both sides resulted in positive and sustainable changes at the individual, institutional, community, and national levels.

[1] Citations for this evaluation report are hereafter referred to as "RTI, 2006."

Whether by establishing community-based health information and resource centers, creating new models for prevention and treatment of diseases, establishing new educational programs for training current and future healthcare managers; opening innovative, patient-focused care centers, or creating and strengthening professional associations, AIHA and its partners have been pioneers of healthcare reform in many of the CEE countries, building critically-needed human and institutional capacity. Nursing professionals have been empowered and are now taking on expanded responsibilities for patient care and outreach. Healthcare administrators have adopted modern, cost-effective practices resulting in streamlined financial and management policies. Clinicians, students, and others have increased access to a wealth of evidence-based medical research, including the ability to consult with specialists around the world via the Internet, at partnership Learning Resource and Nursing Resource centers. And, patients have access to higher-quality care at hospitals and primary care centers.

Through AIHA's programs, partners paved the way for many "firsts" in the CEE region, including:

- comprehensive diabetes control program and model home care services (Hungary);
- joint management and leadership training for physicians and nurses (multiple countries);
- hospice and palliative care programs (Latvia);
- cardiac catheterization laboratory (Bosnia and Herzegovina);
- emergency rescue services (Turcianske Teplice and Banska Bystrica, Slovakia);
- centers to help victims of domestic violence (Romania, Slovakia);
- university degree programs in health management (Czech Republic, Romania);
- comprehensive patient-centered outpatient services for women (Albania, Kosovo, Romania);
- professional journals in nursing (Estonia) and in health management (Slovakia);
- national society for breast imaging and quality assurance standards for mammography (Romania);
- cytology/pathology laboratory for cervical cancer screening (Albania); and
- TB training center designated as the region's only WHO Collaborating Center for Research and Training in Multi-drug Resistant TB (Latvia).

The key contributions of the program as a whole can also be described in eight broad areas of impact that cut across individual partnerships, countries and program areas.

❖ Changes in thinking and mindset

Perhaps the single most profound legacy of the partnership program is what partners have called a "change in mindset," a newfound ability to think critically, to look at problems differently and find solutions, to be more collaborative and work as teams, or simply a new perspective on oneself and the world. The mindset changes described by partners range from the very personal – such as the Kosovar physician who said, "The partnership experience made me realize that I needed to live healthier. I run an hour a day, eat less, and eat healthier… My life changed because of the partnership." – to the more professional, such as how colleagues interact with one another (more as equals), how problems are approached, and how patients are seen and treated. Such changes, by their nature, not only enabled the partnerships to achieve their objectives, but have been responsible for influencing ongoing achievements by the CEE partners.

❖ **New and/or improved health professions**

Thousands of doctors, nurses, and other healthcare professionals received training through the voluntary, peer-to-peer exchanges and other programmatic activities. The interaction with their counterparts in the US and other countries in the region, as well as their exposure to new ideas and ways of approaching the provision of care, enabled these professionals to rethink their roles as healthcare providers and become educators and agents of change at their institutions and in their communities.

Nurses, in particular, embraced the new educational opportunities the partnerships afforded them and assumed increased roles and responsibilities, gaining the respect of physicians and patients alike. As the USAID/RTI evaluation noted, "The elevation of the nursing profession in the region is a clear success story…."

The increased skills and knowledge of the CEE health practitioners in areas such as leadership and management, obstetrics/gynecology, infection control, cardiac surgery, neonatology, emergency medicine, chronic diseases, and family medicine translated into clear improvements in healthcare, better preventative medicine, and healthier lifestyles for the public.

Not only did individual healthcare professionals gain new skills; in several instances, entirely new specialties were created as a result of partnership work, such as in health management, emergency medicine, hospice, palliative care, home care, occupational health, nurse educator, and infection control nurse, among others.

Whether in a new or existing areas of healthcare, many CEE health professionals used their new knowledge and skills to become nationally-renowned specialists or champions in their particular fields. Some have expressed that they owe their dedication to and achievements in specific areas of medicine and public health to their involvement in the partnerships. Among them are:

- Peter Krcho, neonatologist from Kosice, now president of the Slovak Neonatology Society and a leader in creation of Union of European Neonatal and Perinatal Societies
- Anda Jansone, a pediatrician in Riga, Latvia, who established the country's first-ever palliative care team and a Palliative Care Society.
- Aldis Gailis, an ob/gyn, who became a renowned ultrasound specialist in Latvia.
- Daniel Verman, who has become Romania's leading expert and advocate on domestic violence issues.
- Liga Drukalska, a microbiologist at the Children's Hospital in Riga, Latvia, who said, "Without this project [salmonella outbreak investigation], I wouldn't be a microbiologist today."
- Elena Kavcova, who has become a smoking cessation champion and expert in Slovakia.
- Andrus Remmelgas, an anesthesiologist, who developed an EMS training center in his current position as Chief of Medical Service/Surgeon General for the Estonian Defense Forces.
- Dana Farcaseanu, a Romanian healthcare policy expert who says she was nurtured in her professional growth as a healthcare management specialist and "grew up with AIHA."

- Ramize Ibrahimi, a nurse who found her calling as a leader in nurse education and patient outreach in Kosovo.

❖ **Institutional/organizational changes**

> ***"Institutional change was the primary objective of the partnerships, and the changes catalyzed by the partnership have multiplied and endured. For all CEE partnerships evaluated the experience brought structural change to established CEE institutions."***
> *– RTI, 2006*

Partnership activities led to a wide range of institutional changes that endured. Within hospitals, changes included implementing quality improvement processes; creating new departments or restructuring them; developing human resource policies; and instituting cost-accounting and other financial measures, such as the improvements in pharmacy management that resulted in a 35 percent reduction in drug-related costs at a Croatian hospital. These changes led to better and more efficient services and ultimately to higher quality patient care. One indicator of improved efficiencies and quality of care in hospitals is average length of hospital stay (ALOS). Among the many reported reductions in ALOS at partner hospitals are:

- For new patients undergoing arthroscopy at the Orthopedic Hospital in Biograd, Croatia, ALOS fell from 30 days in 1995 to 3 days and then to same-day surgery in 1998
- From 13 days in 1993 to 6.5 days in 2005 at Latvia's Children's Hospital
- From 11.5 days in 1994 to 7.5 days in 1999 at Srebrnjak Children's Hospital for Respiratory Diseases in Zagreb, Croatia
- Tallinn Central Hospital in Estonia from 8.1 to 5.22 from 1994 to 1999
- For diabetes patients at Vác Municipal Hospital from 11.65 days in 1995 to 6.52 days in 1997
- Cluj's Clinic for Occupational Diseases decreased from 13.6 days in 1994 to 10.8 days in 1997.

Beyond hospitals, organizational changes also occurred within the educational partnerships as new courses and curricula were developed, and new capacity was created for conducting healthcare policy analysis and research and for providing consulting services.

❖ **Focus on individual patient and personal responsibility**

For the individual patients and members of communities served by the CEE partnerships and projects, a dramatic change occurred as a result of the partnership program. For the first time in most of the CEE countries and healthcare institutions, the delivery of care became "patient-centered" resulting in, among other innovations, patient privacy policies, patient satisfaction surveys, a customer service department, family-friendly policies such as increasing visiting hours, restructuring of physical facilities to allow parents to stay near their children in intensive care units.

At the same time, as healthcare professionals focused more on the individual patient, the individual was asked to play a more active role in their own health by participating in health promotion and health education activities. This, too, was a major shift in thinking, given the historic lack of public engagement and personal responsibility and accountability in the health arena. Each of the healthcare partnerships – whether hospital, healthy communities or primary healthcare – incorporated and promoted disease prevention and healthy lifestyles

through patient education, community outreach programs including media campaigns and health fairs, and various community-based interventions, populations learned about the importance of taking responsibility for one's own health as well as the health of their community.

❖ **Community building**

The partnerships, through their embracing of the importance of inclusiveness and community engagement as a foundation for improving health in the communities, also leave behind a legacy of strengthened communities able to work together across conflicting backgrounds, professions and ethnicities in the interest of creating health. In places such as Bosnia, Kosovo, Croatia and to some extent Hungary (with its sizeable Roma community), where inter-ethnic differences divided communities, healthcare partnership helped bridge those divides through programs and activities embracing disparate groups. Communities that worked with the partnerships not only benefited from the technical assistance provided by US partners, but also gained the intangible benefits of learning about the importance of taking responsibility for one's own health and the health of the community.

"Volunteering to be peer educators gives teens a greater sense of both personal and community values. They learn not to be indifferent and they are motivated to contribute to community life because, really, the life of the community is one's own life. That is why AIHA partnerships work so well—first we learn new ways of looking at our problems, then we create new ways of solving them."
– Loti Popescu, Constanta, Romania

In the nine communities where partnerships applied the "healthy communities"[2] methodology, there have been permanent shifts in how stakeholders come together to solve common problems. By learning to utilize tools of community mobilization, consensus-building, and conflict resolution, for example, these communities developed a newfound capacity for working together across multiple sectors through such mechanisms as community boards.

The US partners also helped introduce the concept of volunteerism into these communities leading many CEE partners to initiate their own volunteer programs that have been attracting people into community service roles. In a further strengthening of civil society, health-related NGOs were created in communities in Hungary, Croatia, Romania, and Slovakia where none had existed.

❖ **Regional and national-level impact**

AIHA partnerships have also been at the forefront of local and national health reforms, initiating or influencing legislative and policy changes, demonstrating successful interventions that served as models for replication or rollout, and introducing new clinical guidelines and processes for adoption nationally. The USAID/RTI evaluation found that "Success at the institutional level was leveraged to create system-wide impact." Examples include:

- Influenced passage of laws such as requiring sexually transmitted infections (STIs) testing for pregnant women, designating drug use and domestic violence as crimes, prohibiting smoking in public buildings, establishing standards for workplace protection,

[2] Please see section III.F for a description of the healthy communities methodology.

and creating a national committee for control and surveillance of infectious diseases, and adopting the WHO Framework Convention on Tobacco Control.

- Developed model programs that were replicated in other cities such as palliative and hospice care in Latvia, Vác's home care model (Hungary), Constanta's domestic violence program (Romania), Split's school-based program to reduce alcohol use (Croatia), Gjilan's family medicine center's patient flow system (Kosovo), breast health radiology quality assurance program (Romania) children's asthma in Croatia, post-traumatic stress disorder in Croatia,
- Produced guidelines that were approved for national dissemination such as on hypertension (Kosovo), microbiological testing (Latvia), and diabetes patient education (Hungary).
- Established a regional referral system for perinatal care in eastern Slovakia.
- Designed health communications campaigns that served as a model for use by Romania's national health insurance house.
- Contributed to development of curricula for new baccalaureate and master's degree nursing programs in Estonia.
- Initiated national interdisciplinary efforts to address stigma and discrimination around HIV/AIDS.

❖ **Impact on US partners**

"We have a whole new perspective on the concept of giving and receiving... a completely new measure of the relative value of gifts...in return, we also were taught. We were taught about the power of sheer determination, and about what could be achieved with a lot less stuff."
– Barbara Bogomolov, St. Louis, MO

Individual US partners and institutions also reaped unexpected benefits, ranging from a deeper understanding of the meaning of and appreciation for democracy, to a new way of thinking about problems, to improved teamwork, to new clinical approaches that arose from looking at approaches to treatment from a different cultural perspective. Partners described the dramatic enrichment to their personal and professional lives from their participation in the program, such as the physician who wrote, "It was one of the most rewarding experiences in my personal and professional life." Institutions noticed changes in the way participants relate to each other and new energy and ideas brought to their work back home. One university partner said his partnership with Slovakia "has helped develop a very strong sense of cooperation within the health care and university communities in Pennsylvania."

❖ **Sustained benefits of initial investment**

Among the hallmarks of the partnership program is the extent to which relationships are continued, whether at a personal, professional, or institutional level. Of the 30 AIHA partnerships, three-quarters have reported some type of continued relations. At times the relationships are more personal and simply serve to nurture ongoing cultural understanding and international relations; in other cases, the partnerships seeded what have become new areas of collaboration and achievements. Even when partners have moved on to new jobs at new institutions, often they have taken their relationships with them to grow new collaborations or simply to apply the knowledge and skills gained through their partnerships in new ways that benefit their countries. Examples include:

- Rhode Island partners, with funding from a local Albanian NGO, are working with their partners in Albania to train nurses at the Maternity Hospital on early childhood education.
- A physician from Buffalo, NY, moved to Tuzla, Bosnia, after the end of the partnership and has dedicated his life to continuing to help strengthen the hospital there.
- A US nurse executive is using the relationships she forged during the partnership with Zagreb, Croatia, to continue to help advance the nursing profession in that country.
- Partners from Missouri and New Jersey received funding for projects with their respective Latvian and Croatian partners that built upon partnership activities. Other US partners continue to seek outside funding for a variety of collaborative projects.
- Partners from North Carolina have continued to send printed health education and clinical materials to their partners in Vác, Hungary.
- Health management education partners in Scranton, Pennsylvania, and Trnava University in Slovakia have continued to work together and inspired doctors at Trnava to start their own partnerships in the countries developing of Kenya, Sudan, and Cambodia.
- US partners at the Humana Foundation maintain active ties with and provided small grants to their partners in Constanta, Romania. In addition, the former Romanian partnership coordinator has been applying the knowledge and skills gained through the partnership in several positions at the ministry of health.

"It is a tribute to the partners and to AIHA that this USAID investment [the Slovakia/ Scranton partnership] over five years ago has produced such an enduring gift that keeps on giving."
– Forest Duncan, USAID/Washington, DC

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

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This final performance report is a comprehensive overview of AIHA programs in Central and Eastern Europe between 1994 and 2006. The report includes summaries of results by country and by major area of impact, together with profiles of selected US and CEE partners, as well as more in-depth success stories. The conclusions section reflects on the overall legacy and lessons learned from the program. The report incorporates many of the findings from a comprehensive external evaluation funded by USAID and conducted during 2005 by an evaluation team fielded by Research Triangle Institute.

* * *

THE CEE PROGRAM IN NUMBERS

Partnerships and projects	=	34
US cities involved	=	31
US institutions that participated	=	65
CEE cities involved	=	32
CEE partner institutions involved	=	63
Total person exchange trips	=	2,664
US partner volunteer exchange trips to CEE	=	1,397
CEE partner exchange trips to the US	=	1,267
"Management 101" trainings conducted by AIHA	=	11
Learning Resource Centers established	=	42
Health professionals trained by LRCs	=	9,000+
Nursing Resource Centers established	=	9
Women's Wellness Centers established	=	4
Cross-partnership conferences & workshops	=	32
Total USAID funding	=	$70,983,219
Value of in-kind contributions by US partners	=	$137,302,121

I. PROGRAM OVERVIEW

A. INTRODUCTION

AIHA had the unique opportunity, through a succession of cooperative agreements, to collaborate with USAID in the development of a highly successful healthcare partnership program in the countries of Eurasia. AIHA's program in Central and Eastern Europe (CEE) was built on a foundation of USAID support to healthcare reform efforts in the region that began after the collapse of the Soviet Union in 1991. Beginning in 1994 AIHA expanded the application of its unique voluntary partnership twinning model—first implemented in the NIS in 1992—to the CEE region, establishing and managing a total of 30 healthcare partnerships and four special projects in nine countries—Albania, Bosnia & Herzegovina, Croatia, Czech Republic, Estonia, Hungary, Latvia, Romania, Slovakia—and the UN-administered region of Kosovo.

These partnerships and projects addressed a wide range of health sector priorities including women and infants' health, nursing, healthcare management, emergency medicine, and primary care. AIHA's Health Partnership Program was designed to promote sustainable US/CEE partnerships that would foster more effective and efficient delivery of health services in the region. The program emphasized building institutional and human resource capacity to facilitate the sustainability and replication of successful healthcare interventions introduced through the partnerships.

Working with USAID to help meet its strategic objectives in the region, AIHA designed and implemented four types of partnerships, each of which targeted different types of institutions and program interventions. (See section C.3 below for a description of partnership types.) Beginning with the first three hospital-to-hospital partnerships established in 1994, the program grew to 15 partnerships by the end of 1995. New hospital partnerships were added, along with partnerships between universities addressing health management education (HME) and between broad community-based consortia focused on building healthy communities. In later years, AIHA added partnerships that worked at the primary care level to establish comprehensive services addressing the needs of women and families.

In keeping with AIHA's voluntary partnership methodology and model (described below), more than $137 million in in-kind contributions were leveraged against the close to $71 million in funding from USAID, a ratio of nearly 2:1. Several thousand US healthcare and other professionals contributed thousands of hours of their time and expertise to working with their counterparts in CEE. Overall, more than 120 institutions in 31 US cities and 32 CEE communities participated in AIHA's program.

The following sections provide an overview of AIHA's partnership model, the history of AIHA's program in the region, and the key program design and implementation elements, including types of partnerships.

B. AIHA PARTNERSHIP MODEL

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

Key elements of AIHA's twinning partnership model include:

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

"One of the most important aspects of the partnership is the long-term benefit of the people-to-people connections between American partners and their NIS and CEE partners. It is the individual people…who are the real beneficiaries of the health projects you have initiated."
– William B. Taylor, US Ambassador

Over the years, external evaluations conducted of AIHA's twinning partnership model have consistently affirmed the positive and lasting contributions partnerships have made to efforts to improve healthcare—and, in fact, overall health status—in partner countries. These independent evaluations have also indicated that AIHA partnerships have played an important role in transitional nations by building local capacity, creating sustainable relationships, increasing international cooperation and understanding, and promoting democratic values. Most recently USAID's external evaluation of AIHA's CEE program, conducted by Research Triangle Institute, concluded that "The partnership approach produces lasting results" and pointed to several notable strengths of AIHA's partnership approach:

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

As this report documents, many of the program outcomes can be attributed to the unique partnership approach, in which the highly collaborative and participatory approach engendered mutual trust and a high degree of ownership of solutions by those partners (CEE) who were ultimately responsible for implementing and sustaining the improvements. Furthermore, as described more fully in section III.I of this report, the partnership approach had a great and lasting impact on the US partners as well. Please see the conclusions section for a discussion of the key lessons learned related to AIHA's partnership methodology.

C. PROGRAM DESIGN & IMPLEMENTATION

AIHA's CEE program evolved through the years in response to changing country needs as reflected in USAID funding priorities. As countries "graduated" from USAID assistance and missions were closed, AIHA programs in those countries ended. In a few instances, such as in Hungary and Latvia, AIHA was asked to implement targeted new partnerships that met specific USAID objectives for the countries. The following sections include a brief overview of the healthcare context in the CEE region, the history of AIHA's CEE program development, the four main types of AIHA partnerships, the inter-partnership initiatives, and the key aspects of program implementation and management.

1. THE CEE CONTEXT

As the World Health Organization (WHO) has described, the post-Communist fragmentation of central economies, rapid decentralization of resources, and political instability exacerbated what were already deteriorating health care systems in many CEE countries. Among other health indicators, infant and maternal mortality rates were, on average, two to three times higher in the CEE region than in the western part of Europe.

The region faced a need for systematic structural change at every level of the health and social services system and a concomitant engagement of the public at the community level. The process of change would require addressing individual behavioral and lifestyle factors, socioeconomic status, and environmental conditions, as well as improving institutional and system productivity and efficacy. There was a need to emphasize preventive and primary care and to modify institutional structures and programs to respond to changes in the pattern of diseases and affected populations.

There was a general lack of management culture, deficiency in information essential to both clinical and resource decision making, and over-centralization and over-specialization. Fundamental capacity building, individual and community empowerment, increased access to information, and reorientation of mindset were thus key components of the healthcare reform agenda in the region.

2. HISTORY OF AIHA'S PROGRAM IN CEE

Against the backdrop described above, in February 1994, USAID awarded a cooperative agreement (CA) to AIHA (CA#EUR-0037-A-00-4016-00) to expand to CEE countries the health partnership program begun in 1992 in the countries of the former Soviet Union. The program had been designed to provide technical assistance to key healthcare institutions in the NIS through a largely voluntary partnership model. Since 1994, USAID modified the award to AIHA several times to expand the number as well as types of partnerships and projects funded in CEE.

In the initial years of AIHA's CEE program, all USAID health programs in the region were subsumed under the Bureau for Europe and New Independent States (ENI) Strategic Objective 3.2: "Improved Sustainability of Health and Social Benefits and Services." During this period, the ENI Bureau also had a mandate from the US State Department to integrate foreign policy considerations into foreign assistance programs. The dual purpose of Bureau programs following the end of the Cold War was captured by the AIHA partnership program design.

The first three CEE partnerships were hospital-based and began in late-summer of 1994 after an open solicitation process identified the US partner institutions to be partnered with their CEE counterparts in Tirana, Albania; Zagreb, Croatia; and Tallinn, Estonia. The following year, USAID and AIHA expanded the program to Hungary, Latvia, Romania, and Slovakia and a second city in Croatia with the establishment of

five new hospital-to-hospital partnerships. Later that year, AIHA also launched a total of five health management education partnerships in Albania, the Czech Republic, Romania, and Slovakia, together with two new community-based "healthy communities" partnerships in Slovakia. In 1996, the final hospital partnership was added, in Tuzla, Bosnia and Herzegovina, the first and only partnership in that country.

Meanwhile, partnerships in Estonia and the Czech Republic ended in 1996 and 1997 respectively, as those countries were "graduated" from USAID bilateral assistance and Missions were closed. AIHA's initial partnerships in Croatia and Latvia ended in 1998, as USAID Missions in those countries either changed priorities (Croatia) or prepared for closeout (Latvia). Partnerships in Slovakia continued for one more year and ended in 1999 as the USAID Mission in that country eventually closed in 2000.

At the same time, new partnerships were created beginning in October 1998, as USAID modified the initial award that encompassed both NIS and CEE programs and a separate cooperative agreement was signed (no. EE-A-00-94-00016-00) to extend the Partnerships in Health Care Program in CEE through October 31, 2003. Additional funding was provided to enable AIHA to conclude and/or expand existing partnerships, to test the replicability of successful models, and to establish new partnerships consistent with USAID priorities in the region, which had shifted to focus on preventive and primary health care. The extension also allowed AIHA to continue to provide supportive and inter-partnership activities for CEE partnerships including training and dissemination activities. This regional funding enabled AIHA to keep many of the graduated partners involved, providing them with continued benefits of new learning and information sharing.

As described in the RTI evaluation report, "In 1999, the ENI Bureau revised its strategic framework and the role of the renamed Europe and Eurasia (E&E) Bureau programs in foreign policy changed. Health programs fell under Strategic Assistance Area III: Social Transition, which had the goal to 'enhance the ability of all persons to enjoy a better quality of life within market economies and democratic societies.' Under this goal the strategic objective guiding the health programs was S.O. 3.2 'Increased Health Promotion and Access to Quality Health Care.' While the E&E Bureau in Washington, DC continued to provide central funding for [AIHA's] regional activities, individual USAID Missions provided funding for partnerships and projects that were initiated starting in October 1998."

Between October 1998 and 2001, eight new partnerships were added, including two in Kosovo for the first time: 1) healthy communities/women's health in Constanta, Romania (1998); 2) women's wellness in Tirana, Albania (1999); 3) primary healthcare in Lezha, Albania; 4) primary healthcare in Gjilan, Kosovo; 5) healthy communities in Split, Croatia; 6) health management education between Tirana and Bucharest, Romania; and 7&8) two healthy communities partnerships in Hungary. The latter six were all added in 2001.

AIHA was asked in 2002 to develop a unique partnership between Riga, Latvia, and Little Rock, Arkansas, focusing on business development to strengthen Latvia's State Tuberculosis and Lung Disease Center's ability to develop and market its training program. Since USAID no longer had a Mission in Latvia, funding was provided through USAID's Regional Services Center in Budapest, Hungary.

"The AIHA partnership program has been closely aligned and fully responsive to Bureau and foreign policy objectives since the inception of the program. Its program focus has evolved over the life of the project to be primarily Mission driven, as opposed to USAID/Washington and the State Department. Lessons learned from early activities and evaluations have been incorporated into operations." – *RTI, 2006*

In 2003, AIHA supported two special projects—a breast health radiology project in Romania (co-funded by USAID and the Susan G. Komen Breast Cancer Foundation) and a grant to a former HME partner institution in Romania to facilitate its transition to an independent and sustainable research and consulting organization. Also that year, AIHA worked with Doctors of the World to replicate AIHA's Women's Wellness Center model in two sites in Kosovo.

At the end of the five-year award period in September 2003, USAID granted AIHA a further three and a half-year extension to enable completion of partnerships and project activities, as well as limited regional activities that included publications/communications, information and communications technology, and monitoring and evaluation.

The final CEE partnership to be launched was in Gjakova, Kosovo, in 2004. In that year, AIHA's programs in Albania and Hungary ended and the following year, the Riga/Little Rock partnership graduated. The Gjakova/Hanover, NH partnership was the last to graduate, in early-2006, as AIHA also wrapped up the Romania breast health project. The AIHA partnership program in CEE officially came to a close on March 31, 2006.

3. TYPES OF AIHA PARTNERSHIPS

AIHA established and implemented four main types of partnerships in CEE, responding to USAID's and the countries' evolving priorities as healthcare reforms proceeded in the region. Each of these types is briefly described below.

Hospital Partnerships

The original and largest number of partnerships AIHA established was hospital-centered. A total of 49 healthcare institutions in the US and CEE were involved in these nine hospital partnerships, which on average were funded for three years. Partner institutions in the US were both public and private hospitals and health centers; often, however, the US side of the partnership was multi-institutional, involving universities and other stakeholders in the community in broad consortiums. This enabled many of them to bring to bear a wide array of resources and expertise to their partnerships.

Each hospital partnership worked to improve quality of care and delivery of services while managing costs and increasing efficiency. In doing so, they endeavored to respond to specific health care needs identified as priorities in their respective countries, cities and communities, targeting a wide array of clinical and administrative improvements from women and infants' health to pharmacy management. Through an active exchange of specialists in both directions, as well as ongoing communications and efforts, the knowledge and skills of healthcare providers was strengthened in approximately 15 different clinical areas. The individual human capacity building lay the foundation for improved institutional capacity that resulted in numerous new and improved delivery of care and services in the partner hospitals.

While each was tailored to the specific needs of the target institutions and communities, the hospital partnerships shared many areas of common concern, reflecting region-wide priorities. These ranged from hospital administration and management, to clinical areas such as chronic diseases and infection control, to the role of nurses. The partners also stepped outside their hospital walls to address broader health care needs of their communities, whether through health promotion and disease prevention activities, or allying with family practitioners. They recognized that integrated efforts are necessary to achieve real and lasting changes in the health of the population.

Please see the country summaries for a more detailed discussion of the hospital partnerships.

Health Management Education

As part of its strategy for advancing health sector reform in CEE, in 1995 USAID requested that AIHA establish and manage a program to develop and expand the capacity in CEE to educate health management professionals, using the same partnership twinning methodology. AIHA identified dedicated US university programs in health management willing to volunteer the time and energies of their faculty in the partnerships. Those universities were then paired with influential, reform-minded counterpart educational institutions in the CEE to form the first five health management education partnerships in four countries: Albania, Czech Republic (two partnerships), Romania, and Slovakia. In later years, two

additional HME partnerships were implemented – a second one in Romania and one between Albania and Romania, for a total of seven, involving 23 different educational institutions.

As with other types of partnerships, each country's specific needs and existing capabilities were taken into account in early needs assessments, leading to a dynamic, multi-faceted program where each partnership took a unique approach to developing health management education capacity. Some partnerships worked with economics and management faculties to add a health management specialty to existing business and management degree programs. Others developed management coursework for standard medical and nursing curricula. Finally, several partners developed innovative approaches to offer management subjects through specialized, short courses, and through long-term degree oriented distance learning study. Taken together, the partnerships cover the entire spectrum of health management education possibilities, from full-time undergraduate and graduate degree programs to prepare future generations of managers, to continuing education course offerings for health professionals currently occupying management positions.

Please see the country summaries and section III.E for a more detailed discussion of the HME partnerships.

Healthy Communities

While AIHA had always encouraged and supported community-based approaches to addressing priority health problems, beginning in 1995 AIHA developed a third type of partnership, one based on a unique approach to engaging key stakeholders in improving the health of communities. This model, called "healthy communities" and related to WHO's Healthy Cities movement, engages citizens and public and private entities in promoting healthy behaviors and improving quality of life and defines health broadly as not merely the absence of disease but the well-being of the population as a whole.

AIHA adapted the healthy communities (HC) model and applied its partnership methodology to introduce broad-based, community-to-community initiatives that could serve as a unique vehicle for developing skills in community health assessment, planning and improvement. Through HC partnerships, the first two of which were established in the communities of Petrzalka and Turcianske-Teplice in Slovakia, AIHA engaged community leaders from CEE and their US counterparts in a systematic six-phase process. The process combined workshops and professional exchanges, typically over an 18-month period. CEE partners were exposed to strategies on how to mobilize their communities to focus on health. Partnerships using skills in research and epidemiology conducted surveys to assess needs. In addition, they used organizational development skills to gain support from key community stakeholders. They succeeded in creating a well-trained cadre of community leaders who were empowered to develop solutions to problems that they identified. Starting in 1996, a total of seven full-fledged healthy communities partnerships were implemented in four CEE countries, while elements of the HC model were incorporated into two hospital partnerships (Vác, Hungary/Winston-Salem and Riga, Latvia/St. Louis).

"The development impact of the healthy communities partnerships went well beyond the health sector, making an important contribution to civil society, transparency in local government, and promotion of democratic values. Because the model is generic and not specific to issues in the health sector, it has potential for a range of development sectors." – RTI, 2006

Please see the country summaries and section III.F for a more detailed discussion of the HC partnerships.

Primary Healthcare and Women's Health Partnerships

Two other types of partnerships AIHA implemented in the CEE region were similar in their focus on introducing comprehensive healthcare services in an outpatient setting through model health centers, whether focused on women's wellness or family medicine. Both incorporated strong elements of prevention and community outreach activities.

The first partnership in CEE dedicated to developing and opening a Women's Wellness Center (WWC), based on a model developed by AIHA and its partners throughout the NIS, was the Iasi, Romania/ Minneapolis, MN partnership in 1999. The WWC model was designed to provide accessible, comprehensive healthcare services to women of all ages and incorporates an effective programmatic mix of health promotion, education, early diagnosis, treatment and follow-up services. The services are designed to prevent unintended pregnancies and abortions, poor pregnancy outcomes, sexually transmitted diseases, infertility, and unhealthy lifestyles. Each center incorporates enhanced services to meet the needs of their target population, such as special adolescent outreach programs, or counseling and other services for victims of domestic violence.

Three additional WWCs were subsequently opened in CEE—one in Tirana, Albania (which was replicated without AIHA funding) through a partnership with Providence, Rhode Island, and two in Kosovo—Prizren and Gjilan—in collaboration with the NGO *Doctors of the World* (DOW). The four WWCs in CEE are part of a network of over 30 centers in communities throughout Eurasia.

At the same time, in response to changed priorities for healthcare reform efforts in the region and USAID's reorientation to primary healthcare (PHC), AIHA and its partners in 1998 reached consensus on a new and feasible approach to designing PHC partnerships in keeping with the unique needs of countries in Eurasia. They adopted the American Academy of Sciences' Institute of Medicine's definition of primary care: "The provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community." Among other things, the participants of an advisory committee assembled by AIHA identified essential elements of a PHC system, including core services that should be provided, with an emphasis on prevention and community participation.

While the majority of the new PHC partnerships were established in the NIS region beginning in 1999 (collectively they established over 40 community-based model PHC centers), the first in CEE was launched in 2001 between Lezha, Albania, and Pittsburgh, Pennsylvania. Two other PHC partnerships, both in Kosovo (Gjilan and Gjakova), were variations on the AIHA PHC partnership model, with the second one focusing on developing antenatal services at the primary care level.

Please see the country summaries and section III.D for a more detailed discussion of the Women's Wellness Centers.

4. INTER-PARTNERSHIP & PROGRAM SUPPORT ACTIVITIES

Over the years, USAID supported a rich array of collaborative inter-partnership and supportive activities designed by AIHA to supplement and enhance the individual partnerships and projects. These included special initiatives around common priority issues such as nursing, management training, and access to information technology and resources, as well as information-sharing and networking activities such as conferences and publications. Through these and other activities, AIHA promoted a "partnership of partnerships" to encourage and facilitate the sharing of partnership successes, to support cost-effective inter-partnership collaboration, and to involve collaboration with other international health and development agencies. Among the key areas of inter-partnership activity were the following, each of which is described more fully in section III of this report.

- regional nursing task force and other nursing programs;
- introductory management and leadership training workshops;
- the Learning Resource Center project;
- publications, videoconferencing and other information dissemination and communications; and
- regionwide partnership conferences and workshops, including annual partnership conferences.

5. PROGRAM IMPLEMENTATION & MANAGEMENT

AIHA developed and implemented a standardized approach to establishing and managing partnerships, building upon lessons learned in the initial group of NIS partnerships, as well as from ongoing quality improvement processes including feedback solicited from partners themselves and internal assessments by AIHA staff. Among the key processes involved in establishing and managing the CEE partnerships and projects were the following:

- ***Strategic planning:*** AIHA held strategic planning discussions with USAID in Washington and in the Missions in the CEE countries. Consultations were also held with ministries of health and leading healthcare providers in the countries to discuss healthcare priorities and to identify possible partnership sites.

- ***Partner solicitation/selection:*** With a few exceptions, AIHA typically used an open solicitation process to identify a US institution(s) with the requisite capabilities to meet program goals as defined in collaboration with USAID Missions and ministries of health. Solicitations for proposals were widely distributed throughout the US via AIHA's Web site and listservs and reached out to a broad network of health-related associations, health professions education institutions, and healthcare centers. The solicitations included information on the institutional and technical requirements of the partnership and, among other things, indicated the selection criteria for successful applicants, including the importance of voluntary, in-kind contributions. Technical review committees composed of staff, former or current US partners, and outside experts assisted in the selection process. Final approval was given by both the relevant USAID missions and AIHA's Board of Directors.

  In the case of several partnerships—the healthy communities partnerships in Split, Croatia, and Constanta, Romania, for example—CEE partners were also selected based on a competitive proposal process that sought to identify those cities and institutions with the necessary levels of commitment and resources to help the partnerships to succeed.

- ***Partner orientation:*** AIHA developed and implemented orientation sessions for all new partners, typically held separately for the US and CEE partners. These essions ranged from one to two days and covered such topics as introduction to AIHA and principles of partnership, overview of USAID, administrative functions and grant compliance on policies and procedures related to travel, recordkeeping, and reporting; monitoring and evaluation; cultural sensitivity. Later partnerships also benefited from sessions on lessons learned and best practices from earlier generations of AIHA partnerships.

- ***Memorandum of Understanding (MOU):*** AIHA facilitated the preparation and signing of partnership MOUs, a symbolic expression of the commitment by partners and AIHA to develop a productive working relationship and to contribute the necessary resources toward ensuring the success of the relationship. Each MOU described the overall purpose of the partnership as well as the structure of relations and responsibilities specific to each signatory. The MOUs, while legally non-binding, represented important symbols of collaboration and were typically signed in highly public ceremonies, often held in both the US and CEE cities and with local media coverage. Two signings (Riga, Latvia/St. Louis, MO and Tuzla, B&H/Buffalo, NY) were held at the White House at the invitation of then First Lady, Hilary Rodham Clinton.

- ***Workplan development:*** The development of partnership workplans was an intensive and highly collaborative process among US and CEE partners. The workplans were typically based on needs assessments and planning discussions conducted early in the partnership with all relevant stakeholders. The workplan itself represents a significant output of the partnership as it reflects key decisions about priorities, directions and strategies. Partners typically developed an overall goal and workplan for the anticipated partnership period, with more detailed one-year implementation plans, over the course of initial partnership exchanges. AIHA provided a template and guidelines for completing the workplan, which outlined among other things the scope of the partnership and its goal, objectives, activities

(including exchange trips), outputs and outcomes, and in-kind contributions. AIHA also provided feedback to partners as well as guidance and support, where needed, in writing workplans. Partners used the work plan as their guide to the partnership relationship and as a mechanism for monitoring and evaluating their progress.

Workplans were typically reviewed regularly and modified on an annual basis to include specific activities including exchanges for the forthcoming 12 month period. The workplan process is designed to be flexible and accommodate the evolving needs of the twinning institutions and national plans.

- ***Program monitoring & evaluation (M&E):*** As AIHA's partnership program expanded and matured over the years, its M&E system and processes also evolved. Initially, the focus was largely on monitoring of individual partnerships, but as the need for a more comprehensive and systematic M&E system was recognized and in response to recommendations by evaluators and by USAID, AIHA established an M&E unit and implemented a wider range of M&E activities.

  At the partnership level, AIHA worked closely with partners to assist them in developing workplans that incorporated M&E aspects such as measurable objectives, outputs and outcomes, and indicators. AIHA encouraged partners to collect baseline data wherever possible, but many partnerships faced numerous constraints to conducting such baseline assessments or collecting quantitative data on an ongoing basis due to lack of human capacity, resources, and reliable systems.

  AIHA's monitoring of the partnerships occurred at many levels and in varying forms, including: 1) ongoing review of progress in workplan implementation; 2) review of monthly financial reports; 3) tracking of partnership exchange trips through a travel database; 4) tracking of in-kind contributions (of both time and resources) through a special in-kinds database; and 5) regular site visits to CEE partner institutions. Partners reported to AIHA through quarterly progress reports, and AIHA, in turn, reported to USAID quarterly.

  At the inter-partnership level, AIHA developed objectives for its cross-partnership programs and collected data wherever feasible and appropriate, such as service and other program statistics from the Learning Resource Centers (LRCs) and Nursing Resource Centers (NRCs). AIHA also supported over the years a number of internal and external assessments and evaluations. AIHA conducted assessments examining the network of NRCs and Women's Wellness Centers (WWCs) in the NIS and CEE, and outcomes of the International Nursing Leadership Institute (INLI) program. Among the targeted external assessments of relevance to CEE were: "The Diffusion of Medical Information Technology in Central and Eastern Europe and the New Independent States" (Learning Resource Centers), University of Minnesota, October 1998; and Assessment of Women's Wellness Centers, University of Illinois at Chicago, 2001. While largely qualitative and process-oriented, these assessments and evaluations provided useful information about the status of these programs, some analysis of outcomes such as observable attitude changes among staff, adherence to clinical practice guidelines and evidence-based practices, as well as some evaluation of the sustainability of the programs.

  At the program-wide level, AIHA participated in several external evaluations, including a 1997 evaluation of AIHA's overall partnership program (NIS and CEE) conducted by Butler, et.al. The findings from that evaluation were incorporated into the new partnership programs AIHA was awarded by USAID in 1998. In addition, with the end of the first generation of partnerships that year, AIHA commissioned consultants to engage all CEE and NIS partnerships in a self-assessment process. The multi-faceted exercise resulted in a report of partnership achievements as well as recommendations to AIHA for strengthening the partnership program.

  Finally, under the CA awarded in 1998, provisions were made for an interim independent summative evaluation of AIHA's overall program. This mid-term evaluation, conducted by a "Continuing Evaluation Panel" (CEP) of internationally recognized health care experts worked closely with AIHA over the

course of 18 months as they assessed program context, conducted interviews and site visits, synthesized available program monitoring and outcome data, and rendered an assessment of overall program effectiveness as well as recommended strategic directions for future program enhancement, particularly in the area of monitoring and evaluation. The report by Vanselow, et.al. can be found on AIHA's Web site at www.aiha.com.

- ***Program management/administrative support:*** AIHA managed its CEE program largely out of its headquarters in Washington, DC, with support from field offices and representatives based in most of the CEE countries. Over the years, and in response to recommendations of several outside evaluations and advisory groups of partnership representatives, AIHA increased the role of its regional and country offices in program development, project management, monitoring and reporting. Through its headquarters and field offices, AIHA provided ongoing programmatic and logistical support to partnerships to facilitate and coordinate interactions between US partners and their CEE counterparts in the implementation of their workplans. A major part of the logistical support was in the form of travel-related services, including an in-house travel agent. Regional offices also provided some financial, administrative and information technology support and served as AIHA's primary liaison with the national ministries and other authorities, USAID Missions, and other international donors and programs.

I. COUNTRY SUMMARIES

The following pages provide a program summary of each of the nine countries where AIHA worked plus Kosovo. Each summary includes a map, highlights of key results, and a chart of the partnerships and projects supported with the years of activity and institutions involved. A background section provides a brief context of the healthcare situation in the country at the time and a description of how AIHA's program developed or evolved there.

The main section of each summary discusses key results as well as any challenges and lessons learned specific to the country. Rather than reporting by partnership, AIHA presents results by programmatic area to better reflect common areas of outcomes across partnerships. (Partnership-specific descriptions can be found on AIHA's Web site at www.aiha.com. Also appearing in these sections are profiles of selected US and CEE partners which provide a personal perspective on the achievements and experiences of the partnerships. Finally, an in-depth success story explores in greater detail one of the noteworthy achievements in the country.

II.A. ALBANIA (1994-2004)

Program Highlights

- Established Albania's first cytology/ pathology lab as part of a cervical cancer screening program in Tirana.
- Albania's first management short course for primary care providers created by AIHA's first intra-CEE partnership.
- A full range of women's health services is provided to an average of 60 patients a day at the Tirana Women's Wellness Center.
- The Albanian Ministry of Health provided $130,000 for the renovation of the Lezha Town Health Center, which provides primary care services for the community.

Partnerships	Years	Focus Areas	Partner Institutions
Tirana/Bronx	1994-1996	Neonatology, Nursing, Trauma, Emergency Medical Services, Infection Control, Women's Health	• Jacobi Medical Center • Mother Theresa University Medical Center • Maternity Hospital No. 1 • Central Trauma Hospital
Tirana/Grand Rapids (continuation of Tirana/ Bronx)	1996-2000	Neonatology, Nursing, Trauma, Emergency Medical Services, Infection Control, Women's Health	• Butterworth Hospital/Spectrum Health • Mother Theresa University Medical Center • Maternity Hospital No. 1 • Central Trauma Hospital
Tirana/New York	1995-1999	Health Management	• Robert F. Wagner Graduate School of Public Service at New York University (NYU) • University of Tirana • Ministry of Health
Tirana/Providence	1999-2004	Women's Health, Cervical Cancer	• Women and Infant's Hospital of Rhode Island • National Perinatal Information Center • Maternity Hospital No. 1
Lezha/Pittsburgh	2001-2004	Primary Health Care, Pediatrics, Women's Health	• Magee Women's Hospital • Lezha Directorate of Primary Health Care
Tirana/Bucharest	2001-2004	Health Management, Primary Health Care	• National Institute for Health Research and Development (Bucharest, Romania) • Institute of Public Health (Tirana, Albania)

BACKGROUND

The Communist government's collapse in Albania in the early 1990s brought with it a weakening of the health care system in that country. Services, for instance, were being delivered from buildings that were old, deteriorating and oftentimes unsafe. Additionally, the average age of medical equipment used in these facilities was 25 years old. Add to this the fact that almost one-quarter of the nation's health centers in cities and two-thirds of the health posts in small villages were destroyed due to the political changes and violence that occurred in 1991 and 1992.

After the transition to a multiparty democracy in 1992, a critical problem facing the government was finding resources necessary to maintain basic health services. Adding to the problem was the increased violence that occurred in 1997 which led to looting of pharmaceuticals and equipment, and the destruction of hospitals, health centers and public health departments. Human resources were also hard to come by, and Albania lacked a cadre of trained health managers with the education and skills necessary to effectively manage hospitals and clinics. As if the situation was not difficult enough, the influx of ethnic Albanian refugees escaping the war in Kosovo put a further strain on the health care system. (European Observatory on Health Care Systems, "Health Care Systems in Transition: Albania")

Women in Albania often suffered most from a lack of adequate health services, and treatment was not based on any standard practice protocols. The care that was provided did not focus on the long-term, but instead was sporadic, fragmented, and focused on treating symptoms instead of finding and treating the cause. There was no attention paid to wellness or disease prevention, and there was little, if any, patient education provided. The incidence of cervical cancer was high, and the absence of all but limited screening made early detection unlikely. In a pilot study of 973 women (with 1,000 pap smears) conducted by the Albanian Association Against Tumors, the total abnormal cytology rate was 440 patients, or an astonishing 45.2% (from the Tirana/Providence fiscal year 2001 AIHA partnership workplan).

There was clearly a need to develop diagnostic programs and make them accessible, affordable, and available, as well as a need to educate the public to make use of these programs. In Tirana there was limited expertise in all these areas but there was no clinical or laboratory infrastructure to support a large-scale screening effort.

The cultural trend to see a specialist first was a weakness in the system that the Albanian government identified, and they worked to promote primary health care. Seventy-percent of patients, for example, regularly bypassed primary care and went directly to specialists for treatment. Additionally, of the patients seen by family physicians and general practitioners, approximately 85% were referred to specialists for continued care (from the Lezha/Pittsburgh fiscal year 2003 AIHA partnership workplan). This contributed to an ineffective utilization of the primary health care service structure, draining already limited financial resources. Specialists provided basic care that primary care physicians were qualified (and/or could become qualified through training) to provide. The problem was, however, that there was a lack of certified family physicians and general practitioners to staff the primary care clinics. In addition, the primary care staff needed the education and training to better manage the primary care facilities.

AIHA began working in Albania in 1994, to help meet USAID's strategic objective for improved sustainability of social benefits and services. Initially a partnership was established between three hospitals in Tirana and Jacobi Medical Center in Bronx, New York, which focused on a variety of clinical topics, especially those related to woman and infant's health. By the end of 1996, Jacobi Medical Center had withdrawn from the partnership and, after an open solicitation for a new US partner, Butterworth Hospital/Spectrum Health in Grand Rapids, Michigan, was selected. The new partners continued the work of the previous hospital partnership, refocusing their efforts on health management, nursing, infection control, and emergency medicine. In 1995, a second partnership was formed in Albania, this time pairing the University of Tirana with New York University (NYU), focused on health management.

In 1999, a third Albania partnership was established between Maternity Hospital No. 1 in Tirana and Providence, Rhode Island, in order to improve women's health and health care in the country. (This partnership was later extended to address cervical cancer specifically.)

In 2001, the city of Lezha was partnered with Pittsburgh, Pennsylvania, to focus on the development of primary care, and in that same year, the Institute of Public Health entered into a partnership with counterparts in Romania to address management training needs for primary care providers. This partnership between Albania and Romania was the first between two countries within CEE.

KEY RESULTS

➢ *Health Management Education*

The Tirana/New York partnership designed a new course, which was the first of its kind in the country, in health management for undergraduate medical students which was introduced during the fall 1998 term at the University of Tirana. The two Albanian faculty members teaching the course spent eight weeks at NYU working with faculty at the Wagner School to design the course and prepare instructional materials and lectures.

In 1998, the partners established a health management education resource center located on the grounds of the University Hospital Center. The renovated site houses computers, teaching equipment, such as projectors and tape recorders, and educational materials including books and journals.

> ***"By bringing together two Eastern European partners, AIHA supported a new type of collaboration, one in which knowledge gained within former partnerships with US specialists is disseminated, not only in the country, but also throughout the region."*** *– Daniela Valceanu, director of the Romanian National Institute of Research and Development in Health*

Two members of the Ministry of Health (MOH) spent one year at the Wagner School to earn a masters degree in policy analysis, and the hope was that when they returned, they would staff a new policy analysis unit within the Ministry of Health. Unfortunately, this the new unit was never established; however, the Minister did create a policy advisory council in February 1998, and the former Ministry officials trained at NYU still became actively involved in health care reform.

Management Workshop for Primary Care Providers in Berat

After the end of the Tirana/New York partnership, many of the Albanian partners participated in a second partnership with counterparts in Romania. Building on their experience with NYU and working with the Romanians, the partners developed adult learning, health management, and health promotion curricula and worked collaboratively on the content of a three-day short course on practice management for general practitioners. The partners offered the interactive short course to 60 general practitioners in the cities of Berat, Lezha, and Tirana, and 15 Albanian trainers had been trained in adult learning methodologies, and had jointly developed users' and facilitators' manuals with the Romanian partners.

➢ *Quality Improvement*

Five performance improvement (PI) teams were developed through the Tirana/Grand Rapids partnership in order to teach the Albanian partners how they could work together with limited resources to improve the quality of services they provide. The US partners selected and trained Albanian PI trainers to coach new PI

teams at their respective institutions, focusing on integrating the PI process throughout their institutions and sustaining the process after the partnership's end. The outcomes of their work varied due to differences in topic and scope, however some notable accomplishments include the introduction of patient education classes on diabetes, development of a revised medical record for hospitalized patients with diabetes, creation of a hospital-wide infection control committee to monitor and enforce sanitary standards, and the initiation of training courses for hospital staff on hand washing and proper waste disposal.

"If we had not been in America to see what they had done, we would not have known the gaps and what to ask for…" *– Pellumb Karagjozi, former Director, Trauma Hospital*

The Tirana/Grand Rapids partners installed health science libraries at the Trauma and University Hospitals in July 1997, and additional books were sent to the library at Maternity Hospital No. 1. A US team traveled to Tirana to begin setting up a library system, and they established a link between the Spectrum Health library and the Tirana hospital libraries for e-mail information exchanges.

The Tirana/Providence partners instituted a number of innovative quality improvement programs at the Women's Wellness Center in Tirana:

- Scheduling of Appointments: For the first time, patients had the ability to schedule appointments based on their needs and availability, with the physicians they chose. Additionally, all Maternity Hospital No. 1 physicians were able to conduct their outpatient visits at the WWC.
- Individual Medical Charts: Traditionally Maternity Hospital No. 1 had a system of one medical chart per patient per visit. This resulted in multiple charts for the same individual, complicating the accessibility of medical histories. The WWC created a one-chart structure, compatible with their computerized patient tracking system.
- Standardized Billing System: The WWC adapted a billing system for services offered, guided by the MOH on pricing for services. Prices for each procedure are posted at the waiting area and are distributed during patient registration.
- Patient Satisfaction: Questionnaires were developed and distributed to patients that were used to constantly review patient satisfaction, to improve the quality of care, and to make sure the services and programs meet the needs of their entire female population.

➢ *Nursing*

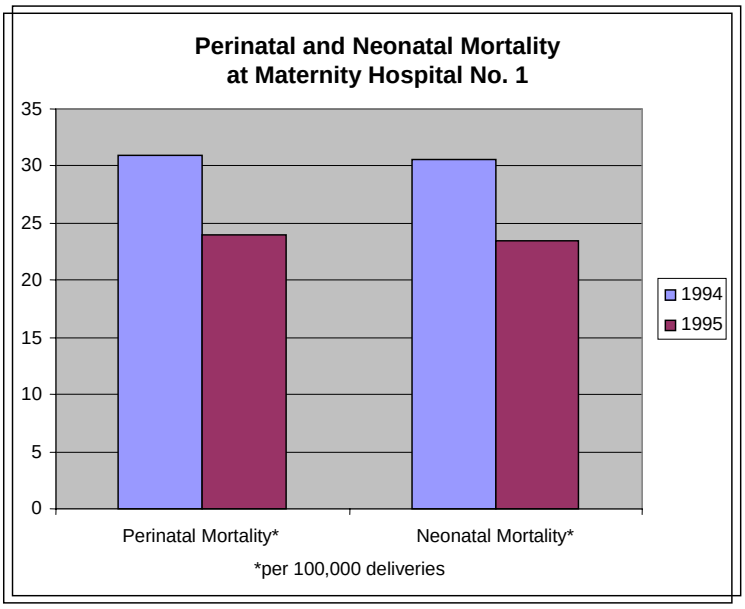
The Tirana/Grand Rapids, Tirana/Providence, and Lezha/Pittsburgh partnerships all focused on developing new roles for nurses, in order to help achieve their goals of improving the quality of care. As a result, the Tirana/Grand Rapids partners reported an increase in collaboration between doctors and nurses, which results in improved processes and patient care. For example, nurse/doctor infection control teams have been established at the Trauma Hospital. In addition, nurses played an important role in the provision of services at the Women's Wellness Center (WWC) in Tirana and the Lezha Town Health Center, providing consultation and care to patients and conducting patient education and community outreach.

The Grand Rapids/Tirana partners sponsored and helped organize two annual conferences on nursing, providing a forum where Albanian nurses could discuss the role of the nurse and various aspects of patient care. The partnership and the annual conferences provided the impetus for the formation of an Albanian Nursing Association. To further support the fledgling association, AIHA sponsored a Nursing Association Workshop for approximately 50 nurses, to focus on strengthening the association and improving communication among the members and the Ministry of Health.

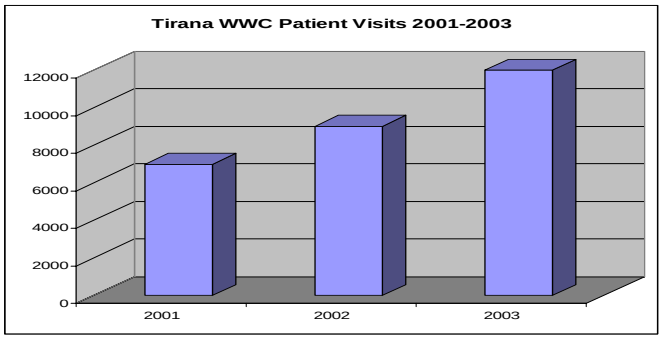
➢ *Women and Infant's Health*

Chief physicians at Tirana's Maternity Hospital No. 1 reported that work done through the Tirana/Bronx partnership contributed significantly to the improvement of health outcomes at their institution. Between

1994 and 1995, perinatal mortality fell from 31/100,000 deliveries to 24/100,000. Neonatal mortality dropped from 30.6 to 23.4 deaths per 100,000 deliveries. Maternal mortalities declined from eight out of 7,200 births in 1994 to three out of 7,437 births in 1995. Maternity Hospital No. 1 also experienced a decrease in their Caesarean section rate and an increase in the use of anesthesia in normal deliveries.



On September 15, 2000 a Women's Wellness Center (WWC) was opened at Maternity Hospital No. 1 in Tirana. The WWC provides a full range of women's health services to around 60 patients daily. The WWC accommodated a steady increase of patient visits with nearly 7,000 in 2001; 9,000 in 2002; and over 12,000 in 2003.



The Tirana WWC is an ambulatory facility aimed at clinically assisting women in need, as well as informing and educating them on a wide range of health issues. The WWC offers a full range of comprehensive health care services, covering family planning, reproductive health, perinatal care, cancer education and screening, mental health education and counseling. Additionally, the WWC offers a variety of educational programs, including prenatal care and preparation for birth, newborn care, breast- versus bottle-feeding, breast health, sexually transmitted infections, family planning, and menopause. Other resources provided by the WWC include printed patient education and health promotion materials and presenting educational videos to patients in the waiting area.

The Tirana WWC has served as a model for several other facilities in the region. The WWC was replicated by the Albanian MOH at Tirana's other maternity hospital. WWC staff also shared its protocols with four

Tirana polyclinics, and provided training in women's health issues for staff at the Lezha Town Health Center. The director and other staff from the Tirana WWC worked with AIHA and Doctors of the World to establish two WWCs in Kosovo. The Albanians provided training for Kosovar WWC staff from Gjilan and Prizren, and traveled to Kosovo to provide additional consultation.

The Providence partners have developed a new partnership arrangement with their former AIHA partners in Tirana. Through a grant from the Organization to Save Abandoned Albanian Babies, funding has been provided to allow the US partners to travel to Albania to conduct additional clinical training of Tirana WWC and Maternity Hospital No. 1 staff in topics such as childbirth, parenting, and early childhood education.

- ***Cervical Cancer***

The Tirana WWC launched a cervical cancer screening program in 2002, and the partners adapted a protocol and established the country's first cytology/pathology laboratory so that the slides could be read onsite. By March 2004, the lab had read more than 2,600 Pap smears and conducted over 400 biopsies, with an irregularity found in one out of 25-30 Pap tests. The Tirana/Providence partners instituted a quality control policy for the cytology/pathology laboratory focusing on specimen identification, processing, and screening. To ensure accuracy in the screening and diagnosis techniques of the cytology/pathology laboratory staff, the partners also created a quality assurance review. Every three months, 10 percent of all negative slides, five percent of all ASCUS, and one percent of all LSIL Pap smear slides were sent to Providence, along with a copy of the original report for each patient slide submitted, to be re-screened by the US partners.

"AIHA's Tirana/Providence partnership has established the gold standard in fighting cervical cancer and is a voice for improved policy on women's health in Albania." *– Pamela Wyville-Staples, USAID/Albania Population, Health, and Nutrition Officer*

As part of the partnership's efforts to train medical professionals from throughout Tirana on cervical cancer screening, the partners delivered a five-part lecture series on Pap smear collection that was offered to 15 OB/GYN physicians from all 10 Polyclinics in Tirana. Some 64 physicians attended the didactic sessions, and four physicians participated in the one-week clinical training session that followed the lecture series. All attendees were certified to the competencies gained in each of the identified clinical, procedural, and administrative areas.

The Lezha/Pittsburgh partnership also worked to improve primary care services available for women. When the partnership began, the city was experiencing late detection of pregnancy, and heavy use of the maternity hospital for services that could have been provided at the primary care level. In response, departments were installed in the new Town Health Center to provide services for women and children and staff members were trained to provide prenatal care, family planning, fertility treatment, and breast examinations. The partners worked to educate patients on the importance of early detection of pregnancy, prenatal care, self breast examination, and STI testing for women and their partners.

- ***Emergency Medical Services***

In May 1998 AIHA, together with the Tirana/Grand Rapids partnership, established Albania's first Emergency Medical Service (EMS) Training Center at the University Hospital Center. The mission of the Center was to improve Albania's emergency care system by enhancing medical education and practical skills of current and future health care providers. It also trained first-responders in pre-hospital emergency care. The Center's training equipment was provided by AIHA and the curriculum was modeled on that used for AIHA's network of 14 EMS Training Centers.

Albanian faculty for the center were trained both in Grand Rapids and at the AIHA-supported EMS Training Center in Moldova. Between May 1998 and July 1999, six 48-hour courses were offered, training a total of

102 physicians and nurses. During this time, however, full-fledged implementation of the EMS training program was hampered by a combination of the crises facing Albania and the resulting inability of US partners to travel to Albania, and issues related to payment for the Center director and trainers. These difficulties were exacerbated by changes in the appointment of a Center director, and of key contacts at the MOH.

Because of these crises, in July 1999 the Center made the difficult decision to stop offering courses. In December 1999, AIHA, the MOH and USAID discussed various options for moving forward with the EMS Training Center and agreed that AIHA should take a more active role in running the Center until the MOH would be able to assume responsibility. Under the leadership of AIHA's expatriate emergency medical services specialist, the Center began to offer courses again in September 2000. However, the funding issues with the MOH were not resolved, and AIHA ended its financial support of the Center in February 2002.

The Center has not reopened, but in 2005 the US Department of Defense funded the renovation of the space for the Center, giving hope that it will reopen and continue to provide training. While open, the Tirana EMS Training Center trained over 250 medical students, first responders, and other health care providers.

- ***Primary Health Care***

The Lezha/Pittsburgh partners focused on developing a model community-oriented primary care site in the Lezha municipality that provides women's and children's health and wellness services. The US partners provided training on a variety of issues, including prenatal care, prenatal care for diabetic women, cardiac problems during pregnancy, hypertension during pregnancy, breast self-exam, anemia during pregnancy, and treatment of abused women. The Lezha partners developed treatment protocols with the assistance of their American partners, and an advisory board consisting of staff and community members was created in Lezha which advised the partnership on areas such as training, primary care model development, and determination of staffing and services. The board met once a month during the partnership and was composed of 10 people, including the director of the planned PHC clinic, a nurse who would later work at the new clinic, an economist from the local government, and a teacher.

The Lezha partners were able to secure approximately $130,000 in funding from the MOH to support the physical renovation of the space for the new Center. The partners coordinated the redesign of the primary care facility and procured necessary equipment, and celebrated the opening of the Lezha Town Health Center (THC) on February 3, 2004. The improved facility provides ultrasound exams, colposcopies, breast exams, and has an on-site laboratory, and staff provides health education to women in the community, through individual consultations and regular group classes. Demand for services continues to increase, especially among pregnant women. (See the Success Story on the opening of the THC for more information.)

- ***Access to Health Information and Communications***

Between 1996 and 2005, AIHA supported the development of Learning Resource Centers (LRCs) at the six following Albanian health care organizations:

- Ministry of Health and Environmental Protection – Tirana (Dec 1997-Sept 2004)
- National Institute of Public Health – Tirana (Jan 1998-Sept 2004)
- Town Health Center, Central Polyclinic – Lezha (Aug 2002-Sept 2005)
- University Hospital Center "Mother Theresa" – Tirana (Oct 1996-Sept 2004)
- University of Tirana, Faculty of Medicine (Oct 1998-Sept 2001)
- Maternity Hospital No. 1/Women's Wellness Center – Tirana (Jan 1998-Sept 2004)

Together, these six LRCs provided training, research support, and improved information access to a community of 4,058 physicians, nurses, policy-makers, and other health professionals in Albania.

Several of these institutions were active in using the LRCs to support telemedicine. For example, the University Hospital Center "Mother Theresa" routinely consulted on difficult diagnoses and treatment questions with a broad network of specialists from Europe and the US. The University Hospital Center also served as a teleconsultation resource for other health care providers within Albania. In one successfully managed case, the LRCs at the University Hospital Center and the Lezha Town Health Center helped the treating physicians in Lezha to identify a hidden fracture in the leg of a car accident victim based on X-rays sent via e-mail.

Many of the LRCs supported the development of patient education materials, often using information resources and materials obtained from the Internet. The LRC at the Tirana Women's Wellness Center helped to organize a "Women's Education Project" in which patients were able to use the LRC computers to access patient education materials online as a supplement to the classes and lectures being organized by the center. This LRC also helped to facilitate the introduction of computerized patient records at the clinic, an experience that later helped the center to be selected by WHO and the Albanian Ministry of Health to serve as the central data collection point for all obstetrics and gynecology hospitals in Albania.

LRC staff at the Town Health Center in Lezha were instrumental in facilitating the formation of a clinical quality review committee for the Lezha district. Made up of representatives from the Primary Healthcare Directorate and the Hospital Directorate, the committee aimed to review current practices and then recommend revisions where these practices were not supported by the most up-to-date research. In 2003, using the practice standard review template developed and provided by AIHA, the committee looked at diagnosis and treatment of anemia during pregnancy and developed recommendations that were disseminated to physicians throughout the district.

Overall, for the period during which these centers received funding LRC staff trained 561 health professionals on the use of computers and the Internet. Collectively, they also received approximately 228 visitors and responded to more than 80 information requests each month.

In 2001, AIHA discontinued its financial support for the LRC at the University of Tirana's Faculty of Medicine due to lack of demonstrated results, and this LRC eventually ceased to exist. The other five LRCs, however, have continued to provide training and information access for the staff of their institutions using their own financial resources, and they continue to be a part of AIHA's LRC Network Association.

CHALLENGES

- Beginning in summer 1998, US partners were unable to travel to Albania due to the security threat caused by unrest in the country, and US visas became very difficult for Albanians to obtain. This hiatus of partnership activity, which lasted until May 1999, adversely affected the partnerships, especially the Tirana/New York HME partnership, which never successfully restarted after the travel ban was lifted. The EMS partners from the Tirana/Grand Rapids partnership managed to arrange a meeting in Chisinau during this period, which not only served as a neutral third-country meeting place, but also served as an example of a successful EMS program to use as a model.
- Discouraged by changes in leadership in the Albanian partner institutions, difficulty of travel, and lack of domestic institutional support, New York University withdrew from the Tirana/New York partnership in November 1999. Because the Albanian partners had not yet achieved their goals, AIHA continued to include the participants in regional health management activities, and eventually involved them in a later partnership with health management experts from Romania. By participating in the intra-CEE

partnership, the Albanians were able to make progress that would not have been possible if AIHA had pulled out after the US partners withdrew.

- The success of the Tirana/Bucharest partnership demonstrated the ability of AIHA's "recipient" partners to become lead partners in their own right, and the Bucharest partners utilized their experience from two previous health management education partnerships with US institutions to help their Albanian partners develop management training courses for primary care providers. The first intra-CEE partnership also demonstrated the potential of developing effective third-country partnerships within the region. (The Albanians were facing challenges in developing its health management capacity which were very similar to those addressed by the Romanians only a few years earlier.)
- Leveraging the support of the MOH and affiliated institutions proved to be crucial in the sustainability of Centers established by AIHA partnerships and programs in Albania. The establishment and continued operation of the Lezha THC was possible because of the MOH's investment in the renovation of the clinic and the municipal government's investment in staff and equipment and supplies. (The MOH supported the establishment of the Tirana WWC, and Maternity Hospital No. 1 continues to support its operations.) While the EMS Center was originally supported by the MOH and the University Hospital Center, neither institution was able to support the continued staff salaries and instructor fees necessary to continue offering EMS training.

SUCCESS STORY: *Providing Primary Care at the Lezha Town Health Center*

Minister of Health Leonard Solis Opens the Lezha Town Health Center

"The establishment of the Lezha Town Health Center (THC) is one more achievement of the AIHA partnership in Albania," said Albanian Minister of Health Leonard Solis, praising the work of the Lezha/Pittsburgh partners during the Center's opening ceremony on February 3, 2004. Referencing the WWC opened several years earlier in Tirana, and AIHA's graduated partnerships programs, Solis noted that the THC "…demonstrates the continuing success of the American and CEE partners to provide quality health services in Albania."

Officials from USAID and the Albanian Ministry of Health and representatives from the Lezha municipal government public health and primary care departments, the health insurance department of the Order of Physicians, and international organizations, such as Swiss Caritas, Sant Egidio, and the University Research Co., attended the THC opening to celebrate the success of the Lezha/Pittsburgh partnership.

The Town Health Center was established to improve the capacity of the Lezha health care system to assure quality primary care services for the local population, which has grown dramatically since 1999 and thereby placed the district's existing medical infrastructure under great strain. To create the most effective model to meet the health care needs of the local population, Lezha/Pittsburgh partners conducted a survey at four ambulatories in the city, and the assessment revealed the most vulnerable areas in the city's patient care services. The results of this research were used to develop the THC's patient-centered care model and serve as baseline data to measure patient satisfaction in the future.

The THC is staffed by general practitioners, midwives, nurses, a social worker, and a lab technician who received comprehensive training from their Pittsburgh counterparts on a variety of topics ranging from general women's health issues and obstetrics care for women with disabilities to genetic testing and various aspects of children's health, including respiratory disease, allergies, environmental influences, and adolescent health. Within the partnership, the Albanian practitioners also learned to develop patient education programs

oriented toward women and adolescents that cover topics such as breast self-exams and prevention of domestic violence and teen pregnancy, among many others.

In addition to working with their Pittsburgh partners, the Lezha professionals also received information about programs developed by Tirana/Providence, Tirana/Bucharest, and Gjilan (Gjilane)/Hanover partners. For example, partners from Tirana shared their knowledge in the areas of breast health, newborn care, and health management, while US colleagues from Hanover trained them in quality improvement techniques.

The Albanian Ministry of Health allocated approximately $130,000 for renovation of the Center, to assure the comfort of THC patients and improve the working conditions of the Albanian health care providers. Partners from Pittsburgh provided the Center with up-to-date laboratory and medical equipment, as well as educational materials, thereby giving patients access to diagnostic, treatment, and counseling services within an integrated framework.

II.B. BOSNIA & HERZEGOVINA (1996-1998)

Program Highlights

- Established Bosnia and Herzegovina's leading "center of excellence" in the modern treatment of cardiovascular disease, which conducts the most open heart procedures in the country (475 in 2004) and includes the country's first cardiac catheterization laboratory.
- With training in neonatal and perinatal care from Buffalo, partners in Tuzla realized a decrease in infant mortality rates from 23/1,000 live births in 1996 to 10/1,000 in 1998.
- Due to the Tuzla/Buffalo partnership's focus on neurology, currently 95 percent of the neurological surgeries conducted in the country take place at Tuzla's department of neurosurgery.

Partnership	Years	Focus Areas	Partner Institutions
Tuzla/Buffalo, New York	1996-1998	Women's Health, Cardiology, Surgery, Neonatology/Pediatrics, Nursing, Management, Infection Control	• Buffalo General Hospital • University Clinical Center Tuzla

BACKGROUND

The 1992-1995 civil war in Bosnia and Herzegovina took a major toll on the country and its citizens. Approximately 250,000 people were killed; 240,000 wounded (including 50,000 children); with 50,000 requiring rehabilitation and 15 percent of the population suffering from post-traumatic stress disorder. The war also destroyed much of the country's infrastructure and economy. In 1990, Bosnia and Herzegovina was a prosperous country with a GDP of $11 billion and a per capita income of $2400. By 1995, however, the GDP had decreased to $2 billion and per capital income to only $500. Industrial production plummeted to 5-10 percent of its pre-war level, and unemployment rose to 80 percent. ("Bosnia Health Briefing Paper": Department for International Development [DFID] Resource Centre for Health Sector Development)

The war devastated the Bosnian health system—a third of all health care facilities were totally destroyed, and the remaining existing facilities were able to function at only a very basic level. The number of staff employed in the health system declined by 40 percent, and approximately 30 percent of the physicians and nurses either left the country or were killed in the conflict. The rates of infant and maternal mortality doubled compared to pre-war levels, and the number of epidemics and communicable diseases increased five-fold compared to pre-war levels due to the destruction of the water and sewage systems. ("Bosnia Health Briefing Paper": DFID)

While there was extensive damage to many health care facilities in Bosnia and Herzegovina, the University Clinical Center in Tuzla (UCCT) was able to function better than many others and maintained a certain degree of advanced services. UCCT was also able to retain a significant portion of its key personnel which greatly contributed to its success. However, in order to provide basic and advanced medical care, UCCT needed more assistance. Tuzla medical staff also needed improved personal and professional conditions to

ensure that they would not become discouraged and leave, which would precipitate a severe human resources crisis evident in other parts of the country.

In 1996, AIHA was asked by USAID to establish a hospital partnership in Bosnia and Herzegovina to assist in the rebuilding of the country's health system while furthering USAID's goals of promoting ethnic reconciliation in the region and strengthening the ongoing peace process set forth in the Dayton Peace Accord. UCCT was able to maintain its operations relatively well during the conflict, and the city of Tuzla was able to maintain a semblance of a multi-cultural society in spite of the war and policy of ethnic cleansing promoted by the Serb leadership. Buffalo General Hospital (BGH) in Buffalo, New York was selected to participate in the partnership with UCCT. During the conflict, BGH initiated an informal exchange program with UCCT, sending teams of US physicians and nurses to Bosnia to lend a hand as well as donated more than $1.5 million in supplies and equipment to Tuzla. The AIHA health partnership provided an opportunity for UCCT and BGH to expand and deepen their relationship through a two-year partnership addressing a number of pressing issues including nursing, health services management and administration, cardiology and pediatrics.

KEY RESULTS

- ***Cardiology***

The partnership helped UCCT become the leading hospital in Bosnia and Herzegovina in providing high-quality cardiac care. The Buffalo partners provided training to a full cardiac surgical team comprised of four surgeons, five nurses, and three anesthesiologists/perfusionists from Tuzla. In July 1997, the partners opened the first cardiac catheterization laboratory in Bosnia and Herzegovina at UCCT and over 300 angiograms were performed in the first year of the lab's operation. Additionally, three stents were placed and angioplastic procedures were begun for the first time in Tuzla.

"In 1994 when our program started at a very small scale between Buffalo and Tuzla, no funds were available for health care development in Bosnia. Fortunately, USAID and AIHA were able to secure funds for our program, and I have been very impressed with the way both AIHA and USAID have cooperated, working together to improve health care for the population of Tuzla specifically and Bosnia in general."
– Jacob Bergsland, MD, Cardiologist, Buffalo General Hospital

The Buffalo partners assisted their Bosnian counterparts in the establishment of a Cardiac Surgery Center in September 1998 which provides advanced treatment for heart attack and stroke patients, and incorporates a teaching initiative on cardiovascular disease risk factors and preventive care for health care workers and patients alike. Seven cases were performed by US and Bosnian partners to inaugurate the Center.

The partners also established a regional referral system for cardiology patients, linking communities throughout Bosnia and Herzegovina, including the major cities of Mostar, Sarajevo, and Tuzla. Through this new system, cooperation between the three cities was enhanced.

Additionally, the Buffalo partners provided training to UCCT staff in pediatric cardiology skills, including the treatment of congenital heart disease, cyanotic heart disease, cardiomyopathies, and pulmonary hypertension.

UCCT continues to serve as the "center of excellence" in Bosnia and Herzegovina in cardiology. The hospital performed 100 diagnostic procedures in 1997; by 2004 UCCT was performing 1,800 procedures a year. The Cardiac Center conducted its first open heart surgery in 1998 and by 2003 and 2004, UCCT averaged 475 open-heart procedures a year. (The hospital in Sarajevo is now capable of offering open heart surgeries, but only conducts 100-200 operations a year. Many patients would rather get on a waiting list—

sometimes waiting up to six months—to have heart surgery at UCCT, rather then have the procedure done elsewhere.

- ***Laparoscopic Surgery***

Over the course of the partnership, the Buffalo and Tuzla partners conducted an assessment of UCCT for the introduction of laparoscopic surgery and obtained necessary equipment to begin offering laparoscopic procedures. UCCT performed more than 130 cholecystectomies with only minimal complications. Five Bosnian surgeons were trained in Buffalo in laparoscopy, and UCCT performed over 300 laparoscopic surgeries during the partnership.

- ***Pediatrics***

The Buffalo pediatric surgery team provided 250 hours of bedside and intra-operative training to nurses and physicians in pediatric surgery, and Bosnian pediatric surgeons were exposed to over 600 major surgical procedures during their training in Buffalo. The chief of surgery from Children's Hospital of Buffalo led six US teams to Tuzla over the course of the partnership to train Bosnian pediatric surgeons and nurses on specific surgical procedures such as neonatal surgery and anorectal malformations; the BGH chief of surgery performed more than 120 operations in Bosnia over the course of his visits. In addition, three pediatric surgeons from Buffalo gave more than 35 hours of training on a wide variety of pediatric surgical topics for general surgeons, pediatricians, pediatric surgeons, nurses and gynecologists in Tuzla. The mortality rate for pediatric patients with anorectal malformations and diafermatic hernias decreased from 70 percent to 20 percent at UCCT during the partnership.

The partners established two definitive referral patterns for pediatric surgery cases. Tuzla and Sarajevo were identified as the two major referral centers, and all pediatric surgeons in Bihac, Tuzla and Sarajevo approved the referral patterns. These sites accept referrals of major neonatal and complex pediatric surgery patients.

The partners held a regional Pediatric Surgery Conference in Mostar in June 1998, which was the first conference held in Bosnia where all three ethnic groups involved in the recent conflict (Bosnians, Croats and Serbs) were represented. It included major discussions on the development of referral networks, and building infrastructure and educational venues for pediatric surgeons. Surgeons presented 40 papers on a variety of topics including esophageal reconstruction, anorectal anomalies, genito-urinary reconstruction, parasitic diseases and neonatal surgery. Videos of surgical procedures were also presented at the conference.

The partnership's work on neonatal and perinatal care helped the hospital decrease its infant mortality rates from 23/1,000 live births in 1996 to 10/1,000 in 1998; the partnership also influenced obstetrical/gynecological care. UCCT now sponsors a program in which a father can be present at a child's birth, and mother and child are no longer separated after birth, per previous practice.

- ***Neurology***

Specialists from BGH provided training for staff at UCCT on neurology and treatment of stroke victims. The Tuzla staff report that they have improved their ability to assess and treat stroke victims, and UCCT now has developed a stroke unit which meets EU quality standards. Before the partnership, the neurology department conducted about 250 procedures per year, but today, the rate is approximately 400/year.

As recently as 2003, staff from Buffalo visited Tuzla to conduct training at UCCT, including a symposium in Tuzla on skull-based surgery. According to UCCT staff, 95 percent of the neurological surgeries conducted in Bosnia and Herzegovina take place at the UCCT department of neurosurgery; the Tuzla partners want to cover the remaining 5 percent of such cases in the future.

- ***Hospital Management***

A major focus of AIHA and the Tuzla/Buffalo partnership was the development of the management skills and capacity of the staff at UCCT. In 1997-1998, AIHA collaborated with the Buffalo partners and the Association of University Professionals in Health Administration (AUPHA) to conduct the three-part Healthcare Management Development Program for 40 Tuzla partners from UCCT.

Part I of the program provided a foundation for the development of management and quality concepts and covered the following topics: concepts of management and leadership, organizational change, quality improvement tools and measurement, and team-building. Part II focused on approaches to implementing specific management tools in the participant's home setting, including planning and project management, decision-making, human resource management, financial management, and free market economics.

Management Workshop in Tuzla

The third part in this series of workshops reinforced the previous topics covered, and provided a training-of-trainers (TOT) course for selected staff from UCCT. The goal of this TOT approach was to help the Tuzla partners develop a cadre of health management trainers at UCCT. These management trainers were then able to train their colleagues at the hospital about these management skills and concepts.

"The management workshops were important in helping us identify each person's potential within the organization. They not only introduced important theoretical concepts, but also helped us learn practical skills in working with each other. While we were playing with a ball, for example, we were really learning very important problem-solving skills." *– Osman Sinanovic, UCCT*

In addition to offering training programs focused specifically on management, the Buffalo partners took steps to teach management concepts to a broad array of staff at UCCT. For example, all Tuzla partners who participated in exchanges to Buffalo underwent training in change management to help them maximize their learning process while in Buffalo and apply partnership-related changes upon their return to Tuzla. The Bosnians completed action plans for improvement projects that could realistically be implemented upon their return to Tuzla.

- ***Nursing***

The Tuzla/Buffalo partnership and AIHA's nursing initiative played instrumental roles in the development of the status and role of nurses at UCCT and in Bosnia and Herzegovina as a whole. With the help of the US partners, the nurses at UCCT developed competencies in a range of clinical areas: use, care and maintenance of new vital signs monitors and IV infusion pumps; conducting exams and monitoring differences in pediatric patients; care of patients in shock; and thermo-regulation in infants and young children. Furthermore, nursing practice expanded to include cardiac and respiratory assessment.

The nurses in Tuzla began to actively perform patient assessments, and stethoscopes provided to them by BGH enabled them to monitor vital signs and conduct neuro/breath sounds. Nurses are now able to care for pre-cardiac procedure and surgery patients, demonstrating their knowledge at the Cardiac Surgical Center established by the partners. In addition, the nurses at UCCT increased hand washing, recognizing it as an important infection-control measure.

The partners opened an AIHA-sponsored Nursing Resource Center (NRC) in March 1998 at UCCT which is open to nurses from all of Tuzla canton and provides a meeting space and training site for educational sessions. AIHA provided over $15,000 worth of training manikins, books, charts and office equipment to

facilitate the work of the NRC staff. Partnership nurses use the NRC to give lectures on a range of nursing topics to other nurses from districts throughout Bosnia and Herzegovina.

"The work that has been accomplished since the start of the partnership has given the profession of nursing the confidence and building tools to move into the 21st century. With the tools of leadership, team building, quality improvement, and clinical skills, Bosnian nursing will become a leader in Eastern Europe in the nursing profession, thereby making apparent nursing's value for all of Bosnia."
– Barbara Allen, RN, Buffalo General Hospital

Training and in-service programs for nurses were established at the NRC, and performance expectations/competencies for eight nurse educators were defined. Now, nursing education is incorporated into weekly rounds and programs that are supported by the NRC. An overwhelming number of nurses attend ongoing educational sessions held regularly at the NRC. Furthermore, train-the-trainer programs for care of the surgical patient, critical care patient management, and care of the cardiac patient have been held.

The leadership of the nursing structure is stronger and has demonstrated the capability to use empowerment, adult education and team-building techniques, as well as new clinical skills. They have also integrated principles of continuous quality improvement into their work. Additionally, nurses now join physicians on rounds, educational meetings and evaluations. The Bosnian partners established nursing committees at UCCT, which are charged with developing policies, procedures, and standards of care at the hospital. The committee system was used to develop an IV therapy policy for pediatrics.

Nursing continues to be an area of emphasis at UCCT. The Tuzla NRC continues to be fully operational, serving as the venue for regular training for nurses in clinical skills and computer use, as well as hosting regular meetings of nursing staff, and serving as a resource center for nurses, and provides an average of 25-30 courses per year. Through the training at the NRC, UCCT offers a six-month certificate program in continuing education for nurses in areas such as urgent care, transport of victims, and handling land mine victims; this certificate is recognized by the Bosnian Nursing Association. The stature of the role of nursing at UCCT has also been elevated, with many nurses saying that they are less dependent on physician input to do their work, and feel like they have a right to express their opinions.

Partnership nurses from both Buffalo and Tuzla were instrumental in lobbying for the formation of a University-level nursing program. The Minister of Education for Tuzla Canton and the President of the University of Tuzla approved the proposed program. This was accomplished through changes in secondary medical school education, supported and approved by the Ministry of Education and UCCT leadership.

- ***Access to Health Information and Communications***

AIHA supported a Learning Resource Center (LRC) at the University Clinical Center in Tuzla from January 1997 through September 2004. This LRC served a community of approximately 2,300 health professionals, who utilized the resources of the LRC for telemedicine and communication with international colleagues as well as to access the latest research on the Internet and compare international standards of practice with their own.

Early on in the partnership, the LRC staff focused on supporting the development of electronic patient record applications and a local area network. The LRC created patient record databases for the cardiovascular clinic as well as the neurosurgery, pathology, and radiology departments. These database and network support functions were eventually absorbed by a newly formed IT services department, at which time the LRC began focusing more extensively on supporting clinical quality improvement. At this time, the LRC became involved in the creation of a working group tasked with the development of standards and policies for the institution. Clincians at the University Clinical Center routinely used the LRC's resources to investigate newly available drugs and develop protocols for their use.

Overall, LRC staff trained 250 health professionals on the use of computers and the Internet to obtain medical information.

CHALLENGES

- The timing of the Tuzla/Buffalo partnership was important for the rehabilitation and development of UCCT. Many professionals left Bosnia and Herzegovina during and after the war, and this flight of personnel also affected the health sector. While some staff left UCCT, relatively more physicians and nurses remained in Tuzla and all of the medical personnel who were on UCCT's cardiac unit at the beginning of the partnership in 1996 are still there today. The partners attribute this staff retention to the changes in management and practice introduced by the partnership and the increased optimism and sense of hope that interaction with the US partners instilled.

- The success of the Tuzla/Buffalo partnership demonstrated the viability of the AIHA partnership program in post-conflict environments. While Bosnia and Herzegovina was still grappling with the economic, social and other adverse effects of the 1992-1995 war, UCCT was able to implement sustainable changes in the delivery of clinical care while instituting better management practices and better utilizing nurses in its work. The partnership focused mostly on capacity-building and staff training, complementing the investment by USAID and other donor organizations in rebuilding UCCT's infrastructure. The partnership also fostered inter-ethnic cooperation by bringing together Bosnian, Croatian and Serbian medical and health professionals for the first time since the end of the conflict.

- UCCT has been able to sustain its partnership with BGH after AIHA/USAID support. Three BGH staff visited Tuzla in the spring of 2005 to conduct training in neurology, and two physicians from UCCT spent one year in Buffalo for specialization training. UCCT also developed 13 new collaborative relationships with organizations in the former Yugoslavia, Western Europe and the US. According to UCCT staff, the experience of the AIHA partnership with Buffalo helped trigger the development of these additional institutional relationships which focus on a number of areas including palliative care, neurology, psychology (including post-traumatic stress disorder), physical rehabilitation, bone marrow transplants and pulmonology. According to the medical director at UCCT, the AIHA partnership experience taught the Bosnian partners how to create new partnerships of their own, and according to the Deputy Minister of Health of the Tuzla Canton, the partnership helped UCCT to raise its profile and enhance its reputation not only in Bosnia, but worldwide. The leadership at UCCT has also demonstrated a commitment to these new relationships, and when a new partnership was created between a hospital in Cleveland, Ohio and Tuzla, UCCT agreed to fund the plane tickets to allow its staff to travel to the US for training and residencies.

  "Without the partnership with Buffalo, it would have taken us five more years to get to the point where we are now. We had cooperated with others before the Buffalo partnership, but Buffalo came at an important time – at the end of the war. The partnership helped us keep people here. The partnership also helped us realize that we cannot be a small, closed hospital – we needed to open up to new ways of learning, e.g. to work more on education and training." *– Nedret Mujkanovic, Director, University Clinical Center Tuzla*

- UCCT continues to introduce new procedures and expand its range of services. In 1998, for example, the hospital began to conduct DNA analysis, particularly important in the identification of victims which were found in mass graves stemming from the recent conflict. The pediatric surgery department also has received training on the "chicken chest" procedure to address this specific deformity which afflicts children. UCCT is now one of only five clinics in Europe that conducts this procedure. Despite all these great advances, UCCT still continues to face challenges in providing quality clinical care. The cardiology

department and cardiac center, for instance, would like to double its capacity to provide diagnostic services and conduct heart surgery, but does not have the resources to make the physical changes, purchase additional equipment and supplies, and add the necessary staff. Some of the UCCT staff working in the pediatric surgery department also wanted to develop a full-fledged children's hospital on the UCCT campus to better care for young patients and improve the conditions of care of children before and after surgery. Instead the pediatric surgical department was moved from UCCT to another hospital. The Tuzla partners interviewed felt this was a missed opportunity to enhance pediatric care at UCCT.

- While AIHA partnerships have generally welcomed the participation of international partners who did not speak English, the Buffalo partners stressed the need for the Tuzla partners to be more proficient in English. The US partners conducted intensive English language courses in Bosnia for the Tuzla partners who were going to be traveling to Buffalo on partnership exchanges in order to elevate their English language ability to a workable level. While AIHA continues to stress an inclusive approach to its programs in which language is not a barrier, there was certainly a value to the Bosnian partners having a better understanding of the English language. After the English courses, UCCT personnel were able to better utilize partner-donated and purchased resource materials in English, and Bosnian nurses were able to more easily garner professional respect from physicians and others.

SUCCESS STORY: *Providing Quality Cardiac Care in Tuzla*

When Buffalo General Hospital (BGH) started collaborating with the University Clinical Center in Tuzla (UCCT) in 1996, Bosnia and Herzegovina did not have the capacity to provide advanced treatment of cardiovascular disease. Instead of investing in local capacity to provide cardiac care, the Bosnian government spent a large portion of its health care budget to transport patients needing open-heart surgery or other advanced cardiac care to other countries for treatment. With cardiovascular disease being the number one cause of death in Bosnia and Herzegovina, the Tuzla/Buffalo partners agreed that a cardiac treatment center needed to be established in Tuzla.

During partnership exchanges to Buffalo, the US partners provided training in advanced cardiac care to a group of Bosnian surgeons, nurses, and anesthesiologists who would make up the cardiac surgical team at UCCT. The partners also established a new cardiac catheterization lab at UCCT, which provides Bosnian patients with cardiovascular disease access to a full compliment of cardiac diagnostic procedures. Partners from BGH helped develop the lab, assisting with obtaining funding for a fully reconditioned cardiac angiography unit, and providing clinical training to many of UCCT's diagnostic cardiologists.

The partners built upon their experience in training a Bosnian cardiac team and opening the lab to establishment a full Cardiac Surgery Center at UCCT in September 1998. Alija Izetbegovic, the president of Bosnia and Herzegovina, presided over the opening ceremony for the center, which was attended by over 200 cardiac specialists. This "center of excellence" provides advanced treatment for heart attack and stroke patients, and staff educates patients on cardiovascular disease risk factors and preventive care.

The Cardiac Center conducted its first open heart surgery in 1998 and by 2004, UCCT averaged 475 open-heart procedures a year. While the hospital in Sarajevo offers open heart surgeries, many patients would rather get on a waiting list—sometimes waiting up to six months—to have heart surgery at UCCT, rather then have the procedure done elsewhere.

"What seemed to be an elusive dream five years ago in the middle of the war had become a reality, and the people of Tuzla and the rest of Bosnia had for the first time been able to develop a center of modern treatment for cardiovascular disease," said Jacob Bergsland, MD from BGH. "What was even more apparent was the enthusiasm with which the team performed their work and their willingness to learn and further advance their abilities."

Partner Profile *Jacob Bergsland*

Jacob Bergsland first traveled to Bosnia in 1994 to volunteer for four months during the height of the war there. As a cardiologist working at Buffalo General Hospital (BGH) in Buffalo, New York, he was assigned to a UN hospital in Tuzla, during which time he got to know the staff from the University Clinical Center (UCCT). Bergsland saw the possibility of working with the staff from Tuzla to develop a more advanced medical center at UCCT, including cardiac surgery and cardiology, which is Bergsland's specialty. At the time, the country had no capabilities in cardiac surgery and cardiology.

Upon returning to the US, Bergsland immediately began to spearhead efforts to collect private donations to fund a medical exchange program between Buffalo and Tuzla. He found funds for a limited exchange program to provide some support, including a training program for nurses, but it became evident that a larger, more coordinated effort was needed.

At this point Bergsland learned that AIHA was starting to support hospital partnerships in Central and Eastern Europe, including in Bosnia. He convinced the leadership of BGH to apply for the partnership, leveraging his existing relationships with leaders in Tuzla to win a grant for the partnership in 1996. During the three years of the partnership, Bergsland and his colleagues at BGH were able to work with their Tuzla counterparts to address cardiology as well as a number of other issues. Bergsland worked with the Bosnian partners to establish a cardiac center at UCCT, including the training of an entire cardiac team.

"We worked very hard on this partnership; it was my main preoccupation for years and still is," says Bergsland.

Bergsland remembers that it was a stipulation of the cardiac center's establishment that some sort of fee-for-service type of payment system be developed to support it. This was a controversial idea at a time when hospitals in the region worked with fixed budgets. But Bergsland explains that this payment system was very important to improve staff salaries and to lessen under-the-table payments, which are not allowed in the cardiac unit. While many staff from UCCT left Bosnia for better opportunities abroad, almost all of the staff in the cardiac unit remained.

"Something changed. We were more respectful of individuals and they felt they had a future, since the hospital was able to pay them better," concludes Bergsland.

Something else happened to Bergsland as he continued to volunteer more of his time in support of the partnership with UCCT. He explains, "When I first visited Bosnia, I thought it was so unfair what was happening to the people there. I became more and more involved in society there, and I thought that this is what I should focus on the rest of my life."

So Bergsland left Buffalo and moved to Tuzla, where he is now the Director for International Programs at UCCT. Since participating in the AIHA partnership, UCCT has developed over 10 new international collaborative relationships, which Bergsland helps to guide, not as a volunteer and a partner, but now as a staff member.

Bergsland now splits his time between Tuzla and Oslo, Norway (his country of origin), but considers Tuzla his home, a city which has undergone major change in the past 10 years. Tuzla was a very multicultural city before the war, but now 80 percent of the population is Muslim. The emotional scars and inter-ethnic tensions still exist, and ethnic Croats and Serbs have been reluctant to come to UCCT for medical care. But according to Bergsland, this is starting to change. "People from around the country heard from their neighbors that they were getting good care, were not being asked for additional money, and were being treated well in Tuzla. People are not afraid to come here anymore."

Bergsland and his colleagues at UCCT are now working to establish stronger professional ties to other communities in the country as well. The Tuzla partners are working with counterparts in Banja Luka, the capital of Republika Srbska (the Serbian entity of Bosnia and Herzegovina). UCCT staff provided training for staff in Mostar and from Kosovo to help them establish catheterization laboratories in their own sites. Bergsland concludes that in some small but significant ways they have contributed to the unification process happening in the country.

When asked why he decided to move to Bosnia, Bergsland answered, "I didn't plan to live and work in Tuzla permanently, but it became my obsession. It became my main goal and ambition in life to get this to work."

II.C. CROATIA (1994–2004)

Program Highlights

- New roles were established for nurses, nursing education was improved, and partnership nurses began to assume new leadership roles in Zadar and Zagreb.
- Wards at Srebrnjak Children's Hospital for Respiratory Diseases realized a 35% reduction in hospital pharmacy costs, due to the introduction of measures to increase efficiency in pharmaceutical management.
- The Split partners introduced an alcohol use prevention program for 1,300 students in 13 community schools.
- An inter-disciplinary team was brought together for the first time to address HIV/AIDS stigma and discrimination through policy change and education of the media and the general public.

Partnerships/Projects	Years	Focus Areas	Partner Institutions
Zagreb/Lebanon, NH	1994-1998	Leadership Development, Nursing, Pharmacy, Infection Control, Respiratory Diseases, Micro Invasive Surgery, Neonatology, Collaborative Practice, Nursing	• Sveti Duh General Hospital • Dr. Fran Mihaljevic University Hospital for Infectious Diseases • Srebrnjak Children's Hospital for Respiratory Diseases • Dartmouth-Hitchcock Medical Center
Zadar/Franciscan Sisters of the Poor Health System, Inc.	1995-1998	Leadership Development, Cardiology, Oncology, Orthopedic Trauma, Geriatrics, Post-Traumatic Stress Disorder, Infection Control, Total Quality Management, Fundraising and Development, Nursing	• Zadar General Hospital • Orthopedic Hospital of Biograd • Franciscan Health System of the Ohio Valley (Cincinnati and Dayton, Ohio) • The Franciscan at St. Leonard (Dayton, Ohio) • Our Lady of Bellefonte Hospital (Ashland, Kentucky) • St. Francis Health System (Greenville, South Carolina) • St. Mary's Community Mental Health Clinic (Hoboken, New Jersey)

Split/Piscataway, New Jersey	2001-2003	Healthy Communities, Youth Alcohol Use	• University of Medicine and Dentistry of New Jersey (UMDNJ) • The City of Split • Split – Zdravi Grad (Split – Health City) Association
HIV/AIDS Stigma	2002-2004	HIV/AIDS	• NGO Udruga ("Help") • Andrija Stampar School of Public Health

BACKGROUND

Croatia became an independent country when the Yugoslavian federation collapsed and officially declared independence in October 1991. War continued with Serbs in the Krajina region of eastern Croatia and with the Federal Republic of Yugoslavia during 1991–1992, and in Bosnia and Herzegovina until the signing of the Dayton peace agreement in December 1995. This agreement recognized Croatia's traditional borders and called for the return of eastern Slavonia to Croatia in 1997, which was held by ethnic Serbs.

During the war which followed national independence, Croatia suffered extensive material damage, particularly in the frontier areas in eastern Slavonia, along the border with Bosnia and Herzegovina, and the area around Dubrovnik. By mid-1995, over 16,000 Croatian citizens had been killed in the war and over 30,000 had been made permanent invalids. A survey in Croatia in March 1996 counted 361,774 displaced persons and refugees. ("Health Care Systems in Transition: Croatia," European Observatory on Health Systems and Policies)

Croatia began to enact healthcare reform after declaring independence, but this was interrupted by the war. The war also placed a financial strain on the Croatian health care system and in 1992, the amount of government funding for healthcare plummeted to one-quarter of its pre-war levels. (European Observatory) In order to effectively reform healthcare with limited funding, Croatia needed to improve the efficiency and productivity of its healthcare institutions through better institutional management and organization. Croatian hospitals needed to develop better standards of care in a number of clinical areas and improved screening and treatment for cardiovascular diseases, asthma, and various cancers. Infection control statistics were not being reported, and healthcare facilities needed to establish preventative infection control techniques.

The war also presented a number of unique pressing issues to be addressed, including the need for training on reconstructive surgical techniques, the use of prosthetics, and training in rehabilitation for wounded patients. There was a high incidence of Post-Traumatic Stress Disorder (PTSD) from those directly affected by the war, especially among children. The high unemployment and lack of opportunities led to an increase in high-risk behavior, including drug abuse and increased alcohol use by youth.

AIHA began working in Croatia in 1994 with the establishment of the first of two hospital partnerships: the Zagreb/Lebanon, NH. A year later, the second hospital partnership was launched involving the cities of Zadar and Biograd. The partnerships focused on hospital management, infection control, nursing, quality improvement, and pharmaceutical management. The partnerships ended in 1998 as the USAID/Croatia Mission shifted its focus away from health programming. In 2001, AIHA was asked to return to Croatia to establish a Healthy Communities partnership. While the incidence and prevalence of HIV/AIDS in Croatia had been low, it became a growing issue of concern in Croatia requiring stronger prevention programs. All member cities of the Healthy Cities Network in the country were invited to apply. AIHA attended an HC meeting where interested cities were interviewed and Split was selected through a competitive process.

The experience of the Healthy Communities partnership led USAID to support a special project focusing on HIV/AIDS. For community intervention the Split partners came up with idea of working with the NGO "Help."

KEY RESULTS

- ***Hospital Management***

Both hospital partnerships worked to improve the management at the partner institutions. By introducing the concept of quality improvement, streamlining processes, improving organization and involving all levels of staff, they were able to improve the quality of care provided at their institutions while boosting morale and making better use of scarce resources.

The Zadar/Franciscan partnership initiated and successfully completed two formal Quality Improvement Team Projects by Zadar General Hospital and Orthopedic Hospital of Biograd utilizing multi-disciplinary teams. The first project implemented in Zadar was aimed at increasing communication between departments and decreasing the burden of non-nursing tasks assigned to nurses. In Biograd, nosocomial infection rates fell substantially as a result of the partnership's focus on quality.

"I was enormously impressed by the resourcefulness of the partners in finding new solutions to old problems, identifying new processes of care to improve patient safety and efficiency of health care delivery. The partners worked very hard despite changing environmental conditions, including the war, limited funding for new programs, and the ever-changing turnover of Ministry of Health personnel who set policy for the country's health sector."
– Jo Ann Kairys, Zagreb/Dartmouth

Some examples of an organizational change brought on by partner efforts was the creation of a sub-acute geriatric unit in Biograd Orthopedic Hospital and an adult day care center in Sibenik; in Zagreb, the role of the respiratory therapist, as a member of the critical care team, was recognized and strengthened, and critical care units created nursing-doctor collaborative management teams.

The use of quality outcome measures was introduced in all three Zagreb/Lebanon partner institutions. Leadership training provided to the Croatian partners reinforced their ability to use quality management principles in their daily work. Methods were introduced to improve collaborative practice and resolve communication and decision-making among team members. As a result, interpersonal relationships (physician-to-physician; physician-to-nurse; nurse-to-nurse) and intra- and inter-departmental collaboration have all improved. Meetings are more efficient, and agendas are prepared one week in advance. Problems are discussed, and conclusions are identified and reviewed at follow-up meetings.

Leadership development programs set the stage for more collaborative interactions rather than "top-down" directives. Head nurses now hold regular meetings where subordinate nurses are asked their opinions, and problem-solving is more participatory and constructive.

Projects implemented at Sveti Duh Hospital (involving the cardiology, orthopedics hematology, trauma, and nephrology departments) achieved measurable improvements in provider teamwork, patient satisfaction, effectiveness of care, and clinical outcomes.

As a result of organizational changes at Biograd Hospital, the length of stay for new patients undergoing arthroscopy fell from 30 days in 1995 to three days and then decreased again to same-day of surgery in 1998.

- ***Infection Control***

Improving infection control practices was another focus of Croatia's hospital partnerships. A national resource center for infection control microbiology was established at Zagreb's University Hospital for Infectious Diseases. Srebrnjak Children's Hospital improved visiting hours in response to patient surveys and began isolating tuberculosis patients to reduce hospital infection rates.

As a result of the Zagreb/Lebanon partnership, the Ministry of Health established a new Committee for the Control and Surveillance of Infectious Diseases, which meets monthly to discuss nosocomial infections and laboratory diagnostic procedures. Additionally, the hospitals in Zagreb have begun to measure risk factors for nosocomial infections, representing a major impact of the conferences and partnership activities. Croatian nurses expressed a better understanding of the importance of infection control in the hospital environment, and an infection control nurse was appointed in Zadar General Hospital.

"A physician at the Infectious Diseases Hospital in Zagreb rushed to assist a patient on dialysis as we looked on. Blood was spurting from the patient's arm onto the bed. The doctor had no gloves or protective clothing. It was the middle of the war with Serbia. There were few resources for medical personnel. He later told us the patient had AIDS. He said, 'You do what you have to do.'"
– Jo Ann Kairys, former Zagreb/Lebanon Partnership Coordinator

Laboratory staff from three Croatian hospitals attended a one-week training course in WHONET, a database system designed and introduced by the World Health Organization to monitor and analyze data related to anti-microbial resistance. WHONET software was introduced in the microbiology laboratories, and data was collected and sent to WHONET collaborating centers on a regular basis following the training workshop.

- ***Clinical Care***

A comprehensive program for diagnosis and treatment of asthma and TB was introduced at Srebrnjak Children's Hospital for Respiratory Diseases. The partners developed patient education materials and assisted with the renovation of the physical space for treatment of patients with TB at Srebrnjak. Additionally, an asthma camp to teach patients and families about prevention and treatment was opened in rural Croatia.

The renal teams at Sveti Duh General Hospital and Dartmouth-Hitchcock Medical Center collaborated to test an innovative method to evaluate the functional health status of patients on dialysis, looking at ways to improve the quality of care for chronic renal patients. The study represented a breakthrough approach, pioneered by the Croatian team, to enhance the daily lives of patients with chronic illness.

The family-oriented care initiative, implemented at Srebrnjak Children's Hospital for Respiratory Diseases and University Hospital for Infectious Diseases hospitals, dramatically influenced the development of new policies permitting increased family visitation on inpatient units. Improved parent/baby contact, increased nurse involvement in parent education, and improved care of babies 1,000 to 2,500 grams, was noted at Sveti Duh Hospital.

An intensive decubitus ulcer (bedsore) skin care research project was implemented in both Zadar partner institutions which demonstrated significant improvement in patient status as a result of improved nursing care. Nurses also demonstrated an improved understanding of skin care and the use of skin care products as well as overlay mattresses. Additionally, a train-the-trainers program was introduced to educate other nurses on assessment skills for specific patient populations with high risk for decubitus ulcers.

The use of a dressing cart in the neurological unit was initiated in Zadar which saved time previously used to gather equipment for dressing changes. In addition, the use of the cart supported the introduction of new treatment plans and protocols that were established.

Most of the new practices and approaches introduced by the hospital partnerships in Croatia are still in use today. The number of cardiac catheterizations in Zadar has continued to increase (680 in 2004). Arthroscopic surgery is still performed at Biograd Hospital, and new physicians are trained in this technique.

US partners at St. Francis Health System in Greenville, SC planned to host a post-partnership exchange of orthopedists from Zadar and Biograd, but when the director of the Orthopedic Hospital of Biograd died suddenly in 2000, there was no one to take over the partnership on the Biograd side. However, many of the Croatian partners maintain contact with the US partners, ranging from continued collaboration on scholarly research (child psychiatry) to occasional professional exchanges by email to purely social exchanges around the holidays. The partners in psychiatry in particular have remained collaborators on a number of presentations and articles.

- ***Nursing***

Improving the status of nurses and the state of nursing care was a main priority in both of the hospital partnerships. The Zagreb/Lebanon partnership upgraded the clinical skills and knowledge of nurses in a variety of areas and introduced management and leadership functions into the role of the nursing staff. The partners also introduced human resource tools for nursing practice, including job descriptions, staff orientation, and performance evaluation. A formal link was established between the School of Nursing in Zagreb and the partnership for purposes of education, research and leadership training. One of the nurses from the partnership who also participated in AIHA's International Nursing Leadership Institute went on to become the president of the Croatian Nurses Association.

As a result of the Zadar/Franciscan partnership, the status of nurses at Zadar General Hospital and Orthopedic Hospital of Biograd changed. Nurses began to be seen as a vital part of the medical team, and two hospital departments added the position of nursing assistant. The nursing school in Zadar began to examine and upgrade the nursing curriculum and educational standards.

The Zagreb NRC is still functioning (except for the computer) and training occurs approximately once a week. The NRC is used at least once a day by nurses or students, and was the first place in the hospital for the nurses to have Internet access. Beginning in 2005, nursing trainings will be accredited by the RN Chamber Association. The Chamber, established in 2003, has adopted many of the protocols and job descriptions prepared through the partnership.

Meanwhile, the NRC in Zadar opened in 1998 but closed in 2000 during hospital renovation. The Croatian partners hope to reopen it in a new location when the renovations are completed. Currently, nurses must find available rooms in the departments for their educational activities and there is limited interest and available time for them to visit the hospital library and use the Internet.

The American Organization of Nurse Executives (AONE) co-sponsored a nursing leadership congress with the Croatian Nurses Association in May 2006. This two-day congress in Opatija, Croatia is an example of the continued cooperation between a former Dartmouth partner, who is now president of AONE, and her Croatian counterparts. The current president of the Croatian Nurses Association participated in the leadership development component of the Zagreb/Lebanon partnership and in AIHA's International Nursing Leadership Institute (INLI). She is also an AONE member and was featured on the cover of the April 2006 edition of the AONE publication *Nurse Leader*.

- ***Pharmacy Management***

The Zagreb/Lebanon partners developed ways to improve pharmacy management during the drug selection, ordering, and dispensing processes, and the pharmacist's role in managing the medication process was strengthened, and quality improvement methods in problem identification and process planning were introduced.

Several pilot programs within the pharmacy initiative demonstrated excellent outcomes in cost reduction. Wards at Srebrnjak Children's Hospital for Respiratory Diseases realized a 35% reduction in hospital pharmacy costs, due to the introduction of unit dose dispensing and a program to control the use of high-cost antibiotics.

The three Zagreb hospitals reported a 16% reduction in medication waste. Prior to the partnership, surveillance of antibiotic infections did not exist and there was a monthly stockpile of medications. This resulted not only in waste, but also promoted over-medication. Since the introduction of a unit dose system, a monthly process control flow chart of medication consumption shows steady reduction of medication waste.

An antibiotic monitoring system was developed and implemented at Sveti Duh, which resulted in an estimated annual savings of approximately $260,000. (Savings were primarily due to the more targeted use of effective antibiotics for particular organism strains.)

Training in database development by the Lebanon partners resulted in the introduction of programs in the three Zagreb hospitals to track the use of medications, leading to significant cost reductions. Programs were established to collect clinical information to monitor patients' diagnosis, treatment, and follow-up care.

- ***Post-Traumatic Stress Disorder (PTSD)***

Partners from the Franciscan Health System provided training for the Croatians in group therapy for children suffering from PTSD. The US partners provided educational materials on PTSD, including translated psychological screening instruments which can be used to work with traumatized children. The partners helped organize and participated in a national symposium on PTSD in Croatia in June 1998.

With the assistance of the US partners, the Croatian partners increased the number of people receiving treatment for PTSD in the Zadar region. During the partnership, the number of children and adolescents in treatment increased to 50 and the number of adults in treatment (most were war veterans) increased to 45. At the initiative of the partners, approximately 250 children in two schools in Zadar were screened for PTSD.

Before the partnership intervention, there was little recognition of the need to provide psychological services to veterans experiencing PTSD symptoms. However, over the course of the partnership, the need to provide individual, family, and group psychotherapy for veterans became very apparent. Many of the suffering veterans were also fathers, so providing treatment for them also helped their children and families deal with the extreme stress. Zadar developed one of Croatia's most active programs for veterans experiencing PTSD.

- ***Healthy Communities/Community Outreach***

Zadar General Hospital started a public education campaign for the early detection of colon and breast cancer, which has proven very effective in increasing public knowledge and awareness of the disease. The Zadar partnership also reached out to the local community by sponsoring a joint cardiovascular and oncology health fair in April 1998. The overwhelming public response affirmed the need for more public educational offerings and cardiovascular screening.

After conducting an initial assessment in November 2001, the Split/New Jersey partners decided to administer the Youth Risk Behavior Survey (YRBS) to more precisely determine particular areas of focus for the Healthy Communities partnership. In June 2002, the Split partners administered the YRBS to 1,000 youth, ages 12 to 17, in 17 primary and secondary public schools throughout the city. Based on the findings of the YRBS, the partners decided to focus on the issue of alcohol use among Split youth.

"We never had the opportunity before AIHA and USAID to actually do a 'needs assessment' to find out what the community wants. This was the first time in my entire work experience that I ever had that opportunity. I was always given a mandate of what needed to be done." *– Diane Abatemarco, former Split/New Jersey Partnership Coordinator*

- ***Youth Alcohol Use***

The New Jersey partners conducted a thorough review of available programs and suggested three possible interventions to address youth alcohol use in Split. The partners selected Project Northland as the appropriate intervention and prepared and introduced the program to sixth-grade students in Split. (Project Northland is a multi-tiered, community-based alcohol intervention launched in 1990 by the US National Institute on Alcohol Abuse and Alcoholism at the National Institutes of Health. The intervention, which has since been implemented in Russia, incorporates behavioral curricula used in schools, parental involvement in programs, extracurricular peer leadership and community-wide efforts for adolescents in sixth through eighth grades, and has been evaluated using a randomized community trial.)

The US partners were trained on the use of the Project Northland curricula, and materials were sent to Split for translation and duplication, and the Ministry of Health and the Ministry of Education in Croatia granted approval for implementation of this intervention. Project Northland materials were adapted to meet local needs, translated into Croatian, and reproduced in Split. The Split partners and 15 teachers received training on the use of Project Northland in the classroom. The sixth grade curriculum was successfully implemented in 13 schools from March to May 2003, reaching approximately 1,300 students. (Pre- and post-test questionnaires were administered to all sixth grade students in the 13 schools that served as cases and 13 non-participating schools that served as the control group.)

While initial data shows that there has been a decrease in the number of students who have drunk alcohol for the first time (comparing survey responses from participating students versus those of the control group), the impact of the program will not be known until after the students complete the entire three-year program. However, it is apparent that Project Northland changed the nature of the relationships between students and their teachers and parents in that the participating students now more readily communicate with their teachers, parents, and peers about issues of alcohol, drug, and tobacco use.

Project Northland Classroom Scoreboard

Although the partnership officially ended in 2003, the New Jersey partners won a grant from the Foundation of UMDNJ to extend the partnership for another 1.5 years. The partners conducted focus groups in Split with teachers, students, and parents who participated in Project Northland to gather their input and find ways to improve the program. The Croatian partners returned to New Jersey last fall to evaluate the program and share their experiences with faculty and students at UMDNJ as well as with community leaders from across the state. Project Northland continues to be implemented in Split, and has been implemented in other Croatian communities.

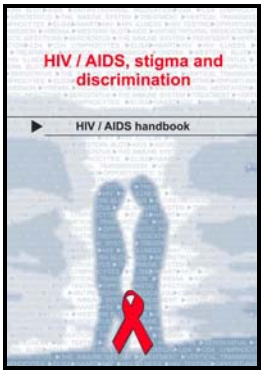
➢ *HIV/AIDS*

In 2002, AIHA contracted with NGO Udruga (NGO Help) in Split to implement HIV/AIDS prevention activities targeting adolescents, including high-risk and vulnerable groups such as intravenous drug users and sex workers. NGO Help provided voluntary testing and counseling services and developed outreach materials to reach the target groups through community awareness materials, peer education activities, a media campaign, and a hotline. From January to July 2003, NGO Help trained 50 student peer educators; printed and distributed 19,000 copies of educational materials (including 10,000 coasters distributed to various Split cafes and restaurants and 9,000 leaflets); and made arrangements with sports, cultural, political, and religious figures to appear in television ads discussing HIV/AIDS. During the same period, 78 calls were received on the HIV/AIDS information hotline, and 212 new clients requested HIV/AIDS testing. Due to concerns related to inappropriate use of USAID funds, AIHA conducted a performance review of NGO Help on September 30, 2003 and based on the findings, a decision was made to terminate the contract with NGO.

HIV/AIDS Stigma and Discrimination Event Poster

To utilize remaining funding, on April 26-27, 2004 AIHA and the Stampar School of Public Health held a workshop and roundtable in Zagreb to address HIV/AIDS stigma and discrimination. The meetings provided a forum in which physicians, journalists, politicians, legal experts, and NGO representatives could openly discuss ways to prevent the continued stigmatization of and discrimination against people living with HIV/AIDS (PWLAs). Meeting participants discussed ways to develop effective programs and activities at the community level to increase the Croatian public's understanding of HIV/AIDS, including stigma and discrimination issues. The meetings were well-publicized in newspapers, magazines, posters, and flyers; and educational materials produced and distributed. Approximately 150 people attended the film event on the evening of April 26, where they saw the film *Pandemic: Facing AIDS*, which further highlighted the issue of HIV/AIDS and stigma/discrimination by the public.

The Zagreb events were the first of their kind in Croatia and provided a much-needed impetus for interested parties to work together to increase the level of public awareness about HIV/AIDS in Croatia – particularly regarding how HIV is (and is not) transmitted. The Croatian participants themselves agreed to implement a number of activities and programs identified during the Zagreb meetings. For example, legal experts and NGO representatives will work together to analyze the current legal and regulatory framework regarding HIV/AIDS, which could lead to the drafting of anti-discrimination legislation. The participants also discussed the need to provide better school-based sex education, develop large-scale media campaigns addressing HIV/AIDS, and suggested creating a new task force to coordinate future HIV/AIDS-related activities and programs.



HIV/AIDS Stigma and Discrimination Handbook Cover

The April events in Zagreb have resulted in many new working relationships formed among Croatian participants who have pledged to continue to work collaboratively on HIV/AIDS programs. The impact of the two-day event supported by USAID will be significant in improving the dialogue and the implementation of effective programs to address HIV/AIDS in Croatia.

During the Zagreb meetings, participants agreed on the need for a handbook for the media and general public on how to report on and discuss HIV/AIDS-related issues, without using terms and concepts that promote stigmatization and discrimination. AIHA provided limited funding to the Stampar School to lead this effort. The handbook was published (officially released at a press conference in Zagreb on December 3, 2004) and includes a glossary of terms and guidelines to use when discussing HIV/AIDS and sexuality, along with

examples of "good" and "bad" coverage of the issues. By urging the media and others to follow these guidelines and terminology, standards will be set and stigmatizing language and reporting minimized.

- ***Access to Health Information and Communications***

Between September 1996 and September 2004, six LRCs were established in Croatia as part of AIHA's healthcare partnership program. These include:

- Orthopedic Hospital of Biograd;
- Split City Hall, Department for Social Welfare and Health Protection;
- Zadar General Hospital;
- Sveti Duh General Hospital – Zagreb;
- Srebrnjak Children's Hospital for Respiratory Diseases – Zagreb;
- University Hospital for Infectious Diseases – Zagreb.

LRCs at all of these institutions except Split City Hall were established in 1996-97. The Split LRC was established only in 2002, following the launch of the Split/New Jersey partnership. Collectively, these LRCs supported a community of over 2,000 health professionals in Croatia.

The LRC at the University Hospital for Infectious Diseases in Zagreb was active in several different areas, including supporting the development of guidelines on topics such as the use of antibiotics to treat upper respiratory track infections. The hospital sought to rationalize the national use of drugs and antibiotics and reduce the number of laboratory tests performed unnecessarily. The resources of the LRC were also used to support the creation of a clinical image database, which staff of the hospital used for continuing medical education lectures and the creation of an infectious disease textbook and atlas.

The resources of the LRC at the Orthopedic Hospital of Biograd were used to help rationalize the use of drugs and antibiotics. LRC staff conducted research to compare usage levels at their hospital with usage at other hospitals around the world. While usage of many drugs was found to be consistent with global standards, they found several drugs were probably being over prescribed, and as a result the director requested cuts in the orders for those drugs.

"The IT horizon is changing so fast, it is good to always be looking ahead – and that's why the partnership was useful. We saw a different system. If you don't talk to others and see how they are doing things, you can't grow or move forward." *– Ozren Pestic, Zadar LRC Information Coordinator*

The LRC at Zadar Regional Hospital became a regional model for the development of healthcare information systems. On behalf of AIHA, the information coordinator (director) of this LRC developed a guidebook to information systems planning and development, and he provided training on this subject to other LRCs at AIHA-sponsored training workshops. The guidebook emphasized a gradual planning approach for resource-limited institutions, reflecting the incremental development of the databases, electronic patient records, and local networks at Zadar Regional Hospital. The Zadar information coordinator also spearheaded the development of an evidence-based practice working group that sought to educate local healthcare workers on how to find and utilize evidence-based resources.

Altogether, these six LRCs trained 520 Croatian health professionals on the use of computers and the Internet to access medical information. They also received an average of 186 visitors and 47 information requests each month. While funding ended in September 2004, all six of these LRCs have continued to function and sustain themselves.

CHALLENGES

- While the length of patient stays in Zadar and Biograd were reduced through the changes implemented during the partnership with the Franciscans, some patients continue to be hospitalized for longer periods unnecessarily, allowing conditions for the development of nosocomial infections to reappear.

- The oncology project by the Zadar/Franciscan partnership aimed at prevention and early detection. The partnership confirmed the belief that treating early stage cancers greatly reduces the cost of treatment and increases survival rates; however, early detection must be followed by prompt treatment. Delays in treatment need to be eliminated to see benefits from early detection. The Croatian partners also realized that they needed to better promote self-care and work to change people's attitudes toward their own health and to teach the importance of screening and early detection.

- AIHA suspended its support of NGO Udruga after concerns were raised regarding possible misuse of donor funds. Instead of simply ceasing activities in support of HIV/AIDS initiatives in Croatia, AIHA utilized remaining funds to work with the Stampar School of Public Health to address HIV/AIDS stigma and discrimination, through a workshop and roundtable in Zagreb and supporting the publication of a handbook on the issue.

SUCCESS STORY: *Fighting Alcohol Use among Adolescents in Split*

A 1999 Croatian study by the Institute of Social Sciences showed that approximately 63% of high school students reported consuming alcohol in the previous month before the survey. In response to these findings, the Split/New Jersey partnership selected Project Northland as an intervention aimed to impact the community on multiple levels—student, parent, peer, school, community, and societal. A citywide meeting was convened, inviting all school principals and several teachers from each school, to determine if the school administration would support Project Northland in their schools. After the presentation, an overwhelming response from principals and teachers showed that Split city schools would welcome the curricula.

Each year of the three-year curricula was translated and culturally adapted for Croatian youth. The translators and editors, which included adults and youth, understood the social marketing messages of the sixth grade "Slick Tracy Home Team" curriculum. Additionally, the translation team realized that Slick Tracy (named after the American comic hero Dick Tracy) would not be culturally relevant to Croatian students and therefore used the name *Luca Vrli* (which means "the clever and virtuous one" in Croatian) instead. The seventh grade curriculum ("Amazing Alternatives!") and the eighth grade curriculum ("Power Lines") were also translated with the assistance of youth from Split.

The New Jersey partners received training and technical assistance in the use of all three grade-level years of Project Northland from its distributor. The training included specific instruction for training-of-trainers (TOT) and emphasized adapting the program based on local needs. In addition to translating and culturally adapting all curricula materials, all training materials were similarly translated and culturally adapted for training teachers in Split.

The success of Project Northland in Split depended on many factors, including student involvement from sixth through eighth grades, teacher and peer training, incorporation of peer-selected peer leaders at all three grade levels, and the role of an effective project coordinator. But perhaps most important was having strong school, community, and government involvement in the project and building on the Healthy Communities model. The enthusiasm of teachers and principals within the city of Split made the teacher trainings both entertaining and effective.

The sixth grade program implemented during the partnership culminated in a series of fairs displaying posters by the students for the wider community. Members of local government and the media attended, as well as all students, their families and teachers. Additional factors in the success of the first year of the project included strong NGO support for the project and ongoing planning meetings with many of Split's NGOs. The media—including television, radio, and newspaper coverage of the project—was involved from early planning stages through culmination of the poster fairs. Additional support from the mayor of Split, who attended many Project Northland events, contributed to the success of the project. The Split and New Jersey partners gained further support by presenting Project Northland in other member cities of the Croatian Network of Healthy Cities. The National Ministries of Health and Education attended events and provided their support for the project and following the conclusion of the poster fair, student posters' were hung throughout the city. The Split partners, in conjunction with NGOs, conducted a social marketing campaign of Project Northland and brochures on the project were distributed throughout the city. The NGO Split Zdravi Grad ("Split Healthy City") promoted the project by marketing the public health message of alcohol prevention in various public newspapers using a brochure developed by the Croatian partners.

Poster by Student Participating in Project Northland

Although the partnership officially ended in 2003, the US won a grant from the UMDNJ Foundation to extend the partnership for another year and-a-half, in order to study the program and find ways to improve it. Currently, the partners are starting to analyze data to evaluate the first year of Project Northland. While initial data shows that there has been a decrease in the number of students who have drunk alcohol for the first time (comparing survey responses from participating students versus those of the control group), the impact of the program will not be known until after the students complete the entire three-year program. However, it is apparent that Project Northland changed the nature of the relationships between students and their teachers and parents in that the participating students now more readily communicate with their teachers, parents, and peers about issues of alcohol, drug, and tobacco use.

The partners conducted focus groups in Split with teachers, students, and parents who participated in Project Northland to gather their input and find ways to improve the program. Based on this input, the partners concluded that Project Northland should be introduced to Croatian students at an earlier age, since Croatian youth are exposed to alcohol at an earlier age, spend more time out in the community with their peers, are more advanced educationally, and are generally more independent than American students the same age. Next year, the Split partners will introduce the first year of Project Northland to fifth graders instead of sixth graders.

Project Northland continues to be implemented in Split, and has been introduced in one of the island communities off the coast of Split. The city of Dubrovnik also plans to start the program in its schools.

A strong commitment from the partners, active involvement by NGOs, Croatian Ministries of Health and Education, local government, and schools all contributed to the success of the partnership. Media participation focused public attention on the project and encouraged community involvement. The partnership made use of the Healthy Communities planning process, beginning with an initial needs assessment and concluding with a detailed evaluation plan, which contributed to the success of the project.

Partner Profile — *Ozren Pestic*

Ozren Pestic was director of Information Technology (IT) at Zadar General Hospital when the partnership with Franciscan Sisters of the Poor Health System started in 1995. He was directly involved in the partnership from its beginning and became Information Coordinator for the Learning Resource Center (LRC) as soon as it was established in 1996.

Through his work at the LRC, Pestic soon realized that IT, the Internet, and easy access to information could have a profound impact on the medical staff at his institution and that he could effectively facilitate the process.

Although Zadar Hospital was among the first medical institutions in Croatia to develop a hospital information system and already had a fully functional system in place, Pestic's ultimate goal was "to make the whole hospital an LRC with PCs in every work space." The LRC started with three computers placed in the library, but today boasts a modern information system with more than 300 computers.

Pestic attended several training workshops organized by AIHA, including those on team building and leadership where he gained valuable insights, but a turning point for him was his participation in a study tour organized by AIHA in 2000.

"This exchange gave me an opportunity to see how things were done in similar surroundings, to look ahead and create goals for my own institution," said Pestic. "I gained some practical knowledge and ideas how to expand their use of information technology and reach my ultimate goal. Zadar Hospital will soon get well ahead of most of their peer institutions in Croatia and regionwide in information system development."

During the partnership, Pestic faced a number of challenges, in part due to the fact that his chief physician changed three times during these years and with each change, Pestic had to convince the physician of the benefits of the program, but each time he was able to do so.

Since the partnership ended, Pestic has stayed actively involved in the LRC project. On behalf of AIHA, for example, he created a Medical Informatics Manual, which is a guideline for hospital information system development that was distributed among LRCs and partnership institutions. He was also asked several times by AIHA to provide training on this subject during AIHA-sponsored workshops. Pestic continuously promotes use of evidence-based medicine (EBM), a concept which was introduced to him during the partnership. Zadar Hospital was the only CEE organization whose staff participated in pilot testing of an AIHA Web-based questionnaire on EBM.

Today Zadar General Hospital has become a regional model for the development of healthcare information systems, and Pestic continues to use his knowledge and expertise to improve the system and help others to improve their own.

"The partnership enabled me to get an overview of world trends in medical IT systems and information access, and that helped me to define our own strategy of development and not to make mistakes otherwise I could have made," said Pestic.

Partner Profile — *Diane Abatemarco*

In 2001, AIHA enlisted the University of Medicine and Dentistry of New Jersey (UMDNJ) to participate in a partnership in Split. Diane Abatemarco, a faculty member at UMDNJ, was asked by her colleagues to participate in the partnership, and was chosen for her experience in social work, community organizing, and community planning.

While previous partnerships in Croatia linked hospitals, this new partnership embraced the healthy communities methodology, requiring a different approach and expertise. Abatemarco began by helping her partners, who were dealing with issues related to the rehabilitation of the country after the war, including high unemployment, determine their community needs. Abatemarco was pleased to learn that despite their difficult recent history the Croatians were well-equipped to address many of their problems. For instance, a strong network of NGOs had developed in Split, and the local government supported their work as well as that of other groups trying to make a difference in the community.

"I was surprised about how sophisticated, savvy, and formal they were," recalls Abatemarco. "They had so much education and so much professionalism. Once we recognized just how sophisticated they were and how much we could learn from them, it became a much better partnership."

Abatemarco worked with her partners to better engage with various levels of government, NGOs and other community-based groups, as well as identify a range of possible community issues to address, but it was when the Split partners came to the US that the program really began to move forward.

When the partners from Split visited a rural county in New Jersey, they learned of a valuable tool called the Youth Risk Behavior Survey (YRBS) that had been developed by the Centers for Disease Control and Prevention. The partners were impressed with the tool and decided to conduct the survey themselves in Split.

Back home, after conducting the survey and reviewing the results, the partners realized that youth alcohol abuse was a serious, growing problem, but one that the partnership could address. Therefore, they implemented Project Northland, a community-based alcohol intervention program which incorporates behavioral curricula used in schools, parental involvement and extracurricular peer leadership and community-wide efforts for adolescents in sixth through eighth grades. The sixth grade curriculum was successfully implemented in 13 schools from March to May 2003, and reached approximately 1,300 students.

Although the partnership officially ended in 2003, Abatemarco won a grant from the UMDNJ Foundation to extend the partnership for another year and a half, in order to study ways to improve on the program.

The Split partners returned to New Jersey in 2005 to evaluate the program and share their experiences with faculty and students at UMDNJ as well as with community leaders from across the state. Project Northland continues to be implemented in Split, as well as other Croatian communities

Although Abatemarco has now left her post at UMDNJ in order to go to the University of Pittsburgh, she still continues to work with her former colleagues at UMDNJ to support the partners in Split. She also shares her experiences in Split with her students, who love to hear about her experiences.

"Many times when the clock is ticking, students are piling up their books," says Abatemarco. "When I do the Croatia lecture, it ends and I am answering their questions 20 to 30 minutes after class. They are tied to their seats."

Partner Profile *Pamela Thompson*

Pamela A. Thompson, MS, RN, FAAN*, had her first encounter with physician attitudes toward nurses in the former communist countries of Eurasia when she met several Russian physicians visiting Dartmouth-Hitchcock Medical Center in the early 1990's. The prevailing attitude in those countries at the time was that nurses were simply physicians' assistants, and the Russians were puzzled that she, a nurse, wanted to meet with them. By the end of their stay Thompson, who was then a vice president at the Children's Hospital, had so impressed them with her knowledge and professionalism that she was later invited to Russia to teach.

An indefatigable advocate for nursing and a skilled leader and trainer, Thompson has personally helped to change attitudes towards nurses and groom nurse leaders in many countries of Eurasia through her involvement in three AIHA projects – as the coordinator of the nursing and administration components of a partnership with three hospitals in Zagreb, Croatia; as co-chair of the CEE Nursing Task Force; and as one of the founders of the International Nursing Leadership Institute (INLI).

Since her involvement with the Zagreb partnership began in 1994, Thompson has witnessed her Croatian colleagues make great strides. She and others at Dartmouth helped strengthen the leadership, management and clinical skills of nurses at the partnership hospitals, and as a result, these nurses became pioneers in their country, doing things that had never been done by nurses, such as developing department budgets, and demonstrating how physicians and nurses could work as a team.

"I found the most memorable moments were watching the nurses and physicians that I worked with take our teaching and create their own projects," says Thompson. Nurses at the Hospital for Infectious Diseases, for example, successfully implemented family-centered care which enabled parents to be physically closer to their hospitalized children rather than being forced to stand outside the building for fear of infection. These and other initiatives are still in place, as Thompson has seen first-hand during her many trips back to Croatia over the years. She also has noticed a marked increase in the nurses' overall confidence and professional achievements, such as their ability to lobby for change and continued advancement of their profession.

Beyond Croatia, Thompson played a key role in the creation of AIHA's CEE nursing task force, involving over 40 nurses from nine countries. Despite the language barriers separating them, with the help of interpreters, they developed strong bonds that enabled them to share and learn from each other. "We did breakout sessions, multi-voting, brainstorming, and all kinds of teamwork exercises, which was completely new to the CEE nurses," Thompson explained. Aside from learning new ways of interacting and learning, for many of the nurses, the task force meetings were the first time they had had conversations with nurses outside of their countries or even cities. One sign of the increased confidence gained by the CEE nurses was that after two years of coaching and mentoring, Thompson was able to turn over chairing of the meetings to Helena Konosova from Slovakia.

Thompson was also one of the founding members and core faculty of the INLI project, an idea for nursing leadership development that grew out of her work in Croatia. Through INLI, 56 nurses from throughout Eurasia gained leadership and management skills enabling them to serve as leaders and mentors to other nurses in their countries.

Thompson's role as CEO of the American Organization of Nurse Executives (AONE), a position she's held since 2000, has also been influenced by her work with the CEE nurses. In 2001, at her urging, AONE opened its doors to international members and Thompson recruited Branka Rimac, a former Croatian student of hers, as the first international member. Thompson returned recently from Croatia where the AONE co-sponsored a nursing leadership congress with the Croatian Nurses Association, currently led by Rimac, who has been described as "a leader to watch." AONE has also initiated a nursing exchange project between a cardiology hospital in Moscow and Thompson's former employer, Dartmouth.

Thompson is thankful for the unique opportunity she's had to work internationally long enough to be able to see the changes in nursing that she has helped to bring about. In the process, she believes she herself has changed. "I learned that *how* you go about implementing change is just as important as *what* you do. One of the best gifts I received was learning that the most important thing you can do is to help people think critically, and that has informed all my international work since."

* Fellow in the American Academy of Nursing

II.D. CZECH REPUBLIC (1996-1998)

Program Highlights

- Trained 159 faculty at Czech educational institutions in health management, resulting in a shift in teaching methodology employed, from didactic to interactive learning.
- Czech educational institutions successfully established undergraduate programs in health management which enroll 70 students a year.
- Smart Classrooms installed at three institutions in East Bohemia which enhanced their teaching by enabling them to teach health management and make information available from diverse sources.
- Developed a Nursing Resource Center in Olomouc, which has trained more than 900 nurses since it opened in 1998.

Partnerships	Years	Focus Areas	Partner Institutions
Bohemia/Nevada	1996-1998	Health Management	• South Bohemia University Faculty of Management (in Jindrichuv Hradec) • Faculty of Health and Social Care (in Ceske Budejovice) • University of Education (in Hradec Kralove) • Postgraduate Medical School (in Prague) • Purkyne Military Medical Academy (in Hradec Kralove) • University of Nevada
Olomouc/Richmond	1996-1998	Health Management, Nursing	• Palacky University Faculty of Medicine • Virginia Commonwealth University

BACKGROUND

During communist rule, Czechoslovakia offered free universal healthcare to its citizens and had an elaborate state-supported healthcare system. However, the system did not receive the necessary investment to continue providing adequate care to the population. In 1989, as the country shifted from communist to reformist governments, healthcare reform was recognized as important, but not given a high priority. By 1990, the Czechoslovakian government set new healthcare goals which related to privatization, public/private cooperation, provider choice, improving the efficiency and quality of healthcare services and management, and modernizing healthcare facilities. USAID was invited to help support these goals, and targeted three objectives: reduction of cardiovascular and cerebrovascular disease (CVD) which was a leading cause of death; improvement of the quality of care and management; and promotion of private markets and innovations in insurance and healthcare financing.

From 1990 to 1996, USAID sponsored health programs which involved Americans assisting the Czechs in a number of areas. One of these programs consisted of a community-based intervention that promoted healthy lifestyles and improved the diagnosis and treatment of CVDs in the town of Dubec; another assisted three hospitals in working on standards for nurse management, improving financial reporting systems, and developing a maintenance program for hospital equipment. USAID also worked with Project Hope on programs for women, infants and children and with the General Health Insurance Company on healthcare financing.

AIHA's program in the Czech Republic was initiated in 1996 to develop the country's capacity to provide quality health management education, and the partnerships followed in the tradition of the earlier model programs, like that in Dubec, which had proven the success of enlisting the expertise of US experts. The goal of the program was to help develop a cadre of well-trained healthcare managers.

KEY RESULTS

- ***Faculty Development***

The US partners introduced new pedagogical approaches in the Czech Republic through several training-of-trainers and health management workshops. Visits to the University of Nevada by Czech healthcare professionals emphasized participation with US faculty involving small group activities such as case discussion, problem analysis, and seminar presentations. The Bohemia/Nevada partnership hosted eight trips to the US that involved 47 Czech faculty, health care practitioners, and health care administrators. In addition, US faculty who visited the Czech Republic often met Czech students in the classroom and led discussions or group exercises that further reinforced small group and other interactive pedagogical approaches.

AIHA Partnership Training in Czech Republic

Training	Date	Number of Trainees
Curriculum Development	Feb-96	16
Managed Care	Apr-96	7
Introduction to Management	Jun-96	47
Instructional Train-the-Trainers	Oct-96	15
Management Training	Oct-96	28
Leadership Training	Nov-96	30
Leadership Training II	Mar-97	8
Leadership Training III	May-97	8
Stress Management	May-97	14
Case Studies	Sep-98	10

The exchange activities resulted in a real change in classroom interaction, as noted by Czech students who participated in the evaluations of the partnership. As stated by a former Czech partner and professor in their partnership self-assessment, "In teaching, there has been a dramatic change in the form of lecturing, from a monologue to a dialogue with students. In research, there has been a change from an individualistic approach to a team effort form of cooperation. In course preparation, we have even started cooperating with students and other organizations."

Following the partners' December 1996 evaluation of instructional technology by media and technology specialists, AIHA upgraded the instructional capacity of partner institutions through the use of "Smart Classroom" technology. Smart Classrooms are media-equipped, user-friendly teaching environments which

provide teachers with the capability to use personal computers and the Internet to more effectively interact with their students.

The partners installed Smart Classrooms at the Postgraduate Institute in Prague, at the Faculty of Management in South Bohemia and at the Faculty of Management and Information Technology in East Bohemia. They have enabled Czech faculty to incorporate Web-based information and other media into their lectures and demonstrations, and via this technology, students in one institution can access material and instruction from faculty in another institution. The Czech partners report that the Smart Classrooms enhance their teaching by enabling them to teach health management and make information available from diverse sources. Student presentations, small group discussions, and lecture/demonstrations are also enriched through the use of the technology and faculty can share each other's instructional materials and expertise, as well as make materials immediately available to their students.

In 2005, the partners reported that the Smart Classrooms still work well and are encouraging other teachers to use new technology. South Bohemia Faculty of Management now has eight Smart Classrooms, and the Faculty of Informatics and Management at the University of Hradec Kralove has four.

A partner from the University of Education in Hradec Kralove served as a faculty member at an AIHA-organized workshop on the case method that was held in Almaty, Kazakhstan in May 2000 for AIHA's new health management education partnerships in the NIS and for Albania. The Czech partner was one of two former AIHA HME partners who presented on their experiences developing cases and using the case method in their health management programs which were begun under the AIHA partnership program.

- ***Curriculum Development***

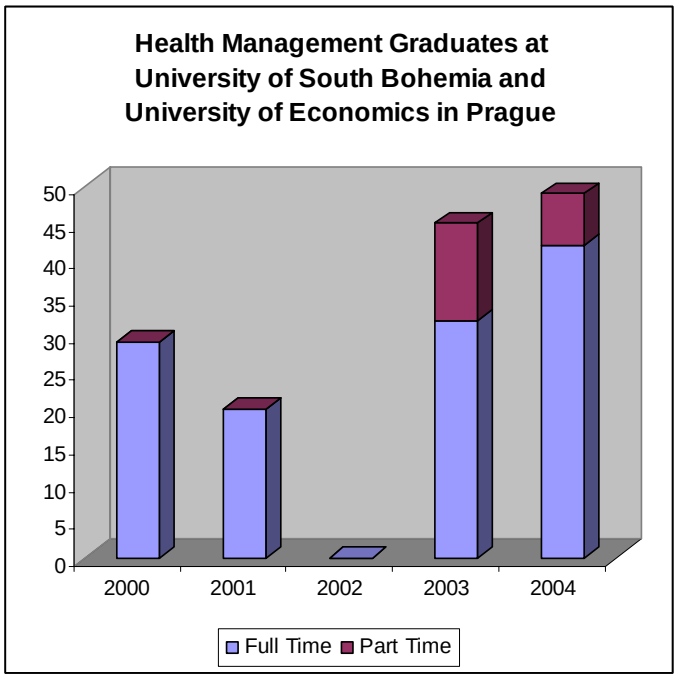
Prior to their involvement in the partnership program, the Czechs had tried to implement a health management curriculum, but they lacked the critical mass of practitioners and educators needed to start the program. Through the partnership, the Faculty of Management in South Bohemia, the Faculty of Management and Information Technology in East Bohemia, and Purkyne Military Medical Academy successfully developed undergraduate programs in health management. In South Bohemia the program began in 1996, while in East Bohemia the first class of students was admitted in 1997. Both programs were designed to admit current practitioners through the use of part-time and distance learning programs.

"Sometimes change begins very quietly, such as the introduction of healthcare management curricula in Czech universities. The graduates make a significant contribution to improving the quality of Czech health care." *– Vladimir Spidla, Chairman, Parliament's Health Care Committee*

Approximately 70 students are enrolled each year in these programs, and most are currently working in healthcare institutions in the Czech Republic. Therefore, the graduates should be able to apply improved management practices immediately in the institutions where they work. In 1998, South Bohemia's health management program was transferred to the University of Economics in Prague. While this caused some delays in student graduation, it allowed the program to be reaccredited and transformed into a master's degree specialization. In 2000 and 2001 there were 29 and 20 graduates in health management, respectively. In 2003 and 2004, 13 and 7 master's-level students, respectively, graduated with a minor specialization in Health Care Management. The focus of this training is primarily cost-benefit analysis and financial management of hospitals.

In 2004, the curriculum was gradually redesigned to meet the requirements of the European Credit Transfer System (ECTS), a program which allows students to apply credits earned at multiple institutions in various countries to their degree program. East Bohemia's program graduated 38 students before it was moved to the

Faculty of Pharmacy. Purkyne Military Medical Academy, now known as the Faculty of Military Medicine, University of Defense, developed an accredited military health management curriculum.



South Bohemia's Faculty of Health and Social Studies introduced a health management specialty as a result of the partnership, and management components were added to the undergraduate programs in public and social medicine, nursing, and rehabilitation care. In addition, new principles of nursing care management were introduced at the Hospital in Ceske Budejovice; these principles were also incorporated in the nursing education program. In the winter semester 2005-2006, a new specialty was introduced at the Faculty of Health and Social Studies in public health protection, with a management component in the curriculum.

After the partnership ended, the University of South Bohemia's Faculty of Management in Jindrichuv Hradec prepared a new baccalaureate program for non-physician health personnel, a new master's program in Management of Health Services for graduates of the baccalaureate programs, and courses for a new healthcare specialization at the Prague International Business School's MBA program. In addition, the Faculty of Management has received two grants for work focused on optimization of hospitals.

The Olomouc/Richmond partners designed a curriculum for a graduate program in health services management which was submitted to the Czech Ministry of Education in the summer of 1997 and accredited in the spring of 1998, authorizing Palacky University to offer a master's degree in health administration through its medical school. (Previously, the medical school could only grant doctorates in medicine.) The initiation of the program was delayed until 2000, but by 2005 they had graduated 62 students with master's degrees in Health Management.

The Faculty of Military Medicine, formerly Purkyne Military Medical Academy, now graduates 4-5 students every year in the courses of Military Health Management. The cooperation between the Faculty of Management and Information Technology, the Faculty of Military Medicine and the Pharmaceutical Faculty which started within the framework of the AIHA partnership continues to thrive. Professors from these universities regularly teach health management courses at all three schools.

In March 1998, a new health management project involving the two graduated Czech partnerships (Olomouc/Richmond and Bohemia/Nevada) was initiated by the Ministry of Education and Ministry of Health. The project, entitled *Complex System of Education of Health Managers*, is supported with finances earmarked by the Ministry of Education for cooperation between Czech and American Universities. The project promotes sustainability of the US and Czech partnerships.

- ***Nursing***

The Institute for the Theory and Practice of Nursing gained official recognition as a separate institute at Palacky University. Although the nursing faculty had developed the institute independently of the partnership, participation in the AIHA program helped validate the institute when governmental approval had become stalled.

The partnership in Olomouc promoted the introduction of bachelor's-level nursing education and assisted in the development of the curriculum. The trend of encouraging higher nursing education continued past the end of the partnership, and by 2003, the Olomouc partners had also introduced a master's-level nursing program.

A Nursing Resource Center (NRC) was opened in Olomouc which houses computer equipment and educational materials that are available to nursing faculty and practitioners within the community. The Center receives an average of 1,520 visits per year, provides seven training courses, and publishes a quarterly bulletin. As of 2005, the NRC conducted training for 919 nurses.

After visiting various sites in the US, the nursing faculty at Olmouc began to raise questions about their own practice and teaching, such as one nurse manager who reorganized her unit as a result of the knowledge she gained during an exchange. The nurses demonstrated the ability to make presentations at AIHA's Nursing Task Force meetings and the Annual AIHA meetings in Central and Eastern Europe; they had never had the opportunity to do this before.

- ***Access to Health Information and Communications***

AIHA supported the training and research support services of Learning Resource Centers (LRCs) at six educational institutions in the Czech Republic from September 1996 through September 2004. These institutions included:

- South Bohemia University – Ceske Budejovice;
- Purkyne Military Medical Academy – Hradec Kralove;
- University of Education, Faculty of Management & Info Technology – Hradec Kralove;
- University of Economics, Faculty of Management – Jindrichuv Hradec;
- Palacky University, Medical Faculty Library – Olomouc; and
- Institute for Postgraduate Medical Education – Prague.

The Czech LRCs were among the most active among all CEE LRCs in providing training for health professionals on how to use the Internet to find medical information as well as how to critically appraise the medical literature applying the principles of evidence-based practice (EBP). Altogether, the six Czech LRCs trained 2,570 health professionals during the period of funding.

The LRC staff at Palacky University and the Institute for Postgraduate Medical Education were particularly active in their training efforts. After receiving support from the Czech Ministry of Health to provide a wide range of training programs for health administrators, medical librarians, and other health professionals in different regions of the country, these two LRCs alone provided computer and EBP training to 1,780 health professionals during the funding period.

Like the LRCs at Palacky University and the Institute of Postgraduate Medical Education, the LRC at the Faculty of Management at the University of Economics in Jindrichuv Hradec helped to introduce evidence-based practice into the faculty's curriculum as part of its course on healthcare management. In addition, an entire course on EBP was developed as an elective.

The LRCs at both Palacky University and the Institute of Postgraduate Medical Education helped to spearhead the development of EBP working groups. At Palacky University, the working group focused on the promotion of EBP for academic medicine, and the role of the LRC was to provide training and assist with information retrieval. At the Postgraduate Institute, a steering committee focused on introducing EBP into postgraduate medical education.

These two LRCs, both located within libraries, were also very successful in obtaining grants to enhance the capabilities of their LRCs. At Palacky University, the LRC received funding to support the acquisition of additional books and journals, more computers, a CD-ROM server, a digital copier/printer, and a video projector. They also received a grant to assess IT training needs at the Olomouc Teaching Hospital. At the Institute of Postgraduate Medical Education, the LRC received a grant to create a medical virtual library, through which full-text journals, guidelines, and other information resources were made available electronically.

Altogether, these five Czech LRCs (not including Purkyne Medical Academy, which declined to provide data because of its military status) supported 4,163 health professionals during the period of AIHA funding. The six LRCs received an average of 545 visitors and 53 information requests each month. While three of the six institutions have not kept in contact with AIHA for several years since funding support ended, AIHA believes that the original functions and capabilities of the LRCs continue to be supported at all six of these sites.

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

CHALLENGES

- The biggest obstacle to improving the health management system in the Czech Republic remains incomplete healthcare reform and the low interest of policymakers in the development of professionally trained healthcare managers.
- Because AIHA's partnerships in the Czech Republic involved a variety of Czech institutions in health management programs, the partners encountered differences in opinion regarding interests and objectives. As a result, funds for travel and other resources such as books and technology were split up in order to avoid conflict, and collaboration among some of the Czech partners was limited to areas of shared interest.
- Many of the partners felt that cross-partnership activities, such as health management training in conjunction with Slovak HME partners, and attendance at international nursing meetings were an important part of the program. However, some of the Czech partners felt they were held back by being grouped together with some less-advanced CEE countries.
- The Olomouc partners remain in contact with their counterparts in Richmond, but the Bohemia partners no longer remain in communication with their Nevada partners. Many of the key US partners have moved on to new positions in different institutions, which is the main reason the Czech partners have reported for the lapse.
- An NRC evaluation conducted in fall 2002 found that the Olomouc NRC was very active in nursing education and was used as a resource for many nurses, and that they still are in contact with their counterparts in Richmond. However, they mentioned that limited space and the fact that many of the

books had not been translated into Czech have limited the number of nurses who can make use of the Center.

SUCCESS STORY: ***Developing Health Management Education in the Czech Republic***

"The successful transformation of the Czech healthcare system cannot be accomplished through the efforts of talented medical professionals alone," noted Roman Prymula, a Czech participant in AIHA's partnership program. As market forces were introduced through new payment systems, professional managers with a strong knowledge of management science, practical skills, and a thorough understanding of economics were necessary to maintain the health of the system as a whole.

Domestic and international efforts had drawn attention to the need for management training at high levels, but the Czech healthcare system still suffered from a lack of well-educated middle-level managers and the few educational programs available (with the notable exception of the Prague School of Public Health) were targeted at high-level management and usually were offered only in the form of continuing education short courses.

To help fill this gap, the two health management education partnerships between US and Czech educational institutions worked to develop full-time career-entry study programs for middle managers in the healthcare system. With the help of their US partners, new bachelor's degree programs were initiated at South Bohemia University in Jindrichuv Hradec and at the Faculty of Management and Information Technology in Hradec Kralove. By the time the partnerships had officially ended in 1998, more than 70 Czech health professionals were studying management in these new programs.

Perhaps even more significant for the long-term growth of health management education in the Czech Republic, though, were the ties that the partnership program created within the Czech Republic itself. By encouraging the sharing of faculty and resources among the partnership institutions, our US partners brought a sense of purpose and a common language to what was previously an uncoordinated effort. The partnerships created a nucleus of dedicated health management educators and professionals to jointly address the issues facing that profession.

Building on the momentum generated by the partnership program, nine Czech partner institutions jointly submitted a grant proposal to the Czech Ministry of Health to increase the exchange of expertise and information among Czech educational institutions in the area of health management education, and to develop uniform standards for health management education in the Czech Republic and establish curriculum requirements. Billed as a follow-up project to the health management education program, the grant proposal was submitted to the Internal Grant Agency of the Ministry and, despite very strong competition, was successfully approved at a level of 2 million Czech Crowns, or about $70,000.

The LRCs established through the partnership program provided the basic infrastructure for networking between the several Czech educational institutions. Access to Internet-based information databases, pedagogical staff development through an intensive exchange program, and teleconferences and various interactive educational programs by satellite were the other key forces in strengthening the new network. The project involved those educational institutions that are in a position to produce well-balanced health management experts, both for middle-level and top-level positions.

Dr. Petr Struk, Director of Education with the Czech Ministry of Health, reaffirmed the continuing work of the Czech partners, noting "We understand very well the key role of health managers' education for the future stability and development of the healthcare system in the Czech Republic. The network of such educational facilities will be the best way to ensure this aim."

Partner Profile — *Jarmila Potomkova*

When the AIHA partnership between Palacky University in Olomouc and Virginia Commonwealth University began in 1996, Jarmila Potomkova was appointed Information Coordinator for the Learning Resource Center (LRC). Although she was the university's Medical Library Director at the time, Potomkova states that she acquired most of her information technology skills through participation in the LRC project. One of her first projects that demonstrated to university staff the usefulness of the LRC was the retrieval of information that would help faculty revise the pediatric dentistry curriculum as part of the university's master's program in dentistry.

In the course of the LRC project, Potomkova developed a particular interest in the principles of evidence-based medicine and helped university staff apply them to their clinical and teaching practice. She was one of the team members who, together with clinicians and university professors, prepared practice standard reviews (PSRs) which were introduced by AIHA as a training tool for evidence-based practice. Among other topics, PSRs were prepared on: managing fever of unknown origin in young infants, relationship between breast-feeding and obesity, and the impact of pre-operative education on the recovery of total hip replacement patients.

The results and conclusions of these PSRs assisted in developing patient education materials and research articles. Together with the information coordinator from the Prague School of Postgraduate Medical Education, Potomkova presented the results of applying PSRs as a tool for implementing evidence-based approaches in clinical practice and the role of medical librarians in evidence-based practice at numerous international conferences. In 2003, Potomkova was granted a certificate of achievement in the area of application of evidence-based practice, community outreach, LRC sustainability and educational technologies from AIHA.

Even after the LRC project officially ended, Potomkova continued to be active in the LRC Network Association, helping other LRCs from NIS/CEE countries with information retrieval, providing full-text articles from her library. In recent years, Potomkova has become one of the leading trainers in evidence-based practice and information retrieval in Central and Eastern Europe, and was invited to deliver training sessions and workshops on these topics in other countries of the region. Additionally, she has developed and is teaching two undergraduate courses dealing with information retrieval and critical appraisal of literature to support EBP decisions. She has focused her doctoral research on developing Web-based tutorials and their implementation in undergraduate medical education.

Currently Potomkova is a team member of two European Union projects aimed at developing an evidence-based medicine information system and the introduction of evidence-based medicine into undergraduate medical curricula. She is also an active member of the European Association for Health Information and Libraries, as well as a member of the editorial board for the Web educational portal for Palacky University School of Medicine.

Partner Profile *Rudolf Stritecky*

Teaching people new concepts and theories is not all that difficult, admits **Dr. Rudolf Stritecky**, head of the Pediatric Department at Municipal Hospital in Jindrichuv Hradec, a beautiful South Bohemiam city in the Czech Republic. "The hard part is getting them to apply their knowledge in new ways." Stritecky—who also teaches healthcare management at Prague Economic University's Faculty of Management in Jindrichuv Hradec—continues, "They must change the way they think if this knowledge is to be put to good use as our health system continues its transition to a more decentralized, cost-effective model."

A member of AIHA's Bohemia/Nevada partnership, an alliance dedicated to creating a strong network of health management professionals within the Czech Republic, Stritecky explains how, under the old "central distribution" system, both healthcare professionals and the public grew accustomed to care being provided at no cost to the patient. "When that system changed to a new arrangement based on obligatory health insurance, hospital administrators were faced with a terrible dilemma. Suddenly, from the inside out, everything was different. Administrators were exposed to the influences of market forces for the first time and most hospitals got into financial trouble," he says. "Fortunately, at that exact moment we were offered the opportunity to participate in AIHA's Health Management Program."

Despite systemic and cultural differences, the partnership offered Stritecky and his colleagues a wealth of examples to draw from—especially new perspectives on healthcare financing. "One of the biggest challenges we faced was making healthcare managers realize that their budgets now rely on patient payments, not the state, for funding and that these funds must be used more efficiently," Stritecky notes.

"When we began our partnership, we had to decide if we should focus on retraining existing managers and health personnel or on preparing curricula that would train a new generation who, in time, could transfer what they had learned to other levels of the health system," Stritecky says, explaining that while the second route is longer, it is more sure. "Our basic approach was to concentrate on students, but we also developed commercial training modules to teach new methods to existing managers."

Partnership exchanges to Las Vegas and Reno, as well as in-country training, proved invaluable, Stritecky continues. "For us, these exchanges provided guidance both on how to structure curricula and to change people's attitudes. Really, it's difficult to put into words the enthusiasm that typified these meetings," he says, noting that he and his colleagues had so many questions they were often afraid they would overwhelm the US partners. The exchanges also introduced Stritecky to another important model—the interactive style of teaching common in American classrooms, yet virtually unheard of in the Czech education system at that time. "I had absolutely no experience with teaching, so it was easy for me to adopt the style I learned through our partnership," he says, explaining that his students often complained about his "Americanized" approach.

"At first the students were uncomfortable with the give-and-take I asked for in the classroom. Their only experience had been with a didactic model that stressed top-down lectures rather than student-teacher dialogue," Stritecky admits. "But, after they got over their initial reservations, they began to enjoy the open exchange of ideas and came to realize the importance of introducing different points of view into the mix."

In 1996, the partners in South Bohemia launched an undergraduate program in health management. One of the first in the nation, this bachelor-level curriculum targets working professionals through part-time and distance learning courses. "From the beginning, the response was incredible," Stritecky says, pointing out that they consistently have many more applicants than they can accommodate. "We enroll approximately 30 students each year and most are currently working at healthcare institutions, which means they can immediately begin to implement improved management practices at their facilities," he states, explaining that the program's first bachelor's class received their degrees in 2000. Since then, a master's program in health management and courses for a new health facilities administration specialization at Prague International School have been instituted.

"Ironically, disaster paves the quickest road to reform and our healthcare system is really not in such terrible shape, so the changes we want to make are slow in coming," Stritecky concludes. "Our biggest problem now is a lack of political will to change what's wrong with the system. We often ask ourselves if the work we are doing is worth it, then we realize change must eventually take place. When it does, we will have prepared people who are ready to implement more effective methods quickly. Our students are using what they have learned to be more effective managers and important resources for her community."

Partner Profile *Romana Svobodova*

"After working as a nurse for 10 years—first in a cardiology unit then in the emergency medicine department—I had a good understanding of patient care," says Romana Svobodova. "But, I really had a very limited view on the healthcare system as a whole and virtually no appreciation of the financial aspects of providing health services," acknowledges the 37-year-old head nurse at Tabor County Ambulance Center in Czech Republic's southern Bohemia region.

Svobodova's view on the health system—and her opportunities for professional growth and development—was greatly enhanced, she contends, after she studied healthcare management at Prague Economic University's Faculty of Management in the nearby town of Jindrichuv Hradec. After receiving a bachelor's degree there in 2000, Svobodova enrolled in a master's program, which she completed in June 2002. "Now I have a broader perspective that includes not only patient care, but the legal, economic, educational, operational, and managerial aspects of healthcare as well," Svobodova says, noting that her classes gave her more insight into the system as a whole than many long-time practitioners.

Understanding healthcare is a service that must be paid for like any other commodity was one of the most important lessons Svobodova says she learned. In addition, she also came to appreciate the value of open dialogue and using a team approach to problem-solving. "What I learned from my professors made it possible for me to understand the business side of healthcare. I'm a much better manager now and I've learned how to make the most of our human resources," she explains, stressing that it is important to make people feel like they are part of a greater whole.

While pleased with the content of her courses, Svobodova was initially disconcerted by their interactive structure. "The teaching style used by all my instructors was totally different from what my generation had experienced in school," Svobodova observes, noting that she and her classmates were encouraged from day-one to voice their opinions and take an active role in discussions. "Really, this was unthinkable at first and I must admit that many of us resisted the efforts of professors who pushed us to speak out," she says with a laugh. "But, as we got used to this type of give-and-take we began to talk in class and amongst ourselves with greater ease. I have even adopted some of these methods at work, encouraging input from the people I supervise."

The courses not only affected Svobodova's management style and contributed to her promotion to head nurse at the Ambulance Center, they also taught her the value of promoting the facility's services. "Until 1993, the Ambulance Center was affiliated with the municipal hospital. Now, as a private company, we must focus on improving the quality and range of services we offer if we want to remain financially viable," she says. To this end, Svobodova developed a way of raising the profile of the Center while, at the same time, giving back to the community. "I approached the local school administration and suggested a course that would teach children how to behave in emergency situations, call an ambulance service, and perform CPR and basic first aid."

The idea was well-received by local educators and parents and, in January 2002, the courses were implemented in 21 schools throughout the county. "So far, my colleagues and I have held about 50 classes that include theoretical lectures on basic anatomy and practical exercises ranging from CPR and immobilizing a fractured bone to stopping bleeding and treating burns or frostbite," Svobodova states, explaining that an average of 20 children aged 10-11 participate in the sessions, which meet three hours a week for one month.

"The children are very enthusiastic because the courses are so different from what they learn in school and the parents are pleased that their kids will know how to respond appropriately if they are confronted with an emergency. In fact, two pairs of our 'junior rescue workers' represented Tabor County in a national competition and placed fifth and tenth out of a field of 31," Svobodova reports.

"I'm very satisfied with my choice to pursue my health management degree," she concludes. "Both personally and professionally I have broadened my understanding and my horizons. I'd like to stay in my current position and help my organization grow and I think what I have learned will allow me to do just that."

II.E. ESTONIA (1994-1996)

Program Highlights

- Transformed the role of nurses and midwives, including establishing policies and procedures and new job descriptions with increased responsibility for patient care and education.
- The Women's Clinic at Tallinn Central Hospital increased its capacity to conduct laparoscopies, performing approximately 5,000 laparoscopies in 2005.
- Decreased perinatal mortality rate from 20.1 cases per 1,000 deliveries in 1994 to 10.4 per 1,000 deliveries in 2004 at the Women's Clinic
- Established baccalaureate and master's degree programs for nurses at Tartu University.

Partnership	Years	Focus Areas	Partner Institutions
Tallinn/Washington, DC	1994-1996	Emergency/disaster medicine, hospital management, nursing, women's health	• Mustamae Hospital (now part of North Estonia Regional Hospital) • Tallinn Central Hospital (renamed East Tallinn Central Hospital) • George Washington University Medical Center

BACKGROUND

After regaining independence from the former Soviet Union in 1991, Estonia made significant changes to the financing and planning of its health system, implementing them in several phases. The most important reform was the passage of the Health Insurance Act of 1991 and the Health Services Organization Act of 1994, both of which provided the legal basis for reforms such as a social health insurance system operated through the Central Sickness Fund (and 22 regional sickness funds) and decentralizing responsibilities for planning health services to the county level. The Ministry of Social Affairs was created in 1993 as a result of the merger of three separate ministries of health, social welfare and labor. The new Ministry had the responsibility for health and social services, policy development, planning and data collection in Estonia (Health Care System in Transition: Estonia)

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During the time of reforms, some of the Estonian health indicators began to improve while others deteriorated. In 1994, for example, the life expectancy for men in Estonia was the lowest since the 1960s. For women, the life expectancy declined from 75.0 years in 1991 to 73.2 years in 1994. However, at the same time, the infant mortality rate improved, declining from 14.1 to 9.5 deaths per 1,000 live births between 1985 and 1999. Another example showed that for both males and females, but particularly men, the Standardized Death Rate (SDR) for cardiovascular diseases in the age group 0–64 increased significantly in the late 1980s and early 1990s. (For men, this rate increased by 40% between 1987 and 1994.) Estonia and the other Baltic

States shared a particular pattern of changes between 1984 and 1996 in deaths related to alcohol (cardiovascular, particularly sudden cardiac deaths, and external causes). In 1986 there was a clear decrease in overall mortality related to a period of restrictive alcohol policy. However, the mortality rate rose and reached a steep peak in 1994. Remarkably, in just two years—between 1992 and 1994—the SDR related to alcohol consumption led to a 12% increase in overall mortality in Estonia (Highlights on Health in Estonia, 2001)

Despite having a comprehensive emergency care system, previous systems of training of first responders and hospital emergency personnel was specialty and discipline specific and there was no organization in Estonia charged with improving emergency pediatric, cardiac, toxicological, and traumatic care on a national scope. There also was a lack of support for the nursing profession in Estonia, with insufficient resources for nurse training and retention. Due to the limitations imposed by the former political system and practice, Estonian nurses did not actively participate in bedside care or management. In addition, healthcare management was a skill which was learned on the job without any formal management training.

The US government provided assistance to Estonia through the US Support for Eastern European Democracy (SEED) Act including programs to support economic growth, build democracy and improve quality of life. The AIHA hospital partnership in Tallinn was one of the first three established in CEE. The ongoing reforms and changes in the Estonian healthcare system offered a good opportunity for the AIHA partnership program to bring new concepts to health delivery in the country. The AIHA partnership also supported USAID activities focused on the reform of the health sector in Estonia, with an emphasis on health promotion and disease prevention. As one former Estonian partner commented, "The time for such changes was absolutely perfect, because changes were on the way and we just needed self-confidence and knowledge." (Helin Raudkepp, former midwife, Tallinn Central Hospital)

KEY RESULTS

The partnership occurred at a time when the Estonian healthcare system had started to transform along with economic reforms from a centrally-planned to a market-oriented economy. Exposure to the American system of care delivery enabled the Estonian partners to see where they could head and to prepare for the upcoming changes such as bed closures or hospital mergers. The Estonian partnership institutions felt their participation put them several steps ahead of other hospitals in the country on the path to reforms. In comparing the AIHA partnership to other technical assistance programs at the time, Maris Jesse, a former partner working for the Ministry of Social Affairs at the time of the partnership said, "The scope for the USAID projects were the widest (family medicine, emergency medicine, nursing, etc.). Their programs had a direct impact on Estonia."

- ***Nursing***

An exchange trip to the US gave Estonian nurses an opportunity to observe how important and independent the nursing profession can be, gaining a new perspective on the role of nurses in patient treatment and delivery of healthcare services. The American partners gave them moral support and strongly encouraged them to implement changes in the nursing profession back in Estonia.

"Because my English is better and I'm more self-confident, it is easier to communicate with people. I'm not afraid anymore of talking to strangers about our education. During the partnership we were forced to do things, to think. The nursing task force also helped because we had to prepare reports and to speak in public." *– Elle Ende, IC Nurse, Tallinn Central Hospital*

After the exchange, the nurses from Tallinn Central made an assessment of nursing management and educational programs which allowed them to identify nurses' training needs and led to the initiation of an educational program with core and elective topics. Furthermore, the partners from Tallinn Central and Mustamae created in every department a new position of nurse educator, responsible for organizing training

activities; began a structured orientation program for new nurses; and (in the case of Mustamae Hospital) a mentoring program for novice nurses.

Imitating the common US practice of "morning rounds," nurses and physicians from Tallinn Central improved their communication regarding patient management. Every morning, for instance, nurses now report to physicians about patient care during the night and outline planned activities for a new day. In addition, a number of units in Tallinn Central initiated "nursing rounds" during which nurses discuss patient cases and specific approaches to nursing care. Nurses from Tallinn Central were also the first in Estonia to offer patient education activities. Initial teaching materials were developed based on documents brought from Washington, DC, but later nurses created their own training programs for their eye clinic, orthopedic unit and cardiology department. Additionally, nurses from Tallinn Central implemented a patient satisfaction survey which helps them to identify problems and improve nursing services.

One of the most important accomplishments of the partnership nursing program was the development of written guidelines and protocols describing nursing responsibilities and patient care procedures, as well as the creation of nursing documentation such as patient history record forms and performance evaluation forms. At Tallinn Central, for example, nurses developed approximately 240 guidelines for nursing procedures, management and patient education. These guidelines served as a basis for creating a hospital manual for the recently merged East Tallinn Hospital.

The visit to the US inspired the Estonian nurses and they became more independent and effective. For example, all nurses from Tallinn Central were trained in the use of a pain management scale, blood drawing, IV procedure, CPR, patient education, and the replacement of bandages and colostomy bags; additionally they obtained permission from the hospital doctors to take patient histories, a responsibility formerly given only to physicians. In both Tallinn Central and Mustamae, nurses started to substitute for physicians in explaining surgical procedures to patients. Notably, the perception of nurses among hospital patients improved as well, and many diabetic, rheumatologic and oncological patients began to turn more frequently to nurses for assistance. (There is still some resentment, though, towards nursing care among outpatient patients who fail to acknowledge nurses' competencies and want to be taken care of only by a doctor.)

The partners from Mustamae Hospital installed an operating department structure similar to the American model with pre-op, operating and recovery rooms (a pre-op room which did not exist prior to the partnership). Also, the hospital decreased the number of patients per nurse from 10 to seven in the recovery room and created the position of a pain nurse responsible for providing care to post-op patients suffering acute pain—a first for Estonia.

Estonian nurses successfully utilized their skills in curriculum development gained during the partnership from the American faculty by creating a new nursing curriculum that led to the establishment of a one-year baccalaureate program for nurses at the Tartu University in 1996, and later to the creation of a master's degree program. The partner nurses were also involved in activities aimed at constituting a new specialization system in nursing which commenced in September 2005.

Thanks to the partnership, the role and responsibilities of midwives in Women's Hospital has also significantly grown. The Estonian partners developed a new job description for midwives that included independent prenatal care treatment and trained them in observing and handling normal pregnancy cases and in-patient counseling. These new competencies allowed midwives to take responsibility for their own patients. In addition, using materials provided by the US partners, the midwives established a pregnancy school for women and future fathers which included lectures on prenatal care, breathing techniques, breastfeeding and other relevant topics. Initially, only two midwives were providing training; but currently the school has expanded and there are approximately 10 midwife educators.

Despite the many advances made by the nursing profession in Estonia over the last 10 years, partner nurses interviewed during site visits in 2005 indicated they still face many hurdles. There is still a common misconception about the role of nurses among Estonian physicians. Estonian medical education needs reform to embrace nursing profession in modern terms similar to those taught by the nursing schools in Tartu and Tallinn. Another continuing challenge for the nursing profession is the large number of nurses who decide to work outside the healthcare system. This situation is caused by unsatisfactory salaries and the negative perception of the nursing profession

- ***Management***

Management training for the first time exposed many of the Estonian partners to the concepts of strategic planning, financial planning, teamwork and change management. Gaining new management competencies helped them to improve as managers and encouraged them to implement changes that fostered more dynamic growth of their institutions. Nurses learned skills that opened up new possibilities and led to new practices. For example, nurses from Tallinn Central Hospital used their management knowledge to prepare nursing budgets, manage nursing salaries, bonuses and vacancies, and revise existing guidelines of patient care. And nurses form Mustamae Hospital gained more financial responsibilities that included the ordering of drugs and supplies. In addition, management training gave nurses the very first opportunity to work on the same projects with physicians.

"We got our independence and we needed know-how to manage, because during the Soviet time there was no management. It was all central planning and you had no right to do anything differently. Leadership and quality control —it was quite new for us." *– Dr. Ulle Aamer, Director of Eye Clinic, Tallinn Central Hospital*

One example of a new management practice is an orientation program for new employees. Initially, the new orientation routine was introduced only in the nursing department of Tallinn Central, but in 2005 it was replicated across the hospital. Currently all new employees have to participate in an orientation meeting with an HR manager and receive an information booklet about the hospital and a list of expectations for the first four months. After that time frame, new employees are required to complete an evaluation form in which they suggest areas for improvement to the training program.

Another important transition was the change of leadership in the nursing department. Unlike in the past, doctors are no longer supervising nurses. Instead, similar to the American system, the partnership hospitals introduced the position of a nurse director who leads a nursing department.

A significant transformation process took place in Tallinn Central Hospital Training Center (TCHTC). The center was established in 1990 but initially was not very active. The situation changed after the initiation of the partnership in 1995 when the center began to offer continuing education and more advanced courses developed based on American materials. Over time, the center created its own training programs which are delivered not only to health providers from Tallinn Central but also to nurses and physicians from other Estonian medical institutions. (Training for external participants is offered for a fee and enables the center to generate a profit.) Currently, TCHTC employs three nurse educators and one assistant who provide training on a daily basis. In 2004, the center delivered over 30 courses to more than 500 participants from Tallinn Central and other institutions. In order to better fulfill training needs, the center introduced a new practice of generating feedback and training suggestions from the Tallinn Central health providers. In addition, the center's employees use their management skills to prepare budgets and to optimize a number of paid workshops.

Participation in the management training led to major improvements in the efficiency of the outpatient clinic in Women's Hospital. A physician from the Women's Hospital developed and implemented an improvement plan which included the enhancement of midwives' responsibilities and bestowed independence in patient handling. Currently, the partners from Women's Hospital are hoping to hire a new staff person to work in the

outpatient setting who would take on paperwork related to patient treatment (e.g., accounts payable and receivables), hence freeing the specialists to focus on clinical work.

Many nurses who participated in the management training became more active in the Nursing Association and nursing unions. They wrote numerous articles, for example, that were published in the association magazine and organized various training programs and seminars. With their efforts and ongoing support, a professional nursing union transformed and grew into a trade association focused on economical outcomes. The number of board members decreased and the president and board members became full-time employees of the association, which considerably improved the effectiveness of the organization. The Nursing Association continues to grow and becomes more influential. In 2005, the Association had about 4,000 members (approximately 48% of all nurses registered in Estonia).

The partners from Tallinn Central Hospital used their management skills to market their institutions and gain additional funds. Their efforts resulted in favorable financial agreements with the sick fund that led to several important developments in the hospital. To obtain additional revenue, Tallinn Central reconstructed operating rooms, the sterilization department, and the radiology clinic. In addition, the partners utilized their new management knowledge during the merger of three hospitals.

The partners from Mustamae Hospital translated their new management competencies into the creation of a modern customer service department that has expanded seven-fold during a five-year period (from 12 employees in 2000 to 84 in 2005, after the merge of eight hospitals). The customer service manager, who participated in the partnership exchanges, initiated a number of improvements observed during a trip to the US. One important change was the introduction of a job rotation system that increased the efficiency of the front desk. The partners set up an "open" registration desk in the hospital's entrance and dressed registration personnel in uniforms. In addition, the hospital installed an electronic queuing system to reduce waiting time and improve patient satisfaction, and all hospital staff began to wear nametags with pictures.

- ***Emergency Medical Services***

At the time of the partnership there was no organized emergency system in Estonia and the specialization in emergency medicine did not exist. During partnership activities, however, the Estonian partners learned how to build emergency and disaster medicine systems and in 1996, Mustamae Hospital organized the very first Emergency Medicine Training Center (EMTC) in the country. Using training materials from the US partners, the Mustamae EMTC started to deliver training in emergency medicine to paramedics, rescue teams, policemen, nurses and physicians from various parts of Estonia. In addition, partners started to provide Advanced Cardiac Life Support (ACLS) courses to the hospital healthcare providers. As a result, ambulance services provided by paramedics improved significantly.

> ***"We had seen and heard from the movies how the American ER (emergency room) and ambulance system works but we had never seen it in real life before…. By going to the States, we had this chance to jump ahead. Now the government follows us!"*** *– Rein Paberit, MD, former director of EMS Training Center, Mustamae Hospital*

In addition, the Mustamae partners used their influence to convince the faculty from the Tartu University to create an emergency medicine specialty in Estonia. (MOH, now the Health Department. under the Ministry of Social Affairs, has a special department of disaster medicine and they took over responsibility.) Because of this political decision, the EMTC lost its national status but it continued providing courses related to emergency care to nurses and physicians from Mustamae Hospital.

In 2004, Mustamae Hospital created the Emergency Medical Center (EMC) which was based on a similar center that the partners saw during an exchange trip to the US. It consists of an Intensive Care Unit (ICU), Emergency Care (ER) and a septic unit. Each day the Center cares for approximately 250 patients.

Furthermore, the Mustamae partners established a national rescue team that consists of 50 health professionals, including 12 from Mustamae Hospital. The rescue team participates in disaster drills organized by the Rescue Service System in various countries, and in 2005, the disaster team took part in a practical drill in Malaysia after the deadly tsunami.

One of the Mustamae partners became the Chief Surgeon General within the Defense Ministry. He used skills gained during the development of the Mustamae EMTC to establish an emergency training center for the Defense Ministry which became one of the best centers, providing emergency instructions to 150 defense medical staff, as well as to conscripts and paramedics. The center offers a 10-week certification program in the basics of emergency care. Many army recruiters use their new emergency skills to change their professional career and a significant number return to civilian life and work in the fire department, police department, or ambulance services.

Partners from Tallinn Central Hospital were also inspired by the US emergency department and in 2002 established their own emergency center—the first of its kind in Estonia. The emergency department continues to grow and currently employs 10 physicians who rotate in 12-hour shifts. The emergency department serves approximately 150 patients a day of which about one-third is trauma patients, while 30 percent are patients with eye emergency cases and the rest include tertiary patients and internal medicine patients. Following the American example, the partners implemented a modern electronic patient system which stores patient records and operation protocols on the hospital computer system.

- ***Women's Health***

The partners from the Women's Clinic not only learned practical skills from their American colleagues, they also gained confidence which allowed them to introduce new ideas that previously they would not have had the courage to express. Thanks to the many improvements implemented by the Estonian partners, the hospital became a benchmark for another women's clinic located in Tallinn.

"Midwives in our hospital are doing such a great job in delivery, in outpatient, in prenatal classes, and breastfeeding counseling. No other place in the country provides such independence and we are very proud of this. Doctors in other hospitals are holding midwives back, but we trained our midwives, and they are very good. We can trust them, we collaborate with them, and we work hand-in-hand with them. We have a great staff." *– Dr. Lee Tammemae, Women's Clinic*

The first important improvement that enhanced the satisfaction of both patients and their doctors was allowing hospital physicians to examine their patients in an outpatient setting. Patient satisfaction also improved after the introduction of the ESTER system, an electronic medical record system for patients which the Estonian partners saw for the first time at the George Washington University Hospital. The system enables the hospital to keep records of patients on a waiting list (both for outpatient visits and surgeries) which helps the hospital to better plan a number of surgical procedures covered by the sickness fund, and provides storage for all information about patients' procedures, lab tests, x-rays, etc.

Another revolutionary change introduced by the Women's Clinic partners was upgrading the role of midwives in both the hospital and outpatient clinic. Inspired by the example of the Bethesda Birth Center, the Estonian partners trained their midwives to autonomously handle patients during normal deliveries, provide outpatient care and counseling, and deliver educational classes to future parents. The Women's Clinic is the only place in the entire country that allows such independence to midwives.

The Estonian partners achieved great success with the implementation of the practice of early discharge after delivery. Prior to the partnership, the average length of stay (ALS) in the delivery department was seven days. Currently, it is three days. Women can leave 24 or 48 hours after a normal delivery and three to five days after

a Caesarean section. After a discharge, a midwife organizes a follow-up meeting with the mother to provide counseling and vaccination.

Thanks to partner training which led to improvements in intensive care for newborns and premature babies, perinatal mortality dropped dramatically at the Women's Clinic. In 1994 the hospital recorded 20.1 perinatal deaths per 1,000 deliveries; in 2004 this number decreased to 10.4 per 1,000 deliveries. The Estonian partners changed their delivery management policy which anticipated an increased number of c-sections for mature babies and for breech deliveries. Also, the hospital started to pay more attention to monitoring procedures during delivery for early detection of problems such as malformations. The partners changed their guidelines about identifying problematic pregnancies based on the baby's weight. In the past only babies who were less than 2.5 kilos were perceived as problematic cases while currently this limit is less than 1 kilo and 200 grams.

The partners from the Women's Clinic learned from their American colleagues about the importance of giving patients an active role in decision-making. The Estonian partners started to describe to patients their treatment and procedures, and introduced a written consent form. Over time, such documentation became a standard practice in Estonia, but back in the mid-nineties it was still new.

Another direct outcome of the partnership was the introduction at the Women's Clinic of voluntary HIV tests for pregnant women and counseling prior to the test. Thanks to this new initiative, in 2004 the hospital identified 14 HIV cases. The same year, the clinic had only two mother-to-child-transmission (MTCT) cases among women who did not know they were HIV positive and showed up at the clinic at the time of delivery.

The partners from Women's Clinic were also very successful in introducing laparoscopy as a mass procedure. Prior to the partnership, the doctors used the laparoscopy technique, but the equipment was old and capable of doing a maximum of only 30 procedures per year. During an exchange trip to the US, the Estonian partners learned about the broad use of laparoscopy and received new laparoscopy equipment. The Women's Clinic started to provide laparoscopy procedures on a very large scale, and rather than just using laparoscopy as a diagnostic tool, the hospital started to use it as an operating tool. This new approach helped the hospital generate additional revenue because the cost for the surgery remained the same but more patients could be served in the same amount of time. The Women's Clinic was the first in the country where laparoscopy operations outnumbered traditional surgeries, setting an example for other hospitals. In 1998 the hospital conducted more than 500 laparoscopies and, as of June 2005, the clinic has performed approximately 5,000 laparoscopies.

In addition, in order to generate additional revenue, the Women's Clinic started to offer private rooms for pregnant women and their husbands. This new service became so popular among patients that in 2005 the clinic planned to double the number of such rooms.

- ***Family Practice***

During the partnership years, family practice was in its infancy in Estonia, with few family practitioners (FPs) in the country. The partnership incorporated a family practice initiative in 1995, in collaboration with the Department of Family Medicine at Tartu University, with the aim of strengthening the education system for FPs, developing models for integrating family practice services into existing health care system, and research new models of reimbursement. One of only a handful of family practitioners working in Tallinn at the time was brought to Washington to see how FP centers in the US operate and to meet with US specialists.

The partnership developed a family practice residency training program, and Tartu University began granting a certificate in family medicine. Through 2004, a total of 996 family doctors had been certified. Partners also established a one-week continuous medical education course for practicing FPs and instituted a licensing exam in family practice that requires physicians to pass the exam every five years to continue to practice family medicine.

Other results include Tartu University's development of a nursing specialization in family medicine, with an emphasis on teamwork and coordination with physicians; the establishment of the Association of Estonian Family Doctors which works closely with the academic health center to improve training.

Since the end of the partnership, the Estonian partners established model independent private family medicine centers throughout the country that focus on providing accessible services with an emphasis on prevention and health promotion within a patient-friendly environment. The centers are funded through direct contracts with the Estonian Sickness Funds. "Ideas that were discussed [with family doctors in the US] were used in development of a new financing system of family medicine in Estonia from 1998." (Heidi Ingrid Maaroos, Tartu University)

- ***Access to Health Information and Communications***

AIHA supported the development of Learning Resource Centers (LRCs) at Mustamae Hospital and Tallinn Central Hospital from September 1996 through September 2004.

During this period, the LRC at East Tallinn Central Hospital provided training on computer and Internet usage to 200 health professionals. Staff of the hospital actively used the LRC to obtain the latest medical research and used this research to evaluate and improve their own standards of practice. For example, based on information obtained through the LRC, clinicians were able to introduce new methods for performing Caesarian sections and conducting fetal assessments. In 2001, the hospital officially established an information services department with seven information coordinators to support the needs of the various departments and clinics. Supported by the main information coordinator at the LRC, these information coordinators were responsible for responding to information requests from staff.

At Mustamae Hospital, the LRC received a grant from the Soros Foundation in 1998 to expand the LRC to a 15-computer classroom. This classroom allowed the hospital to expand its training program and train 271 health professionals during the funding period. By 2000, about 170 computers throughout the hospital were equipped with Internet access, and the hospital had begun providing computer/Internet access to patients and others from outside the hospital (it became popular among the disabled because the center was wheelchair accessible). Eventually, the LRC information coordinator became head of a newly created customer service department, which was responsible for providing hospitality and assistance to both patients and staff.

Together, these two LRCs received an average of 378 visitors and 23 information requests each month during the funding period. Both hospitals have continued to maintain these functionalities after AIHA funding ended in 2004.

The partnership training was very important in developing information technology at the Women's Clinic. The partners learned how to use the Internet and find useful information at the time when evidence-based medicine was not even a part of medical curriculum at the Tartu University. Currently, computers are located in almost every office in the hospital and the vast majority of nurses and doctors are computer literate.

CHALLENGES AND LESSONS LEARNED

On of the main challenge faced by the Tallinn/Washington, DC partnership was its relatively short duration of two years, compared to three years for most of the other hospital partnerships. The partnership ended in 1998 due to the closing of the USAID Mission in the country, as Estonia was graduated from US bilateral development assistance. As one former partner lamented, "I had the possibility to see other international

projects and this one was the best. It just stopped so quickly. We had so many ideas, what to do, and it just stopped." (Andrus Remmelgas)

Other challenges included:

- Overcoming the deeply rooted perceptions on the part of many physicians about the capabilities of nurses. Although many physicians started to alter their attitude towards nurses after the exchange visits to the US, the professional relationship between nurses and physicians remained less than ideal. At the same time, some "old school" nurses, who did not participate in the partnership activities, displayed resentment towards changes and the new style of nursing care. The moral support of the American partners combined with the enthusiasm, patience and leadership skills of the nurses trained in the US helped to surmount their reluctance and change their attitudes.

- Lack of funding and insufficient interest of the Estonian government was probably a cause for two initiatives to fall short. The partners had plans to create the first poison control center in the country as part of the EMS training center at Mustamae Hospital. However, there was no government support for such a center and the training of paramedics was not seen as the hospital's responsibility, so the ministry closed the training center in 2000 and the initiatives died. Ten years later, the government recognized the needs and has decided to establish a poison control center and training for ambulance paramedics. The materials and ideas used by the government are the same as those developed by the Estonian partners years earlier.

SUCCESS STORY: *Women's Clinic Pioneers Innovative Improvements*

When the partnership with Washington, DC started, Tallinn's outpatient services for women suffered from a lack of cohesiveness among physicians and scarce involvement from midwives. Through numerous improvements introduced as a result of the partnership, a Women's Clinic was established and proved to be an example of well-managed quality outpatient services for women.

Estonian partners identified and renovated a facility to house the new clinic, and identified physicians and midwives to staff the center. Changing the attitudes of the medical professionals to elicit their support in creating a new management model complete with new roles for midwives proved to be a challenge, but eventually they were able to institute new policies and procedures that have served as a model for other facilities in the country.

An appointment system was instituted, with physicians seeing their own patients, and midwives also taking appointments for routine pregnancies. The clinic also started using ESTER, an electronic medical record for patients. "When we first saw the system in George Washington University's clinic we were amazed that it's possible that such a thing existed. And now we have our own," noted Lee Tammemae, the Clinic's Director. Via the system, users can put patients on either an outpatient or operation waiting list and everything that is done with the patient, including the procedures, lab tests, and x-rays, is entered this program. Electronic bills for the insurance company are also created through this database, saving the hospital time and money. "And the system is still growing and new possibilities are added. The last thing that was added was [an] operation waiting list. It helps us to plan number of people we can operate [on] based on the sickness fund, because we have financial limits," said Tammemae. The system has been very helpful, despite the initial challenges teaching staff how to use it effectively.

Among the other breakthroughs achieved at the clinic was a change in the practice of handling stillborn deliveries. Initially the American approach to stillborn cases, where the child was shown to the parents, was shocking to the Estonian partners. Prior to the partnership it was common practice in Estonia not to show stillborn babies or babies that died right after delivery to their parents. Until then, Estonians were unfamiliar with the idea that the grieving process of parents cannot be completed without showing them their child.

Despite cultural differences and resistance among the medical staff, the staff of the Women's Clinic started to implement this new and controversial approach. To help midwives and doctors to handle such difficult situations in their daily practice, the hospital organized special lectures for them with a psychologist. The new method was very well received by parents who lost their babies and over time it became a routine approach in the clinic. "I learned how to handle baby loss, when a parent loses a baby, how to manage, how to communicate, how to support parents. It was a big problem for all of us before. Nobody know how to behave, what to say, and who should do it. So it was very interesting for me to see in the US what they do there." (Helin Raudkepp, former midwife)

In 2005, the clinic accommodated 88,000 visits and 3,211 deliveries, with the number increasing each year, and they are continually looking for new ways to improve the management of the center. The next change they hope to make is to hire medical assistants to lighten the paperwork load of the midwives. Noting that the changed role of midwives was integral to the success of the new center, Tammemae concludes: "Midwives in our hospital are doing such a great job in delivery, in outpatient, in prenatal classes, breastfeeding counseling and no other place in the country provides them with such independence. We can be proud of it. Doctors in other hospitals are holding them back. But we trained our midwives and they are very good. We can trust them. We have good collaboration with them, we work hand in hand—we have great staff."

Partner Profile — *Annely Karjamaa*

Annely Karjamaa joined what was then Mustamae Hospital in 1984, progressing in her career from a secretary to head of the administration office responsible for logistics, and later to head administrator in the chief doctor's office. When the AIHA partnership with George Washington University began in 1994, she helped coordinate administrative tasks for Mustamae, one of the two Estonian partner hospitals, and was also appointed Information Coordinator for the Learning Resource Center. But it was her visit to her partners in Washington, DC, and what she saw there for the first time that launched her on a new and most rewarding career path in the field of customer service.

In 2000, four years after her first trip to the US on a partnership exchange, she established the hospital's first ever customer service department, starting with just 12 staff members. Appointed head of the new department, Karjamaa oversaw the growth of her staff to 84 persons just two years later, after a merger involving eight area hospitals to form the North Estonia Regional Hospital. The growth was also a testament to her vision and dedicated efforts to improve the hospital's services and image, applying ideas she had gained from seeing first-hand how a customer service department is organized and functions within a hospital in the United States.

As the head of the new department, Karjamaa says she faced numerous challenges, particularly because the idea of customer service and satisfaction was a new concept within the healthcare arena in her country at that time. Karjamaa explains: "Even if I had a vision of how to create a customer service department, Estonia wasn't ready for it. But then customer service started in business and everybody started to talk about how important it is. It's everywhere now — not only on the first floor where the registration area is, but in every department and every unit."

Her greatest challenges came with the hospital merger. Karjamaa spent four months gathering data from all eight hospitals, doing financial calculations, identifying areas for improvement, and describing the benefits of the new approaches to customer service. She prepared a comprehensive project proposal and then set about convincing her colleagues. She initially met some resistance, but was able to persevere, and credits the partnership for helping her deal with challenges and giving her the ability to better articulate her vision and needs.

The proposal that was eventually accepted included designing a new information and patient registration area with clearly marked desks and chairs for waiting patients. She also bought uniforms for the registration personnel to increase their visibility and sense of professionalism, and introduced an electronic system to replace the long lines that used to form of people waiting to be helped. "Before people were standing in one line; everyone was mad, so I decided to introduce this new system." Other changes included new job descriptions for staff that provide information on how to approach specific tasks, along with expected performance goals, and "complaint boxes" in each department where patients can register complaints, offer praise, or make suggestions. In addition, in each of the eight merged hospitals she created small customer service teams.

Karjamaa also takes customer service training seriously and has organized orientation for new employees as well as in-service trainings for her employees, including a workshop conducted by a psychologist to help registration staff deal with difficult patients and situations. She, herself, has applied the adult learning methods she learned from the partnership's leadership and management workshops and has used role play and videotaping as part of staff training.

Today Karjamaa manages a budget that has been steadily increasing as new ways of meeting customer needs and of improving the hospital's image and services, are found. Her latest project is working with her staff to establish a call center in order to better serve patient needs. In addition to her hospital career, Karjamaa also made academic study a priority, and in the summer of 2005, she received her master's degree. What began as a partnership exchange visit to the US resulted in fulfilling personal and professional growth for someone who started her career as a secretary, and higher satisfaction among patients with their hospital experience.

II.F. HUNGARY (1995–2004)

Program Highlights

- Introduced the country's first home care service in Vác, including the establishment of an independent home care agency.
- Established a model diabetes program in Vác, with over 3,000 patients receiving care each year.
- Vác Municipal Hospital introduced same-day surgery, and the hospital lowered operating costs associated with overnight patient stays.
- Vác Municipal Hospital reduced length of stay from 8.3 days in 1994 to 7.8 days in 1998.
- NGOs established in Győr and Vác to spearhead community health efforts after the end of the AIHA healthy communities partnerships.

Partnerships	Years	Focus Areas	Partner Institutions
Vác/Winston-Salem, North Carolina	1995-1998	Home Care, Management, Diabetes, Community Health, Colostomy Management, Stroke Care and Rehabilitation	• Vác Municipal Hospital • Novant Health Triad Region
Győr/Pittsburgh, Pennsylvania	2001-2004	Community Health, Women's Health	• Győr Healthy Cities Project • Magee WomenCare International • The Family Health Council • University of Pittsburgh
Pécs/Harrisburg, Pennsylvania	2001-2004	Community Health, Women's Health, Network Development	• The Hungarian Association of Healthy Cities • The Institute for Healthy Communities

BACKGROUND

The need for radical health reform in Hungary became apparent during the last years of communist rule in the late 1980s. The widening gap in health status between Hungary and western European countries called for change, and the softening political climate opened the way to reform. The health policy changes instituted during the communist regime included the establishment of the Social Insurance Fund and the recognition for private providers of care. When 40 years of communist rule ended in 1989, however, Hungary faced a number of challenges, but also had an opportunity to continue the reforms begun in the late 1980s. ("Health Care Systems in Transition: Hungary," European Observatory on Health Care Systems)

In the mid 1990s, mortality rates in Hungary remained among the highest in Western Europe. For instance, the mortality rate for males aged 40-59 years increased from 8.4 deaths per 1,000 in 1970 to 15.2 in 1997. Age-standardized mortality from heart disease remained high, with 25.7 deaths per 1,000 in 1996 (versus a European average of 11.4). Cancer and liver disease claimed many lives, and maternal and infant mortality

rates were also much higher than western European averages. In addition, death rates due to accidents and suicide were among the highest in Europe, and morbidity and mortality due to unhealthy lifestyles and behavior was very high. High consumption of alcohol, increasing rates of smoking, and unhealthy diet were seriously affecting the health of the nation.

In addition to improving the quality and standards of care for its citizens, the Hungarian government set out to improve the efficiency and productivity of its healthcare institutions. For example, the elderly and long-term disabled were often kept in hospitals for extended periods when they did not require hospital services, which was both costly and ineffective. A major goal of national healthcare reform was to reduce costs by reducing the number of hospital beds, the length of stay at hospitals, and to decrease hospital operating costs. A reduction in public funding made it imperative that hospitals improve their efficiency and cut costs. For example, Vác Municipal Hospital faced a major challenge when its state funding was cut across the board by 10 percent.

AIHA began working in Hungary in 1995, to meet USAID's goal to increase the quality and efficiency of the country's healthcare system. The first AIHA partnership was established in 1995 between Carolina Medicorp, Inc. (now NovantHealth) in Winston-Salem, North Carolina with Vác Municipal Hospital. In 1998 the partnership was extended for one year to incorporate a community health component using AIHA's healthy communities model. In 2001, with the support of US Ambassador Nancy Brinker, AIHA launched two healthy communities partnerships in Hungary to address women's health. The Győr/Pittsburgh partnership served as the model community site, while the Pécs/Harrisburg partnership linked two networks of communities to more effectively address women's health and effectively work with each other to meet common objectives.

KEY RESULTS

- ***Diabetes***

After the US partners provided training for 40 physicians and nurses from Vác Municipal Hospital and family practices in diabetes education and care, the Vác partners established a model diabetes program including patient education, data collection and evaluation, and a patient support group (diabetes club).

A Vác family physician and his staff implemented a diabetes patient education program, with classes conducted every two months, and their office is equipped with a computer system that provides a connection with the hospital laboratory. In addition, the educators conduct classes with district nurses. Patients are very receptive to the classes and are learning to take responsibility for their own health. As a result, the office had only two hospital admissions in the year following the implementation of the education program, a major decrease from the previous year.

The Vác partners created and adopted into regular use a series of diabetes patient education sheets to estimate the knowledge of the patient at the onset of the education and training. The hospital developed and utilized an educational sheet on the symptoms of hypoglycemia and hyperglycemia. Another instructional sheet, developed by the diabetes team members in collaboration with 85 members of the diabetes club, teaches patients how to tailor their diet. A follow-up sheet allows educators and patients to track their progress in the program. Partners utilized the hospital newsletter and local media to inform patients about the availability of diabetes patient education.

The Ministry of Welfare incorporated Vác Municipal Hospital's diabetes patient education materials and procedures as official teaching instruments and will use them as educational tools in other hospitals. The Ministry included the patient education materials prepared in Vác in a national program for primary care physicians on diabetes care follow-up. The Ministry has asked physicians and nurses from Vác to assist with training in hospitals around the country and with the dissemination of the materials.

Diabetic patients in Vác are now assigned to only one outpatient clinic and one hospital department, where previously they were treated in multiple departments in a less organized manner. The Vác partners developed a patient survey to track customer satisfaction and ensure quality of care and family physicians now keep better patient records.

The knowledge level of diabetic patients and their participation in group activities increased substantially. The percentage of diabetes patients in Vác who self-manage their condition increased from 40% before the partnership to 80% at the end of the partnership.

The number of patients receiving care at the diabetes unit at Vác Municipal Hospital has increased dramatically, from 600 patients per year in 1996 to over 3,000 today. The unit was recently accredited by the Hungarian National Diabetes Mellitus Association.

- ***Emergency Medicine***

Vác Municipal Hospital inaugurated an emergency department treatment area in April 1998, and the design and reorganization of the department was based on observations and training received at Novant Health. Advances incorporated into the new area included triage criteria development and implementation of the triage system; a method of providing information to the family and patients regarding their tests and treatment; and a centralized patient transportation system. Other innovations included the joining of trauma and internal medicine emergency departments, a shock-prevention/life-saving unit at the ambulance entrance, the immediate separation of infectious patients, a new operating theater with air conditioning.

New Emergency Department at Vác Municipal Hospital

- ***Home Care***

With support from the Ministry of Welfare, Vác Municipal Hospital launched a new home care health model in 1996. To help the Hungarians develop their program, the Winston-Salem partners taught a home care education seminar focused on agency management operations and clinical issues. Topics covered included a study of US home care services, staffing and practice issues, clinical pathways, documentation, standards and accreditation, and public relations.

Nurses and private practitioners working for the newly-created home care agency in Vác provided patient education as well as home care treatment. This program helped contribute to a dramatic reduction in the average length of stay at the hospital, and for the first time gave patients the option of receiving care at home that was covered under the national health insurance.

A hospice component was later added, and the program was expanded to include additional services and new positions for home care coordinator and head nurse for home care for the City of Vác were created. The program has served as a model for other Hungarian communities. For further details about the partnership's achievements in establishing the home care model, see the success story below.

- ***Same-day Surgery***

With the guidance and assistance of the Winston-Salem partners, Vác Municipal Hospital introduced same-day surgery for certain less complicated procedures. New anesthesia "blocking" techniques were used instead

of general anesthesia, often allowing patients to return home the day of surgery. In 2000, the hospital decided to close the same-day surgery unit, instead allowing specific hospital departments to provide same-day procedures. The number of same-day procedures has increased in Vác, from 396 in 1998 to 479 in 2005. The Hungarian Health Insurance Fund now provides coverage for same-day surgeries, and Vác Municipal Hospital has made adjustments to meet the increased patient demand for these services. With more same-day surgeries performed, the hospital has lowered operating costs associated with overnight patient stays.

- ***Oncology***

The Winston-Salem partners assisted their Vác counterparts in improving their outpatient treatment unit. For example, the partners developed clinical practice guidelines for the treatment of breast and colon cancer and they also worked to develop and implement a pain management program for cancer patients, helping Vác Municipal Hospital become more efficient in the treatment of patients receiving chemotherapy. The Vác partners developed an internal cancer database to monitor treatment outcomes. The need for such a database was not determined until the partners began to assess how information was currently being monitored, and without the database, it would have been difficult to know the impact of changes in the treatment of the cancer patient.

Utilizing the continuous quality improvement (CQI) process introduced by the Winston-Salem partners, the Vác partners developed oncology teams including oncologists, pathologists, radiologists, and nurses. By developing these teams, the oncology unit was able to ensure smooth working relationships and improved patient care among all the specialists involved in cancer treatment.

The improvements made at Vác Municipal Hospital during the partnership continue to be implemented. For example, the oncology department continues to deliver outpatient care, chemotherapy and palliative care. (In 2004, the unit treated 486 outpatients.) Prior to the partnership, cancer patients had to go to Budapest for inpatient chemotherapy.

The hospital now performs mammography screening for breast cancer and pre-operation diagnostic procedures for patents. Using the team concept introduced by the US partners, the oncology department recently formed a team for the pre-operation diagnosis of colorectal cancer, and plan to create additional teams for other types of cancer. In the future, the oncology department would like to focus on optimizing pre-operative diagnosis, surgery, and follow-up radiation therapy.

- ***Hospital Management***

The Winston-Salem partners conducted workshops and training in CQI, health management and leadership at Vác Municipal Hospital for managers, nursing leaders, and financial staff management staff. With the support of the partners from Novant Health, the Hungarian partners implemented a number of significant changes in the management and organization of operations.

"Limited funds are not always a barrier to providing quality care for the patient."
– Winston-Salem final partner report

For instance, the partners developed a set of "clinical paths" which detail exact responsibilities for hospital staff and a plan for testing and treating patients with specific pathologies during hospital stays. These paths have allowed Vác Municipal Hospital to better anticipate costs associated with each patient. The hospital has increased staff efficiency by allowing hospital staff, particularly nurses, more independence to perform tests and therapy on their own, using the clinical paths as a guide

The Vác partners have taken steps to improve patient customer service levels. Through training and promoting patient care as a service, the staff now takes personal responsibility in caring for the patient. Patient satisfaction surveys help track results.

Vác Municipal Hospital instituted a patient discharge planning system which allows the hospital to make informed decisions on patient release, allowing patients to leave the hospital earlier than before.

As a result of numerous improvements implemented through the partnership, the Vác Municipal Hospital reported a decrease in average length of stay from 8.3 days in 1994 to 7.8 days in 1998. Over the same period, the number of outpatient visits increased from approximately 443,500 to 512,000.

- ***Nursing***

Vác Municipal Hospital introduced a system of supervising nurses that included a nursing supervisor (a separate position) who was hired to direct the professional activities of all nurses, help them resolve any human resource and professional issues, and manage the training of new staff members, as well as conduct continuous nurse training. In addition, documentation by nurses has improved, and nursing techniques have become more consistent with the introduction of clinical guidelines. The supervising nurse plays a leading role in the development and elaboration of these guidelines.

On December 16, 1998, the partners celebrated the opening of a Nursing Resource Center (NRC) with an MOU signing ceremony at Vác Municipal Hospital. The hospital conducts extensive regular training programs for nurses at the NRC and it is also used by the local nursing high school, whose students practice at the hospital, for training of the home care nurses, and in some cases also for other nurses of the Vác district. The NRC provides an educational and training site for nurses from the Vác region and assists Vác Municipal Hospital in four areas: graduate nursing education, support of a credit-based system of nursing professional education, continuous quality improvement, and patient education.

- ***Community Health***

In 1998, the Vác partners determined that they wanted to expand their focus, moving outside of the walls of the hospital and into the community. The partners and AIHA agreed that in the final year of the partnership, an additional partnership objective would utilize the Healthy Communities process to meet the needs of the greater Vác community.

The partners created the Vác Healthy Community Task Force to coordinate the partnership's Healthy Community activities. Regular meetings of the Vác Healthy Community Task Force helped to bring together the community and the municipal policymakers and stakeholders, and convinced them that they were doing significant work for the benefit of the community. These meetings demonstrated to the mayor and local policymakers that everyone must share the responsibility for the community's health and well-being. Task force members learned about the Healthy Communities work conducted by the Riga, Latvia/St. Louis, Missouri partners, and the Winston-Salem partners conducted community health training for Vác teachers and students.

"Healthy Corner" Established in a Vác Supermarket

In April 1998, the Hungarian partners established the Association for the Health of the Citizens of Vác, a task force consisting of local government officials, educators, public health officials, and leading businessmen that was created to develop and implement a community health program in Vác. The association remained active after the end of USAID/AIHA funding, with support of the Vác municipal government. The association promotes community health through various outreach and education programs, involving community stakeholders such the local schools and local businesses. Activities include a program for local supermarkets to include a section devoted to healthy foods and preparation, and involvement of teachers and students in interactive training and programs to better share needed healthy lifestyle information and advice.

In December 1998, the partners celebrated the opening of the Healthy Community Center in Vác. The Center serves as a venue for community education programs and as a resource center and meeting place for the Healthy Community Task Force.

The Healthy Communities Center in Vác continues to operate, with the city supporting the center's operations and staff salaries. The Healthy Community Task Force created by the partnership continues to plan and implement a number of activities for the citizens of Vác.

- ***Utilizing Healthy Communities to Address Women's Health***

In 2002, AIHA had the opportunity to continue to apply the Healthy Communities methodology in Hungary through two additional partnerships. US partners from Pittsburgh, PA assisted their Hungarian partners in Győr in applying the Healthy Communities methodology to engage local government and community-based organizations in developing and implementing women's reproductive health intervention services and education programs. After conducting an initial assessment of women's health needs in the community and being exposed to model community programs in Pittsburgh, the Hungarian partners established a multi-disciplinary Community Advisory Board to organize and implement the Healthy Communities process in Győr.

The partners agreed that to efficiently gather input from women in the community, they would conduct focus groups representing the target populations in Győr. After receiving training from a research fellow at the Hungarian National Drug Prevention Institute and AIHA, the Győr partners conducted eight focus groups with a total of 46 women. After analyzing the focus group interviews, the partners identified the following women's health needs in the community: family planning (including anatomy and puberty; pregnancy prevention; STDs; healthy relationships; and preparing for parenting, pregnancy, and birth), mental health (including stress management and depression) and healthy lifestyles (including nutrition, exercise, addictions, and health screening). The partners identified five target groups on which to focus intervention activities: 14-18 year old girls, expectant mothers, women considering marriage, socially disadvantaged women, and healthcare professionals.

A health educator from Pittsburgh conducted three community outreach education programs during an exchange that had the dual purposes of demonstrating techniques and strategies and of sharing health information with community members. Approximately 75 community members attended, including employees of the Győri Biscuit Factory, representatives of the Roma community, and pregnant women and their partners. A diverse group of 17 trainees observed the programs, including nurses, educators, social workers, and public health institute employees. In addition to observing the education classes, the trainees attended information sessions on community-based health outreach, Healthy Communities programming, outreach campaigns, and education strategies.

Utilizing the skills and techniques learned from their American partners, the Győr Community Advisory Board began implementing programs to share important health and healthy lifestyles information:

- The Győr partners conducted an outreach education program at the local public swimming pool; partners shared healthy lifestyles information with more than 350 people during the week of the program.
- For one month, the partners designed and ran a weekly quiz in the county newspaper that focused on a different women's health topic. The quiz included a short summary of the partnership and its activities. Entries were collected and winners were randomly selected from the correct entries.
- The Győr partners organized peer education training for 17 high school students from five schools. These students conducted outreach sessions to youth on a number of reproductive health topics.
- The Győr partners provided four outreach classes in the spring of 2004 for young couples planning to be married. Topics included communication, healthy relationships, sexuality, family planning, and contraception.

- The partners conducted an adolescent pregnancy prevention campaign which focused on responsible relationships, safe sex, and other related issues targeting 14-18 year old girls in Győr, with a special focus on socially disadvantaged and less educated groups. As part of the campaign, local gynecologists, school nurses, and peer educators gave presentations at 11 local schools. The campaign included three Information Points throughout the city at locations frequented by young people where district nurses, peer educators, and volunteers were on hand to distribute information and to answer questions. The campaign concluded with a teen disco event which included a panel of two Hungarian television personalities and a gynecologist and moderated by a reporter from Radio Győr discussing the campaign topics. About 90 teens participated.
- *Till Human Voices Wake Us*, a play about teen pregnancy and pregnancy prevention was shared by the Pittsburgh partners, translated, and adapted for use in Győr schools. Three participating drama teachers have presented the play at their schools and it is anticipated that the play will be presented at schools throughout Győr, using students from each school as performers. After each performance, a discussion is led by peer educators and nurses that are part of the project.
- As part of the annual "health markets" held in Győr each April, the Hungarian partners set up eight interactive booths in eight different city neighborhoods to provide health information to the public. Approximately 1,800 people visited the health market booths, which held various educational activities including presentations on health topics, quizzes, games, demonstrations, and children's activities.

In March 2004, the partners celebrated the grand opening of *For Women's Health*, the women's health information and resource center in Győr. The center provides women in the community with access to important information about issues such as family planning, healthy childbirth, healthy lifestyles, and mental health. Center staff also offers classes on a variety of topics. The partners also opened two satellite centers and eight information kiosks at key sites throughout Győr, including healthcare sites, a pharmacy, the cultural house, the shopping mall, the business park, the public library, and the family and marriage institute. These additional centers/information points are able to reach target populations throughout the city, especially women who may not be able to visit the main center. The partners report that in its first six months of operation, *For Women's Health* held 54 health classes attended by 1,146 people. Additionally, more than 150 individuals visited the center. Center staff loaned resource materials to 183 people and distributed 10,900 leaflets on a variety of topics.

Following the example of the Vác partners, the Győr community advisory board made the decision to create an entity eligible to apply for official Hungarian NGO status. After a lengthy process, the Hungarian partners created the Association for the Health of Women in Győr. Through the auspices of this newly created NGO, the Győr partners are now able to continue the community education and outreach activities initiated through the partnership. The organization will also be eligible to apply for grants targeted specifically to NGOs.

While the last partnership exchange took place in May 2004, the Győr partners received funding to support additional women's health activities. With these funds, the partners conducted a public relations campaign to promote the network of centers, raising awareness of the centers and their services to targeted groups and the citizens of the wider community. The partners expanded their peer education program, training additional peer educators, provided expanded training on peer education, established a peer educator club and organized additional activities. The partners also conducted training for community health educators, including Roma health educators and hairdressers who will provide health education to their clients. Funding for these additional activities was provided through the new NGO.

➢ *Supporting Healthy Communities Networks*

In addition to the community-based partnership between Győr and Pittsburgh, AIHA also had the opportunity to develop a second partnership which linked networks of cities embracing the Healthy Communities approach. This second partnership (also launched in 2002) linked the Hungarian Association of Healthy Cities (HAHC) with the Institute for Healthy Communities (IHC) in Pennsylvania. Through this

partnership of networks, IHC (which supported 90 community partnerships in all of Pennsylvania's 67 counties) provided guidance on women's reproductive health services in HAHC's 23 member cities and improved the networking capabilities among the member cities.

The partners identified current and potential opportunities for addressing women's health in Hungary, including US models that might be applicable to the Hungarian situation. IHC shared a range of resources to help communities build capacity and collaborative partnerships, including materials related to assessing and improving health status, implementing community health improvement programs, engaging the business community, developing community health policy, and a variety of brochures and newsletters.

The partners determined that HAHC needed to better understand whether its individual member cities considered the health of women as a priority and what specific activities the Hungarian communities were currently sponsoring to address this issue. The partners developed and administered a survey to the 23 HAHC cities to collect information on: the capability of the cities to plan programs and think strategically; the nature of activities planned and/or implemented by the member communities; and what types of assistance member cities need to implement programs meant to improve women's health. The partners also conducted a business leader survey of member cities to determine: the level of business involvement in member city activities; the mechanisms cities use to inform businesses about health-related activities; obstacles cities have encountered in engaging the business community; and ways in which HAHC can further support city efforts to work with businesses.

Based on an analysis of the results of these surveys, the partners determined that support was needed in two areas: better engaging business leaders in garnering their support for programs addressing women's health issues; and increasing the capacity and effectiveness of HAHC coordinators in organizing and implementing community-based programs. To meet these needs, the partners held two meetings in Budapest in February 2004. The Business Leaders Summit engaged Hungarian business leaders in critical dialogue with executives from leading Pennsylvania businesses regarding their corporate responsibility for improving health and quality of life in their own communities.

Following the Business Leaders Summit, the partners hosted a training session 27 HAHC coordinators. The goal of the training was to build capacity and optimize organizational effectiveness of HAHC coordinators to improve health with an emphasis on women's health. Sessions were devoted to skills-building related to effective networking, team development, consensus-building, effective lobbying and advocacy, stakeholder analysis, media relations, and monitoring and evaluation. The partners developed a workbook for the training called *A Guide for Effective Networking and Management Skills*, to be used among coordinators to support their Healthy Communities work.

- ***Continued US Partner Support***

The Vác partners have maintained contact with their Winston-Salem counterparts. This contact is mostly informal and personal, but the US partners continue to demonstrate their support for the Hungarians. For example, the CEO at Novant Health arranged for staff at Vác to have free access to Novant's digital library of medical resources and information.

CHALLENGES

One of the initial goals of the Vác/Winston-Salem partnership was to strengthen the family physician system in the Vác region; however, the partners found it difficult to constructively involve primary care providers, both in Vác and Winston-Salem. Family physicians were reluctant to participate in a program that was mainly focused on improvements in a hospital setting and also resisted the development of home care in Vác. Other AIHA partnerships focused on primary care in Albania and Kosovo were much more successful in involving

family medicine physicians and nurses. The real and perceived divisions between primary care providers and specialists provided a challenge to many partnerships.

The partnership also faced financial challenges in establishing a home care program. Although the increased outpatient services would eventually be cost-effective, the restructuring had a lot of upfront costs that put strain on the already tight budget of the hospital. To be able to start up the program, the US partners worked with the Hungarians to successfully apply for funding from the Soros Foundation to be able to finance the start of the program, and secure additional support from the Hungarian government.

SUCCESS STORY: *Engaging the Roma Minority in Győr*

During the first exchange visit to Győr the Pittsburgh partners learned that a substantial Roma population lived in the community. As part of the initial assessment and stakeholder identification which typically occurs in the early phases of a Healthy Communities partnership, the partners met with local Roma government representatives and the Roma Minority Advocacy Association. The partners learned more about the status of the Roma community in Győr. More importantly, the partners enlisted Roma community representatives to participate in the Healthy Communities process and included the Roma as a target population for the partnership interventions related to women's health.

The partners recognized that a group of trained Roma community educators could provide much needed health information and advice to the Roma women living in Győr. The Pittsburgh partners conducted various training workshops for these educators, including an outreach education program and training on intimate partner violence awareness and its impact on reproductive health. The Roma educators used the skills and information learned to share information with Roma women on women's health and healthy lifestyles, and raised awareness about the availability of additional women's health services in Győr.

The Hungarian partners realized that a new opportunity was created to more effectively engage the Roma population to support the Healthy Communities process in Győr. The partners convened a meeting of the Roma community educators and select district nurses, who provide much of the community and school-based health education, to discuss potential areas of collaboration. The district nurses agreed to develop outreach programs and share training and educational techniques with the Roma educators, who will be trained to conduct additional outreach courses to the Roma ethnic community in Győr. The Roma trainers and district nurses have opened a dialogue, identifying areas where they could assist each other in developing training programs, approaches, and outreach to the Roma population.

The AIHA Healthy Communities process emphasizes the importance of mobilizing community stakeholders to collaboratively address local issues. By embracing this approach, the Győr/Pittsburgh Healthy Communities partnership was able to successfully engage a traditionally isolated and persecuted ethnic group to participate in a process designed to meet the needs of the underserved Roma population in Győr.

SUCCESS STORY: *Creating a Home Health Care Model*

In response to Hungary's primary care health reform, practitioners and administrators at Vác Municipal Hospital restructured the fundamental way patients are seen. Before the program was initiated in 1996, average hospital stays were very long by American standards, partially due to the fact that elderly and disabled patients were often admitted simply because they didn't have a caretaker at home to take care of their needs, and home care was not covered under the National Insurance Fund. By providing more outpatient services and patient education, the hospital was able to reduce the average length of stay from 9.6 days to 8.2 days in in just two years, and prevent 40,000 patient days of hospital stay.

To achieve this, the hospital instituted an education program to teach patients and their families about their illnesses and care. As a result, patients were better able to take care of themselves and are being discharged

earlier. Patient clubs and support groups also facilitated that process. In addition, administrators were given management training so that they could better guide the transition.

"Our experience now makes it possible to see the continuum of care between hospital and home. I am certain home care is a positive force and will be important for the future," said Agnes Katona, MD, partnership coordinator.

In August 1996, Vác Municipal Hospital, with the support of the US partners, applied for and received a grant from the Ministry of Welfare in the amount of 1.8 million forint (approximately $127,000) to fund the development of a home care health model. The Hungarian partners established a home care agency for the Vác region in November 1996, utilizing nurses in conjunction with private practitioners and providing patient education.

The Director of Vác Home Care received another grant of 700,000 forints (approximately $50,000) from the ministry to purchase rehabilitation equipment and mobile phones for patients. The agency worked closely with Vác Municipal Hospital, encouraging the hospital, which changed its operation guidelines, incorporated home care into its continuum of care, set criteria for home care treatment, and created the new position of Home Care Coordinator, who cooperates with the home care agency. The number of procedures the home care service is able to perform has increased because of the enhanced training for staff members.

US partner Frances Hutchison recalls the Home Care Director, Gabriella Molnar, participating in the First World Congress on Home Care in Boston in 1997: "It was a huge step for Ella, who did not speak English, to travel to the US and speak through an interpreter at an international meeting. She was suffering from cancer, but she made many colleagues proud with her contribution to that meeting. She was also able to meet Dame Cicily Saunders, of the Hospice movement, and get her to autograph her book. That trip to the US lifted her spirits and confidence, and gave her momentum to continue her hard work in making Vác home care a model for the country."

Molnar left her position as chief nurse at Vác Municipal Hospital to start the region's first home care agency, which by 1997 employed 13 part-time health professionals (primarily nurses) to make home visits. In November 1996, during its first month in operation, the agency fielded 64 visits; by April 1997, the number had risen to 300.

Patients who take advantage of the service, which is covered by the Hungarian National Health Insurance Fund, are young and old, and often have cardiovascular disease, are undergoing cancer treatment, or are recovering from surgery. "The necessity of home care cannot be questioned because our population is getting older, with very bad health indicators, and there is a greater need for less expensive, more efficient care," Molnar said. "We have found it a practicable way to care for people on an individual basis."

In August 1998, Vác Municipal Hospital, with the support of the US partners, applied for and received a grant from the Ministry of Welfare to further develop home care as a demonstration project for other prospective sites in Hungary. This grant for equipment, education of Vác home care staff, and development of hospice services demonstrated the Ministry of Welfare's continued support for the partnership's home care initiative.

Making home care a focus area for 1998, the Public Health Officer of the City of Vác established a new position of Head Nurse to supervise Vác home care, to serve as a coordinator between home care and district nurses. Hospital physicians, primary care physicians, patients, and families are now informed about the opportunities of home care services, and home care now offers physical therapy and electrotherapy services.

The Vác partners developed a financing mechanism for community home care, serving as a model to be replicated in other Hungarian communities via the National Health Insurance Fund. The partners developed

clinical guidelines, instituted a system for nursing documentation, created a leaflet on patient rights, developed accreditation requirements, and created and utilized promotional materials for public relations. Home care service has been expanded to include most areas of Vác, as well as some neighboring villages, and Nograd and Nagymaros counties. With the introduction of home care services in Vác, some patients do not even need to be admitted to the hospital or they spend less time there.

The home care agency established in Vác by the partnership continues to offer services today, and the partners are now in the process of establishing hospice care in the community. Currently, only two other cities in Hungary offer hospice care.

Partner Profile *Francis Hutchinson*

One day in the spring of 1995, Frances Hutchison received a phone call which would change her life. The call was from the CEO of Forsyth Medical Center, who started the conversation with one simple question: "Do you have a passport?" As it turned out, Forsyth (now a part of NovantHealth in Winston-Salem, North Carolina) was embarking on an AIHA partnership with a hospital in Vác, Hungary. Frances was asked to volunteer her time to go to Hungary to share her expertise and experience in her role as the Director of Home Care; to help the Hungarians to develop a home care system of their own.

Frances was more than a bit reluctant to travel to Hungary at the onset. Frances had years of experience working as a nurse and specifically in home care, but had never traveled to another country, not to mention never working internationally before. "I was excited but also somewhat reluctant about the opportunity. I was unsure what it would be like to travel to Hungary or what the people would be like. I grew up in rural North Carolina…I was a country girl. I went to a large university to study nursing and met people from all walks of life, but I had not been exposed to people who spoke a different language from me and were from a different culture."

But after thinking about it (and with a positive nudge from her husband), Frances decided to go on that first exchange visit to Hungary in June 1995. Her trepidation and worries disappeared soon after arriving in Hungary, and she immediately began working with the Vác partners on the development of home care. "My first trip resolved all of those anxieties. The Hungarians were so warm and welcoming, and just took me in like I was a part of the family. They were so eager, smart, and driven to do what we had set out to do"

Frances' connection with Vác continued to grow, particularly in 1996 when she took on the role as partnership coordinator, overseeing the development of the partnership and the various areas it addressed, as well as continuing to work together with the Hungarians on home care. The partnership experience also helped Frances to better conduct her own work back home. "Professionally it helped me grow; it broadened my involvement in health care, from being a community nurse and as director of home care to having a much better understanding of health care systems as a whole. It helped me become more open-minded, broader-minded, and flexible in dealing with barriers and challenges."

The partnership experience also ignited a desire in Frances to continue to do international work. After retiring, she volunteered as a programmer for her local chapter of the International Visitors Council, coordinating a number of visits to Winston-Salem by international visitors from a number of countries. She hosted a delegation from Moldova in her home for a month. And she traveled to Moldova as part of a trade mission from North Carolina.

Wrapping up her partnership experience, Frances concludes, "This was one of the most wonderful experiences and challenges that I have ever had." And she is making sure that she keeps her valid passport handy, as she plans to return to Hungary with her husband to visit old partners who have become friends in Vác.

Partner Profile — *Paul Wiles*

Paul Wiles was the CEO of Carolina Medicorp (now Novant Health) and Forsyth Memorial Hospital in Winston-Salem NC when the Berlin Wall fell in 1991. At this time in history, when all eyes were watching the remarkable changes happening in this part of the world, he learned about the possibility of partnering with hospitals in Central and Eastern Europe and wanted to get involved. The hospitals had never been involved in international work.

"Our mission is to improve the health of communities one person at a time," says Wiles. "That generally means right where we live, but this was an opportunity for us to maybe do a little good for the world, not just in our little corner of it."

When Wiles visited Hungary for the first time, he was impressed by what he saw during a visit to Vác Municipal Hospital. "Technically the Hungarians were quite capable physicians," recalls Wiles.

Wiles was also impressed with the leadership at the hospital and decided to find a way to provide assistance, first utilizing his hospital's resources in order to fund several visits between physicians in Hungary and North Carolina. Later, Wiles learned about AIHA, which initiated a formal health partnership between Vác and Winston-Salem in 1995. The additional funding allowed the hospitals to develop a deeper relationship, with many more exchanges.

While the partnership provided additional funding, one of the main stipulations was that the Americans involved would be volunteering their time. "It wasn't hard for us to get staff to become involved. We had no issue in getting those people to volunteer or in providing them," says Wiles.

"It was a morale booster, not a chore. It was easy to get doctors and nurses to volunteer and to go over to Hungary or to work with them here," he adds.

During the partnership, which lasted from 1995-1998, the partners from Forsyth worked with their Hungarian counterparts, helping them implement a number of innovative changes, including an upgraded emergency department, a new diabetes program, and improved cancer treatments. But of all the achievements in Vác, Wiles is most proud of the partnership's work in home care.

"In Hungary they didn't have a home health program. (We) helped them develop in-home nursing care," says Wiles. "We shared with them the concepts and the tools, and last I knew they had a functioning home health care program."

Eight years after the official end of the partnership, Wiles and his colleagues continue to stay in touch with and support the Vác partners, such as supplying them with subscriptions to hard copy and online medical journals, so the staff will have access to the latest information.

"We're better off for the experience, we're more enlightened, perhaps a little more worldly," says Wiles. "Maybe that's our little contribution to world order and world peace."

Today, Wiles is looking for additional international opportunities for his hospital, recently returning from a trip to China to explore the possibility of providing assistance in neonatal care.

II.G. KOSOVO (2001–2006)

Program Highlights

- Established a hypertension management program in Gjilan, with 2,359 patients screened; the program was later used as a model to develop a similar program for diabetes.
- Introduced a primary care-based antenatal care program in Gjakova, which provided care to 172 pregnant women in the first year.
- Two Women's Wellness Centers in Gjilan and Prizren provide comprehensive care and services for over 40,000 Kosovar women in the first two years of operation.

Partnerships/Projects	Years	Focus Areas	Partner Institutions
Gjilan/Hanover, New Hampshire	2001-2004	Primary Care, Quality Improvement, Chronic Disease Management, Hypertension	• Dartmouth Medical School • Gjilan Main Family Medicine Center
Doctors of the World	2003-2004	Women's Health	• Doctors of the World • Gjilan Maternity Hospital • Prizren Main Family Medicine Center
Gjakova/Hanover, New Hampshire	2004-2006	Primary Care, Quality Improvement, Antenatal Care	• Gjakova Family Medicine Centers • Dartmouth Medical School

BACKGROUND

Kosovo is located in the southernmost part of Serbia in the Balkan Peninsula, and covers approximately 6,875 square miles (11,000 km). After an escalation of ethnic cleansing and forced evacuation of ethnic Albanians from the region, NATO intervened in March 1999 and since this time the province has been under the protection the United Nations Mission in Kosovo (UNMIK). Decision-making authority is currently shifting to the Kosovar population and its leaders through the local Provisional Institutions of Self-Government (PISG) established in 2002. Today, approximately 1.9 million people live in Kosovo, with 88% of the population ethnically Albanian and 6% Serbian (USAID Profile of Kosovo, July 2005).

When AIHA became involved in Kosovo in 2001, it was evident that an overhaul of the healthcare system was needed as it shifted from a specialist-focused system to a primary care-based system. There was also a need to introduce new healthcare and management skills to the ethnic Albanians who moved into leadership positions after a decade in the parallel Serb-led system. In addition, facilities were in need of upgrading and lacked sufficient basic equipment such as blood pressure cuffs, stethoscopes, and otoscopes.

After a period of UNMIK administration of healthcare services in the province, the Kosovo Ministry of Health (MOH) assumed responsibility and shifted towards the development of primary care. The development of a family medicine training program originally sponsored by WHO and the eagerness of the

MOH to embrace family practice created the opportunity to implement further successful changes in primary care.

However, several barriers existed. It would be difficult, for example, to overcome outmoded care systems, such as working without adequate medical records and using injections as a common mode of delivering medication. As both healthcare workers and the community were being introduced to primary care, more education and demonstration projects were needed.

Medical secondary schools provided minimal clinical experience in educating nurses. In clinics, the nursing role was undervalued, and consisted primarily of giving injections, performing basic registration procedures, and maintaining the office. Many nurses expressed frustration about their limited role, voicing a strong desire to learn new skills, apply assessment skills and increase their interaction with patients.

The clinic environment was also highly disorganized, lacking a systematic patient flow and registration process or medical records. Patients arrived at the clinic without appointments and after registering, they crowded around exam rooms and rushed the door, sometimes before the previous patient had exited the room, and the nurse played no role in assessing or readying the patient before the physician examined him or her. Little health teaching occurred and there were no patient education materials, or even chairs, for waiting patients.

Reproductive health had its own set of specific challenges in Kosova. The regional public primary care system of family medicine centers (FMCs) and village-based family medicine *ambulantas* (small clinics) were not well-structured to provide quality reproductive health services. There was a strong dependence on receiving a cure from a physician, rather than on prevention through health information and education. Additionally, as a consequence of the recent crisis, many women in suffered from psychosocial and/or mental health problems in addition to physical health issues.

The infant mortality rate in Kosovo (estimated to be 35 per 1,000 live births in 2003) was one of the highest in Europe. A UNICEF Report [Survey on Antenatal Care in Kosova, 2003] concluded that, while access to care was universally available, low utilization rates for and poor quality of antenatal services causatively contributed to the high mortality and morbidity rates for women and babies. While 99% of the respondents had gone for at least one antenatal care visit, none of the antenatal care was received from a family medicine physician in (or out of) the public primary care system. While 75% of surveyed women had more than three antenatal care visits, 70% of them did not receive advice or counseling about normal pregnancy, nutrition, possible pregnancy complications, or breastfeeding. There was an average of four ultrasound examinations during pregnancy, demonstrating overuse of routine ultrasonography.

AIHA in Kosovo

In October 2001 USAID/Kosovo asked AIHA to manage a new partnership with Dartmouth Medical School (DMS) in Hanover, New Hampshire. DMS had an existing collaborative relationship with the School of Medicine at the University of Pristina in Kosovo focusing on the development of medical education, including a medical student exchange program. AIHA brokered the new relationship with DMS in Kosovo, stipulating that the partnership focus on the development of primary care in the Gjilan Municipality per USAID priorities. The goal of this partnership was to improve the quality of family medicine practice for the Gjilan Main Family Medicine Center (MFMC) by instituting continuous improvement systems, implementing clinical practice guidelines, improving team communication, and establishing community-based programs, utilizing hypertension screening as the vehicle for the partnership.

To improve the scope and quality of health services provided to women in Kosovo, in 2002 AIHA started a project with Doctors of the World (DOW) in Kosovo to establish two Women's Wellness Centers (WWC). WWCs provide comprehensive, patient-oriented primary care services to women of all ages. Staff from the

Tirana, Albania Women Wellness Center (WWC)—which was established in 2000 through the efforts of AIHA's Tirana/Providence, Rhode Island healthcare twinning partnership—acted as consultants for the two Kosovo centers, providing staff mentoring, practitioner training, and didactic materials.

In 2004, USAID/Kosovo agreed to award an additional AIHA partnership to DMS, to focus on reproductive health in a primary care setting. USAID asked AIHA and DMS to recommend which of the 30 municipalities in Kosovo would serve as the CEE partner, and after conducting an assessment, AIHA and DMS suggested working in the Gjakova Municipality. The Gjakova MFMC included a training site for the Kosovo Center for the Development of Family Medicine, and its leaders understood the AIHA partnership approach. The goal of the Gjakova/Dartmouth reproductive health partnership was to improve the health of mothers and babies in the municipality of Gjakova through the implementation of an antenatal care program at the primary care level.

In Kosovo, AIHA implemented health programs which supported USAID/Kosovo Intermediate result 3.1.1 (Improved Sustainability of Social Services and Community Infrastructure) under Strategic Objective 3.1 (Restored Normalcy in Living Standards and Opportunities) in the USAID/Kosovo Strategic Plan for 2001-2003. AIHA continued to work in Kosovo through 2006, although health was not directly written into the USAID Strategic Plan for 2004-2008. The two partnerships and WWC project with DOW supported USAID goals and objectives in addressing primary care and reproductive health.

KEY RESULTS

- **Primary Healthcare**

The Hanover partners worked with counterparts in the Kosovar municipalities of Gjilan and Gjakova to improve the delivery of primary healthcare. While the interventions selected focused on the specific issues of hypertension management (in Gjilan) and antenatal care (in Gjakova), both partnerships improved the quality of family medicine practice in the primary care facilities by instituting continuous improvement systems; implementing clinical practice guidelines; improving team communication; and establishing community-based education, outreach, and screening programs.

"The partnership experience made me realize that I needed to live healthier. I run an hour a day, eat less, and eat healthier. I stopped smoking and drinking and lost weight in the process. My life changed because of the partnership. My wife says that my life actually started with the partnership." *– Hajriz Ibrahimi, former Director, Gjilan Main Family Medicine Center*

Hypertension Management

"Most of my colleagues will not agree to see a patient without first checking the blood pressure." *– Hajriz Ibrahimi, Former Director, Gjilan Main Family Medicine Center*

After the Hanover partners conducted a training-of-trainers course for two physicians and two nurses from Gjilan, the Kosovar partners in turn trained 61 physicians and 152 nurses (213 of 215 total staff) from the Gjilan Family Medicine Centers (FMCs) in hypertension screening, treatment and clinical practice. Partners developed an orientation package for new staff to learn about the hypertension program and improvements implemented by the partnership project. All new staff and medical students in Gjilan are now trained in hypertension management.

The Gjilan partners developed a clinical practice guideline (CPG) for hypertension, which includes two physician/nurse hypertension algorithms, one clinic-based and one community-based. The hypertension CPG implemented by the partners at the Gjilan MFMC was presented to the CPG Development Committee at the

MOH. The MOH approved, published and distributed the new hypertension CPG for continued implementation throughout Kosovo.

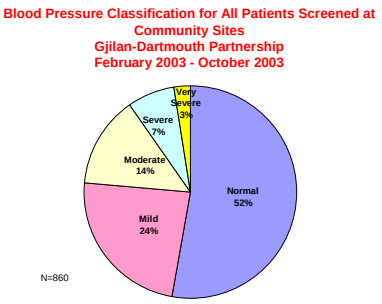
"Most of my colleagues will not agree to see a patient without first checking their blood pressure." *– Hajriz Ibrahimi, Former Director, Gjilan Main Family Medicine Center*

The Gjilan partners created a patient registration card, hypertension health card (*kartela)* for the patient's file, and a form on hypertension that is provided directly to the patient. (The *kartela* was discontinued when the MOH introduced an official medical record which incorporated the *kartela*.) The individual patient blood pressure records given to patients (called blood pressure passports) record multiple blood pressure readings and provide information on hypertension. The new forms were piloted and edited before being officially implemented with the launch of the hypertension management program at the MFMC in October 2002.

As of October 2003, all adults who visit the MFMC have their blood pressure measured and recorded by the nursing staff before being examined by a physician. Hypertensive patients are scheduled for follow-up visits with an assigned primary care physician, improving the continuity of care. The Gjilan partners also expanded the screening program to include patients who present at the MFMC's Emergency Department for care. From October 2002 to September 2003, 2,359 MFMC patients had their blood pressure screened, with 44 percent (1,035) having elevated blood pressure. A number of those hypertensive patients returned for second and third visits (211 and 403 patients respectively) for further care and consultation.

Blood pressure measurement and hypertension screening are still conducted on all adult patients who present to any of the Gjilan FMCs and adults who are screened for hypertension continue to receive individual patient Blood Pressure Passports to help them keep track of their own screening records. Patients are returning to the MFMC for blood pressure screening and advice from nurses and they continue to track hypertensive patients by reporting in the register created during the partnership.

After observing a community blood pressure screening clinic at a senior citizen's center in rural New Hampshire, the Gjilan partners prepared a series of public screenings at various locations in Gjilan. The partners held a training course on the role of the nurse in community screenings for 96 family medicine nurses as well as printed/aired advertisements and visited local mosques, clinics and schools to promote the screenings. The Gjilan partners conducted 10 community-based hypertension screenings from February to October 2003 that reached a total of 860 individuals. A primary care physician was present at the screenings to provide consultations and care for those found to be hypertensive. Twenty-four percent of screened individuals had blood pressures that fell into the WHO categories of moderate (160/100 – 179/109) or higher, and efforts were made to treat each identified case of elevated blood pressure (see chart below).



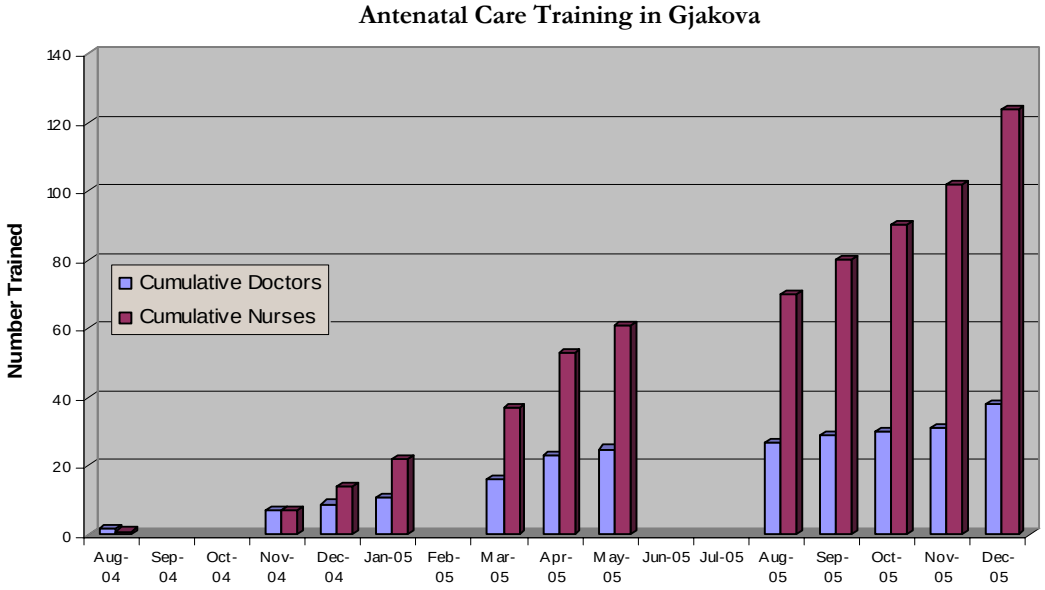
The Microsystems model introduced by the Hanover partners to address hypertension is now being applied by the Kosovars to address diabetes. The Gjilan partners used the hypertension model to establish diabetes screening areas and procedures, conduct staff (particularly nurse) training, and conduct community screenings and education. A team of nine nurses conducts diabetes courses in various villages in the municipality

covering topics such as assessment, exercise and diet, foot care, and medications. The Kosovar partners identified 23 diabetics in the first one and-a-half months of the new screening program.

Antenatal Care

The Hanover partners developed training course materials in antenatal care for both physicians and nurses in Gjakova. The training manual and guide incorporated WHO guidelines for antenatal care which recommends four clinic visits for each pregnant woman with a routine pregnancy. Materials include a training presentation handout, antenatal care training manual, overview of the WHO antenatal care model, an initial patient visit classifying form (also from WHO), the kartela (medical record) for antenatal care, maternal passport, a pre- and post-written test of antenatal care knowledge, practical skills exam, training evaluation, and training attendance and data report.

After the Hanover partners conducted a train-the-trainers course in antenatal care for two Gjakova physicians and one nurse, the three Kosovar partners trained 162 personnel (38 physicians and 124 nurses) to provide antenatal care. In addition to training staff from all nine Family Medicine Centers, the partners also trained nurses assigned to at seven of the 14 Gjakova family medicine ambulantas (small clinics). This is particularly significant because the ambulantas are staffed by one nurse only; physicians from the MFMC or other Gjakova FMCs visit the ambulantas on a rotating basis.



To prepare the FMCs to provide the new antenatal care services, the partners developed staffing schedules, installed necessary equipment and supplies, and determined the area where care will be provided, with patient flow in mind.

The partners launched new primary care-based antenatal care services in two Gjakova FMCs in February 2005, eventually expanding the program to all nine FMCs, including the MFMC. With the implementation of the antenatal care program developed by the partners, for the first time women in Gjakova had access to family medicine-based antenatal care in accordance with the standards of the international community. The Gjakova FMCs provided 172 pregnant women with the new antenatal care services in the first year of the program (see table below for breakdown by FMC), more than triple the original target of providing antenatal care to 50 pregnant women. (The FMCs reported an increasing number of women who returned for follow-up visits as their pregnancies progressed, but a breakdown of patient data is not available at this time. These

return visits demonstrate that patients understand the importance of follow-up visits and believe that they are receiving quality antenatal care.)

Family Medicine Centers in Gjakova Providing Antenatal Care

Family Medicine Center	Date Program Initiated	Number of ANC Visits	Number of Patients	First Visits	Follow-up Visits	Postpartum Visits	Referred Patients
1 & 3 (MFMC)	06/01/05	35	25	22	10	0	5
2 (MFMC)	09/01/05	17	10	9	7	1	2
4 ORIZE	02/14/05	135	79	75	56	17	23
5 ERENIK	09/01/05	9	9	8	0	0	3
6 PONOSHEC	02/14/05	28	20	20	8	7	6
7 CERMJAN	06/01/05	12	12	11	0	0	4
8 SKIVJAN	11/01/05	9	8	5	1	0	1
9 ROGOV	07/01/05	9	9	12	0	0	1
TOTAL		**254**	**172**	**162**	**82**	**25**	**45**

Data through February 28, 2006

All nine Gjakova MFMCs continue to develop the quality primary care-based antenatal care services introduced by the Gjakova/Hanover partners in February 2004. The Hanover partners developed an antenatal care toolkit to be used as a resource for the dissemination of the program in other municipalities in Kosovo and for its possible replication elsewhere. The Hanover partners are embarking on a follow-up USAID-funded project to scale-up the antenatal care program to six other municipalities throughout Kosovo and Dartmouth also plans to address neonatal care in the scale-up program.

- ***Women's Health***

Doctors of the World (DOW) gained approval from the MOH to coordinate with municipal and district health authorities on establishing two new Women's Wellness Centers (WWCs) based on AIHA's center model. WWCs provide a comprehensive range of clinical services within the setting of an ambulatory care facility, as well as a wide variety of health promotion, disease prevention, and educational programs. While the primary emphasis of a WWC is to keep women healthy, it also exists to detect problems early on and initiate effective interventions. In addition to improving the quality of life for the patients it serves, a WWC can also have a positive impact on families and communities by empowering women to become active participants in their healthcare.

After conducting an assessment of various sites in Kosovo, DOW agreed to establish the WWCs at the Maternity Hospital in Gjilan and the MFMC in Prizren, to demonstrate that the WWC model could work in a hospital and primary care setting, and to provide services in two different parts of the province. DOW signed a Memorandum of Understanding with each regional health authority to develop the WWCs, and the municipalities agreed to allow all staff trained by DOW and working within the WWC sites to remain in their positions for at least three years.

DOW coordinated the training of WWC staff in clinical and management issues. Staff from the Tirana WWC (established through the Tirana/Providence partnership) served as mentors to the Kosovars, provided clinical training in colposcopy, and assisted with staff selection and business plan development for the Gjilan and Prizren WWCs. DOW enlisted Population Services International (PSI) to train WWC staff on HIV testing and counseling and the Center for Protection of Women and Children to train WWC healthcare staff on patient rights and domestic violence issues as they relate to their clients. The Gender Training and Resource Center provided training for WWC staff on management issues.

DOW collaborated with the Gjilan and Prizren partners to renovate the physical space for the two WWCs to produce a comfortable, welcoming atmosphere for women and staff. Basic furnishings (including a phone, fax and Internet connection) and necessary medical equipment were installed and health education and counseling rooms were incorporated into each site. The WWCs officially opened in November 2003 and offer the following services:

- Family planning and reproductive health programs, including fertility and contraception counseling
- Perinatal care, including pregnancy, breastfeeding and childbirth classes
- Prevention services directed at HIV/AIDS and sexually transmitted infections (STIs) as well as detection, treatment and management of HIV/AIDS and STIs
- Cancer education and screening services, including cervical cancer screening (Pap tests) and clinical breast examination, and a variety of diagnostic procedures
- Mental health education, counseling and support groups related to issues such as depression, domestic violence and rape
- Substance abuse services (education, problem identification, treatment)
- Chronic disease services, including education, screening, treatment and referral for specialty services
- Education and clinical intervention for peri- and post-menopausal women
- Services promoting healthy lifestyles (including education, nutrition and exercise counseling)
- Adolescent health programs, including sex education and peer support groups
- Community outreach on a wide array of issues

The Gjilan WWC reported 13,526 patient visits in 2004 and 16,417 in 2005. The Prizren WWC reported 6,738 visits in 2004 and 6,227 in 2005. (The higher number of visits at the Gjilan WWC is due to the fact that there is a gynecological outpatient facility for the Gjilan Regional Hospital. In addition, there are no gynecologists working in the Family Medicine Centers in Gjilan, so women visit the hospital or the WWC on-site to see a gynecologist.)

Gjilan WWC Staff Share Information in the Education Room

The Gjilan and Prizren WWCs have remained in operation since opening in November 2003. Like all other public health institutions in Kosovo, the WWCs are facing supply shortages due to delays in the MOH-run tendering process; however, they continue to offer services, demonstrating the sustainability of the WWC model.

The Gjilan and Prizren WWCs are utilizing 25 CPGs developed to cover a number of issues: management of common pregnancy problems, management of pregnancy complications, anemia, gestational diabetes, multiple pregnancy, Rhesus negative, common vaginal infections, identifying women who must see a gynecologist at the first visit, a care plan for women with a normal pregnancy, and conditions arising in pregnancy requiring gynecological assessment. Health promotion activities have now begun in the Prizren WWC with health education sessions being held for large groups of women, both young and old. Topics include healthy pregnancy, breastfeeding, contraception, and other general health topics.

DOW contacted nine reproductive Health Information Centers (HICs) — created by DOW under its USAID-funded Maternal Infant Health project — to inform them about the WWC project and to seek referrals for cases that cannot be treated at those facilities (e.g., colposcopy, Pap smears and domestic violence). All HICs agreed to refer cases to the WWCs and developed protocols for the referrals. Links were created with the local women's shelter that provides care for women who are victims of violence so that the shelter can now bring these women to the WWC for healthcare needs.

A women's health seminar was conducted in Pristina November 2003 to share the WWC project and models with Kosovar health professionals, MOH policymakers, and project stakeholders. Representatives of the

Kosovo Institute of Public Health visited the Prizren WWC and noted that it was the best women's health facility they had seen in Kosovo and should be used as a showcase for the future.

DOW is currently working to replicate the WWC model in Pristina, the capital of the province and Johnson & Johnson is providing the funding for the development of the third WWC in the country. The staffs from the Gjilan and Prizren WWCs are providing clinical training (colposcopy), health education training and guidance on organizational and management issues (setting up an appointment system, collecting data, etc.) to the Pristina staff. DOW is including family medicine physicians in the Pristina WWC staff to help ensure the center's success in a primary care setting and to provide family physicians with much needed experience treating women.

- ***Quality Improvement***

The Hanover partners introduced a quality improvement approach called Clinical Microsystems in the implementation of their two partnerships in Gjilan and Gjakova municipalities. Developed by Dartmouth scholars, the Microsystems approach promotes internal leadership, fosters teamwork, encourages self-confidence, optimizes the role of every staff member to assure efficiency of care, and empowers improvements in healthcare delivery. After providing training to the Kosovar leaders on the Microsystems approach, the US partners guided them as they utilized this approach to address hypertension and antenatal care within the context of primary care.

"After the inputs made by the partnership, the health system in Gjilan is better organized than in other regions. People were encouraged to increase their skills and knowledge."
– Arsim Kastrati, Information Coordinator, Gjilan Learning Resource Center

The Kosovar partners developed working groups to address patient flow, staff training, community outreach and education, and data collection. The partners implemented changes at their primary care facilities, including the development of staffing schedules, installation of necessary equipment and supplies, and determination of the area where care will be provided, with patient flow and other quality issues in mind.

DOW also stressed quality improvement by providing training in organizational development to Kosovars, assisting future staff of the Gjilan and Prizren WWCs to develop patient charters and help promote a customer-oriented approach.

Patient Flow

The Hanover partners worked with their counterparts in Gjakova and Gjilan to analyze patient flow in their primary care facilities. Based on studies at the MFMCs, the Kosovar partners reorganized the physical space and redefined staff (particularly nurse) roles to improve patient flow. The MFMC patient reception/registration areas were renovated and reorganized, and waiting areas redesigned and supplied with new furniture and a television and VCR for patient education. The CEE partners installed dedicated rooms in the MFMCs for hypertension screening (Gjilan) and antenatal care registration (Gjakova), to reduce crowds at the main entrances.

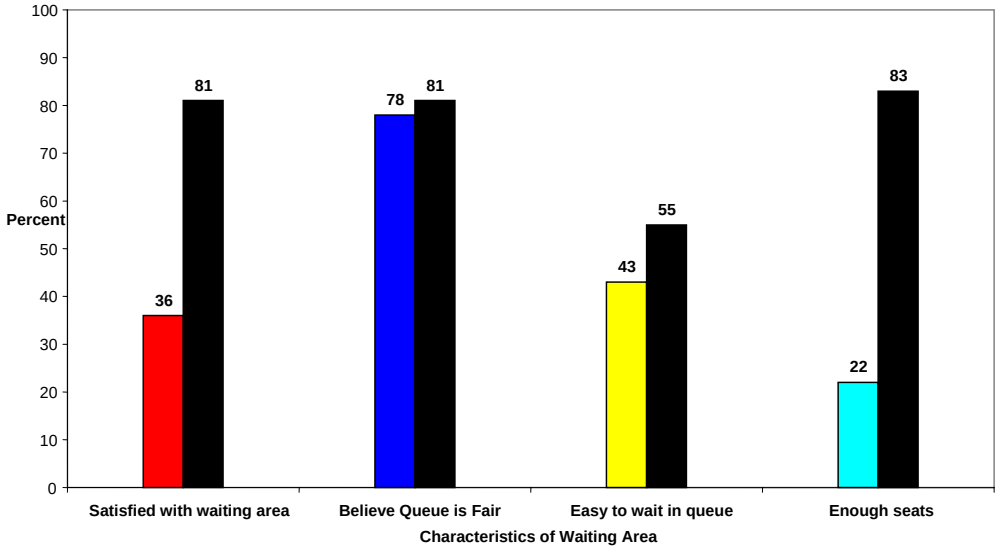

Patients Use the Map at the Entrance of the Gjilan WWC

DOW worked with staff at the WWCs in Gjilan and Prizren to establish a patient appointment system and design a patient flow process. Now, women who make an appointment at a WWC are given a reminder card with the time and date of their next visit and the WWC phone number and clients are informed that they may call to change or cancel their appointment. The new patient flow system implemented by WWC staff resulted in decreased patient congestion around the reception area.

To monitor the volume of patient flow in Gjilan, all patients were tracked with data forms which were completed as they navigated through the reorganized Gjilan MFMC. The partners learned that the average patient visit at the MFMC, from registration to completion of visit, lasted 13 minutes. For the first time, the Gjilan MFMC was able to collect data on patient volume by gender, age category, residence zone, and reason for visit to the MFMC, all recorded by day, week, and month.

The improved patient flow at the Gjilan MFMC resulted in shorter waiting times, less confusion and improved patient satisfaction. Based on patient satisfaction surveys conducted by the partners, the percentage of patients reporting satisfaction with the registration desk at the MFMC increased from 60% in March 2003 to 87% in October 2003 (see chart below). The Kosovar partners began implementation of a patient flow assessment at all other Family Medicine Centers (FMC) and Punkts in Gjilan municipality.

Comparison of Proportion of Patients Satisfied with Characteristics of the QKMF Waiting Area Before and After Patient Flow Changes March and October 2003



The Gjilan partners now have a system in place at the MFMC to continuously track and improve patient flow. Several areas for improvement were identified and new innovations introduced: the registration area was reorganized to accommodate the large volume of patients by installing a desk and adding chairs to the waiting area outside the triage and exam rooms; new file cabinets were installed to improve the handling of the new forms; a new computerized registration system was created; and emergency room patients were incorporated into the new patient flow system.

Representatives from the MOH and various Kosovo MFMCs conducted site visits to the Gjilan MFMC to see the patient flow changes implemented by the partners. According to the director of maternal and child health of the MOH, the patient flow changes installed at the Gjilan MFMC were replicated in three additional MFMCs in other municipalities by the MOH.

Patient Satisfaction Surveys

All three projects in Kosovo utilized patient satisfaction surveys as a quality improvement tool. In 2003, the Gjilan MFMC administered surveys to track patient satisfaction before and after the partnership intervention.

According to these surveys, patients continue to be satisfied with the quality of care offered. (A report by the local television station in Gjilan echoed these sentiments.)

After providing a tutorial on survey methodology to the WWC staff, DOW supplied 100 patient satisfaction surveys to be completed at each site and a midwife at each site was responsible for data collection. The Gjakova partners conducted a patient satisfaction survey at the MFMC and the results identified areas which require the most improvement, including patient flow, cleanliness and comfort, wait times, and availability of patient education materials and classes.

Organizational Development

After DOW administered two one-day workshops on holistic care, the staff of the Gjilan and Prizren WWCs wrote mission statements and created a patient charter. The mission statements were translated into the appropriate languages for each site (Albanian and Serbian for Gjilan and Albanian, Serbian and Turkish for Prizren) and placed at the entrance of each WWC for all staff, patients, and visitors. Each WWC developed a patient charter and printed it as a small booklet to educate women clients on their rights as patients.

- ***Community Education and Outreach***

The Hanover partners worked with Kosovar partners in Gjakova and Gjilan to better educate their respective communities about health issues and reach out to the community to increase awareness about the enhanced services being provided. Both partnership sites established work groups to come up with ways to better educate the public. The Kosovar work groups produced educational and promotional materials about hypertension (Gjilan) and antenatal care (Gjakova) and displayed and distributed them in the FMCs and other selected community sites. The Gjilan partners trained 89 family medicine nurses to provide better health education to patients. The Gjilan nurses began offering monthly patient education classes on a variety of topics, both at the MFMC and in outreach sessions in various locations in the community.

"I have experience from before the war. There were no community-based programs—nothing was done. And after the war, we are especially motivated by visits to the US community-based projects. We are getting commitment from the community and are satisfied and pushing ourselves more." *– Jashar Ramadani, Gjilan Municipal Representative*

Nurses from the Gjakova FMCs piloting the new antenatal care services developed creative ways of connecting with women in the community. The nurses at the Ponoshec FMC, for example, conducted outreach in the 10 area elementary schools, making presentations about the antenatal care program to students and giving them informative brochures to take home to their families.

DOW collaborated with eight local NGOs in Prizren (including the Center for Counseling for Women, Children, and Family and the Center for Women and Children) to promote the WWC, distribute health education materials, and participate in health education campaigns.

All partners in Kosovo utilized media (television, radio, and print) to share information with the public about the specific projects, inform citizens about the enhanced services available at the FMCs and WWCs, and provide health education and messages.

- **Access to Health Information and Communications**

AIHA supported the opening of Learning Resource Centers (LRCs) at the Gjakova and Gjilan MFMCs. Both Kosovo LRCs held open houses attended by local leaders and community members including staff from the MFMCs, the directors of the regional hospitals, health municipality representatives, and medical students.

The Gjilan partners completed and submitted a practice standard review on the management of crisis hypertensive patients in a primary care setting. Utilizing the Gjilan LRC, the Kosovar partners conducted research on the diagnosis of crisis and emergency hypertensive cases and the drug treatment in these cases. Using the LRC's Cochrane Library and other Web resources devoted to evidence-based practice, the partners found the results of a number of various randomized control trials and systematic reviews of such trials. The information from this practice standard review will assist physicians at the MFMC in diagnosing and treating future crisis and emergency hypertensive cases. By the end of the funding period in September 2004, the Gjilan LRC had trained 162 health professionals on the use of computers and the Internet.

Following the opening of the LRC at the MFMC in Gjakova, the LRC staff began to organize regular information technology training sessions for the center's healthcare professionals and other staff. In total, 306 physicians, nurses, and other health professionals have received training on basic skills related to the computer, e-mail, and the Internet. Prior to the LRC training only about 3% of the staff had active e-mail addresses; now this number has increased to about 47%. The LRC is also accommodating many physicians who are searching for medical information in Albanian and Serbo-Croatian languages. The LRC staff also plans to conduct training on such topics as Medline search, Cochrane reviews, and other Internet resources for those healthcare workers who have at least a basic knowledge of English and is also hoping to provide English-language training to those physicians and nurses who need it.

The Gjakova partners utilized the LRC to develop a handout on medication use during pregnancy to be used by staff as a reference in providing antenatal care and counseling services to pregnant women who are taking or need medications.

The two Kosovo LRCs received an average of 106 visitors and 21 information requests each month during the funding period, and both have continued to sustain themselves.

- ***Nursing***

Nurses played a crucial role in the development and implementation of the hypertension and antenatal care partnership interventions in Gjilan and Gjakova. American nurses from Hanover acted as role models through their full participation in work groups designing and implementing practice changes. Kosovar nurses struggled to overcome cultural constraints which had taught them to defer to leadership and physician staff. With coaching from their US counterparts, the Kosovar nurses realized their ideas were of equal value to their physician team members, which ultimately paved the way for changes in roles and responsibilities of the nursing staff. Nurses felt empowered and supported to further explore opportunities to improve the care for their patients. Competency testing on measuring blood pressure readings helped to assure the physicians that the nurses were capable of taking accurate blood pressures. Implementing patient education and triage guidelines for patients with hypertension further enhanced the role of nurses.

Nurses at several of the family medicine centers in Gjilan took a further step towards continuity of care by instituting "nurse-only" patient education visits to follow some of the hypertensive (and other chronic disease) patients. These visits — documented in logs specifically created for this purpose — were periodically reviewed by nursing supervisors in FMC-wide nursing meetings. In a survey of Gjilan MFMC staff conducted in 2003, 75 percent agreed and 25 percent partially agreed that the new role of nurses at the MFMC was having a positive effect at the center.

The Nursing Educator from Gjilan regularly traveled to Gjakova to work with the Nursing Educator and other nurses there to help improve the systems for nursing education in Gjakova and to train nurses in the blood pressure measurement module developed as part of the graduated Gjilan/Hanover Primary Care Partnership. Nursing Educators from Gjakova and Gjilan worked together to train 30 nurses from Ponoshec, Cermjan and Orize Family Medicine Centers in blood pressure measurement techniques.

By the time Hanover began working in Gjakova to address antenatal care, the leadership at the MFMC needed less convincing that nurses could play a necessary role in the implementation of antenatal care in the FMCs. The US partners provided the TOT course to a Kosovar nurse alongside two physicians, since they would in turn be training family medicine nurses as well as physicians to provide enhanced antenatal care. Gjakova nurses have not only been key providers of antenatal care services, they have also led efforts to expand the program to all of the FMCs and additional ambulantas; provide additional continuous education courses for Gjakova family medicine nurses in antenatal care and other topics; develop ways to educate more women on healthy pregnancy, nutrition and pregnancy complication danger signs; and spread the word in the general public about the availability to enhanced antenatal care in primary care in Gjakova.

By highlighting ways in which nurses could participate in patient care in family practice in Gjilan and Gjakova, and explaining to local leaders how each individual nurse was needed to contribute to the success of the partnership interventions, the partners helped to instill a vision of the ideal nursing profession in Kosovo.

CHALLENGES

- ***Local Leadership***

The involvement and support of local leadership — including MFMC and hospital directors, municipal health directors and other local political leaders — were crucial to the development and successful implementation of AIHA programs in Kosovo. The CEE partnership coordinators in Gjilan and Gjakova were the directors of the respective MFMCs, and the heads of the health departments at the municipal governments were also very involved in the development of partnership workplans and organization of specific activities. DOW negotiated with the director of the Prizren MFMC and the director of the Gjilan Maternity Hospital for the provision of space and staff time for the new WWCs.

However, local leadership issues and changes posed difficulties for the partners and threatened the sustainability of changes implemented. After the graduation of the Gjilan/Hanover partnership, the municipal authorities replaced the director of the MFMC (who was also the CEE partnership coordinator) after he changed political parties, and this new director closed the blood pressure screening rooms for several months in early 2005. The physicians and nurses at the MFMC convened a meeting with their leadership to express their displeasure at the suspension of the screening program. Ten days after the meeting, the blood pressure screening areas were reopened and the program resumed. Now, once again, every patient at the Gjilan MFMC over 18 receives blood pressure screening. By involving staff at every level of the organization, the partners were able to instill a sense of ownership by all of the physicians and nurses in the hypertension screening program. The MFMC staff demonstrated its commitment to the changes implemented by the partnership, by challenging the MFMC administrators and knowing enough about the value of the program to lobby for the reopening of the screening rooms.

The new director of the MFMC closed the LRC (established in 2002) for a number of months in 2005 due to issues of space at the facility and the resignation of the LRC Information Coordinator. At the time of the site visit to the MFMC, the LRC was reopened with the Information Coordinator reinstalled in his former position. The director expressed his support for the LRC, perhaps now understanding the important role it can play in supporting information and data collection and other quality improvement activities at the MFMC.

DOW experienced some difficulties with local authorities in establishing the two WWCs. Municipal leaders and the directors of the Prizren MFMC and Gjilan Maternity Hospital needed to be convinced to invest limited physical space, equipment and supplies, and staff time for the WWCs. To address this issue, DOW engaged in negotiations with local leaders, culminating in the signing of the Memoranda of Understanding with the municipal health authorities in Gjilan and Prizren. In signing the memoranda, the municipalities agreed to allow all staff trained by DOW and working within the WWC sites to remain in their positions for at least three years.

- **Linking Primary Care and Specialists**

Some OB/GYN specialists in Gjakova resisted the development of antenatal care at the FMCs. They were concerned that these services provided at the primary care level could draw patients away from specialists, therefore depriving them the opportunity to provide revenue-generating services, particularly ultrasounds.

Before any antenatal care interventions were implemented, the Gjakova/Hanover partners recognized the need to develop strategic relationships with key stakeholders, particularly with specialists working at the local maternity hospital and in private practice. The partners established the Specialists Alliance — consisting of the partners from the Gjakova MFMC and DMS, and local obstetricians and gynecologists — to provide a forum to discuss the antenatal care project and find ways to effectively cooperate and exchange information.

In April and May 2005, the partners formally presented the partnership antenatal care project to interested stakeholders, including obstetricians from the local hospital and private clinics. The presentation was followed by an open house at the Orize FMC, where the partners demonstrated how family medicine-based antenatal care is being implemented. The partners also met with the director of Gjakova Hospital to share information about the antenatal care services provided at the FMCs and to discuss ways of sharing information about patients between the FMCs and the hospital and specialists. The hospital director expressed her support for the antenatal care program implemented by the partners. The gynecologists at the hospital would benefit from knowing which of their patients delivering babies at the hospital have received antenatal care from one of the FMCs, and the family medicine staff at the FMCs would benefit from having outcomes information from their patients who deliver at the hospital.

Although there are still some skeptical specialists in Gjakova, thanks to the continuous outreach efforts by the partners, more OB/GYNs understand that quality antenatal care at FMCs in fact enhances the ability of specialists to provide better, more focused care.

- **Ministry of Health Support**

The Gjakova/Hanover partners confronted many issues regarding the antenatal forms developed for use in implementing the project. Not only did the forms have to be easy-to-use and tailored to the model of care being provided in Gjakova, but also needed to meet requirements set out by the MOH. The partners spent much time and energy naming the forms and determining the content, intended use and end user of the forms. The partners developed strategies to improve communication with MOH representatives and others to find ways to collaborate and agree on the final use of the antenatal forms used at the FMCs in Gjakova.

After a period of UNMIK administration of healthcare services in the province, the Kosovo Ministry of Health (MOH) assumed responsibility in 2002 with the establishment of the local Provisional Institutions of Self-Government (PISG). The MOH signed a Memorandum of Understanding with USAID/Kosovo governing the entire range of USAID-sponsored development projects in the province, including the Gjilan/Hanover partnership and DOW WWC project. However in late 2004, the MOH announced to the Gjakova/Hanover partners that formal MOH approval would be required for the partnership to be able to continue and AIHA and the partners were able to secure a formal letter of approval from the MOH in

January 2005. AIHA and the partners also agreed to share information with the MOH on a regular basis. Since AIHA and the Hanover partners had already developed working relationships and lines of communication with the MOH and related agencies in Kosovo, a potentially damaging situation was quickly resolved and the work of the partnership could continue in Gjakova.

The partners invited MOH representatives to the formal partnership presentation and antenatal care open house held in Gjakova for interested stakeholders. The Minister of Health expressed his support for the dissemination of family medicine-based antenatal care services throughout Kosovo.

- ***Data Collection***

While all of the AIHA partnerships and projects in Kosovo instituted systems to collect and share data regarding their interventions, the partners faced many challenges in collecting timely, accurate and useful information.

Because of the work with the Hanover partners, for the first time the Gjilan MFMC was able to collect data on patient volume by gender, age category, residence zone, and reason for visit to the MFMC, all recorded by day, week, and month. The Gjilan MFMC recorded information about all hypertension screenings and identified hypertensive patients in a register created by the partners specifically for this purpose. The Gjilan partners continue to conduct blood pressure measurement and hypertension screening in all adult patients who present to the MFMC, and many hypertensive patients are returning for treatment and advice, however, in order to find out how many hypertensive patients are being identified and successfully treated, one must search for this information in the patient register.

Through data collection methods instituted during the Gjakova/Hanover partnership, each FMC is able to track how many patients are receiving the new antenatal care services. The FMCs report an increasing number of women who returned for follow-up visits as their pregnancies progressed, but a breakdown of patient data is not available at this time. These return visits demonstrate that patients understand the importance of follow-up visits and believe that they are receiving quality antenatal care. While the Gjakova partners are able to report on the total number of antenatal care patients, there is confusion about the number of second, third, and fourth antenatal care visits. A system to better track these numbers will be necessary to determine whether pregnant women in Gjakova are adhering to the minimum four-visit model of antenatal care as recommended by WHO. Better reporting forms to track the number of referrals between obstetric specialists and FMC staff providing antenatal care will also need to be developed.

For the first time in Kosovo, primary care facilities were able to track the number of patients visiting clinics and being screened for hypertension (in Gjilan) or receiving antenatal care (in Gjakova). The Kosovar partners understood the importance of tracking this information to develop and refine interventions, improving the quality of primary care offered to patients. However, these data collection measures focused on the processes being implemented, not on the expected outcomes. With the limited timeframe and resources available for these partnerships, perhaps these process measures were all that could effectively be developed during the partnership funding period. But capacity has been developed in data collection that could be built upon to more effectively measure the outcomes of the interventions implemented by the partners.

SUCCESS STORY: *"Microsystems" Approach Transforms Primary Care Delivery*

When AIHA initiated its first partnership in Kosovo in 2001, the primary care system faced a number of serious challenges. Primary care clinics were unorganized and faced resource constraints. Clinics were highly disorganized, lacking a systematic patient flow and registration process or medical records. Patients arrived at the clinic without appointments and crowded the exam rooms, overwhelming the family medicine physicians

providing care. The role of the nurses at the clinics was administrative in nature with very little contact or communication with patients. Administrators were frustrated with the mounting challenges of managing overburdened clinics with limited resources and assistance.

The Hanover partners introduced a quality improvement approach called Clinical Microsystems in their work through two partnerships in Kosovo. Developed by Dartmouth scholars, the Microsystems approach promotes internal leadership, fosters teamwork, encourages self-confidence, optimizes the role of every staff member to assure efficiency of care, and empowers improvements in healthcare delivery.

The Hanover partners conducted intensive quality improvement training for their counterparts in Gjilan and Gjakova. The partners developed a common understanding of the Microsystems approach for systematically improving primary healthcare/family medicine, developed a working understanding of change and improvement concepts (customer focus, quality, systems change, staff/team, PDCA [plan, do, change, act] cycles, leadership, feed forward and feedback system with measurement and monitoring), and established a foundation for peer exchange and expansion of improvement of care.

After providing training to the Kosovar leaders on the Microsystems approach, the Hanover partners guided their CEE counterparts as they applied this approach throughout the life of the partnership, from the assessment phase to workplan development and implementation. Every decision made by the Gjilan and Gjakova partners was made in the context of the quality improvement processes and decision-making mechanisms driven by the Microsystems approach.

In March 2003, three Gjilan partners participated in the European Clinical Microsystems Network Invitational and Festival held in Jönköping, Sweden and the Kosovo MOH provided financial support to help cover travel costs. The meeting was the first convened as a uniquely European event designed to develop an active Microsystems learning group around European health systems applications. Gjilan partners shared their experience in applying the Microsystems approach in the development of the hypertension screening program, and participants from the UK, Sweden, and other European countries were surprised to learn about the extensive experience with. The Gjilan partners realized that they could become a regional leader in the utilization of Microsystems to improve primary care. Linkages with other European leaders in health improvements will enhance the sustainability and future direction of change in Kosovo.

In October 2004, the Gjilan partners gave a presentation entitled "Using Microsystems to Improve Family Medicine in a Post-Conflict Society" at the annual meeting of the World Organization of Family Doctors (WONCA) in Orlando, Florida. AIHA funded the participation of the two Gjilan partners at the WONCA meeting, so the Kosovars could further spread the story of their success in utilizing the Microsystems approach.

The Gjilan partners utilized the Microsystems approach in developing a diabetes screening program, this time without any assistance from their US partners. The Gjakova partners have embraced Microsystems as well, not only in the implementation and refinement of the antenatal care program, but also in making other general improvements in the management of primary care in the municipality. By utilizing the Microsystems model, the Kosovars were able to not only implement successful partnership interventions addressing chronic disease screening and antenatal care, but to also institute a number of changes to improve the management and organization of primary care in Kosovo. The Kosovar partners have learned a new way of thinking which will help them in their work for years to come.

Partner Profile — *Hajriz Ibrahimi*

Hajriz Ibrahimi was the director of the Main Family Medicine Center in Gjilan when AIHA established a partnership with his institution, providing him an opportunity to work with Americans for the first time. Ibrahimi was pleased with the peer-to-peer approach employed by the partners, and soon realized that this partnership would be much different from other assistance provided by organizations which came to Kosovo in the wake of the ethnic conflict that embroiled the province in 1999.

"The Dartmouth partners didn't pressure us about what we should do," explains Ibrahimi. "At first, they wanted to know what we needed and asked us how we identified our problems. Our partners tried to help us to think about what we need to do, what we need to change in our health system, in our own behaviors." The Kosovars were not used to such a participatory process, one in which they were being treated as peers more than as recipients of assistance.

To help the Gjilan partners think differently about primary care, the US partners introduced a quality improvement approach developed at Dartmouth called Clinical Microsystems. Ibrahimi explains that before the partnership he and his staff didn't have enough skills, experience or opportunity to work on this type of project.

"We wanted to learn about Microsystems, because it was something new for us," says Ibrahimi. "For the first time we understood that we can do more using this approach to select what we need to do and what we have to change in our work."

Using Microsystems as a guide, the partners implemented a number of changes to improve the quality of and access to primary care in Gjilan. The US partners not only helped their counterparts in Gjilan gain important clinical skills, but also helped them find ways to improve the way that they work. Communications and teamwork on this level were important new concepts for Ibrahimi.

"Before the partnership, it was very difficult for us to work as a group, to listen to, and understand each other," Says Ibrahimi. The concepts of better communication and enhanced teamwork instilled in the staff at the Gjilan MFMC would prove to be crucial outside the walls of the clinic as well.

The Gjilan municipality, like other communities in Kosovo, was faced with strained relations between ethnic Albanians and Serbs, who were struggling to coexist so soon after end of hostilities. Ibrahimi thinks that the partnership played an important role in bringing the community together at a time when it was very starkly divided.

"We went to the Serbian clinics with our American partners, informed them about what we were doing, and tried to include them in our project. The Serbs were engaged with us. This was one of the first great contributions of the partnership," says Ibrahimi.

Ibrahimi believes that the overtures by the partners to Serb primary care providers helped contribute to the relatively improved situation in Gjilan today compared to other communities in Kosovo. Gjilan still has a significant Serbian population, and in three of the community's primary care clinics, Albanian and Serbian physicians work together to provide care to patients of all ethnicities.

"The situation is 100 times better than when the Americans first came here. Serbs are walking freely in Gjilan. They are starting to rebuild their homes," explains Ibrahimi. "In Gjilan the Serbs are in a better position than in other places in Kosovo, because when the American partners were here we tried to integrate the Serbs into our system. The partnership made connections between us and the family physicians in the Serb areas."

Partner Profile — *Ramize Ibrahimi*

Ramize Ibrahimi has been a nurse at Gjilan Health House in Kosovo for many years and has participated in health development activities sponsored by a variety of international organizations, including the World Health Organization. Despite her participation in numerous training courses, workshops and conferences offered by these organizations, she lacked the self-confidence to openly express her opinions – especially in front of the physicians and other medical professionals she interacted with. "I just always felt like I was in a lower position than those I was with," Ibrahimi says, explaining that in Kosovo nurses have traditionally been viewed as subordinate to the will and dictates of physicians, not as equal partners in the provision of medical care.

When AIHA's Gjilan/Hanover, NH partnership was established in October 2001, Ibrahimi was asked to lead several working groups tasked with health education programs, clinical practice guidelines for nurses, and community education and outreach. Drawing on the expertise and support of her partners at Dartmouth Medical School, Ibrahimi conducted training courses for nurses working in family medicine clinics throughout Gjilan and its environs. She also spearheaded efforts to develop community education materials on hypertension, conducted outreach and awareness activities throughout the community, and even spoke out about the subject on local radio programs urging listeners to pay heed to the early warning signs of high blood pressure and ask their healthcare provider about screening tests.

Ibrahimi credits her participation in the partnership not only with giving her important new skills as a nurse and a health educator, but also with giving her confidence in her own abilities and the courage to voice her opinions. "By the time our partnership entered its second year, I had developed enough courage and self-confidence to freely express my opinions and share my ideas during training courses and other meetings," she says. "I am no longer scared to speak out, to voice my opinions."

Although the partnership with Dartmouth ended in 2003, Ibrahimi has continued her work as the head nurse for patient education at Gjilan Health House. Empowered by her newfound self-assurance, she is now applying her considerable talents and the knowledge she gained through her partnership experience to the task of providing better health education to the people of Gjilan. In addition to developing an annual plan for community-based diabetes education, Ibrahimi has been invited by the Ministry of Health, the Association for Health Education and Promotion, and the Institute of Public Health to serve on a number of national advisory groups addressing topics ranging from reproductive health and family medicine to health promotion activities throughout Kosovo. Perhaps most importantly, she now serves as a strong leader representing all Kosovar nurses striving to enhance the role they play in providing quality clinical and patient education services to the people in their communities.

Partner Profile — *Don Kollisch*

While Don Kollisch had been involved in Dartmouth Medical School's own medical exchange program with the University of Pristina Medical School, he did not travel to the war-torn province until Dartmouth began participating in an AIHA partnership focusing on primary healthcare. Kollisch vividly remembers his first visit to Kosovo in October 2001, when thousands of NATO soldiers were stationed there.

"I was shocked at the extent of the military presence there. Although Kosovo had demilitarized dramatically in the year before my first visit, I was not accustomed to seeing troop carriers and tanks rolling down the city streets, the land mines, the armed soldiers everywhere," says Kollisch.

Kollisch was also surprised that while the partners needed to in some way address the broad issue of primary care, they were given a great deal of latitude in determining what specific issues to address.

"It was wide open," says Kollisch. "We did not know if we were going to be working on an acute care issue, a chronic care issue, or what. All we knew was that the partnership was going to improve health by working in family medicine. That was really a wonderful opportunity."

Kollisch learned many lessons through the partnership, which he now applies to his other work.

"In quality improvement projects I've been involved in here at Dartmouth, I've been better able to focus myself and my teams on really being clear of what our aims are for a project. The time spent upfront in clarifying your aims is extremely useful throughout the whole project."

Kollisch also learned something about being a more clear and effective communicator. "The use of plain language in the development of aims and how you communicate them with people enhances the buy-in of everybody. With each bit of jargon you lose somebody," says Kollisch.

The partnership in Kosovo also had a profound personal impact on Kollisch, whose father was beaten, kicked out of school, and shunned by his friends before being relocated out of Nazi Austria as a child. Kollisch explains, "I grew up hearing stories about Jews being persecuted just for being who they are. Being able to talk with Albanians and Serbs in Kosova, to sit with them in a café, has really helped me understand, both intellectually and emotionally, my father's and my people's life history."

In addition to working in Gjilan, Kollisch and his colleagues participated in a second AIHA partnership in Gjakova, where they helped establish antenatal care at in the municipality's family medicine clinics. The partnership has officially ended, but Dartmouth is embarking on a USAID-funded project to expand antenatal care to primary care sites in six additional municipalities throughout Kosovo.

"I am grateful to AIHA for giving me the chance to develop a whole new skill set. I'm doing things now that I never thought I would ever do," explains Kollisch. "The big picture is that my life is phenomenally enriched by having had this opportunity. What an amazing five years it's been."

II.H. LATVIA (1995–2005)

Program Highlights

- Established hospice and palliative care programs at Bikur Holim and Children's Hospital.
- Initiated a new approach to treatment of salmonella patients which helped to decrease the number of salmonella cases at Children's Hospital.
- The Tukums Healthy Communities project led to nationwide implementation of health classes into teaching curricula.
- The Riga Center for Training in Multi-drug Resistant Tuberculosis Center became the region's only WHO Collaborating Center.

Partnerships	Years	Focus Areas	Partner Institutions
Riga/St. Louis, Missouri	1995-1998	Cardiology, Pediatrics, Health Care Management, Pediatric Infectious Diseases, Hospice, Nursing, Maternal and Child Health, Obstetrics and Gynecology, Community Health	• Barnes-Jewish Hospital • St. Louis Hospital • Washington University School of Medicine • Bikur Holim Hospital • Riga Maternity Hospital • Clinical Children's Hospital
Riga/Little Rock, Arkansas	2001-2005	Tuberculosis, Organizational Management and Leadership, Business Development	• The University of Arkansas for Medical Sciences • The State Agency of Tuberculosis and Lung Diseases of Latvia

BACKGROUND

Until 1991, Latvian healthcare was organized according to the Soviet model and was centrally planned by Moscow. Although the old system supported development of high-level specializations and advancements in medical science, it led to deterioration of primary healthcare and to corrosion of the social status of health professionals.

Two years after Latvia gained independence from the Soviet Union, the Latvian healthcare system was decentralized and the three former Ministries of Health, Labor and Social Welfare were merged into one Ministry of Welfare. Other healthcare reforms included establishing of sick funds, launching mandatory health insurance that entitled citizens to state-funded healthcare services, and creating new financing mechanisms that gave hospital administrations more freedom in making strategic and business decisions. Health reforms improved the autonomy of physicians and initiated the revitalization of primary healthcare. However, despite positive changes, in the mid 1990s the number of Latvian physicians decreased by almost a quarter and the number of nurses declined by 40%. Two key contributors were low salaries and inadequate responsibilities for both professions. In addition, the low social status of the health profession created little interest in medical studies and a lack of education and skills in the field of health management hindered institutional changes.

At the same time, health status indicators in Latvia were deteriorating. In 1994, life expectancy at birth was very low (58.4 years for men and 72.3 for women) due to increased mortality from cardiovascular diseases and external causes (e.g., traffic accidents). Since the 1980s, the standardized death rate (SDR) for cardiovascular diseases among men and women in Latvia remained the highest among the group of 10 Central and Eastern European (CEE) countries. The main contributing factors included increased alcohol consumption, smoking, poor dietary habits and a lack of exercise. At the same time, the SDR for cancer was the second highest for men and the highest for women.

In the mid-1990s, the incidence rates of prostate cancer, malignant tumors of lymphatic and blood-forming tissue and pulmonary cancer increased among men, and the incidence rates of stomach cancer, leukemia and lymphoma, breast cancer and ovarian cancer increased among women. The SDR for infectious diseases (including diphtheria, tuberculosis, and viral hepatitis) have also more than doubled and remained the highest among the 10 CEE countries. Between 1991 and 1997, the incidence of tuberculosis in Latvia increased from 35 to 81 cases per 100,000 citizens. Alongside this, in 1993, the fertility rate was well below replacement levels, at 1.6 children per woman of childbearing age. (Highlights On Health in Latvia, April 2001; Health Care Systems In Transition – Latvia, 1996)

AIHA in Latvia

AIHA began working in Latvia in 1995, when new hospital partnerships were being established in CEE. Barnes-Jewish Hospital, with St. Louis Hospital and the Washington University School of Medicine, applied for a new hospital partnership to build upon a pre-existing relationship with Bikur Holim Hospital in Riga. AIHA awarded the partnership to the consortium from St. Louis, linking the US institutions with Bikur Holim and two other hospitals (Maternity Hospital and Clinical Children's Hospital) in Riga. The establishment of this partnership at a time of transition in the Latvian healthcare system created an opportunity to help Latvian health providers develop a basis for improved health management and strengthen the medical profession and the delivery of selected services.

The Riga/St. Louis partnership was one of three new hospital partnerships announced in May 1995, as part of USAID's broader support for the development and implementation of partnerships in CEE.

Although its Mission in Latvia officially closed in 1999, USAID continued to provide limited support for health initiatives in the country. USAID along with other organizations including WHO, NIH, and the CDC supported the development of the Regional Center for Excellence for the Management of Multi-drug Resistant Tuberculosis (MDR-TB). In 2001, USAID regional funding provided AIHA the opportunity to support a partnership that enlisted the University of Arkansas for Medical Sciences to help ensure the long-term sustainability of the Riga MDR-TB Center of Excellence.

KEY RESULTS

- ***Hospice and Palliative Care***

One of the main accomplishments of the Riga/St. Louis partnership was the development of hospice programs in Bikur Holim and Children's Hospital. Prior to the partnership, a hospice was an unheard-of concept for the Latvian doctors who had a different philosophy regarding the treatment of terminal patients. Hospices in Latvia have not yet been legally institutionalized, but inspired by their American colleagues, both Bikur Holim and Children's Hospital initiated hospice and palliative care programs in their institutions.

Currently, the palliative team at Children's Hospital consists of 11 full- and part-time employees. The hospice provides consultation for patients and family members and offers bereavement support. From 2003 to 2004, the number of palliative care patients has more than doubled, due primarily to better knowledge and

understanding of palliative care by the hospital doctors who started to refer their mortally ill patients to the hospice unit.

The director at Children's Hospital founded a national palliative care society to advance the new specialty in Latvia, developing legislation that would establish palliative care as an independent branch of healthcare. Currently, palliative care is being phased into the university and postgraduate education of social workers and physicians in the country. In September 2005, the university began admissions for a clinical social worker program, instituting a new profession in Latvia.

To improve pain management outcomes, the St. Louis partners provided doctors from Bikur Holim with medical equipment such as anesthetic machines, monitors, and automatic syringes which continue to serve the hospital today. The Chief of the Intensive Care Unit (ICU) and Anesthesiology and his colleagues were trained in palliative care, pain management, and anesthesiology for geriatric patients. After the training the Latvian partners implemented new methods of pain control during treatment, including epidural steroid injections, long-term epidurazation (morphine injections) and use of direct anesthetic agents. The new equipment and skills allowed the hospital to achieve good results in the treatment of geriatric patients with severe pain and to successfully handle a number of oncology malignancy cases.

Doctors from Bikur Holim used their skills learned during the partnership to initiate hospice care at their institution. The hospice unit treats 60 patients a day of whom 15 are terminal. Annually, the hospital provides hospice care to approximately 120 patients. The doctors try to spread the hospice ideology among Latvian physicians and educate visiting students about hospice care. The directors of the hospital strive to legalize the status of hospices in Latvia by lobbying policymakers and talking to representatives of relevant ministries.

- ***Cardiology and Rehabilitation***

Through the partnership, doctors from Bikur Holim were exposed to new approaches in cardiology and rehabilitation. For example, the St. Louis partners taught the head of the Cardiology Department how to use the treadmill technique for conducting stress tests and how to provide psychological support to cardiac patients. Before the partnership, the hospital used only bicycle tests which were not optimal for all patients. Shortly after training, the hospital received a treadmill from a hospital in Montreal, Canada and started to utilize the new method. Bikur Holim was the first institution in Latvia that initiated this technique which significantly improved the hospital's diagnostics. Currently, the hospital conducts approximately 10 to 12 treadmill assessments each month.

During their visit to the US, the Bikur Holim partners observed the rehabilitation process from the moment of hospitalization through outpatient care to home therapy. The partners visited various departments including cardiac rehabilitation, trauma, and the rehabilitation department for burn patients. They also participated in home visits and observed the work of outpatient clinics. This experience gave the Latvians the solid understanding of rehabilitation techniques necessary to develop their own rehabilitation system tailored to the hospital's needs and budget. Introduction of this new rehabilitation process was one of the factors that contributed to a decrease in the average length of stay. Prior to the partnership, Bikur Holim patients stayed in the hospital on average 35 days. Currently the average length of hospitalization is 18 days.

- ***Hospital Management***

The Latvian partners gained new management skills from AIHA and the St. Louis partners which helped them introduce important changes. For many partners, the introductory management training provided by AIHA was the first source of information about healthcare management principles and was often a starting point for various improvements. The partners learned how to create strategic financial plans, write vision and mission statements, and set realistic objectives and goals. They found out about the importance of teamwork and continue using teamwork principles in their daily work.

Following the American example, Bikur Holim physicians more frequently discuss among themselves the results of treatment and talk about individual cases and occurring problems. In the Maternity Hospital, the partners instituted weekly meetings to discuss administrative and organizational issues, weekly conferences to provide clinicians with the opportunity to analyze cases, and weekly meetings for housekeepers and engineers. Riga Maternity Hospital also introduced daily meetings for medical staff, chiefs of departments, and duty staff. Following the recommendations of the St. Louis partners, all three hospitals improved their security systems. Children's Hospital, for example, introduced checkpoints at the entrance and exit of the hospital, and Maternity Hospital hired two security guards.

"We earned a lot about issues we've never heard about. We also had heard about a lot of issues such as quality improvement, quality management, economical aspects of medical care, how to improve patient satisfaction, etc., but thinking was done at the individual doctor level. We had never thought about these issues in such an organized manner."
– Dr. Ilze Kreichberga

Armed with new management skills and competencies, the Bikur Holim directors developed and introduced various documents and protocols improving the hospital's quality control, staff development and patient recordkeeping. The hospital introduced new protocols for hand disinfection and infection control, computerized its accounting department and implemented several organizational changes, including a revision of job descriptions.

Children's Hospital initiated a series of management changes with the reorganization of the hospital's structure from wards into clinics. In addition, all doctors and nurses obtained specific job descriptions and a clear scope of responsibilities. The hospital reorganized infection control practices and improved the neonatal intensive care unit (NICU) by installing a new, American-styled monitoring system. Children's Hospital also improved its financial management system by installing an internal network that allowed for the more effective administration of patient records, and provided better control of money and supplies. A similar patient record system and internal network will be developed and implemented in Maternity Hospital.

Encouraged by the US colleagues and forced by a new market economy, the partners started to pay more attention to cost efficiency. Maternity Hospital reduced the number of hospital staff to an optimum level and implemented other cost-cutting measures. For example, to reduce heating-related expenses (which previously consumed approximately 30% of the hospital budget), the partners replaced windows, installed regulators, and built their own central heating generator. They also began outsourcing laundry which further saved costs. The hospital's average lengths of stay for a vaginal delivery (three days) and for Caesarean sections (three to four days) are currently the shortest among all institutions delivering babies in Latvia.

The partners from Children's Hospital improved the efficiency of short-term treatment which led to earlier discharge of patients and saved costs. Children's Hospital managed to reduce the average length of stay from 13 days in 1993 to approximately 6.5 days in 2005 (despite the fact that the number of admissions to the hospital continued to grow). In recent years, Children's Hospital has been admitting roughly 25,000 patients a year and provided care to more than 120-130,000 outpatients (compared to 22,000 inpatient visits and 90-100,000 outpatient visits 10 years ago). New management skills were also crucial during the merger of two Children's Hospitals which entailed a significant reduction of beds (from 800 in 1995 to 600 in 2005).

While in St. Louis, physicians from Riga Maternity Hospital learned how to generate money from internal and external sources. The hospital introduced paid services and individual contracts between patients and physicians/midwives which guarantee more attentive care and a relatively steady flow of income. The hospital started to offer private rooms for a fee, run its own cafeteria and rent commercial space for a maternity shop. The Latvian partners learned to be persistent and more effective in lobbying local government officials for additional funding. As a result, the hospital obtained funds from the City Council for renovation of the

NICU, building a heating generator unit, changing windows, and renovating a conference room and working space for family physicians.

- ***Infection Control***

Children's Hospital improved infection control practices and the operation of its microbiology laboratory. After the training, the laboratory introduced new testing methods for blood culture and enhanced its quality control program, which currently includes an auto-control system linked with a Finnish quality control lab and the collection of culture strains. Thanks to AIHA training, Children's Hospital was the first in Latvia to introduce standardized antibiotics resistance susceptibility testing which significantly improved the accuracy of testing results. The hospital microbiologists held a series of workshops for other Latvian microbiologists on the new testing guidelines, which were subsequently applied nationally.

Children's Hospital introduced a new method for identifying and growing haemophlius influenza and other standardized media for growing microbes. Another significant improvement in the work of the microbiology lab was the use of a sheep blood supplement to detect pathogens. Prior to the partnership, the hospital used only human blood supplement, which did not always produce desirable results. The US partners initiated the Zoo Project which involved the Riga zoo in growing and bleeding sheep for the hospital lab. The zoo continues to donate to the laboratory about 200 cc of sheep blood weekly.

Another important outcome of the partnership was the identification of a problematic strain of salmonella in Latvia. Based on research results, the St. Louis and Children's Hospital partners developed a set of guidelines for treatment of salmonella patients and patients with intestinal infections. Subsequently, Children's Hospital initiated a new approach to treatment of salmonella patients which helped it to decrease the number of salmonella cases and salmonellosis, and in 2004, the hospital lab registered only three patients with salmonella. This tremendous success was presented by the hospital during several national and international conferences, and the results were published in Latvian and foreign medical journals.

Encouraged by many positive outcomes, Children's Hospital pioneered a new subspecialty in microbiology and became actively involved in the education and accreditation of pediatricians. In addition, the hospital included microbiology and infection control topics in the curriculum of a residency program for pediatricians. Following St. Louis' example, in the summer of 2004, the hospital created its own infection control team consisting of a microbiologist, an epidemiologist, doctors and nurses. Collaboration of team members has prevented the spread of various infections within the hospital and resulted in the better monitoring of co-infections. The infection control team introduced new hygienic requirements for the hospital staff and educated health providers about the necessity to report on all internal outbreaks.

A similar infection control committee was established by Maternity Hospital. Although the committee was organized after the partnership's graduation, the idea of such a team first emerged during the partnership. The committee currently consists of five members representing different departments who meet regularly to discuss the infection situation and protection standards in the hospital. As there are no national standards in Latvia, the committee developed its own standards of work in the operation theater and in the delivery department.

- ***Patient Education***

The St. Louis partners taught their Latvian colleagues about the importance of patient education courses. As a result, Maternity Hospital started to organize classes for current and future parents related to prenatal care, childbirth, and infant care, and the partners developed a special strategy to encourage more future fathers to participate in the "fathers in birth" classes. The hospital currently allows a man who attends the birth course to participate in his wife's delivery for free, but it requires payment from those who do not sign up for the

class. Typically, Maternity Hospital advertises its courses on its Web site or patients learn about various workshops through word-of-mouth.

- ***Community Health***

The partners established a community health project that involved students and teachers from the primary schools in Tukums, a rural region of Latvia outside of Riga. Many citizens of Tukums, including the municipal police, Latvian National Guard, Red Cross employees and community health and medical workers benefited from the partnership by establishing long-lasting professional relationships with each other and by learning how to coordinate their work to conduct outreach activities. Over time, the project led to nationwide implementation of health classes into teaching curricula, altered the way of thinking about healthy lifestyles among the population, and forced city municipalities to focus more on community health issues. According to one of the Tukums partners, without the AIHA partnership, there would not have been such education reform in Latvia. In September 2005, the Latvian schools began a new national social science program that includes the following four components: economics, health, ethics, and civil sciences.

After the partnership ended, schools in the Tukums region continued offering various health-related initiatives for students. Every year, for instance, one of the local schools devotes a week to a selected health issue. During that time, students work on projects and prepare oral presentations on the chosen topic. Throughout the year, the school arranges various lectures delivered by First Aid employees, physicians, nutritionists and cosmetologists. In addition, a school nurse and two psychologists meet with students during health classes to discuss issues of interest. For example, psychologists occasionally conduct anonymous tests on the "psychological health of the class" in which students describe their relationships with their peers. Results from these tests identify potential problems and serve as a basis for further discussions.

The Latvian partners have noticed a significant change in students' attitudes towards a healthy lifestyle. Students became more interested in health-related topics, and they search for information on the Internet, television, or ask questions during health lessons. Very often children provide their parents with health materials distributed at school. Nevertheless, smoking remains a serious problem among teenagers in the Tukums region.

One of the notable changes resulting from the partnership was the larger involvement and financial support of the City Municipality in outreach projects. The local government became more engaged in Healthy Community programs and started to sponsor a sport club for disabled children and children with posture problems. Unfortunately the local padoma (council) formed by the partners ceased its operations due to a lack of financial support and official approval from the City Hall, where change in leadership led to a change in priorities.

- ***Business and Leadership Development***

The relationship between the State Centre of Tuberculosis and Lung Diseases of Latvia and the University of Arkansas for Medical Sciences (UAMS) was established through the US Center for Disease Control (CDC). The goal of this venture was to ensure long-term financial stability for the Multi-drug Resistant Tuberculosis (MDR-TB) Center of Excellence and its International Training Center. Specific objectives focused on delivering a management training curriculum to six key members of the faculty and staff of the (MDR-TB) Center and on developing a business plan for the institution. Over time, the program also embraced the development of marketing and operation research plans.

"I never thought that something like this training center for international specialists could become a reality."
– Dr. Vaira Leimane

Participation in the Riga/Little Rock partnership gave the Latvian partners a new perspective on healthcare and training. Learning new management skills and competencies helped the Riga partners to move ahead with their training program. During

partnership exchanges, the Latvian partners learned about principles of teamwork, management, and advertising, and how to develop vision and mission statements. After the training, the Latvian partners started to think about their services in business terms and began to generate small profits which enabled them to cover trainers' compensations, facility and transportation costs, and miscellaneous purchases like new multimedia equipment.

The center provides free-of-charge training on MDR-TB for Latvian nurses, physicians and pharmacists; and for-fee courses for international trainees from the former Soviet Union and various European countries. The training is offered in three languages (Latvian, Russian, and English), and during the first half of 2005, the center trained more than 100 professionals from various countries.

Trainers from the MDR-TB Training Center learned from the US partners about collaborative teaching methods and operational research and behavior, and also gained new skills in curricula and lesson plan development. They also acquired new knowledge about management principles and continuous quality improvement (CQI). As a result, after each training workshop, the center conducts a course evaluation to obtain feedback from participants and identify areas for improvement. The Latvian partners also organize regular staff meetings during which they discuss work-related issues and facilitators prepare post-training assessments of their performance.

Another important outcome of the partnership was training the Latvian partners in fundraising. For the partners, gaining fundraising skills was a groundbreaking experience. The Riga partners helped pioneer this concept which today remains both underdeveloped and culturally unaccepted in Latvia. However, they used their new skills to organize a fundraising event in collaboration with the Latvian opera and raised money from selling opera tickets to cover most of the expenses of the international conference held in Riga during a World Health Organization (WHO) ceremony.

Undoubtedly, the partnership experience helped the Riga partners to transform the center into a modern and successful institution. In November 2004, the center was designated as an official WHO Collaborating Center for Research and Training in Management of MDR-TB and its staff automatically gained the status of international experts. As a result, the center began to participate in WHO's collaborative meetings and to deliver regular reports. In return, the partners obtain training support from WHO and additional funds from various international organizations such as Médecins Sans Frontières, the Red Cross and the Global Fund.

The TB Training Center continues its efforts to obtain university accreditation which would allow the incorporation of the TB training program into the medical curriculum. Another problem faced by the center is a shortage of new lab specialists. The partners estimate that about 35% of current doctors will retire in the near future and only 11% of them will be replaced. Although the center offers relatively attractive salaries, many specialists do not want to work in the TB lab and commute to the remote location of the center.

Another significant success of the Riga/Little Rock partnership is the effective dissemination of the center's activities. In 2004, through the University of Arkansas, the Riga partners became involved in another AIHA project which aimed to strengthen the national laboratory network for TB control in Moldova. The Riga Center developed its own training curriculum and conducted two training sessions for Moldovan physicians and nurses — one on Directly Observed Therapy (DOTS) and MDR-TB and another on training methodology. The center also plans to conduct training of trainers (TOT) in Georgia and establish a training center there.

- ***Nursing***

In the mid-1990s, nursing in Latvia was not perceived as an independent medical profession and the role of nurses was minimalized. Nevertheless, nurses who participated in the Riga/St. Louis activities demonstrate a number of notable improvements in the nursing profession instigated by the partnership.

Involvement in partnership exchanges helped many nurses to discover their leadership potential and strengthened their self-esteem. The partnership activities gave them opportunities to work with physicians as a team and, as a result, nurses gained more professional independence. The relationship between physicians and nurses also began to improve. For example, nurses from Children's Hospital started to collaborate with doctors in the infection control task force.

Latvian nurses learned about the importance of customer service and CQI. Nurses from Children's Hospital, for example, learned from their American colleagues how to talk to young patients and their parents about their condition and treatment. These new competencies helped nurses to improve the overall relationship with patients and their families.

Thanks to the partnership, Children's Hospital began to monitor nursing time per patient. This new practice helped hospital departments to set time benchmarks for every procedure and estimate staffing needs more accurately. Bikur Holim initiated cross-functional training for nurses that increased the hospital's efficiency.

Despite these advances, the nursing profession in Latvia continues to face challenges. One of the main problems is an ongoing nurse shortage, primarily because many nurses choose to work for pharmaceutical or cosmetic companies because they offer much better compensation. In addition, low salaries force many nurses to work double shifts, which might have a negative impact on the quality of the care they provide. Hospitals try to deal with the shortage in various ways. Children's Hospital, for example, started to offer three scholarships to nurse students who are then expected to work in the hospital for five consecutive years after graduation.

Physicians' continued failure to recognize nursing as a profession creates another continuing challenge. Although doctors participating in the partnership began to give nurses more autonomy, generally speaking, they still do not see nurses as equal partners. The partnership succeeded in promoting the nursing profession at the individual level, but Latvian medical education needs urgent reform which will define a new role of nurses in health delivery. Otherwise nurse-physician teamwork will remain an elusive concept.

- ***Access to Health Information and Communications***

AIHA supported the development of Learning Resource Centers (LRCs) at the three Riga partner institutions. All three LRCs were active in supporting teleconsultations, access to research and training, and collectively trained 836 health professionals on how to use computers and the Internet to access medical information during the period of funding (September 1996 through September 2004).

Physicians at Riga Maternity Hospital routinely used the LRC to update guidelines and protocols related to obstetrics, gynecology and neonatology. They took advantage of quarterly CD-ROM updates with systematic reviews from the Cochrane Library to keep informed about the latest randomized control trials from various fields of medicine. Physicians at the hospital also used the LRC to support teleconsultations with colleagues around the world—including a successful consultation with the LRC at Faculty Hospital in Kosice, Slovakia, to diagnose a newborn with renal problems.

The LRC information coordinator at Riga Maternity Hospital also played a significant role in helping to establish a computer network at the hospital, and by working with the local Internet provider and a local medical equipment company, she was able to negotiate a faster and higher quality Internet connection for the hospital. The LRC also obtained access to a database containing information about pharmaceuticals available to physicians in Latvia.

The LRC at Children's Hospital supported a large pediatrics conference being hosted at the Latvian Medical Academy by preparing 27 reports on various pediatrics-related topics, using research obtained from the LRC.

These reports were distributed to all conference participants and then published in Latvia's main medical journal and LRC staff estimated that the reports were ultimately seen by over 3,000 physicians in Latvia. The LRC information coordinator became a regular contributor to the *Latvian Medical Journal*, with a monthly column highlighting the sources of the best medical information on the Internet for different specialties.

To expand use of the Internet among new physicians, Children's Hospital incorporated an LRC component into its residency program and now the hospital holds nine seminars for residents on how to extract medical information from the Internet every year. Also, once or twice a year the hospital provides postgraduate-level courses for infectious disease specialists on information technology. The LRC coordinator at Maternity Hospital runs the hospital's Web site which provides information about services in English and Latvian.

All three LRCs actively supported teleconsultations, successful grant proposals and the development of medical databases. Collectively, these LRCs received an average of 69 visitors and 73 information requests each month. The functions and capabilities of the LRCs continue to be supported at all three sites.

CHALLENGES

- US partners stated that one major challenge involved the disparity of resources between the US and Latvia. The US partners were accustomed to having high patient resources in respect to access to drugs and technology. Transferring their knowledge to Latvian partners, where those resources were not available, proved to be a problem at first. To overcome this, US partners were able to learn from the Latvian partners and let them take the lead. By listening to the success and failures Latvian partners faced in their own context, the US partners were able to work with them to incorporate appropriate techniques and technologies to improve overall patient care.
- The continued shortage of nurses in Latvia provided different challenges for the partnerships. For instance, nurses were made responsible for the Learning Resource Center at Children's Hospital in Riga, but since they were constantly working long shifts, their energy and motivation to use the LRC were diminished. The information exchange between nurses and physicians as a result has not progressed as quickly as possible.

SUCCESS STORY: *Latvian TB Institution Gains Regional Prominence*

The State Agency of Tuberculosis and Lung Diseases of Latvia (SATLD), designated in November 2004 as an official WHO Collaborating Center for Research and Training in Management of Multi-drug Resistant Tuberculosis (MDR-TB), was the first such center in the European region. This accomplishment can be attributed to the Riga/Little Rock partnership and specifically to the University of Arkansas for Medical Sciences (UAMS), which assisted the center in enhancing its teaching methodologies and management skills and developing a business plan for financial stability.

The SATLD is a treatment and teaching facility which was a guiding force in introducing TB control efforts in the region and was one of the first to follow WHO's DOTS strategy. By participating in the Riga/Little Rock partnership, the Latvian partners started to look at their institution from a business perspective. They created a business and marketing plan, and initiated activities including fundraising efforts to obtain financial sustainability. "Now, we think like business people," noted Vaira Leimane, program director in the TB Training Center. The Latvian partners also learned basics of management and how to develop a vision and mission statement. These new competencies almost immediately brought tangible results. The Latvian partners started to generate profits which enabled them to cover trainers' compensations, facility and transportation costs, and other purchases. They also established the center's vision which focuses on eradicating MDR-TB in the world, and a mission statement which aims "to provide medical staff from countries with a high burden of MDR-TB an opportunity to study and to implement the DOTS-Plus

program in the treatment of MDR-TB; to advance research and disseminate knowledge that enables physicians to better treat this disease in their respective countries."

The center also became involved in the dissemination of SATLD activities. In 2004, through the University of Arkansas, the Riga partners became a part of another AIHA project which aimed to strengthen the national laboratory network for TB control in Moldova. The Riga Center developed their own training curriculum and conducted two training sessions for Moldovan physicians and nurses, one in DOTS and MDR-TB and the second in training methodology.

Today, the center's faculty is internationally acknowledged and the center itself is recognized for its world-class training in diagnosis, treatment and management of MDR-TB offered to program managers, social workers, nurses and laboratory staff across Europe. The center's training modules focus on key issues such as the improvement of laboratory diagnostic methods, patient education, and MDR-TB in prison, and training is delivered in three languages: Latvian, Russian, and English.

SUCCESS STORY: *Partnership Brings a New Specialty to Latvia*

When a doctor diagnoses a life-threatening illness, what is his or her obligation to the patient? Must the doctor disclose the diagnosis, or must the patient be protected from this information? Rasele Saca, a physician in Latvia, thought she knew the answer to this question until she visited a hospice in St. Louis, Missouri, a decade ago.

Artwork created by young patients of the pediatric palliative care team at Clinical Children's Hospital has been turned into postcards that are sold to support the Make a Dream charity.

"I was shocked. It was really something new for me. In our country the philosophy was different – you didn't tell the patient the truth about his bad prognosis," Saca explains. During the Soviet era, it was a common practice not to inform patients about the severity of their illness or prognosis. Patients and their families had to struggle alone with their terminal sickness accompanied by physical and psychological pain.

But in the St. Louis hospice, Saca saw terminal patients who weren't suffering under the burden of this knowledge. In fact, they seemed to be enjoying life despite their illnesses. "I saw that these patients were really very happy and satisfied." Saca's eye-opening visit was made possible though an AIHA partnership between hospitals in Riga, Latvia, and the BJC Health System in St. Louis, a partnership that lasted from 1995 to 1998.

The St. Louis partners showed Latvian colleagues a different approach to this difficult matter during partnership exchanges, and held a large national conference in Riga that same year to share information about hospice and palliative care. The conference hosted approximately 200 participants including doctors, social workers, psychologists, and priests from all over Latvia.

After her visit to the United States, Saca collaborated with colleagues from both Riga and St. Louis to lay the groundwork for a hospice program at Bikur Holim Hospital in Riga. Rather than creating a stand-alone hospice, the Riga/St. Louis partners integrated palliative care services – pain management, social and psychological support, and rehabilitative services – into care provided not just to terminal patients, but to those suffering from other serious or chronic diseases as well. Seven years after the partnership ended, Bikur Holim has institutionalized its palliative care services, providing benefits to some 120 patients annually.

At the Latvian Medical Academy's Clinical Children's Hospital, the only full-service acute care hospital for children in Latvia, the AIHA partnership set the stage for a similar transition. Dr. Anda Jansone traveled to St. Louis in 1997 to learn about hospice care for children with the goal of establishing a pediatric palliative care team in her country. In 1998 Dr. Jansone and her colleagues at Children's Hospital established a pediatric

palliative care team consisting of a doctor, a nurse, a social worker, and a chaplain; the first hospice-related efforts that had ever been established in the country. In 2000, the hospital opened a palliative care department. The palliative care department continues to thrive and has successfully leveraged support from other governmental and international sources, such as the European Union's PHARE program, to continue to expand its services. Starting in February 2005, the palliative care team began working on a large project financed by the European Commission's EQUAL program. The three-year project will develop a set of documents that will provide a definition of palliative care, admission criteria, quality standards, and cost of care.

The hospital plans to establish three mobile pediatric teams to provide palliative care to children in remote areas of Latvia. The hospital and its supporters have also started the Give a Dream charity to fulfill the wishes of young terminally ill patients. This charity serves a secondary goal of raising awareness about pediatric palliative care in Latvia. The palliative team from Children's Hospital has instituted innovative ideas to help sick children and their families. One of them is "sand therapy" during which children draw pictures in sand to help express their feelings during psychotherapy. "Memory days" bring together families of children who have died to help celebrate their lives and support each other during the time of mourning.

Outside of the successes they've made at Children's Hospital and Bikur Holim, Dr. Jansone and Latvian partners have worked tirelessly to advance the new specialty in Latvia, through the founding of the national Palliative Care Society and developing legislation that would allow for the establishment of palliative care as an independent branch of healthcare.

Palliative care is now being phased into the university and postgraduate education of social workers and physicians in the country. In September 2005, the university began admissions for a clinical social worker program which introduces a new specialization in palliative care.

In the fall of 2005, Jansone began intense research and doctoral studies in pallative care. Jansone and the Palliative Care Society cooperate with a number of partners such as Belarusian Hospice, Warsaw Hospice for Children (Poland), BJC Home Care Service in St. Louis, and Hospice Information Service at St. Christopher's Hospice in London.

The St. Louis-Riga partnership has brought a new perspective to the concept of giving and receiving. While we, the St. Louis partners, were prepared to provide the materials and expertise developed in the United Sates, including medical equipment and supplies, pharmaceuticals and technology, we received from our Riga partners unanticipated gifts that have been invaluable in our own quest for improving health care here at home. Some examples are:

- Our hospice team has been led to explore new delivery models and settings.
- Our community health team has discovered innovative and effective methods of leading stakeholders through massive change initiatives.
- We have seen and learned from amazing positive outcomes resulting from a more measured application of technology than is customary in the United States.
- The area of pediatric infectious disease, which has been a major focus of our work, provides one of the most striking examples of the partnership's far-reaching benefits. With Dr. Dace Gardovska's Riga team, we were able to identify the cause of Salmonella outbreaks in Latvia's children. We also made the alarming discovery that the strain is antibiotic resistant, and then determined a management strategy that would be successful in Latvia. Most important, we came to realize the serious implications of well-meaning humanitarian donations of powerful antibiotics to countries with limited access to antibiotic sensitivity testing. We have shared these findings internationally with other health care professionals with the hope of addressing this important issue.

- Memo from St. Louis Partners, July 1998

Partner Profile — *Aldis Gailis*

Aldis Gailis, a young obstetrician at the Maternity Hospital in Riga, traveled to St. Louis in 1996 to take part in a two-week training session with his US partners. During his visit to Barnes-Jewish Hospital, Gailis observed the work of ultrasound specialists and studied intrauterine blood transfusions, a highly specialized procedure used to treat fetuses with life-threatening conditions by increasing the amount of healthy blood in the fetus. The brief educational experience was a turning point in Gailis' life and career that led to his becoming a renowned ultrasound specialist in Latvia.

Not only was Gailis the first and only physician in Latvia to do intrauterine blood transfusions, the Maternity Hospital remains the only facility in the country to offer this lifesaving procedure. Gailis had done five such transfusions as of June 2005.

Upon his return from the US in 1996, using equipment purchased by the Riga municipality and applying the skills he had gained in St. Louis, Gailis began to work in earnest as an ultrasound specialist. "I had done some ultrasound training for one month before I went to the US. But there, I could see with fresh eyes how it works in practice. I learned a lot and saw new and better ways of dealing with problems related to ultrasound."

In 1999, Gailis again participated in a training session, this time organized by AIHA partners at Sveti Duh General Hospital in Zagreb, Croatia, where he spent three weeks with leading Croatian specialists learning techniques of Doppler ultrasound examinations and its application in testing fetal blood velocity and diagnosing fetal anemia. At the time, there was only one doctor in all of Latvia using Doppler ultrasound and it was not a procedure available at Gailis' hospital. Gailis has since conducted over 100 examinations to assess fetal anemia and a fetus' blood group.

Gailis' technical skills, broadened and strengthened through the partnership trainings, as well as his attentiveness to patients have resulted in a high demand for his services (he performs approximately 5,000–7,000 ultrasounds a year) among women who know of his outstanding reputation and who are willing to wait months just to be seen by him.

II.I. ROMANIA (1995-2006)

Program Highlights

- Established a domestic violence program in Constanta which was the model for a National Strategy approved by the Ministry of Health to monitor, prevent and combat domestic violence.
- Provided comprehensive care and services for women at a new Women's Wellness Center in Iasi.
- Increased the capacity to train health managers in the country through two health management partnerships, by training faculty to include interactive teaching methodologies; initiating new courses, certificates, and degree programs in health management; and introducing health communication techniques.
- Established a new ambulatory service in the Clinic for Occupational Diseases in Cluj which now involves a higher number of nurses and doctors and is networked on the hospital's computer network and on the Internet.

Partnerships/Projects	Years	Focus Areas	Partner Institutions
Cluj-Napoca/Philadelphia	1995-1997	Occupational Health	• Institute of Public Health • Inspectorate of Public Health • Clinic for Occupational Disease • Thomas Jefferson University
Bucharest/Chicago	1995-1999	Health Management Education	• Carol Davila University of Medicine and Pharmacy • National Institute of Research & Development in Health (NIRDH, formerly the Institute of Health Services Management) • University of Chicago
Iasi/Minneapolis	1998-2000	Women's Health	• The Center for Reproductive Health and Family Planning • Hennepin County Medical Center
Constanta/Louisville	1998-2000	Healthy Communities, Women's Health, Domestic Violence, Sexually Transmitted Infections	• Constanta County Health Authority • Department of Health Promotion and Health Education • Humana Foundation • University of Louisville • Jefferson County Health Department

Bucharest/Lexington	2001-2004	Health Management Education	• Carol Davila University of Medicine and Pharmacy • NIRHD • University of Kentucky School of Public Health
Bucharest/Tirana, Albania	2001-2004	Health Management Education, Primary Healthcare	• NIRDH • Institute of Public Health (Tirana)
Organizational Development Grant	2003	Organizational Development, Marketing	• NIRDH
Breast Health/Radiology Project	2003-2006	Mammography, Quality Assurance, Capacity Building	• Fundeni Institute (Bucharest) • Oncology Institute (Bucharest) • Cluj District Hospital • Oncology Institute (Cluj) • Renasterea Foundation (Bucharest)

BACKGROUND

From the 1960s to 1990s, health status in Romania steadily declined in several respects, particularly as it related to women's health and infant mortality. In the mid 1990s, for example, infant mortality was three times higher than in Western Europe, and the infant mortality rate (20.5 per 1,000 in 1998) and maternal mortality rate (40.5 per 100,000 in 1998) were among the highest in Europe. (Maternal mortality was six times the European Union average and three times the CEE average, despite a huge decline since 1990, which was the result of new abortion policies and their implementation.) Additionally, life expectancy at birth for Romanians was five years lower than in Western Europe. The main causes of death were cardiovascular disease, cancer and respiratory disease. (Health Care Systems in Transition: Romania, European Observatory on Health Care Systems, 2000)

The healthcare system has undergone — and is still undergoing — rapid transformation and is making gradual improvements, and health sector reform is part of the country's broader transition to political pluralism and a market-style economy. Starting in 1995, new regulation regarding the structure and organization of the healthcare system were passed, changing the structure of the country's healthcare system and establishing the legal framework for a shift from an integrated, centralized, state-owned, and controlled tax-based system to a more decentralized and pluralistic social health insurance system. Despite these changes to the structure, however, few improvements actually resulted: little was spent per capita on health; equity remained a concern; social care was limited; and there was still overuse of hospital care. (HIT Summary: Romania, European Observatory, 2002.)

AIHA's program in Romania began in 1995 and was designed to complement USAID/Romania's broader goals to pursue key social service restructuring opportunities. By 1997, the USAID aimed to move beyond earlier service delivery programs in family planning and help for institutionalized children to address broader constraints in the health and social service delivery systems. For example, health management training was designed to build capacity to better manage the shift to primary healthcare, and a diagnostic-related cost (DRG) system was introduced to allocate scarce resources more rationally. USAID/Romania's two strategic objectives were designed to support Romania's health reform law, which mandated that individuals receive more effective and sustainable health and social services and benefits, and the public would be exposed to fewer environmental risks that could negatively impact their health. AIHA's occupational health partnership in Cluj and health management education partnership in Bucharest were designed to meet these challenges.

In 1998, AIHA launched a healthy communities partnership in Constanta and another partnership in Iasi to address USAID priorities in women's health. USAID/Romania also requested AIHA implement a second health management education partnership, involving the same Bucharest partners, but focused on health communications. In 2001, AIHA enlisted the National Institute for Research and Development in Health in Bucharest to address health management needs for primary care providers in Albania (through a partnership funded by USAID/Albania). At the same time, AIHA supported the NIRDH through a limited grant to strengthen its organizational development. Additionally, in 2003, AIHA initiated a breast health radiology program with the support of USAID and the Susan G. Komen Foundation.

KEY RESULTS

- ***Health Management Education***

The Bucharest/Chicago partnership enhanced knowledge in specific areas of health management, including health economics, communications, human resource management, and quality assessment. Eighteen Romanian partners participated in three-month exchange programs at the University of Chicago, designed to prepare them to become leaders in health management teaching, research, health policy design and analysis, and consulting. In addition to the new information they obtained, the exchanges introduced students to a different, interactive style of pedagogy that they can apply in their roles as instructors in Romania.

The Bucharest partners completed five country-specific case studies: The Evaluation of Wound Infections in a Surgery Department; The Impact of Introduction of a New Information System on the Structure of the Sibiu District Hospital; Health Services Reform in the Brasov District; Family Planning Case Study; and How the College of Physicians Was Founded. The cases have been incorporated into the partners' teaching activities and have been well received by trainees.

The Chicago partners helped the National Institute for Research and Development in Health (NIRDH) and Carol Davila University establish master's degree programs in health management at their institutions. Carol Davila University later restructured and refined the curriculum of its master's degree program through a program sponsored by the Association of Schools of Public Health in the European Region (ASPHER), in order to comply with European standards. Graduates of the program are now in high-level positions in the Global Fund, UNFPA, the National Insurance House, the Ministry of Health and Open Society Institute.

In addition, the Romanian partners introduced post-graduate teaching training, practical courses for hospital managers, and an accredited short course for people in and outside of Bucharest. US partners at the University of Kentucky assisted the NIRDH in the development of hospital management short courses and continuing education programs for healthcare professionals. The Bucharest partners also learned more about adult learning techniques and focused on the case studies method in developing and improving their programs. NIRDH extended the health management curriculum to include new subjects like evidence-based medicine, social marketing and health research, and the modules have been improved to include case studies and examples. New curricula have been developed on health economics and financial management, health promotion and prevention and managing general practice. Additionally, as of 2005, nurses were able to participate in the short courses offered by Carol Davila University.

Courses at the National Institute for Health Research and Development (as of 2005)

	Students Per Year
Certificate of Competence in Health Services Management	403
Master's Course in Health and Social Services Management	200
Social Marketing/Distance Learning	200
Short Courses	89

The Romanian partner institutions increased capacity to provide technical assistance in healthcare management and policy. After mastering partnership topics, the Romanian partners provided technical assistance for healthcare management and health policy reform to several countries in the NIS and CEE. (Materials used in courses are primarily written by Romanian participants in the partnership.) The case study methodology has been presented to other AIHA partners in the region, including a one-week training course in Kazakhstan in 2001, to introduce the Romania experience.

In 2001, AIHA enlisted the NIHRD to participate in a partnership to address health management needs for primary care providers in Albania. The Romanian partners assisted their Albanian counterparts in developing adult learning, health management and health promotion curricula, and worked collaboratively on the content of a three-day short course on practice management for general practitioners. The Romanian partners demonstrated that they could apply the experience and lessons learned from the previous two partnerships (with Chicago and Kentucky) to become an effective mentoring partner institution in their own right.

AIHA provided the NIHRD with a grant to develop its legal framework and organizational structure, as well as a business plan to help guarantee its sustainability, as it transitioned to an autonomous status no longer guaranteed MOH funding. With the grant, the NIHRD created a plan which included a human resources plan, internal procedures, staffing and training needs, performance criteria and a staff handbook. An important addition to the organization of the Institute was a grant writing unit which would work on submitting successful proposals for additional projects and funding. The AIHA sustainability grant also enabled the NIHRD to develop a marketing and communication strategy, which included printed marketing materials, a new Web page (www.incds.ro), upgrades to computer equipment and Internet connection, and the ability to hold a staff team-building retreat and annual conference.

- ***Health Communications***

The Bucharest/Lexington partnership built on the successes of the previous health management partnership to focus on developing and implementing health communications and community mobilization strategies essential to the implementation of health reforms efforts, including a new health insurance system. Partners received training on communication skills and methods and once they successfully mastered them, they implemented several specific health communication and advocacy activities. In addition they developed a training package for health education and communications.

"At an AIHA annual conference, the participants noted that there is a lack of communication. Reform is happening at the central level, but the front line physicians don't know, the patients don't know that the policy has changed and we have new rights."
— Bogdan Pana, Carol Davila University

The partnership culminated with the implementation of a health communications campaign, to more effectively share updated and accurate information about available healthcare services and how the public can access these services. The partners crafted messages which were included in television and radio spots, newspaper, and magazine advertisements, and brochures and posters. The printed materials were distributed to general practitioners, the local insurance houses, and public outpatient clinics throughout the country. In addition, the partners developed a Web site containing information about available health services and contact information of local public providers that was advertised in all of the media spots. From the launch of the campaign, on June 26, 2002 through October 7, 2002 there were an impressive 17,635 visits to the Web site.

The campaign was publicly launched on June 26, 2002 with a launch and press conference at the National Health Insurance House in Bucharest. The partners distributed a press kit containing all of the relevant

information and printed materials to the media representatives covering the launch. National and local media outlets covered the campaign, including three television stations, two radio stations and three newspapers.

- ***Nursing***

The Cluj/Philadelphia partnership worked to improve the status of nurses by enhancing their role, improving their skills in clinical settings, and increasing the level of professional interaction between physicians and nurses. At the Inspectorate of Public Health, a nurse trained through the Cluj partnership was designated to coordinate the implementation of new concepts of nursing in occupational medicine. In September 1997, the partners held the Conference on Nursing and Occupational and Environmental Hygiene. Romanian and American partner nurses made presentations on nursing in the acute care setting in the US, industrial nursing, tuberculosis communication in nursing, and professionalism in nursing.

Romanian nurses enthusiastically participated in activities of AIHA's CEE Nursing Task Force and made presentations at the annual meetings of the task force, as well as participated in other AIHA nursing activities, including the International Nursing Leadership Institution. As a result of her participation in the International Nursing Leadership Institution (INLI), the National Honor Society of Nursing (the Delta Rho chapter of Sigma Theta Tau), inducted one of the Cluj partner nurses as a member in 1998.

AIHA enlisted the founder and executive director of the Romanian Nursing Association, Gabriela Bocec, to participate in the CEE Nursing Task Force as well as INLI. Participation in the task force provided her with the support of a network of nurses in the region and the opportunity to communicate and collaborate in ways not otherwise possible. By participating in INLI, first as a participant and later as a trainer, she was able to develop her leadership skills and gain access needed resources which could benefit the association. She shared her knowledge and skills with more than 400 nurses throughout the country through workshops on a number of topics, including time and change management, leadership, negotiation and conflict resolution, and project development. The INLI experience helped her inspire nurses in her country to work toward healthcare reform and find ways for nurses to play an enhanced role in making these changes and improvements.

AIHA supported the establishment of a Nursing Resource Center (NRC) which opened in Cluj in May 1999. The NRC provided training to more than 250 nurses on computer-related and clinical skills training. The Cluj nurses successfully applied for a grant from the Soros Foundation for supplemental support for the center and for a time occupied space free-of-charge, with support from a local foundation. Finding a permanent home has been a challenge for the NRC.

In 2001, the NRC began to collaborate with the Romanian Nursing Association and began holding its courses under the aegis of the association, and the association paid the training fees to the NRC from revenue generated from membership dues. The three part-time staff at the NRC teach courses on basic computer skills, wound management, and other courses accredited by the University of Medicine and Pharmacy in Cluj. The NRC provides about 20-30 hours per month of training.

- ***Healthy Communities/Domestic Violence***

The primary goal of the Constanta/Louisville partnership was to promote community involvement to improve women's health in the community. In the community assessment phase of the partnership, 1,311 women in Constanta were surveyed to identify perceptions and concerns related to women's health. The top three health concerns listed by those surveyed were sexually transmitted infections (STIs), domestic violence and family planning. The Romanian partners created interdisciplinary commissions on domestic violence and STIs to develop strategies for addressing these two issues in Constanta.

Constanta poster-wall

The Constanta community developed an integrated approach to responding to the problem of domestic violence. In March 2000, the partners launched the domestic violence awareness campaign in a busy downtown area of Constanta. Seventeen young volunteers handed out brochures about domestic violence and pins and pens with the motto "Live Safely." Citizens were asked to answer simple questions about their knowledge of and attitudes toward domestic violence. Three hundred questionnaires were completed and the results analyzed in the development of additional programs addressing the issue. The partners also used the media to reach out to the local community, raising the profile of community programs and sharing important information about domestic violence. Two newspaper articles about Constanta's domestic violence program appeared in the *Independentul* (Independent) and *Observator* local newspapers, a television show on the MTC local television station, and three radio broadcasts on Radio Constanta, Radio Sky and Radio Contact.

Realizing the need for ongoing coordination of the network that had been developed, the partners saw the need to create a foundation that would be able to continue the initiatives after the ending of the partnership. In 2000, the partnership founded the Constanta Community Foundation with a $10,000 grant from the Humana Foundation. This was Constanta's first community foundation.

The Constanta Community Foundation opened the Office for Women in December 2000 to advocate on behalf of women, provide a voice in the legislative process, and support community health promotion activities. The office houses a domestic violence hotline and serves as a walk-in referral center for victims of domestic violence. The Office for Women continues to operate today, with funding from the Constanta County Council and other donors, including their former partners at the Humana Foundation in Louisville. In 2004, the Constanta Office for Women recorded 242 new cases of domestic violence. The Romanian partners have been working to affect policy changes at the Ministry of Health, and to institute a country-wide domestic violence program based on the model initiated through the Healthy Communities process in Constanta.

"For us, the collaboration with AIHA and the Louisville partners was a great opportunity to learn new things to get experience and to put ideas into practice. The fact that the Constanta Office for Women is still active and our experience was replicated at the national level means, from our point of view, that we had excellent partners."
— Loti Popescu and Daniel Verman, Constanta

The Constanta experience is being used as a model in six different counties in Romania and for the Ministry of Health National Strategy to monitor, prevent and combat domestic violence. In April 2002, the national strategy on fighting domestic violence was approved. It includes provisions for all levels of government to be active. The law created an interministerial committee of the Departments of Health, Justice, Youth, Police, Education, and Sports with responsibility for improving the laws to protect victims. It also calls for a National Commission for monitoring and preventing domestic violence and it requires counties to establish an Office for Women and a shelter for victims.

- ***Sexually Transmitted Infections (STIs)***

In Constanta, the partners developed programs to improve syphilis surveillance and to prevent the spread of HIV/AIDS. With partnership support, they were able to conduct programs in rural places where it was difficult to conduct outreach. The partners worked with general practitioners in the rural areas and the result

was increased detection of syphilis cases. Additionally, communication has improved between the general practitioners and specialists, and among specialists as well. (Initially the STI specialists were reluctant to work with the general practitioners, but now they cooperate more freely.) Pregnant women are now tested for STIs in pregnancy and delivery throughout the country.

The STI program in Constanta received a donation of 4,000 condoms from Project Services International (PSI). These condoms, along with STI prevention information, were distributed to visitors to the beaches during the summer as part of an STI awareness campaign. In addition, peer-to-peer workshops about STIs were held at two high schools and the Pedagogical College in Constanta. The workshops included role-playing and presentations by teens on the correct use of condoms and explanations of disease transmission. The trained peer educators conducted educational sessions in their schools and participated in the awareness campaign.

The STI partnership team, using a model from the University of Louisville School of Medicine, developed a report form designed to collect data on STIs. The report form was distributed to general practitioners and STI specialists through the Constanta District Insurance House and is still used by them.

- ***Women's Health***

With the assistance of US partners from Hennepin County Medical Center in Minneapolis, a Women's Wellness Center (WWC) was established in Iasi in 1999. The WWC provides a full range of services for women, including consultations for breast cancer, cervical cancer and STIs, family planning counseling, health education classes for teens, birthing classes for expectant couples, consultations for infertility, voluntary counseling, and testing for HIV and domestic violence counseling.

In its first year of operation, the Iasi WWC documented 18,845 visits, including services for prenatal care, gynecological examinations including diagnostic testing, contraceptives, and health education classes. Nurses and physicians from the Iasi WWC began providing health education programs for pregnant couples, and the inclusion of fathers made the program unique — and it was met with a high demand.

"I have very pleasant memories of the partnership with the United States and it was a great experience for my career. When you achieve something that is sustainable and viable, it gives you great satisfaction."
— Otilia Casian-Botez, Iasi WWC Director

The Iasi WWC reached out to primary care providers in neighboring regions to provide training on family planning, and initiated a program to screen patients for domestic violence and provide the necessary counseling and referrals for victims of abuse.

To ensure sustainability after the AIHA funding period, the Iasi WWC was successful in soliciting private funding and local support for its activities. Donations included $17,000 for renovations and laboratory supplies from the Health Insurance House, $10,000 for renovations and equipment from the Public Health Department, and $3,000 in contraceptives from the Ministry of Health. The WWC also established a contractual relationship with the Health Insurance House to provide 8,000 exams per month in the private system. The WWC also maintains its partnership with the Ministry of Health in the menopausal and contraceptive programs, which provides another means of financial support. The Iasi WWC is still operational today, and the director is still in contact with some of the US partners. In addition, WCC staff continue to share information with the WWC in Moldova.

- ***Breast Health/Radiology***

Following the purchase of 50 mammography machines by the Ministry of Health, AIHA and USAID recognized the need for training of both radiologists and radiology technicians to ensure that both types of specialists were skilled in the use of the equipment and in detecting breast cancer in its early stages. In 2003, AIHA received $200,000 from USAID/Bucharest to establish a project to enhance mammography training. These funds were used to leverage additional funds from the Susan G. Komen Breast Cancer Foundation to incorporate quality assurance standards into the training critical to achieving accurate mammography films and to creating standards for accurate diagnosis. Five sites participated in the initial program in 2003-2004, five more sites were added in 2005, and four additional sites in 2006. Through the project, training for Romanian radiologists and technicians was provided by a group of US volunteer radiologists and quality assurance experts. Equipment to support the quality-assurance activities was delivered to the 14 participating sites. In addition, two physicists (one each from Bucharest and Cluj) were trained to implement quality guidelines and conduct routine tests on the quality assurance equipment. Using the procedures and forms from the *American College of Radiology Quality Assurance Manual*, a guidebook was developed and translated into Romanian for use at each of the model centers. A group of Romanian specialists were trained as trainers and served as faculty during the project rollout phase, initially with support from US specialists.

The project also led to the creation of the Romanian Society for Breast Imaging (SISR) which includes radiologists and technicians trained through the program. The society meets regularly and has received technical support from US experts in developing a process for conducting film and quality assurance reviews, and in planning for broader implementation of the quality assurance guidelines in Romania and for developing a mammography screening program.

Computers were purchased and delivered to 10 of the participating sites to facilitate the data collection and peer review process among the centers. Each center in the project is collecting data on a common set of data elements. Additionally, SISR members and project faculty developed a computer-based program for tracking diagnostic information, the radiology/pathology correlation, and the impact of the quality assurance process. The software has been distributed to all participating sites, and the sites will collect data quarterly. The ultimate aim of this effort is to be able to demonstrate the effectiveness of the quality control process and the need for a national breast cancer-screening program. The four newest sites will be added to the data collection and review process once their films have been submitted and reviewed to ensure they meet the established quality standards.

- ***Occupational Health***

The Cluj/Philadelphia partnership focused on reducing occupational health hazards. Romanian partners were trained in techniques of occupational risk assessment and management, and air monitoring. They visited a water pollution control plant in Philadelphia and participated in a vendor fair where four occupational health and environmental safety products companies donated synthetic latex gloves, safety goggles, respirator face pieces, and particulate filters. They also visited the local OSHA office where the Romanian partners gained useful information about standards and regulations in occupational health, and developing and implementing new national legislation in occupational health. The experience gained by visiting Thomas Jefferson University Hospital provided the staff of the Clinic of Occupational Health with concrete ideas on department reorganization, development of ambulatory services, implementation of a one-day hospitalization procedure, and overall improvement of the quality of the services.

The partners purchased portable spirometers which had a profound impact on the respiratory function testing of workers conducted at the Institute of Public Health and Clinic for Occupational Diseases. The testing was easier and the quality of the procedure improved, and since staff can test an increased number of patients more quickly, the workload has decreased. The clinic has become the leading respiratory function

testing laboratory in the Transylvania region of Romania: in 1993, 3,200 patients were tested, and in 1996 6,243 patients were tested—almost a 50% increase in the number of tests performed.

After being introduced to a standardized treatment of asthma and cardiac deficiency, the Clinic for Occupational Diseases established an allergy center to increase their diagnostic capabilities. The allergy center is known as one of the best in Cluj, visited by more 20 patients a day for ambulatory examination.

As part of the partnership, a new ambulatory service was established in the Clinic for Occupational Diseases in Cluj. The admittance policy was changed, so that after screening tests, the patient is admitted or treated in the ambulatory service. The clinic now involves a higher number of nurses and doctors in these ambulatory activities. Another change instituted at the facility because of the partnership resulted in cigarette smoking being banned from the Clinic for Occupational Diseases.

Partners at the clinic reported that the quality of patient care improved as a result of the partnership. Medical staff put more time and effort into educating their patients about their illnesses, their characteristics and treatment. They now conduct one-on-one and group discussions with patients on health promotion issues and specific aspects of their diseases. During outpatient check-ups, the staff discusses the role and importance of safety equipment, occupational risks and hazards, occupational disease prevention methods and the importance of periodic medical check-ups. The Inspectorate for Public Health also reported an increased efficiency in their operations by decreasing the amount of time spent in providing such services as authorizations, bulletins, and medical check-ups.

"This partnership changed my life. I gained new knowledge in management. My new job is based on the experience from the partnership."
— Partner from Cluj

Although it was not an explicit goal of the Cluj partnership, training in care management and hospital management provided through the partnership program resulted in a reduction of the average length of stay in the Clinic for Occupational Diseases from 13.6 days in 1994 to 10.8 days in 1997. At the clinic, teams of doctors and nurses were created with the goal of decreasing the average hospital stay. The teams made tests at their place of work, took lab tests, and admitted only the cases that could not be resolved in ambulatory services. This was done in collaboration with the Institute of Public Health and the Inspectorate of Public Health, at their respective institutions.

On a policy level, the Cluj partners lobbied with the Ministry of Health and the Ministry of Labor and Social Protection to improve working conditions and to stop the payment system related to hazard pay, whereby workers received additional pay to compensate for working under hazardous conditions. Although ultimately unsuccessful in changing the laws, they raised awareness of the issue for the first time among both policymakers and key stakeholders. As a result of the Cluj partners' efforts, however, new national regulations were enacted establishing standards for workplace protection and a statute was adopted creating the medical specialty of occupational health.

The partners also successfully worked to improve communication regarding occupational disease between the factories and the policy makers as a result of the partnership. Many physicians became consultants on occupational health and safety in factories' BOA and/or workers' unions, actively participating in their meetings.

- ***Access to Health Information and Communications***

AIHA supported the development of Learning Resource Centers (LRCs) at the seven following Romanian health organizations:

- University of Medicine and Pharmacy "Carol Davila" – Bucharest (Sept. 1996-Sept. 2004)
- National Institute for Health Research and Development – Bucharest (Sept. 1996-Sept. 2004)

- Hospital of Occupational Medicine – Cluj (Sept. 1996-Sept. 2004)
- Institute of Public Health – Cluj (Sept. 1996-Sept. 2004)
- Inspectorate of Public Health – Cluj (Sept. 1996-Sept. 2004)
- Public Health Directorate of Constanta County – Constanta (April 1999-Dec. 2000)
- Elena Doamna Women's Wellness Center (Sept. 1999-Sept. 2004)

These LRCs supported over 550 staff at their institutions by providing access to research, training, teleconsultation support, database design, and other services. They provided training on how to use computers and the Internet to access medical information to 2,151 health professionals during the funding period (including more than 1,600 students enrolled at the University of Medicine and Pharmacy and the National Institute for Health Research and Development).

One of the ways staff at the Institute of Public Health in Cluj used the LRC was to support their public health research. LRC staff helped several epidemiologists and other public health professionals to investigate other countries' approaches to health promotion in order to improve the design and implementation of their own programs and research methodologies. This LRC later won a grant from the European Union, which included support for the LRC to develop the Institute's information system and Internet connection.

"I will never forget the first e-mail messages sent to the US saying, 'We are connected' which meant that we are connected to the world. For me I felt like — to use a metaphor — the change from candlelight to the light of knowledge, which was the computer. We were not able to use modern technology in the past, during the years of communism."
— Mihaela Sinca, Cluj

At the Hospital of Occupational Medicine in Cluj, hospital residents used the LRC to find new research articles to present during daily staff meetings. The LRC staff also supported the development of the hospital's health information system, starting out with a database for the radiology department.

At the Iasi Women's Wellness Center, utilizing the LRC quickly became an integral part of the staff's daily work routine. Internet access was made available to patients during visits and educational seminars, and e-mail messages between staff and patients became a frequent and oftentimes preferred form of communications for patients wishing to remain anonymous. Staff also used the LRC to develop patient education resources as well as treatment protocols on topics such as prevention of congenital infection and treatment of toxoplasmosis during pregnancy. The LRC was also later able to obtain free Internet access by negotiating with the local Internet provider and a local technical university.

Romanian LRCs have also been active in supporting the development of Web-based distance learning programs (through the University of Medicine and Pharmacy) and evidence-based medicine training programs (at the National Institute for Health Research and Development).

Collectively, the seven Romanian LRCs received an average of 166 visitors and 111 information requests each month. While AIHA closed the LRC at the Public Health Directorate of Constanta County at the end of 2000 after it was learned that LRC resources were being used inappropriately, the other six LRCs have continued to be active, sustaining the LRC functions and capabilities on their own.

As one Bucharest partner commented, "This [the LRCs] was also very important because it made a good connection between the specialists in the area. This is the first time we met specialists from Czech Republic, from Slovakia, from Croatia, from Hungary."

CHALLENGES

- Romanian partners spoke of challenges related to the acceptance of new technologies and communication systems by medical staff who had to become comfortable using and optimizing them.
- Many of the Romanian partners faced challenges in finding funding and other material support to continue some of the programs initiated through the partnership program. The NRC in Cluj had to scale back its activities after being relocated from its previous donated space, but has been able to fund regular training activities by developing a collaborative relationship with the Romanian Nursing Association. The partners at Carol Davila University would like to more regularly conduct health communications campaigns, but their budgets generally to not fund such activities. But through constant collaboration with general practitioners, the local insurance houses, and public outpatient clinics, pertinent information is distributed to patients. The Constanta Community Foundation has been able to find funding to continue to support the Office for Women and other community programs addressing domestic violence, STIs, and other pressing issues.

SUCCESS STORY: *Local Institutional Capacity is Built in Health Management*

When partners from the Institute of Health Services Management (IHSM) first started participating in an AIHA partnership in 1996, the idea of developing a cadre of professionals specializing in health management was a new one. The IHSM was a government organization established in 1992 under the auspices of the Ministry of Health (MOH) to design and develop the health reform strategy and training programs on health management. The IHSM was the main provider of health policy and health care management analysis and advice for the MOH, and provided critical support to the ministry in the area of health promotion and prevention programs.

The IHSM participated in a health management education partnership with the University of Chicago from 1996-1999, providing the Romanian partners the opportunity to learn important health management concepts and the skills to better teach these topics. The American partners from Chicago provided training in specific areas of health management, including health economics, communications, human resource management, and quality assessment. Staff at the IHSM also studied adult learning techniques that represented a different interactive style of teaching that they could apply in their roles as instructors. For example, the Chicago partners shared the idea of using case studies as an effective health management teaching tool, and the Romanian partners developed country-specific case studies which they could use in teaching topics such as health reform, health promotion, and infection control. The partnership culminated in the establishment of a master's degree program in health management at the IHSM.

Mona Moldovan, an instructor at the Institute, learned about human resources management from the partners in Chicago, and she used this knowledge to develop a human resources management course now offered regularly at the IHSM. "The Chicago partnership was the basis for everything that came afterwards," said Moldovan.

In 2001, the IHSM had another opportunity to participate in an AIHA partnership, this time with the University of Kentucky. This second health management education partnership provided staff from the institute with an opportunity to build on their experience with Chicago to broaden the health management curriculum to include new subjects like evidence-based medicine, social marketing, and health research. The institute also developed hospital management short courses and continuing education programs for healthcare professionals, once again utilizing adult learning techniques and focusing on the case studies method in developing and improving their programs. Through the partnership with Kentucky, new curricula were developed on health economics and financial management, health promotion and prevention, and managing general practice.

"Because of the experience and previous training with Chicago, when we had the partnership with Kentucky, we knew what to ask for and what to look for," explained Daniela Valceanu, project coordinator at the IHSM.

While the Institute grew in stature and continued to train new health managers through the two partnerships with Chicago and Kentucky, it faced challenges which hindered its effectiveness. For example, as a public entity, the IHSM encountered difficulties in retaining well-trained staff, which were attracted to private institutions that could offer higher pay and other incentives. Since it could take years to train and develop experienced staff and trainers in health management, the loss of talented staff threatened to weaken the Institute.

National Institute of Research and Development in Health

The leaders at the Institute decided to seek a more autonomous status for the organization. In 2003, the Institute changed its status to an "extra-budgetary" public institution, which allowed it to compete on the market for projects and use that money to support its operations. With this change in status came a change in name to National Institute of Research and Development in Health (NIRDH). While the institute could now compete for projects, potentially garnering more funds for its own development and for higher salaries and better incentives for staff, the new autonomous status meant the institute could no longer count on guaranteed funding from the MOH. Its success would depend on its ability to gain new business through grants and contracts.

"Even if we ask others to deal with change [in the courses we teach], we lacked this skill," explains Dana Farcasanu of the IHSM. "We did not know how to conduct change with accurate planning, a sensible development strategy and an exact business plan."

AIHA provided the NIRDH with a grant to help the new institution develop its legal framework and organizational structure, and to develop a business plan to help it to achieve sustainability. The AIHA grant also enabled the NIRDH to develop a marketing and communication strategy. An important addition to the organization of the institute was a grant writing unit which could work on submitting successful proposals for additional projects and funding. The NIDRH was able to win a number of new grants from various funding organizations, including EU PHARE, the MOH, the Global Fund, and John Snow International.

The NIRDH also began to work in other countries in CEE, such as providing expertise on case mix financing in Bulgaria through a World Learning grant. Additionally, the institute was enlisted by AIHA to participate in another partnership, but this time as the mentoring partner in Albania to help develop a short course in management for primary care providers.

The Albanian partners were initially resistant to the role-playing exercises introduced by their Romanian counterparts, as the Romanians were when first introduced to this technique in Chicago. But the Albanian partners quickly embraced the new ideas. "We applied the adult learning concepts we learned from our American partners in Albania, and the Albanians liked the approach," said Valceanu. "The US partners taught us how to work and make decisions collaboratively, and we used this knowledge to work with the Albanian partners to make a curriculum appropriate to their needs."

The partners at the NIRDH are still in touch with their Albanian partners, and hope to collaborate again in the future. The Albania/Romania partnership not only heralded a new type of collaboration in which partners in CEE could learn directly from each other, but also demonstrated the NIRDH had grown from its partnership experiences in the US to become a leading institution in health management and health reform in Romania and throughout the region.

Partner Profile *Otilia Casian*

When AIHA first established a women's health partnership linking the Elena Doamna Clinical Hospital in Iasi, Romania, with the Hennepin County Medical Center in Minneapolis, Minnesota, Dr. Otilia Casian-Botez realized right away that the collaboration represented a wonderful opportunity for learning—and for making real changes in the scope and quality of medical care available to women in her town and its environs.

At that time, Casian-Botez recalls, she was working as an ob/gyn at the hospital while also coordinating the Elena Doamna Center for Family Planning and Reproductive Health on the hospital's campus. Describing how a visit to nearby Chisinau, Moldova—where AIHA's Chisinau/Minneapolis partners had already established the Dalila Women's Wellness Center (WWC)—convinced her to participate in the partnership, Casian-Botez says, "The professional commitment I saw from both sides during the partnership exchanges made me eager to see a similar relationship bloom in my own community."

Together, the Romanian and American partners created in Iasi a WWC from the ground up, turning the Center for Family Planning and Reproductive Health into a warm, patient-friendly environment that welcomed women of all ages. Casian-Botez and her colleagues worked hand-in-hand with their partners to develop and implement a comprehensive range of clinical services rooted in modern, evidence-based medicine and designed patient education and outreach programs that focused on reproductive health, sex education for teens and young adults, parenting classes for prospective mothers and fathers, menopause, and much more. "Our goal was to change people's attitude toward women's health…not just among patients, but also among medical personnel," she points out.

When the Iasi WWC opened its doors in October 1999, Casian-Botez was appointed its director. She has worked hard to build—and maintain—a strong team of expert care providers who share her desire to improve medical care for women in Iasi and the nearby rural areas. Looking back on what has been accomplished since the partnership was established in 1999, Casian-Botez laughs, saying it seems unbelievable that she can still recall the smallest events. Things that, at the time, seemed to be almost impossible challenges are now remembered with pleasure.

"I will, of course, always cherish the Center's grand opening, which was attended by Romania's First Lady, and the positive reactions of our very first patients, who had never had access to the care and services we offered," she says. "And, I will never forget the unique and effective way our partnership worked—particularly the strong working relationships I formed with US partners like Cheryl Hensen, Cheri Galbraith, and Vickie Gustafson, who were so wonderful to share with us their very real and useful knowledge."

Casian-Botez is proudest, however, that the WWC continues to expand its services and that the number of patients visiting the center increases year after year. This is proof positive that her work is a success. "Without a doubt," she concludes, "the partnership has had an impact beyond the WWC walls. What we have done here reaches out into the community and positively influences the attitude of the entire population."

Partner Profile — *Dana Farcasanu*

Dana Farcasanu entered the medical profession at a time of change in her native Romania. During her years in medical school she learned how to treat patients and that it was the government's responsibility to manage the nation's healthcare system. Her graduation in 1990 coincided with the fall of Nicolae Ceausescu's communist regime and Farcasanu began hearing magic words such as reform, decentralization, management, health policy—words that promised a new paradigm and a new vision of her professional future. At that point, she was faced with a difficult choice: work as a physician in a broken, dysfunctional system or become a pioneer in the efforts to change that system from the inside out. Farcasanu chose the latter and is quick to admit that 16 years later she has never regretted her decision.

Today, Farcasanu is CEO of the Center for Health Policies and Services, a nongovernmental organization in Bucharest, and, for more than a decade, she has been at the vanguard of health systems reform in Romania. For much of that time, she has also been an AIHA partner. "I grew up with AIHA," Farcasanu says, explaining that AIHA and its partnerships have nurtured a whole generation of healthcare administrators and policymakers through its Health Management Education program in Romania.

Farcasanu has been a key member of three AIHA partnerships that linked Bucharest's Institute of Health Services Management with the University of Chicago's Graduate Program in Health Administration and Policy (Bucharest/Chicago, 1996-1999), the University of Kentucky's School of Public Health (Bucharest/Lexington, 2001-2004), and the Institute of Public Health in Tirana, Albania (Tirana/Bucharest, 2003-present).

Through the Bucharest/Chicago partnership, the Institute initiated a post-graduate course in health management. During that time, Farcasanu earned a diploma of specialist physician in public health and health management. Soon the student became a teacher and Farcasanu scoured countless resources looking for new professional and educational practices in the field of health services management that would help improve the contents and methodology of the course she was delivering.

When that first partnership ended, another soon followed. "Through the partnership with Kentucky, I met wonderful new people and we worked together to develop the first hospital management course in Romania," Farcasanu recounts. "But, to me, the AIHA partnerships did not just expose me to a new system of teaching. They exposed me to a new way of life, the American way of life, which I have come to love."

The third partnership was a watershed union; it was AIHA's first partnership linking only regional institutions and Bucharest's Institute of Health Services Management took on the role of educator and mentor. At that time, Farcasanu was the Institute's deputy director and professionally seasoned enough to manage this challenging project. "I am so proud and grateful for the trust both USAID and AIHA had in me and my ability to lead this partnership. Even more so, I hope my partner-colleagues are proud because the investment they—along with AIHA and the US government—made in us through the previous partnerships has paid off," she professes.

At the end of 2003, Farcasanu launched a new phase of her career, moving into international relations and consulting. She represented Romania in various regional and international networks, including the South-Eastern Europe Health Network of the Stability Pact and the Global Fund to Fight HIV/AIDS, TB and Malaria. In 2004, she served as the vice chair of the Global Fund's Governance and Partnership Committee and as a consultant to Romania's Minister of Health. Additionally, Farcasanu's expertise has helped her excel as a management consultant and program evaluator in Albania, Moldova, Ukraine, and of course throughout Romania. "All of this, I can credit to my first professional experience abroad—the AIHA partnership with Tirana," she maintains.

In Farcasanu's current position leading the Center for Health Policies and Services, she continues her efforts to make health systems more responsive to public health priorities. "The work done over the past decade through our AIHA partnerships has helped assure sustainable system-wide change in Romania," Farcasanu says, concluding, "As for myself, the partnerships had a profound impact on me and my professional development as well."

Partner Profile — *Daniel Verman*

Daniel Verman, MD, first heard the term "healthy communities" at an AIHA health promotion conference held in Mamaia near his hometown of Constanta in December 1997. He was immediately intrigued by the concept that community members themselves could take a much more active role in improving their health, and that this alone could make a profound difference in the overall health and well-being of his community. After the conference, he returned home to his position as head of health promotion for the Constanta County Health Authority and immediately set to work preparing a proposal to create Romania's first healthy communities partnership. Verman gained the necessary support from key stakeholders and wrote the winning proposal.

Today, Constanta is a transformed community, due primarily to Verman's vision and efforts. Verman continues to advocate for healthy communities, with an emphasis on women's issues and for using community mobilization as a way to improve lives. "As an energetic champion for women's rights and for healthy communities, Dr. Verman became the voice and face of the prevention and protection of women against domestic violence," says Bernice Bennet, former AIHA Senior Program Officer.

"Under Dr. Verman's leadership and that of his partners [Humana Foundation and University of Louisville in the US], I observed a small Romanian community go through a transformation that included an initial stakeholders' meeting; scientific community survey on issues affecting women; prioritization and selection of community-based interventions; community awareness campaigns; creation of laws and policies to protect women; and finally the implementation of an Office for Women focusing on assisting and advocating on behalf of abused women. Dr. Verman made all of this happen!," says Bennett.

Verman believes the partnership was a turning point in his life. "My life changed!" he says. "I became more committed to the community's problems, to listening to the voice of the community. I enlarged my family to the community level."

He credits the partnership with helping identify the underlying cause of many of Constanta's health problems. "To be honest, we didn't really know what the problems were. We knew medically — such as the high rates of infant mortality, abortions, STIs, smoking, etc. — but these weren't the same problems the community saw as most important." A survey and focus groups with women led them to identify domestic violence as one of the main problems facing women — and the community — in Constanta.

Using interdisciplinary teamwork, a completely new approach for Verman and his Romanian colleagues, the Constanta/Louisville partnership developed a unique program for addressing domestic violence. Family practitioners, nurses, social workers, police officers, prosecutors, lawyers, and forensic specialists all came together for the first time in a powerful, collaborative force during a training workshop conducted by the partner group in Louisville. As a result of the meetings at this workshop, the idea to establish the Constanta Community Foundation developed, which, with Verman at the helm, has since led the charge against domestic violence. Together with the creation of the Office for Women, these are partnership achievements Verman is most proud of.

In addition to attitude changes among healthcare professionals and other stakeholders, Verman saw a shift in attitudes among community members at large, who better understood their role in improving their health and how to make their voices heard. As people saw the results of partnership efforts — for example, resolved domestic violence cases and victims speaking on TV about how the Office for Women had helped them — initial skepticism and mistrust about the project gradually disappeared. The mass media played a critical role in shedding light on the issue of community health and, ultimately, in improving it. Verman himself became known as an expert on health issues, as well as somewhat of a television celebrity, through an hour-long weekly show, "Together for Health."

In 2002, Verman was asked to serve temporarily in the Ministry of Health (MOH) to coordinate an inter-ministerial commission for groundbreaking efforts to develop a National Strategy for Preventing, Monitoring and Combating Domestic Violence. In 2003, the Parliament approved a bill Verman had drafted, and the following year, the National Agency for Family Protection was established, with Verman serving as its first executive director. Since 2002, five other cities/regions in Romania have replicated the integrated domestic violence program with help from Verman and his colleagues.

In his current position as Senior Counselor, Office for Mother & Child Care for the MOH, Verman continues to work tirelessly to help improve the lives of women and children in his country. As Romania's liaison to the World Health Organization on domestic violence issues, he recently presented the Constanta experience at a United Nations session on discrimination against women.

Partner Profile — *Tracy Schiller*

Tracy Schiller was a lieutenant and commander of the Training Unit for the Louisville Division of Police in Kentucky when he got a call from Deborah Wilson, Chair of the Department of Justice Administration at the University of Louisville, asking if he would be interested in getting involved in a domestic violence project in Romania. Schiller, who had never worked internationally nor traveled overseas, was a bit apprehensive but excited to find himself on a plane to Romania several months later (in March 2000) as part of a multidisciplinary team from Louisville heading to Constanta under an AIHA healthy communities partnership.

Schiller had, a few years earlier, been assigned to the police department's newly formed Domestic Violence/Sex Crimes Squad and in that capacity had been working on implementing and supervising two federal grants awarded under the Violence Against Women Act. This included an innovative project that involved using multidisciplinary teams of law enforcement and social service providers to address the problems of domestic violence and providing comprehensive services to families, not just to the victims of domestic violence.

His connections to the University of Louisville came from his role in providing professional training and public education to targeted groups at the university on issues relating to sexual assault and intimate partner abuse. With his experience in developing courses and providing training on these topics, he was well-suited to represent the law enforcement side of the multidisciplinary approach and team working to launch a similarly innovative project to address domestic violence in Constanta.

During his two partnership exchange trips to Constanta that year (2000), Schiller helped train the Romanian partners on addressing domestic violence within their community. He shared with them the principles underlying law enforcement's response to domestic violence in the US, and lessons learned – the successes, failures, and barriers faced. Even in the US, a multidisciplinary approach to the problem is not fully ingrained and practiced, so he found the Romanian partners' openness to the idea somewhat surprising.

"I was impressed with their eagerness to take on this new concept and new way of thinking and working," Schiller says. "It says a lot about them that they were willing to take on the challenge of changing their cultural norms."

During the workshops, Schiller witnessed people from agencies that had traditionally not worked together making a concerted effort to find solutions for their community. Given their positive attitudes and hard work, Schiller felt certain they would succeed. Constanta's success has now been replicated in a number of other communities in Romania, thanks to the leadership of the Constanta partners.

For this police officer from Louisville, the relatively brief participation in the partnership never-the-less left a deep impression.

"When I left Romania, I took as much back with me as I had left with them. The experience made me aware of how fortunate we are in this country; and how much we take things for granted," says Schiller. "I also realized that police are police no matter where you are… we're in it for the same reasons of helping communities to be safe places."

Schiller is now retired, but continues to work to further disseminate the philosophy and practices of community policing through his work for the Regional Community Policing Institute.

II.J. SLOVAKIA (1995–1999)

Program Highlights

- In a three-year period, the perinatal mortality rate decreased from 19.1 to 5.15 percent at Kosice Faculty Hospital, and the regionalization of services helped decrease the rate in Eastern Slovakia from 14 to 10.9 percent.
- Due to the efforts of the Healthy Communities partnership, the prevalence of smoking in Martin decreased from 36 percent in 1998 to 29 percent in 2002.
- New nursing protocols, educational curricula and specialties were developed, and two Nursing Resource Centers were opened to provide a repository of electronic and print materials for nurses and nursing students.

Partnerships	Years	Focus Areas	Partner Institutions
Kosice/Providence	1995-1999	Neonatology, Women's Health	• Woman and Infants' Hospital of Rhode Island • Hasbro Children's Hospital • National Perinatal Information Center • Kosice Faculty Hospital and Polyclinic
Martin and Banska Bystrica/Cleveland	1997-1999	Social Work, Community Health, Hospice, Substance Abuse	• MetroHealth System • Institute for Public Health Services (Case Western Reserve University) • Federation for Community Planning (Cleveland, Ohio) • Cleveland-Bratislava Sister Cities • City of Banska Bystrica • City of Martin
Petrzlaka/Kansas City, MO	1996-1998	Domestic Violence, Substance Abuse	• Truman Medical Center • Missouri Department of Health • Missouri Hospital Association • Hope House • Citizens Association of Aid to Children at Risk
Slovakia/Scranton	1996-1999	Health Management, Nursing	• University of Scranton • Trnava University • University of Matej Bel (Banska Bystrica) • Health Management School (Bratislava)

Turcianske Teplice/Cleveland	1996-1998	Community Health, Medical Education	• MetroHealth System • Institute for Public Health Services (Case Western Reserve University) • Federation for Community Planning (Cleveland) • Cleveland-Bratislava Sister Cities • Town of Turcianske Teplice

BACKGROUND

Although Czechoslovakia had offered free universal healthcare to its citizens and had an elaborate state-supported healthcare system while under communism, that system didn't receive the necessary state funding to be able to provide adequate care to the population. When a reformist government took control in 1989, healthcare reform was recognized as important, but not a top priority. However, by 1990, the Czechoslovak government had set new healthcare goals relating to privatization, public/private cooperation, provider choice, improving the efficiency and quality of healthcare services and management, and modernizing healthcare facilities. USAID was invited to help support these goals, and targeted three objectives: reducing cardiovascular disease, improving the quality and management of care, and promoting private markets and innovations in insurance and healthcare financing.

In the mid-1990s, the Slovak population suffered from a high rate of chronic non-infectious diseases (particularly cardiovascular disease), resulting in a rising rate of people developing disabilities and shorter life expectancy. Slovaks also exhibited unhealthy lifestyle behaviors, including poor eating habits, lack of physical activity and smoking. As Slovakia proceeded on its path toward democratization, the nation's senior citizens and their families struggled to cope without a safety net of state-run and financed social and healthcare services.

The influx of people to the capital Bratislava and its surrounding districts placed additional strains on the city's resources and insufficient infrastructure. Rising unemployment and a lack of opportunities, especially for youth, contributed to increased substance abuse and criminal activity. In 1995, 9,518 deaths in Slovakia (17% of all deaths) were attributed to smoking. ("The Long-Term Impact of International Collaboration on Tobacco Control in the Slovak Republic," Elena Kavkova)

Infant mortality rates were high, particularly in eastern Slovakia where the rate was 14 per 1,000 live births in 1995 (more than twice as high as in Bratislava). The state of medical art in the deliver facilities was high, but there were problems in the organizational efficiency and the delivery patterns of care. With the move away from centralized control, there were also problems in the regional referral system for both obstetric and pediatric care.

As Slovakia transitioned to a privatized health sector, healthcare leaders needed to ensure the continued delivery of affordable universal healthcare. Local capacity was needed for educating health administrators who would be skilled in decision making, budgeting, accounting, information systems, data collection and analysis, outcomes measurement, and other management techniques.

Even before Slovakia became an independent republic in 1993, USAID had established a separate office in Bratislava and targeted the region for specific programs, and reforming the healthcare system was one of its primary goals. Project Hope started working with hospitals and Slovak NGOs to distribute medical supplies and equipment in 1991, and the US Department of Health and Human Services worked with the Ministry of Health and the newly formed health insurance agency on health financing and health reform. Project Hope

also supported a partnership between Boston Children's Hospital and Bratislava Children's Hospital, and Healthcare Enterprise International supported a project pairing Trnava Hospital and Polyclinic with Franklin Delano Roosevelt Hospital.

AIHA's program in Slovakia followed on the successful model of pairing US and Slovak partners to work on targeted areas of the healthcare system. Five partnerships were formed starting in 1995 which focused on maternal and child health, healthcare management and local health reform. When AIHA's program ended there in 1999, USAID/Slovakia commissioned an external evaluation of AIHA's activities in the country. (The report of the evaluation, conducted by Temple University, can be found on AIHA's Web site at: http://www.aiha.com/resources/EvaluationSlovakRepublic.pdf)

KEY RESULTS

- ***Maternal and Child Health***

Dr. Peter Krcho attends premature babies.

The Kosice/Providence partnership improved maternal and child health in eastern Slovakia, in particular perinatal, neonatal, pediatric, and gynecological medicine. Numerous clinical and operational procedures were changed and new regional referral and nursing educational services initiated. These resulted in higher overall occupancy rates, a doubling of admissions to the neonatal intensive care unit (including referrals from the five outlying hospitals also benefiting from the program), and significant drops in neonatal mortality rates at the hospital and in the Kosice region.

There was a rapid decrease in perinatal mortality in the Faculty Hospital as well as in other hospitals in Kosice and in the surrounding regions. From 1995 to 1997, the perinatal mortality rate in Kosice Faculty Hospital declined from 19.1% to 5.15%; the neonatal mortality rate excluding congenital anomalies declined from 24.2% in 1995 to 7.2% in 1997.

Table 1: Infant Deaths per 1,000 Live Births
Kosice Compared to the Rest of Slovakia and Europe

	1995	1997
Kosice	19.10	5.15
Eastern Slovakia	14.00	10.90
Slovakia*	10.99	8.70
WHO Europe Region*	13.37	11.89
European Union*	5.63	5.22

*WHO Euro data
http://data.euro.who.int/hfadb/

The decline of mortality in the neonatal intensive care unit of the Faculty Hospital between 1995 and 1997 was already documented; however, in Eastern Slovakia early neonatal mortality from 1995 to 1997 decreased from 6.9 per 1,000 live births to 4.1 per 1,000 live births. This influenced the total infant mortality rate with a reduction from 14 per 1,000 to 10.9 per 1,000 live births. In addition, during 1996, high-risk neonatal referrals to the Faculty Hospital more than doubled: 39 in-utero transports and 66 infants were transported to the hospital in this period. During the same period, there was a 67% reduction in neonatal deaths among low birth weight infants in the hospital.

There was a corresponding increase of high-risk transfers to the Faculty Hospital for delivery, which is an indication of the success of the regionalization program sponsored by the hospital. As a result of interventions by the partnership, there is better identification of high-risk problems of the patients receiving antenatal care and improved treatment protocols for high-risk mothers. Not only have neonatologists from the Faculty Hospital reduced the infant mortality rates for Eastern Slovakia, but they have also changed the way in which regionalization of perinatal care occurs in the entire republic. A proposal was submitted and accepted by the Ministry of Health through legislative edict to establish networks of care in Slovakia that are comparable to the levels of care used in the US. This has further encouraged the development of referrals for both high-risk mothers and infants to Level III centers within Slovakia.

The partners improved infection control procedures, resulting in a significant reduction of infections that had plagued the NICU at Faculty Hospital. The unit not only introduced preventive activities to reduce neonatal infections, but also created the means to identify the type of infection and the antibiotic to be used. As a result, less expensive antibiotics of a lower generation were able to maintain control over neonatal infections, resulting in a cost savings of almost $9,000 in just one year. Various protocols and procedures were used for hand washing, single use towel, liquid soaps and disinfections and also monitoring of infections within the unit. Also, treatment protocols were introduced that have dramatically improved infant care in the neonatal unit over the past two years, which also resulted in a reduction of morbidity.

The partners introduced a series of new technologies in the delivery of emergency and intensive care. These included new approaches for nutrition, intracranial pressurized monitoring, and new invasive monitoring using arterial blood pressure and blood gases on critically ill patients. As a result, patients received better care and the department used less oxygen concentrates in critically ill patients and improved the treatment for shock. The partners also helped nurses provide better care for ventilated patients, and now they take an active role in monitoring patients undergoing ventilation within the intensive care unit. Additionally, the number of physicians and nurses working in the pediatric intensive care unit was increased to allow for 24-hour coverage in this department.

Kosice Faculty Hospital continues to enhance its status within the region, updating its facilities to host 15 intensive beds. In March 2004, they renovated the NICU, and the Neonatal Clinic was selected as a center for undergraduate and postgraduate education.

- ***Health Management Education***

The Slovakia/Scranton partnership developed the health management education capacities of the Trnava University School of Nursing and Social Care, the Health Management School in Bratislava, and the Faculty of Economics at the University of Matej Bel in Banska Bystrica. All three institutions added health management courses, made curriculum changes and established accreditation standards. A master's degree program for Nurse Managers was established at Trnava University and accredited in 1998, as were health management programs. The University also established a Nursing Resource Center, a Center for Rehabilitation Medicine and a Health Management Institute. Matej Bel's health management program was strengthened, where the Center for Health Strategy and Policy is a strong center of analytical expertise. A Center for Training and Consulting Skills Development was added at Bratislava's Health Management School.

The Slovak and US partners created the *Journal of Health Management and Public Health* and published 10 issues, and more than 80 manuscripts were prepared and/or published by the journal. The partners also successfully submitted seven articles on health management issues in Slovakia to the Journal of Health Administration Education.

The partners conducted three international healthcare conferences in Slovakia, and students sponsored two conferences of the American College of Healthcare Executives. The partners participated in three clinical research conferences. In total, more than 375 partners participated in these conferences.

The Scranton/Slovakia partnership has continued and flourished. All Slovak partners are still in contact with the Scranton partners, some serving as co-authors on articles and co-sponsoring of conferences. Since 2000, the School of Public Health has had an exchange of PhD students with the University in Scranton each year. Each school pays for the transportation of their students to the other country and then the host country school covers the students' living expenses. In addition, they have one or two faculty exchanges each year. These exchanges are funded through the schools' budgets and not through outside sources.

- ***Healthy Communities***

Local health reforms were undertaken in four cities (Banska Bystrica, Martin, Petrzalka, and Turcianske Teplice) through three Healthy Community partnerships, in which partners identified health risks in the community and designed interventions to address them. Exchanges helped the partners determine how US programs could best address the needs of Slovak cities and local stakeholders mobilized volunteer support for health improvement activities. In the process, communities were empowered to develop health programs and gain experience in effecting change.

Needs Assessment and Data Collection

As part of the initial stages of the healthy communities process, the partnerships addressed the need for a collection of data to develop more effective community health interventions. For example, a behavioral epidemiologist from Case Western Reserve University assisted Turcianske Teplice in the development of a Family Stress Survey. In 1996, 1,687 of the 1,850 children enrolled in grades 5-12 (91%) completed an extensive questionnaire covering many topics including health and social risk behaviors, school and work achievement, peer and family relationships, and evaluation of personal and family stress.

The Petrzalka partners conducted their own community survey on lifestyle and behavior among children and youth which revealed rising rates of drug abuse among teenagers. 816 children and youth between the ages of 12 to 18 participated in the survey. An unexpected finding of the survey was that domestic violence was also an issue in Petrzalka where the unemployment rate was extremely high following the collapse of the old regime. One-fifth of the respondents reported that they considered committing suicide.

Healthy Communities Programs Implemented

Martin opened a Healthy City Office and its first program was a vigorous anti-smoking campaign. The Cleveland partners introduced the concept and skills of using mass media to communicate about public health which enabled the Martin partners to reach the entire Slovak population via newspapers, radio shows and press conferences. The Healthy City Office holds a "Stop Smoking Day" annually and established a Web site with information about tobacco control, as well as a telephone hotline that provides advice on how to quit. The partners also published evidence-based guidelines for smoking cessation in the Slovak language and established the Center for the Promotion of Non-Smoking. The prevalence of smoking in Martin has decreased from 36 percent in 1998 to 29 percent in 2002.

In Banska Bystrica, a new city department for healthcare was established, the regional hospital designated a 20-bed ward as a geriatric care unit, and a municipal 18-bed unit was established for pensioner care. The city also began a program that encouraged self-management of chronic disease that included the initiation of the area's first ambulance service, a family stress reduction program, and a city clean-up campaign.

The Turcianske Teplice partners opened the Community Health Advisory and Education Center in Slovakia to make health promotion and disease prevention services accessible at no cost. It was the first center of its kind in the country to be operated and financed entirely by a municipality. The center provides hypertension and cholesterol screening; diabetes screening and counseling; education for women in self-breast examination; prenatal education; as well as drug, alcohol and smoking cessation counseling. The center is open five days a week for four hours a day, and is staffed by a part-time physician and a full-time nurse. Funding for staff salaries and supplies is provided by the City Hall of Turcianske Teplice, with partial funding from the Ministry of Health. The center provides approximately 180 cholesterol screenings, 150 diabetes screenings and 450 hypertension screenings per year.

"Once people in Turcianske Teplice saw what was possible—what could be changed—they were eager to participate. But we had to take the first step to help them understand problems such as unhealthy lifestyles and environmental pollution." *– Alena Chlapikova, former mayor of Turcianske Teplice*

With the help of Truman Medical Center in Kansas City, Petrzalka's Citizen's Association of Aid to Children at Risk (CAACR) worked to prevent domestic violence and drug abuse among teenagers. It designed and implemented an extensive drug awareness campaign and trained teachers to recognize signs of drug or child abuse. Approximately 30 to 50 community residents participate in monthly anti-drug forums; in 1997 the partners helped the city of Piestany establish its own anti-drug forums.

"We cannot offer much, but we can offer active listening. We can help people to mobilize their own powers and help them solve their own situations. We know we will be successful if people can have a sense of well-being and feel safe at home in Petrzalka." *– Jana Sturova, PhD, president of the Association of Aid to Children at Risk*

When the Petrzalka partners learned from their community survey that domestic violence was a major issue, CAACR opened the Hope Center for battered women, which provides counseling and self-help activities for women and children fleeing domestic violence. The center (the first center for abused women in Slovakia) offers family, individual and group therapy and daily counseling services in psychological, social and legal issues surrounding domestic violence; individual therapy is also offered to offenders. The center also helps women find safe housing, employment and legal assistance and provides services to approximately 500-600 clients each year. In addition to these services, more than 40 volunteers were trained to respond to calls to a crisis hotline.

Fundraising and Sustainability

The Cleveland partners helped CAACR develop a viable ongoing marketing plan to increase the awareness of CAACR's efforts and implement fundraising activities. CAACR received approximately $17,200 from EUPHARE and the City of Petrzalka in the Fall of 1998 which enabled the foundation to hire four full-time employees to work on domestic violence issues and the Hope Center's fundraising and public awareness campaign.

Emergency rescue services were established for the first time in Turcianske Teplice and Banska Bystrica. The Turcianske Teplice partners recognized the need to provide reliable emergency transportation and chose to initiate a voluntary community fundraising drive to purchase an ambulance. US partners in Cleveland enlisted the help of the Cleveland-Bratislava Sister Cities organization, which raised funds by raffling prizes within Cleveland's Slovak community. The partners raised $40,000 in donations and purchased and equipped a Citroen ambulance which now serves a wide area (12-20 km); within 10 minutes, anyone within the area can access emergency services. Through the process of raising funds, the community learned the importance of

approaching new donors, establishing a system to recognize contributors, and changing the tax laws to encourage charitable contributions.

The Center for the Promotion of Non-Smoking in Martin continues to operate with support of the city's Healthy Cities Office, which was founded during the Healthy Communities partnership with Cleveland. The center continues to conduct the annual "stop smoking" days, operate the hotline, manage the Web site, and lobby for additional tobacco control legislation. The center received new funding from Comenius University and the UN and WHO to implement new activities, including the writing and editing of textbooks on smoking, the organization of conferences and support of lobbying efforts.

For about four years after the partnership ended, the Banska Bystrica partners stayed in touch with their US counterparts. But since that time, the US partners have moved to other positions and they have lost touch. A personal relationship continues between Martin and US partners. WIHRI and the Kosice partners are still in contact, but they have more contact with other institutions in New York and Michigan, where the US partners have moved on to. In all of these cases, the continuing relationships from the end of the partnerships appear to be on an individual professional level, rather than an institutional level.

Policy Impact

The communities involved in AIHA's programs also pushed the government to pass laws supporting healthy lifestyles. As a result of lobbying by the city of Martin, Haemophillus Influenza is now fully reimbursed by insurance, and in 2004, Martin was successful in getting legislation that had been pending for seven years passed which prohibited smoking in public buildings. And as a direct result of the advocacy of the Petrzalka partners, there is now national legislation to protect victims of domestic violence.

- ***Nursing***

Significant improvements were made in the area of nursing in Kosice, including nursing protocol development and nursing education. During the second half of 1996, nurses in the post-surgical department of gynecology introduced new nursing protocols and a new nursing care checklist for each particular operation. The Providence partners assisted in the development of a curriculum for the education of Slovak nurses.

As a result of the partners' work in infection control, a new system was developed in Kosice to prevent nosocomial infections through improved hand washing, single use paper towels, and improved suturing materials, and there was also a nurse assigned as the infection control officer for the department. Improved nursing documentation helped to track the patient throughout the system and reduce levels of hospitalization for periods of up to 2-4 days.

In Martin, the partners established new programs at the medical school to train nurses in community public health, which covers social health and hospice care for the dying.

Nursing Resource Centers were established at Trnava University and Kosice Faculty Hospital to serve as information and technology resources and training sites for nurses. The center in Kosice held monthly meetings for nurses from throughout Eastern Slovakia and discussion topics included infection control, the nursing process and the role of the nurse.

As part of a collaborative effort with other nurses throughout Slovakia, the Kosice and Providence nurses participated in the first Slovak national nursing conference, "Out-of-Hospital Nursing." The conference provided a forum for discussion and health system planning between hospital- and community-based nurses, with presentations on health insurance and home care agencies, nursing care of terminally ill patients, and volunteerism in nursing.

CHALLENGES

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

- The Petrzalka partners felt that the use of a professional research firm to conduct the community research provided valid and reliable data for planning. The entire program was refocused as a result of the information revealed by the data analysis. The Slovak partners actually found that the partnership was not sufficiently oriented to data collection and analysis and thought that evaluation criteria should have been established in the beginning of the collaboration, and that numerical targets should have been set.

- Both of the NRCs established under the partnerships were unable to thrive after the partnerships ended. An assessment of NRCs conducted by AIHA in 2003 found that both the centers had been unable to garner enough support from their host facilities or interest from nurses to function as they had been designed. Hospital nurses did not have incentive to participate in continuing education courses, and often were not able to get support from their employer to attend; student nurses did not have adequate knowledge of English to use the books, and many are distance education students who also have families and jobs, and don't have time spend at the NRC. The partners also reported that the lack of space, inability to hire full-time staff, and inadequate marketing resulted in the centers being used as rooms for photocopying and using the Internet, rather than a hub for nursing education.

SUCCESS STORY: *Giving Women the Strength to Break the Cycle of Violence*

In a suburb of the Slovakian capital of Bratislava, AIHA's Petrzalka/Kansas City partners established Hope Center, a crisis center for victims of intimate partner violence, to shine a spotlight on the problem and help women break free from their abusive relationships. This is the story of one of Hope Center's counselors.

"So many of the women who call us say that they have been carrying our number around for six months or even a year, but they were afraid to call," says Hanka Konecna, a psychologist at Hope Center, a crisis center for victims of intimate partner violence (IPV) in Petrzalka, Slovakia. That's the nature of IPV, she continues, noting that the many myths that cloak abuse may keep victims away from the help they so desperately need.

"The situation in Slovakia is similar to other countries in the region. People tend to believe that family problems should stay in the family, not be aired in public. Prevailing attitudes also place blame for the abuse on the victim—she must have done something to provoke it. Even the women themselves often think they deserve such treatment, that it is normal," the 22-year-old Konecna explains, her eyes flashing angrily as she dismisses these age-old myths as the nonsense they are. "Things are slowly starting to change, though, because we are starting to get more and more calls from friends, family, and neighbors of women who are being abused. They all want to know what they can do to help."

Established in 1998 by AIHA's Petrzalka/Kansas City partners to provide assistance to women who are victims of IPV, as well as support services for their children, Hope Center has approximately 300 women each year who come in for counseling or other services at least three times. The hotline operated by Center staff gets nearly 800 calls annually—not just from Petrzalka, a sprawling concrete jungle just across the Danube from Braltislava, but from all over the country. "We have a total of 30 volunteers; half of that number come in at least once a week," Konecna explains, noting that in addition to counselors and psychology students from local universities, other volunteers include healthcare workers, legal professionals, and teachers.

"We offer social, legal, and psychological counseling, as well as a self-help group that meets twice each month and, although we don't yet have a crisis center of our own, we do cooperate with other groups throughout the area that have secret houses that provide shelter to women in critical situations," Konecna states. "We often help our clients find permanent housing and try to place them in jobs if need be, so they can be more self-sufficient."

Because so many victims of abuse have grown used to the indifferent—or even hostile—attitudes of family, healthcare professionals, police, and others they may have turned to for help, they are often surprised to find people willing to do whatever it takes to get them away from their abuser, Konecna says. "An abused woman is so confused and alone. The abusive partner works hard to cut her off from people who could help, and her feelings of shame and worthlessness further isolate her. But, by the time she calls or comes into the Center, she has already begun to question her situation. She is curious about whether the violence is normal and wants to know what her options are."

This little crack in the brittle wall that victims of IPV erect around themselves is what Konecna and her colleagues at Hope Center need. It is how they gain the access necessary to make these women realize that their situation is anything but normal. "Of course, each woman is different, but they all want to find their way out of the cycle of violence. We work with them, attempting to make them see that men who are abusive seldom change. Through a combination of individual and group therapy sessions, we try to make them see that other women have gone through similar circumstances and survived," she says.

Even with all of the counseling and support available at the Center, about 10 percent of the women they see wind up going back to their abusers. "Many women think that even an abusive man is better than no man at all, so it can be a struggle to build up what IPV has stripped away. That's why I feel good when I am able to help someone like Tamara," Konecna concludes. "She survived so much and still has such a kind, good heart. It's not an easy thing for her to cut herself off from the man who abused her; she still loves him. But, now she loves herself more and that is the first step."

SUCCESS STORY: *Kosice's Perinatal Mortality Declines in Response to Regional Efforts*
(Adapted from an article by Stefan Lukacin, Ican Fric, Katarina Studena, and David Gagnon, *CommonHealth*, Fall 1999)

From 1995-1999, healthcare professionals in Kosice, Slovakia and Providence, Rhode Island worked together to implement new models of perinatal education, delivery system reform, and technology transfer within obstetrical and high-risk neonatal care settings in Eastern Slovakia. Their combined efforts have resulted in dramatic improvements in maternal and child health reflected in a significant decline of perinatal mortality rates for low birth-weight infants in Kosice. One direct cause of this decline is the partnership's emphasis on identifying at-risk infants and mothers and transferring them to regional perinatal centers for appropriate care.

Before 1995, the survival of babies born in Eastern Slovakia to high-risk pregnant mothers largely depended upon where the birth took place. AIHA's Providence/Kosice partnership changed that.

In recent years, Eastern Slovakia, which has a population of over 15 million, has experienced a birth rate decline. In 1995, there were 21,038 obstetrical deliveries performed in the region. That number dropped three percent in 1997 to 20,497. A corresponding decline in abortions accompanied this trend, the most dramatic being a decline in pregnancy terminations between the 8th and 12th weeks after conception. This overall decline reflects a growing shift from larger (four to five children) to smaller (one to two children) families as women continue to postpone their first pregnancies. Slovakia's continuing economic transformation represents increased financial hardships for larger families, contributing to the decision of many to have fewer children. But in spite of this decline in Eastern Slovakia's birth rate, the number of high-risk births continues

to increase, resulting in perinatal mortality rates as high as 14.1 per every 1,000 births in Trebisov and 10.2 per every 1,000 births in Michalovce.

Two specific groups represent a large portion of Eastern Slovakia's high-risk pregnancies: single mothers and Roma (Gypsies). In 1995, the percentage of low birth-weight babies born to single mothers was 11.2 percent, a significantly higher rate than the 7.9 percent typical of the general population. While Roma constitute 20 percent of the population of this region, they experience a low birth-weight rate nearly twice that of the general population. Since low birth-weight rate is related to mortality risk, both Roma and single mothers have correspondingly higher infant mortality rates.

However, regions of Eastern Slovakia affected by the Providence/Kosice initiative that introduced perinatal regional care by transferring both infants and high-risk mothers to Slovakian-designated perinatal centers have greatly increased the survival rate of low birth-weight babies. Transfers to Kosice's First Clinic of Gynecology and Obstetrics (FCGO) and the Department of Neonatology at the Faculty Hospital, as well as to the regional partner hospitals of the Second Clinic of Gynecology and the Louis Pasteur Hospital, have been highly beneficial to the health of both mother and child.

The city of Kosice has one of the lowest perinatal mortality rates despite the high percentage (10.6 precent) of low birth-weight infants delivered at FCGO. Since FCGO serves as the regional perinatal center, it is responsible for an increasing number of low birth-weight infants. The other hospitals show a corresponding decline in both low birth-weight infants and perinatal mortality as a result of transferring high-risk pregnant patients to the perinatal center. This reflects the outcomes of an effective regionalization of perinatal care.

Similar declines in perinatal mortality have also occurred in areas where the partnership successfully implemented the principles of regionalization, including the cities of Michalovce, Roznava and Gelnica. In addition to establishing lines of communication and means of transport for moving high-risk mothers and infants, the Providence/Kosice perinatal program focused on improving clinical care at the perinatal center and providing training for resuscitating, stabilizing and transporting at-risk infants after birth.

Partner Profile *Stanislav Bernat*

When Martin's *healthy communities* partnership with Cleveland started in 1997, Mayor Stanislav Bernát and his colleagues were deeply immersed in dealing with the social problems that had developed in this Slovakian city as a result of political changes that occurred in 1989 after the fall of the communist regime. The town's once heavily active defense industry, building weapons for the armies of the Warsaw Pact, had suddenly dried up, leaving a large percentage of the citizens unemployed.

The partnership had piqued Bernát's interest immediately, particularly because it accurately identified a number of problems facing the municipality. Bernát eventually became coordinator for the Martin side of the partnership. In this role, he worked to bring together various stakeholders who had an interest in improving the quality of life in Martin.

"To improve the life of the city we had to start thinking differently and using new tools," said Bernát. "Using ice-hockey terminology, we had good players but we needed new and better hockey-sticks. The 'players' were especially outstanding medical specialists from the Martin Medical Faculty, its Faculty Hospital and research departments."

As a result of the partnership, the partners in Martin were able to create an interdisciplinary team including people from the local government and the mayor's office, doctors and nurses of various specialties, teachers and even youth and schoolchildren. Despite the fact that each group approached problems differently, they were able to put aside differences and share similar goals and work together to find solutions that would lead to a better quality of life in the city.

In particular, the partnership was able to have a significant impact on the health of the nation by establishing the Center for the Promotion of Non-Smoking in Martin. By the end of the partnership, the number of smokers in the country decreased by 7%, and the Center continues its work to this day.

According to Bernát, the community itself has changed considerably thanks to the partnership, and although unemployment is still an issue, the rate is now under the Slovakian average and its impact feels less severe.

"People got courage to surmount their provincialism fostered by the communist regime and are open to participate in other international projects," said Bernát. "The world became smaller and we have sort of grown up. For instance, in 1997 Martin joined the WHO Healthy Cities Network and established an Office for Health. It became so successful in organizing health-promoting activities that since 2005 the Association of the Slovak Healthy Cities has its center in Martin."

Bernát states that the partnership has had a lasting impact on his work- and problem-solving style as well, and his way of dealing with people both personally and professionally. "I prefer activity and high-quality results," said Bernát. "Writing projects is becoming a national sport, but they are often purposeless and don't build on people's responsibility. The Americans from MetroHealth arrived, made some proposals and we all started to work. The individual activities were always well prepared, perfectly organized, financially covered and regularly controlled. America also strengthened my conviction that politicians should serve the citizens. Now I attempt to act this way in my everyday work and personal life."

The partnership also helped Bernát recognize the importance of personal accountability, particularly when it comes to one's health, and the need to promote this concept further in his country.

"Healthcare starts with prevention which is not only the government's task but the duty of each of us," said Bernát. "Nature is the largest gymnasium and we must plan there our timetable. Even in the most advanced countries health and social care is not able to cope with all tasks. Therefore we all must help the system and ourselves."

Currently, there are several community projects being implemented in Martin and the Office for Health serves as a bridge, connecting the mayor's office with the citizens, mediating their problems and soliciting their ideas.

This collaboration fosters better cooperation amongst the city's social and healthcare institutions and the professional commissions of the local government. The city's 2006 healthcare and social budget currently stands at 21 million Slovak Crowns (less than $1 million), but city leaders are seeking additional support from various foundations and agencies, both Slovak and international, to fund more city improvement projects.

Partner Profile — *Peter Krcho*

Dr. Peter Krcho remembers when his American partners from Rhode Island first visited Faculty Hospital in Kosice, Slovakia in August 1995. At the time, the Kosice region in eastern Slovakia had the largest number of premature births, low birth weight deliveries, and high-risk births in the entire country, as well as a high infant mortality rate. The US partners saw the challenges in improving neonatal and perinatal care at the hospital, but also decided that the hospital's NICU had a sound existing structure that they could work with to help improve the existing level of care.

Krcho also saw other opportunities that the partnership could provide — in particular the role enhanced communications could play in the effectiveness of the partnership as well as the operations of the NICU.

"While traveling to the US was important for us, the implementation of activities which needed to take place between trips was very hard," explains Krcho.

Therefore, he coordinated the AIHA-supported videoconferencing initiative, which linked the Slovak and US partners for this first time through this technology.

The partners would meet via videoconference for two hours each month to discuss progress and problems. This allowed the US partners to provide frequent guidance as Krcho and his colleagues were implementing changes to the NICU.

Krcho describes himself as "a simple doctor" when the partnership first started in 1995, and now has moved forward in his career, currently as director of the NICU and neonatal department in Kosice. Dr. Krcho is known as a leading Slovak expert in neonatal resuscitation, and is on the executive committees of national societies of pediatric intensive care and neonatology.

Krcho continues to utilize the experience and resources gained from the partnership to support his work today. The communication and technology tools and concepts introduced during the partnership allow Krcho to effectively collect and analyze data, and create graphic charts and presentations to help his colleagues and others better understand the issues being addressed, both at the hospital and at a national level.

The partnership also helped turn Krcho's love of photography into a powerful tool for documenting cases, getting more useful consultation and advice, and sharing the story of his department's successes and continued challenges with a wider audience.

"AIHA provided us with our first digital camera, which we still use today," says Krcho. Krcho is able to send digital pictures of difficult cases to his US partners and experts elsewhere, and he displays pictures he takes of successful cases in the hospital and in public.

Krcho explains, "Before I would send an e-mail describing a case; but now I can also attach a photo of the baby, x-rays and ultrasounds when I am asking for advice."

In addition, according to Krcho, seeing a picture of a premature baby weighing less than 500 grams at birth, for example, and another picture of that same baby as a healthy growing young boy sends a powerful message.

"People really see our cases if they can see them directly in pictures, and they are more sensitive to that," says Krcho.

With the help of his US partners, Krcho had an opportunity to display his photography at an exhibition in Providence, Rhode Island. Now these photos adorn a wall at AIHA headquarters documenting some of the most dramatic examples of the achievements of the partnership.

Partner Profile — *Wendy Guida*

In 1996, the National Perinatal Information Center (NPIC) won a grant from AIHA to participate in a partnership in Slovakia. At the time, Wendy Guida was working as a part-time business manager for NPIC, and initially, she provided logistical support to the partnership, organizing exchanges between Slovakia and Providence. Over time, however, she got more involved, eventually traveling to Slovakia for the first time in 1998 to give a presentation on hospital budgeting. As an accountant and business manager, Guida did not have many opportunities to speak in public and struggled to deliver the lecture. "I really wanted to crawl under the table," she recalls.

That first trip to Slovakia was very trying for Guida, but she would learn and grow from this and many other partnership experiences. Supporting the partnership in Slovakia sparked Guida's interest in international development, giving her an opportunity to try a different kind of work that she had not imagined doing before.

Guida continues: "Having lived my entire life in Rhode Island, marrying my high school sweetheart and raising my children in the community where I grew up, I was not very worldly or culturally aware. Working in Slovakia opened up a whole new world for me."

When NPIC later embarked on a second partnership in Albania, Guida was able to play a greater role and further refine her skills. She learned to create more effective and meaningful exchanges for foreign visitors to the US and began to feel more engaged in the work of the partnership.

"My role began to move from a support function to a decision-making function," explains Guida. By helping to identify and resolve difficult issues and suggesting creative ways to more effectively train and educate the CEE partners, Wendy gained the respect of her colleagues and trust of her superiors to play a more direct role in the partnership.

Today Guida plays a leading role as coordinator for NPIC's current partnership addressing HIV/AIDS in Russia. Through this work, she has had an opportunity to develop a whole new set of skills, and gained an international perspective which allows her to analyze a situation and find the opportunities for change and improvements, and as a result, help improve the lives of those living with HIV/AIDS in Russia.

III. REGIONAL & CROSS-CUTTING OUTCOMES

This section provides an overview of the results of AIHA's CEE program, organized by the main areas of impact across countries and individual partnerships and projects. It provides a different perspective from the country-specific descriptions and seeks to capture outcomes in terms of the key areas of contributions made by AIHA's program in: healthcare delivery and services; leadership and healthcare management; nursing; women's wellness; educational capacity for health management; community mobilization; access to health information and communications; knowledge transfer, dissemination and networking; and US partner impact. Many of these areas represent common approaches taken by AIHA to address key issues across multiple partnerships, such as with the health management education and healthy communities partnerships, or where partnership-level priorities were supplemented by special AIHA initiatives such as in nursing and management/leadership training. For further details, please refer to the country summaries.

III.A. HEALTHCARE DELIVERY & SERVICES

BACKGROUND

"*If they [policymakers of the CEE and NIS] are to bring about the changes in health care delivery that will meet the complex needs of patients, they face four main dilemmas. They must improve the performance of hospitals, restructure health care facilities, shift the boundaries between primary, secondary, and tertiary care, and strengthen and modernize primary care.*"
– Figueras, et.al., *Health Systems in Transition*, *WHO, 2004*

After the collapse of the Soviet Union and communist bloc countries, the centrally-planned healthcare systems in these countries were dominated by hospitals, with primary care and prevention undervalued by both clinicians and citizens. RTI summarized the deteriorating conditions in their 2006 evaluation of AIHA's programs: "Medical professionals were isolated; medical education was not grounded in modern science; and medical practice was decades behind the Western developed world. Health status was declining, and death rates from non-communicable disease were among the highest in the world and growing. In addition, health services had long been under-funded; medical professionals were demoralized by low wages; facilities and equipment were antiquated; and pharmaceutical supplies were limited. Patients endured poor quality care, non-existent social services, complete lack of privacy and other indignities."

When AIHA became involved in the countries of Central and Eastern Europe in 1994, it was evident that the hospitals needed improved infrastructure, the clinicians required exposure to Western healthcare innovations, and the leadership needed updated management skills. Among the priorities facing the CEE countries were the need to reduce the number of hospital beds and decrease hospital lengths of stay; to update the clinical skills of healthcare professionals; and to reorganize staffing and clinical services. Clinical areas of priority included chronic diseases, pediatrics and neonatology, obstetrics and gynecology, emergency medicine, and surgery; outpatient services and patient education were also seen as areas needing strengthening.

By the late-1990s, countries in the region had increasingly recognized the need to shift focus from the highly centralized treatment by specialists to a primary care-based system that included the development of family medicine practitioners.

PROGRAM STRATEGY

In support of reform efforts to improve the quality of care and delivery of services while managing costs and increasing efficiency, partnerships between health care institutions formed the core of AIHA's CEE program. These institutions were initially hospitals, as countries in the region were relying largely on a hospital-centered system that consumed the largest amounts of national healthcare resources. At the same time, increased attention by national healthcare leaders and WHO to the importance of addressing the entire continuum of care–from primary care to home care– made it essential that partnerships encompass the different levels of health care, including disease prevention, health promotion, and public health.

AIHA's nine hospital partnerships were formed between 1994 and 1996 and, on average, were funded for three years. While the partnerships were free to identify their areas of focus based on local priorities, they had a common overarching goal of modernizing clinical practice in the CEE partner institutions through peer-to-peer technical assistance and training. In general, the individual partnerships identified the following objectives and integrated them into the focus of their workplans:

- Enhancing professional knowledge and skills of medical staff;
- Introducing and promoting evidence-based medicine;
- Instituting continuous quality improvement methodology;
- Elevating the status and role of nurses;

- Improving hospital management and administration;
- Improving hospital infection control practices;
- Reducing lengths of hospital stays; and
- Developing a clinical care team approach.

Beginning in 1999, under the new cooperative agreement from USAID, AIHA shifted emphasis from hospital-based healthcare services to primary healthcare, reflecting the changed priorities in the region. While the majority of PHC partnerships were established in the NIS, USAID missions in Albania and Kosovo, both in 2001, requested AIHA to apply its partnership methodology to improving PHC in targeted communities.

KEY RESULTS

"Hospital partnerships set in motion a series of changes at the human and institutional levels that have had lasting impact. Dedicated CEE clinicians working with U.S. partners have led their colleagues and institutions to adopt modern clinical practices guided by the latest published research which has greatly improved the quality of patient care. In the years since USAID/AIHA support ended, the CEE partners' advancement has been limited only by their imagination and their financial resources. In general, they have continued to focus on new approaches to health care delivery and the organization of hospital systems to improve the quality of care." – RTI, 2006

This summary provides an overview of results of the nine hospital partnerships as a whole (please see country summaries for details of each of the partnerships), highlighting achievements in clinical care and services. Related achievements that are more attributable to administrative/management changes are discussed in section III.B of this report.

The results are grouped into five main categories: 1) increased knowledge and skills of healthcare professionals; 2) new and improved services; 3) infection control; 4) improved continuum of care; and 5) regional and national-level impact.

The nine hospital partnerships addressed a number of healthcare service issues, as the chart below shows:

Hospital Partnerships	Infection Control	Chronic/NC Diseases	Peds. & Neonatology	Ob/Gyn	Pt. services & educ.	Outpatient Services	Emergency Medicine	Hospice/Palliative	Surgery/Critical Care	Gerontology	Home Care	Pulmonary Medicine
Tirana, Albania /Grand Rapids, MI	■		■	■	■		■					
Tuzla, Bosnia /Buffalo, NY	■	■	■	■	■	■			■			
Zadar, Croatia /Franciscan	■	■			■				■	■		
Zagreb, Croatia /Lebanon, NH	■	■	■	■		■			■			■
Tallinn, Estonia /Washington, DC				■	■	■	■				■	
Vac, Hungary /Winston-Salem, NC		■			■	■	■	■	■		■	
Riga, Latvia /St. Louis, MO	■	■	■	■		■		■		■		
Cluj, Romania /Philadelphia, PA		■				■						■
Kosice, Slovakia / Providence, RI	■		■	■								

- ***Increased Knowledge and Skills of Healthcare Professionals***

As a result of the partnership program, thousands of CEE doctors, nurses, and other healthcare professionals received training through voluntary, peer-to-peer exchanges and other programmatic activities. The interaction with their counterparts in the United States and other countries in the region, as well as their exposure to new ideas and ways of approaching the provision of care, enabled these professionals to rethink their roles as healthcare providers and become educators and agents of change at their institutions and in their communities. The increased skills and knowledge gained by the health practitioners in specific clinical areas translated into immediate benefits for patients.

Among the nearly 15 different clinical areas of training addressed by the partnerships are:

- The Providence, RI partners provided training on specimen identification, processing, and screening for staff at the cervical cancer screening cytology/pathology laboratory opened in Tirana, Albania.
- Physicians and nurses in Tuzla, Bosnia received 250 hours of bedside and intra-operative training in pediatric surgery, and pediatric surgeons were exposed to over 600 major surgical procedures during their training in Buffalo, NY.
- Partners from the Franciscan Health System provided training for partners in Zadar, Croatia in group therapy for children suffering from Post Traumatic Stress Disorder (PTSD).
- Physicians in Bosnia, Croatia, and Estonia learned about laparoscopic techniques.
- The Winston-Salem, NC partners provided training for 40 Hungarian physicians and nurses from Vác Municipal Hospital and family practices in diabetes education and care.
- In Latvia, the St. Louis partners helped doctors from Maternity Hospital improve their skills in risk assessment which led to more c-sections and decreased the mortality rate among newborns.
- Also in Latvia, partners at Children's Hospital pioneered a new subspecialty in microbiology and became actively involved in the education and accreditation of pediatricians.
- Partners in Cluj, Romania were trained in techniques of occupational risk assessment and management, and air monitoring.
- Staff at Kosice Faculty Hospital in Slovakia received training in perinatal, neonatal, pediatric and gynecological medicine.

Not only did individual healthcare professionals gain new skills; in several instances, entirely new specialties were created as a result of partnership work, such as in health management, emergency medicine, hospice, palliative care, home care, occupational health, nurse educator, and infection control nurse, among others.

For example, hospitals in Zagreb, Croatia implemented continuing medical education for physicians and nurses. In Zagreb and Cluj, Romania partners reported that they improved patient care by organizing clinical care teams. In Kosice, Slovakia and Zadar, Croatia, partners adopted modern infection-control practices from U.S. partners.

- ***Introduction of New/Improved Clinical Care and Services***

Both by applying new or improved clinical skills as well as by applying newly learned approaches to evidence-based medicine and to organizing services, each CEE hospital partner institution increased its capacity provide care in a number of clinical areas, including neonatology and pediatrics, obstetrics and gynecology, chronic diseases, emergency medicine, surgery, hospice and palliative care, and outpatient services.

Neonatology and Pediatrics: Improved care for children, from the earliest premature infants to adolescents was a focus of five partnerships in Bosnia, Croatia, Estonia, Latvia, and Slovakia. Neonatal programs focused on improvement of hospital infrastructure, increased training of medical professionals, as well as systematic changes such as the regionalization of care for high-risk pregnant women. Pediatric programs focused on improving surgical results, and emergency and intensive care. Examples include:

- The Faculty Hospital in Kosice, Slovakia, greatly improved perinatal health in eastern Slovakia by changing numerous clinical and operational procedures and initiating new regional referral services. In a three-year period, the perinatal mortality rate decreased from 19.1 to 5.15 percent at Kosice Faculty Hospital, and the regionalization of services helped decrease the rate in Eastern Slovakia from 14 to 10.9 percent.
- In Tuzla, Bosnia, the mortality rate for pediatric patients with anorectal malformations and diafermatic hernias decreased from 70 percent to 20 percent at the partner hospital during the partnership, and improvements in neonatal and perinatal care helped the hospital decrease its infant mortality rates from 23/1,000 live births in 1996 to 10/1,000 in 1998.

Obstetrics and Gynecology: Hospital partnerships in Albania, Croatia, Estonia, Latvia and Slovakia focused on the improvement of obstetric and gynecologic care. Maternity services often provided limited options. Fathers, for example, were not allowed to be present during labor and delivery, and newborns were usually not kept with their mothers. Partnership efforts focused on strengthening knowledge and skills of practitioners and improving inpatient and outpatient services for women. Examples include:

- Partners at Tallinn Central Hospital's Women's Clinic in Estonia introduced numerous new practices learned from their US partners, some of which were revolutionary, that improved patient care and satisfaction. The hospital introduced broader use of laparoscopy beyond just a diagnostic tool the hospital started to use it as an operating tool, both improving care and generating additional profits. The hospital allowed parents to handle still-born deliveries, after seeing in the US how showing the babies help the parents' healing process. The new method was very well received by parents who lost their babies and over time it became a routine approach in the clinic.
- Partners at the Maternity Hospital in Riga, Latvia introduced for the first time in the country intrauterine blood transfusions, a life-saving procedure. To this day, it is the only place in Latvia that offers this treatment. Use of ultrasound examinations also improved and expanded, and use of the Doppler ultrasound was introduced for testing fetal blood velocity and determining fetal anemia.

Chronic Diseases: As chronic diseases were and are among the leading causes of morbidity and mortality in the countries, partnerships targeted major chronic diseases such as cancer, cardiovascular disease, diabetes, asthma. Partners generally focused on improving diagnoses, improving inpatient and outpatient care and treatment, and increasing patient education and public awareness. Examples include:

- ***Oncology:*** The Vác/Winston-Salem partnership developed clinical practice guidelines for the treatment of breast and colon cancer, implemented a pain management program for cancer patients, and developed an internal cancer database to monitor treatment outcomes. The oncology department continues to treat outpatients and delivers chemotherapy and palliative care. In 2004, the unit treated 486 outpatients. The hospital now performs mammography screening for breast cancer and pre-operation diagnostic procedures for patents.
- ***Cardiology:*** The partnership with Buffalo helped the University Clinical Center in Tuzla, Bosnia become the leading hospital in the country in providing high-quality cardiac care. The Buffalo partners assisted their Bosnian counterparts in the establishment of a Cardiac Surgery Center in September 1998 which provides advanced treatment for heart attack and stroke patients. The hospital performed 100 diagnostic procedures in 1997; by 2004 UCCT was performing 1,800 procedures a year. The Cardiac Center conducted its first open heart surgery in 1998 and by 2003 and 2004, UCCT averaged 475 open-heart procedures a year.
- ***Asthma and TB:*** In Zagreb, Croatia, a comprehensive program for diagnosis and treatment of asthma and TB was introduced at "Srebrnjak" Children's Hospital for Respiratory Diseases. The partners developed appropriate patient education materials and assisted with the renovation of the physical space for treatment of patients with TB at Srebrnjak. An asthma camp to teach patients and families about prevention and treatment was opened in rural Croatia.

- ***Diabetes:*** In Hungary, the Vác partners established a model diabetes program including patient education, data collection and evaluation, training for family physicians and nurses, and a patient support group (or "club"). Patients learned to take responsibility for their own health, resulting in a decrease in hospital admissions. The percentage of diabetes patients in Vác who self-manage their condition increased from 40% before the partnership initiative to 80% at the end of the partnership. The number of patients receiving care at the diabetes unit at Vác Municipal Hospital increased dramatically, from 600 patients per year in 1996 to over 3,000 today.
- ***Post-traumatic stress disorder (PTSD):*** The Croatian partners increased the number of people receiving treatment for PTSD in the Zadar region. During the partnership, the number of children and adolescents in treatment increased to 50 and the number of adults in treatment increased to 45. Most of the adults receiving treatment were war veterans. At the initiative of the partners, approximately 250 children in two schools in Zadar were screened for PTSD. Before the partnership intervention, there was little recognition of the need to provide psychological services to veterans experiencing PTSD symptoms. However, over the course of the partnership, the need to provide individual, family, and group psychotherapy for veterans became very apparent. Zadar developed one of Croatia's most active programs for veterans experiencing PTSD.
- ***Renal disease:*** The renal teams at Sveti Duh General Hospital in Zagreb collaborated with their US partners to pioneer an innovative method to evaluate the functional health status of patients on dialysis, looking at ways to improve the quality of care for chronic renal patients. The study represented a breakthrough approach to enhance the daily lives of patients with chronic illness.

Emergency Medicine: When AIHA began working in the region, the specialty of emergency medicine did not exist, nor did any of the countries have a modern, coordinated and efficient emergency medical or disaster response service. Four partnerships addressed this area of emergency and disaster medicine - Albania, Estonia, Hungary, and Slovakia. The focus of efforts were on training paramedics and other first responders, training physicians and nurses, and reorganizing and modernizing hospital emergency rooms and departments. Examples include:

- Vác Municipal Hospital in Hungary established a comprehensive emergency services department, where the Emergency Department was reorganized with the combination of previously separate outpatient walk-in clinic and trauma services. Borrowing the design of its US partner institution in Winston-Salem, NC, the Vác Hospital built a state-of-the-art emergency department which includes a triage center and had essential emergency services (e.g., CAT Scan) in close proximity to the patient care areas. Also, a centralized transportation system was created to transport patients more efficiently. Other innovations included a shock-prevention/life-saving unit at the ambulance entrance, the immediate separation of infectious patients, a new operating theater with air conditioning, and overall better facilities for the doctors and nurses.
- In 1996, Mustamae Hospital in Tallinn, Estonia organized the very first Emergency Medicine Training Center (EMTC) in the country, providing training to paramedics, rescue teams, policemen, nurses and physicians from various parts of Estonia. Advanced Cardiac Life Support (ACLS) courses were given to hospital physicians and nurses for the first time. As a result, ambulance services provided by paramedics improved significantly and were often better than those delivered by health professionals. Mustamae Hospital also created the Emergency Medical Center (EMC) in 2004, a center consisting of an Intensive Care Unit (ICU), emergency room (ER) and a septical unit. Each day the Center takes care of approximately 250 patients.

Surgery: Many of the CEE hospital partnerships focused on improving general surgical techniques in the CEE institutions, helping them to provide better quality care in a number of areas. Some of these new techniques introduced also improved the efficiency of the hospital surgical wards. Examples include:

- Surgeons at the Orthopedic Hospital in Biograd, Croatia, were trained to perform arthroscopic knee surgery, allowing the hospital to provide treatment for patients who would have had to travel elsewhere for the procedure.

- Obstetricians/gynecologists in Zagreb, Croatia, were trained in laparoscopic surgical techniques, paving the way for other laparoscopic procedures throughout the surgery department. Replacing traditional surgical approaches with these less invasive techniques is known to significantly reduce the complication risk for surgical patients.
- In Tuzla, Bosnia, partners introduced laparoscopic surgery. UCCT performed more than 130 cholecystectomies with only minimal complications. Five Bosnian surgeons were trained in Buffalo in laparoscopy, and UCCT performed over 300 laparoscopic surgeries during the partnership.

Hospice and Palliative Care: Three partnerships in Hungary, Latvia, and Slovakia HC introduced hospice and palliative care. These were the first services of their kind in their respective countries. Examples include:

- One of the main accomplishments of the Riga, Latvia/St. Louis partnership was the development of hospice and palliative care programs in Bikur Holim and Children's hospitals. Prior to the partnership, a hospice was an "unheard-of" concept for the Latvian doctors who had a different philosophy regarding treatment of terminal patients. The hospice provides consultation for patients and family members and offers bereavement support. Between the years of 2003 and 2004, the number of palliative care patients has more than doubled largely because hospital doctors now understand need and refer their terminal patients to the hospice unit. The hospital and its supporters have also started the *Give a Dream* charity to fulfill the wishes of young, terminally ill patients. The palliative team from Children's Hospital has instituted innovative ideas to help sick children and their families. One of them is "sand therapy" during which children draw pictures in sand to help express their feelings during psychotherapy. "Memory days" bring together families of children who have died to help celebrate their lives and support each other during the time of mourning.
- Bikur Holim Hospital also introduced hospice and palliative care. Currently, the hospital provides such care to its elderly patients, including those with stroke, with chronic disease, and terminal patients (mostly cancer). Annually, the hospital provides hospice care to approximately 120 patients. The hospital continues to use equipment donated by St. Louis partners to assist in pain management. After training they implemented in the treatment regime new methods of pain control including epidural steroids injections, long-term epidurazation (morphine injections), and use of direct anesthetic agents. The new equipment and skills allowed the hospital to achieve good results in the treatment of geriatric patients with severe pain and to handle successfully a number of oncology malignancy cases.

Outpatient Services: CEE hospital partnerships introduced and/or improved the delivery of outpatient care in their institutions. These new services allowed patients to lessen the length of hospital stays or eliminate them altogether. This improved the level of patient satisfaction and decreased hospital costs. Examples include:

- With the guidance and assistance of the Winston-Salem partners, Vác Municipal Hospital introduced same-day surgery for certain less complicated procedures. New anesthesia "blocking" techniques were used instead of general anesthesia for surgeries, allowing patients to return home the day of surgery. The number of procedures carried out within 24 hours has increased in Vác, from 396 in 1998 to 479 in 2005. The Hungarian Health Insurance Fund now provides coverage for same-day surgeries, and Vác Municipal Hospital has made adjustments to meet the increased patient demand for these services. With more same-day surgeries performed, the hospital has lowered operating costs associated with patients having to stay at the hospital overnight.
- As part of the Cluj, Romania/Philadelphia, PA partnership, a new ambulatory service was established in the Clinic for Occupational Diseases in Cluj. The admittance policy was changed, so that after the screening tests, the patient is admitted or treated in the ambulatory service. The Clinic now involves a higher number of nurses and doctors in these ambulatory activities.

- ***Infection Control***

By working to stop the emergence of new infections, as well as the re-emergence of old ones, AIHA partners strived to improve healthcare practices in CEE. One potential breeding ground for infectious disease is in hospitals, where patients often transfer the microbes they are carrying to others. Discovering how hospital-acquired (nosocomial) infections are perpetuated by existing hospital procedures and obtaining support for implementing evidence-based infection control measures are the first steps to reducing such infections. Realizing the danger of patients becoming sicker from the spread of infections within the hospital, all the hospital partnerships addressed infection control. Many CEE partnerships adopted infection control practices and policies learned from their American counterparts. Activities focused on training hospital staff in infection control techniques, establishing infection control committees and protocols and guidelines, and reductions in nosocomial infection rates and resulting decrease in costs related both to hospital stays and to antibiotic use. Some examples:

- Partners in Riga, Latvia reported significant improvements in infection control practices in Children's Hospital and in the work of its microbiology laboratory. After partnership training, the laboratory introduced new testing methods for blood culture and enhanced its program of quality control. Children's Hospital was the first in Latvia to introduce standardized antibiotic resistance susceptibility testing which significantly improved the accuracy of testing results. The new testing guidelines were disseminated among other Latvian microbiologists and subsequently were applied nationally. Another important outcome of the partnership was the identification of the strain of salmonella that caused many problems in Latvia. Based on research results, St. Louis and Children's Hospital partners developed a set of guidelines for treatment of salmonella patients and patients with intestinal infections, which helped it to decrease the number of salmonella cases and salmonellosis.
- The improvement in infection control procedures resulted in a significant reduction of infections that had plagued the neonatal intensive care unit at the Kosice Faculty Hospital in Slovakia. The unit not only introduced preventive activities to reduce neonatal infections, but also created the means to identify the type of infection and, therefore, to more carefully identify the antibiotic to be used in the infection control. As a result, antibiotics of a lower generation and at less cost were able to maintain control over neonatal infections. The result was a significant cost savings of almost $9,000 USD in just one year. Finally, treatment protocols were introduced that have dramatically improved the care of infants in the neonatal unit over the past two years also resulting in a reduction of morbidity. Finally in the area of infection control, various protocols and procedures were used for hand washing, single use towel, liquid soaps and disinfections and also monitoring of infections within the pediatric ICU in Kosice. Although pre-partnership data are unavailable, the Perinatal Centre of Kosice Hospital documented a 70% reduction in nosocomial infections (from 29 in 1999 to 8 in 2004) over the past 5 years. Similarly, the pediatric intensive care unit at this site experienced a 40% reduction in mortality over the same period (from 8.4% in 2000 to 4.9% in 2003).

- ***Improved Continuum of Care***

The CEE hospitals learned to step outside their hospital walls to address broader health care needs of their communities, whether through health promotion and disease prevention activities, allying with family practitioners, or implementing targeted community-based interventions. They recognized that integrated efforts are necessary to achieve real and lasting changes in the health of the population. Their common goal was to develop cooperative relationships and integrate levels of services to achieve greater efficiencies, continuity and effectiveness of health care delivery. Examples include the following:

- ***Home care:*** Vác Municipal Hospital in Hungary successfully developed and implemented a home health care model unique in the country. An independent home care agency for the Vác region was opened in November 1996, utilizing nurses in conjunction with private practitioners and providing patient education, in close collaboration with the hospital. The hospital changed its operation guidelines, incorporated home care into its continuum of care, set criteria for home care treatment, and created the

position of Home Care Coordinator, who cooperates with the home care agency. The number of procedures the home care service is able to perform has increased because of the enhanced training for staff members. The Vác partners developed a financing mechanism for community home care, serving as a model to be replicated in other Hungarian communities via the National Health Insurance Fund. The partners developed clinical guidelines, instituted a system for nursing documentation, created a leaflet on patient rights, developed accreditation requirements, and created and utilized promotional materials for public relations. With the introduction of home care services fewer hospital admissions into the Emergency Department are made possible because of the new alternative of referring the patient to home care.

- ***Rehabilitation:*** Bukur Holim Hospital in Riga, Latvia reorganized their services to improve care for rehabilitation patients, based on processes and techniques they had seen in the US from the moment of hospitalization through outpatient care to home therapy. Latvian partners developed a rehabilitation system tailored to the hospital's needs and economic conditions, and contributed to a decrease in the average length of stay. Prior to the partnership Bikur Holim patients stayed in the hospital on average for 35 days, but currently the average length of hospitalization is18 days.
- ***Youth health:*** The Riga/St. Louis partnership created a community health project that drew on the expertise of the Riga partner hospitals while reaching out to communities outside the capital city in the community of Tukums. Educators, municipal police, national guards, Red Cross employees, and community health and medical workers were joined in a collaborative process to educate especially youth on how to improve their health and well-being. Although the project was not replicated in other communities as initially hoped and planned, it did result in … increased health-related initiatives involving students; greater awareness along youth of health-promoting behaviors; greater involvement and financial support of the City Municipality in the outreach projects.
- ***Public education and campaigns:*** Zadar General Hospital in Croatia used a public education campaign for the early detection of colon and breast cancer, which has proven very effective in increasing the public's knowledge and awareness of the disease. The Zadar partnership also reached out to the local community by sponsoring a joint cardiovascular and oncology health fair in April 1998. The public response was overwhelming affirming the need for more public educational offerings and cardiovascular screening.
- ***Workplace health:*** In Cluj, Romania, the partners worked in factories and other worksites in order to identify major sources of occupational environmental illnesses, implement hazard control programs, and monitor the health of workers to assess the effectiveness of interventions.

➢ *Impact at Regional and National Levels*

"The legacy of the program was found in the systems and organizational changes that were brought about through the work of the partnerships. For example, the clinical care teams at the Vác Municipal Hospital still serve as a viable model for the provision of coordinated patient care in several medical departments. In Kosice, Zagreb, Zadar, Vác and Cluj where the partnership led to an improvement in the status and role of the hospital nurses, the nurses continue to enjoy their elevated status today." – RTI, 2006

The hospital partnerships also generated changes and impact beyond the individual institutions and communities involved. Although in many cases, the partnerships did not initially set out to work at a broader level, the successful introduction of improvements at the partner institutions were either directly or indirectly replicated or scaled up for more systemic impact. The partnerships broke new ground with exciting, innovative initiatives that played a direct national role or served as models for replication at the national level. Examples include:

- The Kosice/Providence partnership established a regional referral system for obstetric and pediatric care in the face of continuing decentralization of control of health care delivery in Slovakia. The perinatal regionalization program was built along the lines of a similar program in Rhode Island. In just 2.5 years the impact on outcomes is equivalent to what occurred in the US over almost a decade and a half. Not only have the neonatologists from the Faculty Hospital reduced the infant mortality rates for Eastern

Slovakia area but they have also changed the way in which regionalization of perinatal care occurs in the entire country. A proposal was submitted and accepted by the Ministry of Health and recorded as a legislative edict to establish networks of care in Slovakia that are comparable to the levels of care used in the United States.

- Latvia's first fully-functioning hospice program at Bikum Holim Hospital, became a clinical training site and replication model for other hospice programs in the country. Doctors from the Bikur Holim hospital try to spread the hospice ideology among Latvian physicians and educate visiting students about hospice care. The directors of the hospital strive to legalize the status of hospices in Latvia by lobbying policymakers and talking to representatives of relevant ministries.
- The home care model developed in Vac in response to Hungary's nationally identified need to reduce the number of hospital beds and decrease hospital lengths of stay served as a demonstration project for other sites in the country with Ministry of Welfare support.
- As a result of the partners' efforts in Cluj, Romania, new national regulations were enacted establishing standards for workplace protection and a statute was adopted creating the medical specialty of occupational health. The partners raised awareness among policymakers of need to stop the hazard pay system, whereby workers receive additional pay to compensate for working under hazardous conditions.
- The Hungarian Ministry of Welfare incorporated Vác Municipal Hospital's diabetes patient education materials and procedures as official teaching instruments and will use them as educational tools in other hospitals throughout Hungary. The Ministry included the patient education materials prepared in Vác in a national program for primary care physicians on diabetes care follow-up. The Ministry has asked physicians and nurses from Vác to assist with training in hospitals around the country and with the dissemination of the materials.

III.B. LEADERSHIP & HEALTHCARE MANAGEMENT

BACKGROUND

The ability of health care institutions in Central and Eastern Europe (CEE) to provide adequate services to patients while managing the many changes taking place in the years following the collapse of the Soviet Union was severely hindered by the lack of effective managers. While it was crucial to begin developing graduate and post-graduate level educational programs to develop a cadre of skilled health administrators, the existing clinical and non-clinical staff in CEE hospitals and clinics also needed to learn important management skills and leadership concepts to meet the changing healthcare needs of their communities and to successfully adjust to rapid health reform.

When AIHA became involved in CEE, hospitals and clinics in the region needed to improve the management of services provided while more effectively utilizing scarce resources, both human and material. Since the centralized command and control management systems of the Communist era were being dismantled and more control over decision-making devolving to local policymakers and institutions, the influence of hospital and health clinic directors was becoming greater in influencing the success or failure of their institutions. Head physicians and nurses in hospital departments also started playing more important roles in the management of their institutions. By being introduced to modern management techniques and tools of quality improvement to address issues such as communications and teamwork, finance, pharmacy management, and human resource management; these healthcare managers could become more effective in leading their institutions forward.

PROGRAM STRATEGY

AIHA's strategy to address health care management needs in CEE was two-fold. AIHA conducted developmental activities in eight CEE countries designed to strengthen health management practice toward the end of improving management practice in health care organizations, and ultimately, the larger health sector. These activities involved the delivery of AIHA-sponsored workshops on various management-related topics for CEE partners, including the introduction to management "101" course.

In addition, AIHA worked with the partnerships in CEE to ensure that they also addressed management through their activities. Utilizing various methods and concepts such as continuous quality improvement and Clinical Microsystems, the US partners worked to introduce new management and leadership concepts and ideas to their CEE partners. By utilizing these concepts and ideas while implementing workplan activities, the partners were able to realize better outcomes in the clinical areas they were addressing while teaching important health management and leadership skills.

➢ *AIHA's Health Management Training Activities*

In the Fall of 1993, with the support of the Association of University Programs in Health Administration (AUPHA), AIHA began conducting a series of workshops for partners in Eurasia on various management topics. When AIHA began working in CEE in 1995, these workshops were offered for CEE partners as well. AUPHA assisted in the development of the curricula and provided faculty to provide the training. AIHA translated all workshop materials into the local language. Of the more than 10 different training topics offered through this collaboration between AIHA and AUPHA, three workshops were provided to CEE partners: Introduction to Management (101), a Training-of-Trainers (TOT) seminar, and Budgeting and Financial Management.

Introduction to Management ("Management 101"): The purpose of the workshop was to provide a broad overview of the conceptual and applied foundations of healthcare management. Managers in the CEE

needed practical management tools they could apply to improve the health care administered to their patients, as well as the financial health of their institutions. The intent of the workshop was to empower managers to go back into the workplace with pride in their profession and confidence in their ability to bring together their colleagues to make the tough decisions that could transform their institutions.

Six modules were developed for the Management 101 workshop, and their order was carefully determined to support the objectives of the workshop: Management and Leadership; Planning; Information Management with Application to Quality; Human Resources Management; Team Building, Communications, and Presentation Skills; and Financial Management.

The Management 101 workshop was offered in Albania (four times), Bosnia (three times), Croatia, Estonia, Latvia, Romania (two times, once for nurses), and Slovakia (two times, once for Healthy Communities partnerships).

Training-of-Trainers (TOT) Seminar: TOT workshops were conducted to train promising executives and educators who previously attended the basic management workshop. The TOT workshop developed a cadre of local trainers who could then serve as faculty for future in-country workshops. Topics covered during the TOT workshops included principles of adult learning, experimental learning techniques (such as case studies, role plays, and executive games), educational strategies, and the development of faculty talent. The TOT workshop was offered in Albania and Estonia.

Budgeting and Financial Management Workshop: This workshop stressed the importance of sound budgeting for optimum organizational performance and financial management. Topics covered techniques of budgeting, use of budgets for managing departmental performance and control, principles of budget development, and adjustments over time. The workshop assisted participants in adapting and developing modern techniques and commonly accepted practices in their own organizations. The budgeting and financial management workshop was offered in Estonia.

- ***Partnership Training in Health Management***

In addition to participating in AIHA-sponsored management workshops, the CEE partners were also exposed to management concepts and ideas through their specific partnership work. The US partners provided training in management-related topics during exchanges, and utilized important management concepts in the implementation of partnership activities, allowing the CEE partners to practice and refine the skills they learn during training in real life situations.

Management Concepts: Many AIHA partnerships in CEE provided training focusing on the issue of quality for hospital and primary care personnel. For example, the Winston-Salem partners conducted workshops and training in Continuous Quality Improvement (CQI), health management and leadership at Vác Municipal Hospital in Hungary for managers, nursing leaders, and financial staff management staff. In Kosovo, US partners at Dartmouth Medical School introduced a quality improvement approach called Clinical Microsystems in the implementation of their two partnerships in Gjilan and Gjakova municipalities, and Doctors of the World (DOW) stressed quality improvement by providing training in organizational development to Kosovars.

In addition to offering training programs focused specifically on management, the Buffalo partners took steps to teach management concepts to a broad array of staff at University Clinical Center of Tuzla (UCCT). All Tuzla partners who participated in exchanges to Buffalo underwent training in change management to help them maximize their learning process while in Buffalo and apply partnership-related changes upon their return to Tuzla. Participation in the Riga/Little Rock partnership gave the Latvian partners a new perspective on healthcare and training. During partnership exchanges, the Latvian partners learned about principles of teamwork, management and advertising, and how to develop vision and mission statements.

Teamwork: As part of the partnerships' focus on management, many AIHA partners focused on the concepts of teamwork and the use of teams to effectively implement new management practices. For example, the Zadar/Franciscan partnership forming multi-disciplinary teams consisting of physicians, nurses, and administrators at Zadar General Hospital and Orthopedic Hospital of Biograd.

Five performance improvement (PI) teams were developed through the Tirana/Grand Rapids partnership in order to teach the Albanian partners how they could work together with limited resources to improve the quality of services they provide. The US partners selected and trained Albanian PI trainers to coach new PI teams at their respective institutions, focusing on integrating the PI process throughout their institutions and sustaining the process after the partnership's end.

The partners Dartmouth Medical School worked with their partners in Kosovo to develop teams to address patient flow, staff training, community outreach and education, data collection, and other issues related to quality. Leadership groups in Gjakova and Gjilan were formed to coordinate all partnership activities.

Partnership Implementation: In order to reinforce the management concepts being shared by US partners during exchanges, many partnerships utilized those ideas in the development and implementation of partner programs. For example, the use of quality outcome measures was introduced in all three Zagreb/Lebanon partner institutions. Leadership training provided to the Croatian partners reinforced their ability to use quality management principles in their daily work. Methods were introduced to improve collaborative practice and resolve communication and decision-making among team members.

At the end of the management training provided to Bosnian partners participating in exchanges to Buffalo General Hospital, the Bosnian participants were expected to complete an improvement project upon their return to Tuzla. Each Bosnian partner completed an action plan laying out the objectives and activities for each individual project to be implemented at UCCT.

Similarly, the multi-disciplinary teams formed by the Zadar/Franciscan partnership were expected to initiate and successfully complete Quality Improvement projects in the Croatian partner institutions.

KEY RESULTS

The AIHA-sponsored management workshops and partnership-initiated management training and processes exposed many health professionals in CEE to a new way of thinking and provided the skills which allowed them to develop personally and professionally. These individual partners also played an instrumental role in instituting important changes in their institutions.

- ***Impact on Individual Partners***

Change in Individual Mindset: Partners throughout CEE realized that a new approach would be necessary to adjust to the changing realities of the post-Cold War environment. Attitudes changed regarding the role of the health care worker in the communities and countries in which they work. Instead of seeing their role as simply answering directives from superiors or a central policy-making authority, the CEE partners began to think about what changes they could make to improve their individual effectiveness, as well as the effectiveness of the departments and institutions in which they work. They began to see and think critically, to look at problems differently and find creative solutions, and be more collaborative and understand the value of teamwork.

"The most valuable result of the partnership program is surely the change in the behavior and attitudes of healthcare workers in all structures, to be more responsible for their particular job, to have better relationships and collaboration as part of a healthcare team. This led to significant improvement in the quality of work." – Tatiana Jeren, MD, *University Hospital for Infectious Diseases, Zagreb, Croatia (Zagreb/Lebanon, NH partnership)*

The change in mindset among CEE partners happened at a fortuitous time, with the CEE countries transitioning from a centralized system to one based on democratic principles and market-driven. As a partner from the Latvian Ministry of Health explained, "The project [Riga/St. Louis partnership] helped to change our post-Soviet type of thinking and let us work more freely."

A physician at the Infectious Disease Hospital in Zagreb explained to his US partner, "You didn't teach us how to do a lot of 'things'; you taught us how to think differently about our work. Now we will be able to use that on any project, not just the ones we are working on now." By changing the way that they thought about and approached issues, CEE partners were able to adjust and work more effectively in their local context. The US partner commented, "We helped them shape their problem-solving and their work. I found that to be a profound moment of understanding how true change can be implemented. They would continue to change based on what would work in their systems; we just gave them the thinking tools."

The AIHA partnerships and management training also changed attitudes among CEE partners about the role of donor funding and programs in assisting their institutions When Albania's Trauma Hospital began participating in a partnership with Bronx, New York, the hospital director thought that the Albanians only needed equipment and argued that USAID funds would be best spent on simply upgrading their medical technology. After several years of the partnership and participating in a series of leadership and management seminars organized by AIHA and the partners, this physician confessed in a lengthy and heartfelt letter to AIHA's executive director he that he had been "absolutely wrong" in his initial dismissal of the partnership. He apologized profusely for his negative attitude and said he now realized that "the new way of thinking my colleagues and I gained was far more important than money or any equipment we could have received from the US."

Personal Development: AIHA and partner-sponsored management training provided CEE partners with the knowledge, skills, and tools to enhance their performance at work. Many CEE partners have noted that they continue to use the techniques taught in the management 101 courses on such topics as adult learning, conflict resolution, communication, and priority-setting in their everyday work. The heads of leading CEE institutions use tips from the management 101 training manual to prepare workshops and presentations for colleagues, high-level managers, and ministry officials.

"Things I learned, like SWOT analysis and force field analysis, are things I still use today. I use very practical tips that I learned from this course, for example, how to behave in front of a classroom, which tools to use, and how to use them to get people's attention. It was really very practical. I used these skills as a midwife and in my current job." – Helin Raudkepp, *former midwife, Tallinn Central Hospital*

Many nurses in CEE who participated in the management training became more active in their institutions as well as in national nursing associations. By participating in management training activities, often times in the same workshops as physicians and administrators, they became integrated into a team oriented process and became more confident in contributing to the institutional changes taking place through the partnerships.

By changing individual mindset and providing important concepts and tools which CEE partners could apply in their everyday work, the AIHA and partner-sponsored management training also led to advancements in personal development. Many partners directly credit their participation in AIHA and partner management

training for advancements in their career, either by gaining promotions in their partner organizations or moving to influential positions in ministries, universities, or other institutions.

For example, one of the CEE partners was the chief physician at the Maternity Hospital in Riga, when the hospital began participating in a partnership with St. Louis. He emphasizes that the partnership was an important factor in his professional career because he learned from his American colleagues key management skills which he continues to use every day. In 1997 he began working for the Ministry of Welfare and in 2004 he became director of the Department of Public Health in the Ministry of Health in Latvia.

- ***Impact on Partner Institutions***

The management training provided by AIHA and the US partners contributed to a change in attitudes among individual CEE partners, providing them the tools to become more effective managers in their practice and more influential leaders in their institutions. Concurrently, the partnerships' focus on management and quality improvement processes also had a profound impact on the structure, management, and operation of the CEE partner institutions.

"[The US partners] understood how business works. I never thought that medicine can be a business. It was a completely different attitude toward medicine. Now, we think like business people." – Dr. Vaira Leimane, *TB Training Center, Riga, Latvia*

Cost Effectiveness: Encouraged by the management training by AIHA and the US partners, CEE partners started to pay more attention to cost efficiency. Many leaders of CEE institutions involved in the partnerships began to realize that in order to survive in the evolving market-oriented system, their hospitals and clinics would need to be run more like businesses with an eye to cutting costs and generating revenue while not sacrificing the quality of care. For example, in order to cut costs, Riga Maternity Hospital had to reduce the number of hospital staff to an optimum level. But the hospital also found other innovative and less painful ways to reduce costs. To reduce heating-related expenses (which previously consumed approximately 30 percent of the hospital budget), the partners replaced windows, installed regulators and built their own central heating generator. They also began outsourcing laundry which further saved costs.

At Vác Municipal Hospital in Hungary, the partners developed a set of "clinical paths" which detail exact responsibilities for hospital staff and a plan for testing and treating patients with specific pathologies during hospital stays. These paths have allowed the hospital to better anticipate costs associated with each patient. The hospital has increased staff efficiency by allowing hospital staff, particularly nurses, more independence to perform tests and therapy on their own, using the clinical paths as a guide. A decrease in average length of and an increase in outpatient visits also increase the cost effectiveness of the hospital.

The Zagreb/Lebanon partners developed ways to improve pharmacy management during the drug selection, ordering, and dispensing processes, and as a result the three Zagreb hospitals reported a 16 percent reduction in medication waste. Wards at Srebrnjak Children's Hospital for Respiratory Diseases realized a 35 percent reduction in hospital pharmacy costs, due to the introduction of unit dose dispensing and a program to control the use of high-cost antibiotics. An antibiotic monitoring system was developed and implemented at Sveti Duh General Hospital, which resulted in an estimated annual savings of approximately $260,000. The savings were realized primarily due to the more targeted use of effective antibiotics for particular organism strains.

Revenue Generation: In addition to cutting costs, CEE partner institutions began finding ways to increase revenue and generate profits for some of the innovative programs introduced during the partnerships. For example, the Training Center at Tallinn Central Hospital created its own training programs which are delivered not only to health providers from Tallinn Central but also to nurses and physicians from other

Estonian medical institutions. The training for external participants is offered for a fee and enables the center to generate a profit.

While in St. Louis, physicians from Riga Maternity Hospital learned how to generate revenue from internal and external sources. The hospital introduced paid services and individual contracts between patients and physicians/midwives which guarantee more attentive care and a relatively steady flow of income. The hospital started to offer private rooms for a fee, run its own cafeteria and rent commercial space for a maternity shop. The Latvian partners learned to be persistent and more effective in lobbying local government officials for additional funding. As a result, the hospital obtained funds from the City Council for renovation of the NICU, building a heating generator unit, changing windows, and renovating a conference room and working space for family physicians.

Changed Facility Operations: To increase the effectiveness of their facilities, CEE partners instituted changes in the way that hospitals and clinics operate, incorporating management ideas learned from the AIHA and the US partners and utilizing quality improvement processes. For example, the use of a dressing cart in the neurological unit was initiated at Zadar General Hospital in Croatia, which saved time previously used to gather equipment for dressing changes. In addition, the use of the cart supported the introduction of new treatment plans and protocols that were established. Other organizational changes brought on by partner efforts were the creation of a sub-acute geriatric unit at Biograd Orthopedic Hospital and an adult day care center in Sibenik.

Vác Municipal Hospital in Hungary instituted a patient discharge planning system which allows the hospital to make informed decisions on patient release, allowing patients to leave the hospital earlier than before, and thus cutting costs. Diabetic patients are now assigned to only one outpatient clinic and one hospital department, where previously they were treated in multiple departments in a less organized manner. With the guidance and assistance of the Winston-Salem partners, the hospital introduced same-day surgery for certain less complicated procedures. New anesthesia "blocking" techniques were used instead of general anesthesia, often allowing patients to return home the day of surgery. The Hungarian Health Insurance Fund now provides coverage for same-day surgeries, and the hospital has made adjustments to meet the increased patient demand for these services. With more same-day surgeries performed, the hospital has lowered operating costs associated with overnight patient stays.

Vác Municipal Hospital inaugurated an emergency department treatment area in April 1998, and the design and reorganization of the department was based on observations and training received at Novant Health. Advances incorporated into the new area included triage criteria development and implementation of the triage system; a method of providing information to the family and patients regarding their tests and treatment; and a centralized patient transportation system. Other innovations included the joining of trauma and internal medicine emergency departments, a shock-prevention/life-saving unit at the ambulance entrance, the immediate separation of infectious patients, and a new operating theater with air conditioning.

The Latvian partners gained new management skills from AIHA and the St. Louis partners which helped them introduce important changes. Following the American example, physicians at Bikur Holim Hospital more frequently discuss among themselves the results of treatment and talk about individual cases. In Riga Maternity Hospital, the partners instituted weekly meetings to discuss administrative and organizational issues, weekly conferences to provide clinicians with the opportunity to analyze cases, and weekly meetings for housekeepers and engineers. Riga Maternity Hospital also introduced daily meetings for medical staff, chiefs of departments and duty staff. Following the recommendations of the St. Louis partners, all three hospitals improved their security systems. Children's Hospital, for example, introduced checkpoints at the entrance and exit of the hospital, and Maternity Hospital hired two security guards.

Utilizing the Clinical Microsystems approach to quality improvement, Kosovar partners in Gjakova and Gjilan implemented changes at their primary care facilities, including the development of staffing schedules,

installation of necessary equipment and supplies, and determination of the area where care will be provided, with patient flow and other quality issues in mind.

Organizational Development: In addition to implementing changes in the way clinical care is organized and delivered, CEE partners realized that their institutions also needed to evolve and grow to be able to manage change. Also, new institutions established through AIHA partnerships and projects were able to utilize the management concepts learned to grow and sustain their early activities.

A new management practice implemented in Estonia was the introduction of an orientation program for new employees. Initially, the new orientation routine was introduced only in the nursing department of Tallinn Central, but in 2005 it was replicated across the hospital. Currently all new employees have to participate in an orientation meeting with a human resources manager and receive an information booklet about the hospital and a list of expectations for the first four months. After that time frame, new employees are required to complete an evaluation form in which they suggest areas for improvement to the training program.

Vác Municipal Hospital introduced a system of supervising nurses that included a nursing supervisor (a separate position) who was hired to direct the professional activities of all nurses, help them resolve any human resource and professional issues, and manage the training of new staff members, as well as conduct continuous nurse training. In addition, documentation by nurses has improved, and nursing techniques have become more consistent with the introduction of clinical guidelines. The supervising nurse plays a leading role in the development and elaboration of these guidelines.

After Doctors of the World (DOW) administered two one-day workshops on holistic care, the staff of the planned Gjilan and Prizren Women's Wellness Centers (WWCs) wrote mission statements and created a patient charter. When the WWCs opened, the mission statements were placed at the entrance of each WWC for all staff, patients and visitors. Each WWC developed a patient charter and printed it as a small booklet to educate women clients on their rights as patients. These documents help the WWC staff understand their role and build better relationships with new patients from the moment they enter the center for the first time.

Many CEE partner institutions created occupation-specific and intra-hospital committees to address a number of organizational issues. For example, at University Clinical Center in Tuzla the Bosnian partners established nursing committees, which are charged with developing policies, procedures, and standards of care at the hospital. The committee system was used to develop an IV therapy policy for pediatrics.

Change in Staff Roles: CEE partners applied the management and leadership concepts learned to change the roles and responsibilities of hospital and clinic staff, in order to increase overall productivity and effectiveness. In Zagreb, Croatia, the role of the respiratory therapist, as a member of the critical care team, was recognized and strengthened, and critical care units created nursing-doctor collaborative management teams. As a result of the Zadar/Franciscan partnership, the status of nurses at Zadar General Hospital and Orthopedic Hospital of Biograd changed. Nurses began to be seen as a vital part of the medical team, and two hospital departments added the position of nursing assistant.

At Tallinn Central Hospital in Estonia, nurses obtained permission from the hospital doctors to take patient histories, a responsibility formerly given only to physicians. In both Tallinn Central and Mustamae, nurses started to substitute for physicians in explaining surgical procedures to patients. Notably, the perception of nurses among hospital patients improved as well, and many diabetic, rheumatologic and oncological patients began to turn more frequently to nurses for assistance.

Nurses from Tallinn Central Hospital used their management knowledge to prepare nursing budgets, manage nursing salaries, bonuses and vacancies, and revise existing guidelines of patient care. And nurses form Mustamae Hospital gained more financial responsibilities that included the ordering of drugs and supplies. In addition, management training gave nurses the very first opportunity to work on the same projects with

physicians. Tellingly, unlike in the past, doctors are no longer supervising nurses. Instead, similar to the American system, the partnership hospitals introduced the position of a nurse director who leads a nursing department.

Thanks to the partnership, the role and responsibilities of midwives in Women's Hospital has also significantly grown. The Estonian partners developed a new job description for midwives that included independent prenatal care treatment and trained them in observing and handling normal pregnancy cases and in-patient counseling. These new competencies allowed midwives to take responsibility for their own patients. Another revolutionary change introduced by the Women's Clinic partners was upgrading the role of midwives in both the hospital and outpatient clinic. Inspired by the example of the Bethesda Birth Center, the Estonian partners trained their midwives to autonomously handle patients during normal deliveries, provide outpatient care and counseling, and deliver educational classes to future parents. The Women's Clinic is the only place in the entire country that allows such independence to midwives.

Nurses at several of the family medicine centers in Gjilan, Kosovo instituted "nurse-only" patient education visits to follow some of the hypertensive (and other chronic disease) patients. These visits — documented in logs specifically created for this purpose — were periodically reviewed by nursing supervisors in FMC-wide nursing meetings. In a survey of Gjilan MFMC staff conducted in 2003, 75 percent agreed and 25 percent partially agreed that the new role of nurses at the MFMC was having a positive effect at the center.

Patient Focus/Customer Satisfaction: Another important concept shared with CEE partners during the AIHA-sponsored management workshops and interactions with US partners was the idea that the patient is a customer. CEE health institutions and their staff were traditionally not welcoming places for patients to visit. By treating patients more as customers and making their satisfaction a priority, the CEE partners were able to improve the delivery of services, increase the demand for services, and improve relations with patients and the general public.

The partners from Mustamae Hospital in Estonia translated their new management competencies into the creation of a modern customer service department that has expanded seven-fold during a five-year period (from 12 employees in 2000 to 84 in 2005, after the merge of eight hospitals). The customer service manager, who participated in partnership exchanges, initiated a number of improvements observed during a trip to the US. One important change was the introduction of a job rotation system that increased the efficiency of the front desk. The partners set up an "open" registration desk in the hospital's entrance and dressed registration personnel in uniforms. In addition, the hospital installed an electronic queuing system to reduce waiting time and improve patient satisfaction, and all hospital staff began to wear nametags with pictures.

A number of institutions instituted regular use of patient surveys, not only to measure customer satisfaction with the health services being rendered, but to use as a continuous quality improvement tool in making improvements to meet patient needs. Srebrnjak Children's Hospital in Zagreb, Croatia improved visiting hours in response to patient surveys. Nurses from Tallinn Central Hospital in Estonia implemented a patient satisfaction survey which helps them to identify problems and improve nursing services. The partners in Vác, Hungary developed a patient survey to track customer satisfaction and ensure quality of care and family physicians now keep better patient records. The Vác partners have taken steps to improve patient customer service levels. Through training and promoting patient care as a service, the staff now takes personal responsibility in caring for the patient. Patient satisfaction surveys help track results.

The director of Maternity Hospital No. 1 in Tirana in Albania instituted patient satisfaction surveys, and the results showed patient frustration with having to make "under-the-table" payments in order to receive quality care. This issue became a priority at the Women's Wellness Center (WWC) which opened on the campus of the Maternity Hospital and was staffed by physicians and nurses from the hospital. Patients visiting the WWC reacted positively to the publicly posted price list and policy that WWC staff would not ask for nor accept these informal payments.

In 2003, the Gjilan Main Family Medicine Center administered surveys to track patient satisfaction before and after the partnership intervention. Based on patient satisfaction surveys conducted by the partners, the percentage of patients reporting satisfaction with the registration desk at the MFMC increased from 60 percent in March 2003 to 87 percent in October 2003 According to subsequent surveys, patients continue to be satisfied with the quality of care offered. (A report by the local television station in Gjilan echoed these sentiments.)

Patient Records: The CEE partners focused on the development of more efficient record-keeping systems and procedures, which in many cases had not previously existed. For example, the Bronx, NY partners helped the partner hospitals in Tirana, Albania develop revised medical records for hospitalized patients with diabetes.

The Vác partners developed an internal cancer database to monitor treatment outcomes. The need for such a database was not determined until the partners began to assess how information was currently being monitored, and without the database, it would have been difficult to know the impact of changes in the treatment of the cancer patient. The database allows the Hungarian partners to keep better patient records.

Patient satisfaction at the Estonian partner hospitals improved after the introduction of the ESTER system, an electronic medical record system for patients which the Estonian partners saw for the first time at the George Washington University Hospital. The system enables the hospital to keep records of patients on a waiting list (both for outpatient visits and surgeries) which helps the hospital to better plan a number of surgical procedures covered by the sickness fund, and provides storage for all information about patients' procedures, lab tests, x-rays, etc. The ESTER database also helps with other functions, such as enabling them to create and send electronic bills to the insurance company, saving the hospital time and money. More frequent use of epidural procedures also had a positive impact on patient satisfaction.

Communication and Team Building: Two of the most important concepts shared during the management 101 training were the importance of effective communication and the necessity of developing strong teams to realize organizational change. Many CEE partner institutions made changes to enhance communication and foster the development of effective teams.

In Croatia, leadership development programs set the stage for more collaborative interactions rather than "top-down" directives. Head nurses now hold regular meetings where subordinate nurses are asked their opinions, and problem-solving is more participatory and constructive. As a result, interpersonal relationships (physician-to-physician; physician-to-nurse; nurse-to-nurse) and intra- and inter-departmental collaboration have all improved. Meetings are more efficient, and agendas are prepared one week in advance. Problems are discussed, and conclusions are identified and reviewed at follow-up meetings. The first partnership project implemented in Zadar was aimed at increasing communication between departments and decreasing the burden of non-nursing tasks assigned to nurses.

After their visit to George Washington University, partners from Mustamae Hospital in Tallinn, Estonia started to have staff wear nametags with pictures. The nametags were seen as way of improving relations and communications among staff and with patients.

Utilizing the continuous quality improvement (CQI) process introduced by the Winston-Salem partners, the partners at Vác Municipal Hospital developed oncology teams including oncologists, pathologists, radiologists, and nurses. By developing these teams, the oncology unit was able to ensure smooth working relationships and improved patient care among all the specialists involved in cancer treatment.

CHALLENGES

The CEE partners who tried to institute management-related changes in their institutions and own daily work sometimes met resistance from the leadership of their institutions, ministry of health and other government officials, and even patients. For example, there is still some resistance towards nursing care among patients who fail to acknowledge nurses' competencies and want to be taken care of only by a doctor. AIHA and the US partners involved the leaders of CEE partner institutions, ministry representatives, and others as appropriate in management training and partnership activities. This facilitated "buy-in" to partner-driven changes taking place in CEE institutions, and exposed these leaders to the same management concepts being shared with other partners.

The status of health care reform in the CEE countries also hindered the ability of partner institutions to change management practices and implement innovative programs. Some new services introduced in CEE hospitals could not be sustained because those procedures would not be covered by state-sponsored health insurance funds. However, some CEE partners were successful in lobbying for new services to be covered. For example, The Hungarian Health Insurance Fund decided to provide coverage for same-day surgeries, which Vác Municipal Hospital had introduced during its partnership.

III.C. NURSING

BACKGROUND

Despite notable progress in some areas in recent years, nurses working in the CEE countries face numerous challenges compared to their colleagues in the United States and Western Europe. In the mid-1990s, nursing was seen throughout the region as merely an extension of the role of the physician rather than as an independent profession. "Most doctors and, indeed, many nurses believe this professional hierarchy is necessary and proper. Very few have had the chance to see the modern nurse in action, so they lack the knowledge to assess the validity of their current situation." (WHO, *Nursing in Europe*, 1997) With training equivalent to a high school education, and jobs that more closely resembled those of a nurse's aide or housekeeper, a separate word for "nurse" or "nursing" did not exist.

The relatively low status of nurses is reflected in a number of ways, including the lack of professional standards for nurses, the inability of nurses to engage in clinical or administrative decision-making, and the lack of independent nursing care plans. "Regardless of the state of development of nursing services, a variety of factors impedes their effective delivery in many countries. These factors include the exclusion of nurses from policy-making and decision-making at all levels of the health care system, shortages of well trained nurses relative to needs, insufficient financial support and the undervaluing of nursing…." (WHO, 1997)

With low salaries and a lack of respect from their medical colleagues, as well as a low opinion of them by patients, nurses continue to have a high turnover rate, which in turn leads to low morale, poor self-image, and reduced quality of care. Many young nurses elect to leave the profession after starting families, or to leave their home countries in order to seek out work in Western countries. Furthermore, since nurses were not considered professionals, separate professional associations did not exist in the majority of CEE countries to lobby for bettering their status or creating standards for their work.

These problems were also reflected in nursing education in the region. Education of nurses has traditionally been viewed as vocational training, rather than university-based. The great majority of nurse educators have been and still are physicians, and nursing curriculum has consisted merely of a less extensive version of physicians' medical education. Baccalaureate-level and advanced practice nursing were not available options for nurses.

PROGRAM STRATEGY

Recognizing the critical role nurses need to play in healthcare reform efforts, AIHA promoted – both through its partnerships and through special inter-partnership initiatives – the empowerment and strengthened role of nurses. Each partnership identified nursing as a prominent focus area and actively worked to upgrade and expand nurses' clinical and administrative roles in order to effect improvements in the quality of patient care and health sector productivity. Partnership workplans addressed such needs of nurses as changes in nursing practice, strengthening nursing as a profession, improving nursing education, and allowing for information exchange and networking. US partners made sure to demonstrate the importance of nurses by including nurses in exchange trips in both directions, and providing training to physician-nurse teams across all program areas, including in leadership and management workshops.

At the regional and inter-partnership level, AIHA developed a number of initiatives to supplement individual partnership efforts through activities aimed at building nursing leadership, education and networking.

CEE Nursing Task Force: In order to facilitate a coordinated approach to strengthening the role of nurses in the region, to encourage sharing of ideas and experiences across countries, and to empower nurses, AIHA assembled a Nursing Task Force (NTF) beginning in September 1995. The task force consisted of US and

CEE representatives of all the partnerships. At its core were the US and CEE steering committees, each of which met regularly (including via videoconferencing) to plan activities. The NTF met annually for three years to exchange ideas and gain new knowledge and skills in areas such as leadership, communications, and association building.

Training for Nurses at the Cluj Nursing Resource Center

Nursing Resource Centers (NRCs): To provide nursing faculty, students and clinicians with a facility to support learning and sharing, AIHA established nine NRCs at partnership sites in CEE, as part of a broader network of NRCs across Eurasia. AIHA supplied each NRC with approximately $15,000 worth of computers and other educational equipment; training mannequins; textbooks, videotapes, and CD-ROMs; and educational posters and other learning materials. These materials addressed a wide range of clinical, managerial and psycho-social aspects of health care. The centers encouraged independent learning and offered resources for alternative teaching methodologies. The NRCs also serve as meeting places for local nursing associations and enable nursing colleagues to collaborate on a variety of nursing issues. (A report of AIHA's 2003 assessment of the NRCs can be found at www.aiha.com).

Association-building: AIHA's nursing program also focused on strengthening or helping to establish national nursing associations. These associations serve a vital role in creating favorable political and legal environments to enable nurses to play a more full and prominent role in improving health care. AIHA supported nursing associations in organizational development and the formulation of strategies to influence policy change aimed at strengthening the nursing profession. One of the key activities was the convening of nursing leaders from 16 CEE and NIS countries and the US in June 1998 in a conference entitled "Nursing Associations: Leadership and Organization for the 21st Century." Participants, including nursing association leaders, ministry of health representatives, and partnership nurses, discussed such issues as the role of nursing associations within the nursing profession, leadership and consensus-building, recruitment and retention of association members, development of standards for nursing practice, the role of associations in policy development, and ways to increase nursing's power and legislative influence.

International Nursing Leadership Institute (INLI): AIHA supported a joint CEE/NIS nursing initiative in which four carefully-selected CEE nurses joined their NIS colleagues to develop the skills and knowledge necessary to be successful nursing leaders in their countries. The Institute offered a series of intensive participatory workshops, mentoring, and electronic communications to create an integrated year-long curriculum. Participants were asked to develop projects to be implemented in their home countries as an integral part of their Institute experience. (A report of a 2003 assessment of the INLI program can be found at www.aiha.com.)

The overall goal of AIHA's nursing program was to improve patient care through effective, quality nursing practice and through strengthening the profession's contribution to systemic health care reform within the NIS/CEE. Specific objectives included:

- To enhance capacity for professional nursing education that meets international standards;
- To increase the status of nursing as a profession;
- To improve nursing practice through nurse training and introduction of new models of nursing care and nursing roles; and
- To increase access of nurses to information resources and networking opportunities through sustainable Nursing Resource Centers.

KEY RESULTS

Both during and after the end of the CEE partnerships, advances in nursing effected through partnership efforts have been among the most consistent and notable achievements. Nurses from every CEE partnership cite personal, professional, and institutional gains, speaking of the courage, the confidence, and the skills that the partnerships gave them to seek changes in their roles. The critical first step in all cases was the opportunity that both nurses and physicians had to see first-hand how nurses work in the United States. These eye-opening experiences transformed their attitudes about what nurses are capable of.

➢ *Strengthened Nurse Leaders and Nursing Profession*

"The elevation of the nursing profession in the region is a clear success story of the hospital partnerships. CEE partnership nurses stated that through both exchanges to the US and discussions in their own countries, they learned about the potential of the nursing profession. The example of US nurses instilled a professional pride in the CEE nurses who observed that US nurses are not subordinate to physicians." – RTI, 2006

AIHA's nursing program aimed to strengthen nurses as individual leaders and professionals in order to enable them to impact hospital efficiency and quality of care. In an independent evaluation of AIHA's program in CEE published in 2006, found that at all the hospital sites they visited, "nurses reported increased authority, self-confidence, and greater involvement in direct patient care and clinical decision making." CEE partnership nurses stated that through both exchanges to the US and discussions in their own countries, they learned about the potential of the nursing profession. The example of US nurses instilled a professional pride in the CEE nurses who observed that US nurses are not subordinate to physicians.

Through participation in the INLI program, four CEE nurses—one each from Romania, Slovakia, Croatia, and Slovakia—received training on topics related to nursing leadership, scholarship, and networking. Upon graduation, each nurse implemented an individual project to benefit their home institutions in order to practice the skills learned in the Institute. Three of the four CEE nurses who graduated from INLI went on to serve as faculty for later classes of INLI students, providing further opportunities to strengthen their training and leadership skills.

A 2003 internal assessment of the INLI program found the program met its objective of helping nurses develop new leadership skills and competencies. The program modified nurses' attitudes toward their profession, enabled them to gain self-confidence, helped advance careers, promoted standardization of nursing processes, and strengthened ties among nurses across regions. Of the graduates surveyed as part of the assessment (from both CEE and NIS), 72% said the program helped them gain respect from physicians. Almost all (87%) felt that graduating from the Institute had helped them recognize their professional and leadership capabilities. And during or after training, 34% were promoted at their workplace and 23% were offered a new job at a different workplace. (The full report of the assessment can be found on AIHA's Web site at www.aiha.com.)

AIHA partner nurses were active in nursing associations and other efforts to influence nursing reform at a national level. Through their work with US partners, they learned about the benefits of establishing associations for strengthening nursing as a profession. For example, the nurses at Mustamae Hospital in Tallinn helped to establish a Society of Anesthesia Nurses in Estonia. The Estonian partners also supported the Estonian Nursing Association, which began publishing the journal *Estonian Nurse*, the first of its kind in the region. One of the Croatian partner nurses eventually became president of the Croatian Nursing Association. In Slovakia, partner nurses played a role in the creation of legislation which gives nursing a professional status. There is now a Slovak Chamber of Nurses. In Albania, national nursing conferences organized by AIHA partners led to the formation of an Albanian Nursing Association.

- ***Changes in Nursing Practice and Roles***

AIHA partnerships worked to better define the role of nurses and helped create new nursing roles, having an impact on patient care, teamwork with physicians, and self-esteem for the nurses. Among the examples of changes in nursing roles and responsibilities was the creation of a nurse educator position in Tuzla, and the addition of new nurse assistants to two hospital departments in Zadar. Nurses in Tuzla and Tallinn are now able to take patient histories, perform patient assessments, and monitor vital signs. They also began to join physicians on rounds, at educational meetings and during evaluations. In Zagreb, the partners added new management and leadership functions to the role of nursing staff and at Mustamae Hospital in Tallinn specialized nursing positions, such as dressing change nurse, were replaced with modified primary nurse positions. In Kosovo, partners instituted nurse-only patient education visits for some patients with chronic diseases. And at the Women's Clinic in Tallinn, midwives were given a new job description that included independent prenatal care and treatment. Midwives were trained in observing and handling normal pregnancy cases and in counseling patients, which allowed them to take responsibility for their own patients.

In Vác, a new specialization was created for diabetes nurse (nurses now provide most of the care to patients on the Diabetes Unit), and a dedicated "social care nurse" assigned to work on discharge planning for stroke patients (prior to the partnership there had been only one social care nurse for the entire hospital.). Also in Hungary, nurses in Gyor participated for the first time in conducting focus groups with community members to identify health needs of women.

Increased confidence and knowledge by partner nurses also resulted in nurses in Vác influencing the reorganization of the layout of wards; nurses in Zagreb participating with physicians as collaborators in a study of care of bed sores; the head at the occupational disease clinic in Cluj initiating the development of an outpatient respiratory diseases unit.

New nursing management structures were implemented at many partner institutions. The Zagreb partners introduced job descriptions, staff orientation, and performance evaluations for nurses. In Tallinn, the partners succeeded in eliminating the 24-hour nursing shift, replacing it with 10-14 hour shifts. Vác Municipal Hospital introduced a new system of nurse supervision nurses, including a new nursing supervisor role, which helps direct the professional activities of all nurses, helps them resolve any human resource and professional issues, and manages the training of new staff members, as well as conduct continuous training of nurses. Nurses at partner hospitals in Tallinn were given budgetary responsibilities for the first time, and in many partner hospitals such as in Vác, nurses are now members of the management team for patient care.

Partner nurses also established numerous new protocols for nursing care. A nursing committee established in Tuzla developed an IV therapy policy for pediatrics. In Zadar, partner nurses initiated the use of a dressing cart in the neurological unit to save time during dressing changes. At the same time, they established new treatment plans and protocols. Nurses in the post surgery department of gynecology in Kosice introduced new nursing protocols and a new nursing care check list for each particular operation, and in Tallinn, a partnership nurse developed and piloted a patient record that allows for continuous monitoring of the patient's condition and allows for nurses' notes and observations. Through the Zagreb partnership, among the protocols developed were those for care of decubitus ulcers, insertion and care of foley catheters, obtaining and handling blood cultures, bathing patients, and care of dying patients. The stroke team at Vác Municipal Hospital developed clinical pathways for stroke patients which became part of routine care protocols. In many partner hospitals, nurses took a leading role in improving infection control (IC) practices, serving on hospital infection control teams and helping to develop IC protocols and conducting training on proper infection control techniques.

Partners recognized the importance of continuing education for nurses and developed numerous in-service training programs for nurses designed to develop new or improve clinical competencies among the nurses. In

Tuzla, nurses received training in cardiac and respiratory assessment, and demonstrated the ability to care for pre-cardiac and surgery patients. In Zadar, nurses participated in the train-the-trainers program to improve nursing care to patients with decubitus ulcers, and in Tallinn, regular monthly in-service programs were established for nurses at Mustamae and Tallinn Central Hospitals. Those programs focused on topics such as CPR, nurse assistant and anesthesia nurse training.

- ***Strengthened Nursing Education***

Many of AIHA's partnerships worked to improve access to and quality of nursing education. Some worked with universities to establish and improve higher-level nursing education. For example, a University-level nursing program was established at the University of Tuzla in Bosnia & Herzegovina. A curriculum was drafted and a task force convened to steer its development. Partnership nurses on both the Buffalo and Tuzla sides were instrumental in lobbying for such a program. In Estonia, with input from partnership nurses, Tartu University revised its nursing curriculum, and nurses now have the opportunity to participate in a part-time study program. And at Palacky University in the Czech Republic, the Institute for the Theory and Practice of Nursing gained official recognition as a separate institute. Although the nursing faculty had developed the Institute independently of the partnership, participation in the AIHA program helped validate the Institute when governmental approval had become stalled. In Martin, Slovakia, partners established new programs at the medical school to train nurses in "community public health" which includes social health and care for the dying.

Other partnerships focused on improving continuing education opportunities and clinical skills training for nurses. Every hospital partnership incorporated new or expanded in-service trainings for nurses. In Zagreb, a formal link was established between the School of Nursing and the partnership for purposes of education, research and leadership training. Latvian partners developed a program for teaching nursing systems theory and practice to nurses. They compiled a "how-to" guide, with a series of self-learning modules, including nurse/physician joint documentation, evidence-based nursing practice, developing quality improvement and re-engineering teams, and conducting in-service training.

- ***Greater Access to Information and Networking***

Partnership nurses spearheaded or participated in networking and information sharing at the country, regional CEE and Eurasia-wide levels through individual partnership-organized efforts as well as AIHA initiatives.

At the national level, the following are examples of national nursing conferences organized by partners to provide a forum for discussing the role of the nurse, to disseminate learning and information about various aspects of patient care and nursing, and to build stronger communities of nurses.

- Slovakia National Nursing Conference held in Bratislava for approximately 65 nurses. The conference focused on hospice and home care, community nursing and nursing agencies.
- "Nursing Partnerships in Action" conference held in Zagreb, Croatia, for approximately 100 nurses and physicians from hospitals throughout Croatia and eight nurses from Bosnia and Herzegovina.
- The Tirana/Grand Rapids partners organized two national nursing conferences for Albanian nurses, in 1998 and 1999. The conferences attracted over 70 and 100 nurses each from Tirana and other cities attended the conference, designed as a forum for nurses from throughout the country to learn about nursing practice theory, discuss nursing care, share ideas, build clinical skills, and strengthen the Albanian Nursing Association.
- Representatives of the three separate Bosnian nursing associations met in Sarajevo and, with AIHA facilitation, formed a unified Nursing Association of Bosnia & Herzegovina. This conference was the first opportunity for representatives from the three major ethnic groups to come together since the beginning of hostilities in the country.

Cross-partnership activities organized by AIHA, such as the International Nursing Leadership Institute, CEE Nursing Task Force, and Nursing Resource Center directors' meetings provided nurses with further opportunities to increase their knowledge and share ideas by networking with their colleagues from other cities and countries. After returning home from these meetings, the nurses were able to continue a professional dialogue through e-mail access provided at their partnership's NRC or Learning Resource Centers. The 2006 evaluation of AIHA's CEE program found that "the Nursing Task Force provided an important mechanism to support selected nurses to attend international conferences and training. It offered access to international nursing associations, moral support, and a sense of solidarity for a beleaguered profession."

The Nursing Task Force was, for many of the participating nurses, the first time they had had conversations with other nurses outside of their countries or even cities. As the US chairperson of the NTF commented, "How stunned they were that they had so much in common! Nursing is a remarkable unifying force…. Nurses are nurses no matter where they practice…. In spite of the language barriers, it worked! Anything was possible." Through the NTF meetings, nurses not only networked and found strength from each other, they learned specific skills.

Of the nine Nursing Resource Centers established at CEE partnership institutions between 1997 and 1998, seven were still functioning and active as of 2003 when AIHA conducted an assessment of the NRCs, with two centers temporarily closed for hospital renovations. The NRCs house computers and other educational resources, which are available to nursing faculty and practitioners in the facilities and communities where they are located. In most instances, the NRC was the first place in the hospital where nurses could have access to the Internet. The 2006 USAID/RTI evaluation noted that, "The significance of providing nurses their own computers at a time when computers in the hospital were scarce should not be underestimated."

The NRCs serve as a site where training and in-service programs for nurses were developed and continued to be organized. In Tuzla, nursing education is incorporated into weekly rounds and programs that are supported by the Center, including ongoing educational sessions held on the second Saturday of each month. The NRC at Kosice Faculty Hospital served as an information and technology resource and training site for all nurses in eastern Slovakia, with the Center holding monthly nursing meetings attended by nurses from around the region.

Often the NRCs served as a springboard for institutionalizing broader continuing education opportunities for nurses. In Cluj, Romania, the NRC's trainings are now conducted by the Romanian Nursing Association and all courses are accredited. The Vác NRC offers a number of accredited courses, including in advanced cardiac life support.

Main activities/services offered by NRCs

NRC	Computer-related training	Clinical skills training	Meetings	Advocacy for nursing	Library/ resource center	Other trainings	M&E activities
Cluj	regularly***	quarterly		quarterly	✓	✓	✓
Kosice		monthly **	irregularly		✓		✓
Olomouc	2/year	6/year	regularly	irregularly	✓	✓	✓
Riga	on request	1-5/month	1-4/month	daily	✓		✓
Trnava	annually*	annually **	irregularly	regularly	✓		✓
Tuzla	2/year	daily	irregularly	irregularly	✓	✓	✓
Vác		monthly	2+/month		✓		
Zagreb	annually	weekly	irregularly	2+/year	✓	✓	✓
Zadar	2/year	monthly	weekly	annually	✓	✓	

** One course in 1998 and one in 1999; ** Until 2000; *** Last year for 9 months.*

Local partners have been responsible for the operations and continued funding facility renovations, staff salaries, and providing continuing financial support for the upkeep of the resources. While most of the financial support comes from the facilities that house the NRCs, or the Ministries of Health, some NRCs have sought out grant money to fund their operations. For example, after the end of their partnership, the Cluj nurses successfully applied for a grant from the Soros Foundation for supplemental support for the NRC.

External Collaboration/Communications

NRC	Other NRCs	AIHA partnership	Local Nursing Association	International Nursing Organization	University Overseas	Other Organization
Cluj		✓	✓		✓	
Kosice	✓		✓			✓
Olomouc	✓	✓	✓	✓	✓	✓
Riga			✓			✓
Trnava		✓	✓	✓	✓	
Tuzla		✓	✓			✓
Vác			✓	✓		
Zadar	✓		✓			
Zagreb	✓		✓			

AIHA invited all CEE and NIS NRC directors to a workshop in 2000 where they were able to share experiences and exchange best practices. Five of the nine CEE NRCs were represented. Nurses from the two regions also met and networked at other nursing-related events organized by AIHA.

AIHA also fostered regional cooperation among partners in nursing. For example, Bosnian nurses developed collaborative relationships with their Croatian counterparts, especially at the 1998 Croatian National Nursing Conference held in Zagreb. The Latvian nurses worked closely with their Estonian counterparts to sponsor a series of Baltic nursing workshops, where participants discussed the status of nursing in the two countries and recent changes brought about through the partnerships.

In addition to networking with their regional colleagues and US partners, several nurses also had the opportunity to join international nursing societies. Two CEE nurses were inducted as members of Sigma Theta Tau International Honor Society of Nursing, and several INLI graduates were able to participate in meetings of the International Council of Nurses. Through these international ties they were able to network and gather ideas for furthering nursing reforms in their own countries.

CHALLENGES

While notable strides were made in nursing in the CEE countries, particularly within the partnership institutions, numerous challenges were faced during the AIHA program and many remain to this day. The fundamental restructuring of the profession that is needed does not occur overnight, or even in a decade. Some of the main challenges faced by AIHA and its partners in the area of nursing were:

- Continued resistance from physicians to nurses having greater independence and an increased role;
- Resistance in some cases from "old-school" nurses feeling threatened and not wanting change;
- Language barriers (few of the nurses, compared to the physicians, had English language skills) which hampered their ability to access broader range of current, evidence-based information on the Internet. (Also the lack of availability of current nursing education materials in CEE languages);
- Language was also a challenge for regional activities given the lack of a single common language. However, as a testimony to the strong motivation of CEE nurses to interact and learn from each other, they successfully transcended language barriers. Through a combination of interpreters, English skills,

common third languages and non-verbal communication, the NTF held productive and successful meetings;

- Fundamental changes in nursing profession required radical changes in basic nursing education; in entire nursing education system. Problem of nursing schools starting at high school level. Countries are still addressing how best to revise and standardize their system of nursing education;
- Some of the Nursing Resource Centers thrived more than others; those that were less successful cited among the challenges: physicians co-opting the use of the NRC computers and lack of human resources to consistently staff the centers; and
- National regulations sometimes limited what nurses were allowed to do.

KEY ACTIVITIES AND EVENTS

1995

- First meeting of the US representatives of CEE Nursing Task Force, Washington, DC, September
- Meeting of US Steering Committee of CEE Nursing Task Force, Washington, DC, December

1996

- First meeting/workshop of CEE Nursing Task Force., Budapest, Hungary, April 30
- NTF US Steering Committee meeting, Washington, DC. August 11
- First meeting of the CEE Steering Committee , Zagreb, Croatia, September 15-16
- NTF US Steering Committee meeting, Washington, DC. December 9

1997

- CEE Steering Committee meeting, Bratislava, Slovakia., January 20-21
- US Steering Committee meeting. Washington, DC, February
- Second meeting of the CEE Nursing Task Force, Zagreb, Croatia, for approximately 45 nurses from throughout the CEE region, May 13-14
- Opening of the Nursing Resource Center in Riga at the office of the Latvian Nursing Association. September 9
- US Steering Committee meeting in Washington, DC, September 22
- CEE planning sub-committee meeting of the NTF, Bratislava, Slovakia, October 20-21
- First videoconference between US and CEE Steering Committee nurses in Washington, DC and Bratislava, Slovakia. December 9

1998

- Second videoconference meeting between US and CEE NTF Steering Committees, February 10
- NRCs opened at the University Clinical Center in Tuzla, Bosnia & Herzegovina, and at the Kosice Faculty Hospital in Kosice, Slovakia, March 5 and 8
- Nursing Leadership and Management workshop (25 nurses from Cluj, Romania and Moldova), Tihuta, Romania, March
- Third annual CEE Nursing Task Force meeting, Bucharest, Romania, May 4-5
- AIHA-organized Nursing Associations conference, Riga, Latvia. June 14-16
- NRC opened at Trnava University, Slovakia, July 2
- NRC opened in Olomouc, Czech Republic, at Palacky University, September 24
- NRC for the Zadar/Biograd – Franciscan partnership opened in Zadar, Croatia at Zadar General Hospital, September 28

- Opening ceremony for Nursing Resource Center at University Hospital of Infectious Diseases in Zagreb, Croatia, October 20

1999

- International Council of Nurses Meeting, and INLI-Session 1, London, June 18-25
- Sigma Theta Tau induction ceremony for 2 CEE nurses, July 1
- "Leaders for a Scholarly Profession" workshop, London, sponsored by AIHA and Sigma Theta Tau, July 1-2
- INLI-Session 2, Louisville, KY, November 4-13

2000

- NIS Nursing Conference (four CEE nurses attended), Tbilisi, Georgia, April 9-14
- NRC Directors' Meeting, Yerevan, Armenia. June 29-July 1
- INLI-Session 3, St. Petersburg, Russia, July 7-16

2001

- Workshop on Technology and Health Education for Nursing (10 NRC directors and information coordinators from CEE), St. Petersburg, Russia, August 1-4

2002

- Primary care skills workshop for 25 Romanian nurses, Cluj, Romania, March 25-27

III.D. WOMEN'S WELLNESS

BACKGROUND

The post-Soviet years in Eurasia saw the inadequate and fragmented healthcare services that had existed for women in the region eroded further, leaving considerable gaps in coverage for millions of women living in the region. The transition to a market economy and breakdown of state-supported social and health systems resulted in a decrease in economic self-sufficiency for millions of women, according to studies conducted by UNICEF. This financial instability–coupled with increased rates of tobacco use, alcohol and drug abuse, unsafe sexual practices, intimate partner violence (IPV), and a host of other medical and behavioral concerns–led to reduced life expectancy for women in more than half of the countries in the region. Among other trends seen in the region were: increases in reported cases of breast cancer, many with late-stage diagnoses; limited access to contraception with abortion often used as the primary method of birth control; increasing numbers of women infected with HIV; and IPV resulting in increasing deaths among women.

As far as the status of healthcare services for women in the CEE region, services addressing women's health problems outside of reproductive needs (especially childbearing) have been underdeveloped and non-existent or inaccessible within public health care. Family planning counseling and services usually do not constitute an integral part of reproductive health services, resulting in abortions being all too common in most countries. Furthermore, women lack information crucial to their health and to the health of their families, particularly in the areas of nutrition and breast feeding, prevention of unwanted pregnancy and family planning, self-care during pregnancy, prevention of female cancers and other health problems. Violence against women is not addressed by the health sector in any systematic way. And most countries lack adequate screening services and preventive medical services for female diseases such as breast and cervical cancers, resulting in late detection when the cancers have reached an advanced stage.

PROGRAM STRATEGY

In an effort to provide accessible, comprehensive healthcare services to women throughout their lives, AIHA and its partners developed a model for and a network of Women's Wellness Centers (WWCs) in more than 30 communities throughout Eurasia. These innovative centers were designed to offer a client-centered approach to meeting the primary care needs of women—from adolescence to post-menopause—through a combination of health promotion, education, early diagnosis, treatment, and follow-up care. Each center uses a common model that emphasizes comprehensive clinical services and cost-effective health promotion and disease prevention strategies. The goal of each center is to structure services to prevent unintended pregnancies, abortions, and sexually transmitted infections (STIs), as well as to improve pregnancy outcomes and promote healthy lifestyles throughout the span of women's lives.

Each WWC seeks to create an atmosphere of comfort and efficiency using a common set of guidelines that include recommendations for staffing, facility design, and equipment and supplies. The WWCs were typically equipped with examination tables, lamps, sterilizers, microscopes, blood pressure devices, doppler ultrasound monitors, colposcopes, and laboratory supplies. In addition, the centers received televisions, VCRs, and slide projectors for use in educational activities, along with a wide variety of printed materials pertaining to women's and children's health issues, and anatomical models used to help patients understand their bodies and the changes that can occur as a result of pregnancy, aging, or disease.

Specific objectives of AIHA's women's wellness program were:

- Increased capacity to deliver comprehensive, outpatient health services to women of all ages;
- Increased utilization of health promotion and prevention services within the WWC;
- Maintenance of a high level of patient satisfaction with the WWC and its services;
- Increased implementation of women's health clinical practice guidelines;

- Increased use of contraceptive methods among women of reproductive age who wish to avoid pregnancy (excluding women who have had hysterectomies); and
- Improved sustainability of the WWC model.

In order to promote the practice of evidence-based medicine within the WWCs, AIHA compiled and distributed to all WWCs a *Clinical Practice Reference Manual.* AIHA also supplemented partnership efforts with training and information sharing activities for the network of WWCs through a series of workshops for center directors and staff. The workshops attended by CEE partners included one on quality assurance (Kiev, Ukraine, December 2001), and on clinical practice guidelines with a focus on HIV/AIDS (Odessa, Ukraine, September 2003). A meeting for all WWC directors was also held in Washington, DC, in April 2001.

In CEE, a total of four Women's Wellness Centers were opened by partnerships with AIHA funding – in Iasi, Romania (October 1999); Tirana, Albania (September 2000); Gjilan and Prizren, Kosovo (November 2003). A fifth, in Tirana, was opened in July 2001 as a replication site with funding from the Albanian Ministry of Health.

Through an initiative of the Romanian Ministry of Health, the "Elena Doamna" WWC in Iasi is a national reference center, one of 11 in the country for reproductive health. Addressing women's lifelong needs for healthcare, the Center provides clinical and educational services in an ambulatory outpatient setting. Services include:

- prevention and detection of sexually transmitted infections (STIs);
- prevention and treatment of reproductive system cancers;
- practical training for future parents;
- family planning with a wide range of educational information;
- education and treatment for menopausal and post-menopausal women;
- adolescent health programs and counseling;
- education for healthy lifestyle choices; and
- domestic violence counseling.

Located at the Tirana Maternity Hospital, the Tirana Women's Wellness Center is an ambulatory facility aimed at clinically assisting women in need, as well as informing and educating females of all ages on a large variety of health issues. The Center offers a full range of comprehensive primary care services. Health information and education efforts include disease prevention, early diagnosis of problems, treatment of these problems, and long-term follow up. The WWC also offers a variety of educational programs and every patient who visits the clinic is given a schedule of classes.

The two Kosovo WWCs at the Maternity Hospital in Gjilan and the MFMC in Prizren were established to demonstrate that the WWC model could work in a hospital and primary care setting, and to provide services in two different parts of the province. The WWCs officially opened in November 2003 and offer the following services:

- Family planning and reproductive health programs, including fertility and contraception counseling
- Perinatal care, including pregnancy, breastfeeding and childbirth classes
- Prevention services directed at HIV/AIDS and sexually transmitted infections (STIs) as well as detection, treatment and management of HIV/AIDS and STIs
- Cancer education and screening services, including cervical cancer screening (Pap tests) and clinical breast examination, and a variety of diagnostic procedures
- Mental health education, counseling and support groups related to issues such as depression, domestic violence and rape
- Substance abuse services (education, problem identification, treatment)
- Chronic disease services, including education, screening, treatment and referral for specialty services

- Education and clinical intervention for peri- and post-menopausal women
- Services promoting healthy lifestyles (including education, nutrition and exercise counseling)
- Adolescent health programs, including sex education and peer support groups
- Community outreach on a wide array of issues

KEY RESULTS

Each of the Women's Wellness Centers provides comprehensive care to women, including obstetrical and gynecological care, cancer and STI screenings, family planning services, menopause and aging-related counseling, and primary care mental health services. A 2001 independent assessment of the WWCs in CEE and the NIS (including the center in Iasi, Romania) found that the WWCs "have distinguished themselves" in four main ways: 1) being "patient-centered" and considerate of patient needs and offering patient-friendly environments; 2) quality of care delivered and quality and professionalism of staffs; 3) offer a comprehensive range of services to meet the needs of women of all ages and work to ensure continuity of patient care; 4) focus on prevention, early detection, education and counseling, providing services generally not available elsewhere. (The evaluation report by the University of Illinois at Chicago can be found on the AIHA Web site at www.aiha.com.)

➢ *Increased Knowledge and Skills of Healthcare Professionals*

The partnerships introduced physicians, nurses and other professionals working in the WWCs to a broad range of new knowledge and skills to enable them to provide quality, evidence-based care and services. In addition, AIHA offered a series of specialized workshops that brought together representatives of all WWCs throughout Eurasia for learning as well as sharing of experiences.

In addition to the WWC staff who gained new knowledge and skills, other healthcare providers in the countries also benefited through conferences organized by the WWC partnerships. In Tirana, a women's health conference in 2000 was attended by approximately 100 health professionals from throughout Albania. Over 250 physicians, nurses, and NGO representatives participated in the partnership's two conferences on cervical cancer held in Tirana. Similarly, the WWC in Iasi, Romania, reached out to primary care providers in neighboring regions to provide training on family planning.

➢ *New and Comprehensive Services for Women*

WWCs filled a void in many countries by providing not only diagnostic screening and clinical services for both acute and chronic conditions, but also much-needed patient and community-health education and support programs. For the first time, women in these countries can come to a single place to seek treatment and advice on health-related matters ranging from cancer, cardiovascular disease, and diabetes to family planning, maternal care, behavioral health, and menopause. Thousands of women in the communities served by the WWCs established in the CEE countries have been empowered through programs that teach the value of good health and the importance of taking charge of their own well-being by adopting healthier lifestyles, performing monthly breast self-examinations, and avoiding situations that put them at greater risk of developing health problems.

In its first year of operation, the Iasi WWC documented 18,845 visits, including services for pre-natal care, gynecological examinations including diagnostic testing, contraceptives and health education classes. The Gjilan WWC reported 13,526 patient visits in 2004 and 16,417 in 2005. The Prizren WWC reported 6,738 visits in 2004 and 6,227 in 2005.

The WWCs, in addition to providing a standard set of core services, also expanded to meet the needs of their communities. New services offered at the WWC in Iasi include infertility counseling and treatment and a menopause clinic that opened in June 2002.

"We were so depressed. We wanted very much to have a child. The people [at the Iasi Women's Wellness Center] are so kind and warm. They make their patients feel like they are part of a team and that anything is possible, that miracles can happen . . . for us, our miracle is our daughter Raluca. She is a little wonder … very impulsive, funny, and full of energy. I can't even begin to imagine what our life would be like without her." – Dana Bran, *infertility patient at the Iasi Women's Wellness Center*

Tirana's Women's Wellness Center provides a full range of women's health services to around 60 patients daily. The WWC accommodated a steady increase of patient visits with nearly 7,000 in 2001; 9,000 in 2002; over 12,000 in 2003. As part of their work, the WWCs established new treatments and instituted new diagnostic procedures. The Tirana WWC launched a cervical cancer screening program in 2002. The partners adapted a protocol, and established the country's first cytology/pathology laboratory so that the slides could be read in-house. By March 2004, the lab had read more than 2,600 Pap smears and conducted over 400 biopsies. In one out of 25-30 Pap tests they find an irregularity. They developed the first cytology laboratory in Albania, and trained staff to be able to administer cervical cancer screenings. The laboratory also hosts a cervical cancer screening registry. The partners created a quality control policy for the cytology/pathology laboratory focusing on the following areas: specimen identification, specimen rejection, specimen processing/staining, screening accuracy, re-screen of negative Pap smears, reporting accuracy and timeliness, assurance of staff competence, specimen adequacy, diagnostic categories, and follow-up policies. To ensure accuracy in the screening and diagnosis techniques of the cytology/ pathology laboratory staff, the partners also created a quality assurance review. Every three months, 10 percent of all negative slides, 5 percent of all ASCUS, and 1 percent of all LSIL Pap smear slides were sent to Providence, along with a copy of the original report for each patient slide submitted, to be re-screened by the US partners.

"At our Center, we don't just provide medical consultations to the women who come in for treatment. We understand that a visit to the OB/GYN can be a very frightening ordeal . . . and our goal is to make each patient feel as comfortable as possible." – Calin Bueru, *physician, Iasi Women's Wellness Center*

➢ *Quality Improvement*

The WWCs also instituted new ways of organizing outpatient care, new standards for care, and new roles for nurses. A 2006 evaluation of AIHA's programs in CEE reported that: "The Iasi WWC introduced the notion that providers other than obstetricians can provide family planning care, at the time a fairly radical concept". Similarly, in Kosovo, midwives at the WWCs were trained to provide antenatal care to women. This was a first in Kosovo where the gynecologist had traditionally provided this care. In Albania, questionnaires were developed and distributed to patients that were used to constantly review patient satisfaction, to improve the quality of their work, and to make sure the services and programs meet the needs of their entire female population. To do this the WWC introduced several innovative programs, including:

- For the first time, patients had the ability to schedule appointments based on their needs and availability, with the physicians they desire. Additionally, all Maternity Hospital physicians were able to conduct their outpatient visits at the Center.
- Traditionally the Maternity Hospital had a system of one medical chart per patient per visit. This resulted in multiple charts for the same individual, complicating the accessibility of medical histories. The WWC created a one-chart structure, compatible with their computerized patient tracking system.
- The WWC has adapted a standardized billing system for services offered. They are guided by the Ministry of Health on pricing for services. Prices for each procedure are posted at the waiting area and are distributed during patient registration so that the clients can familiarize themselves with the pricing structure.

The Gjilan and Prizren WWCs are utilizing 25 CPGs developed to cover a number of issues: management of common pregnancy problems, management of pregnancy complications, anemia, gestational diabetes, multiple pregnancy, Rhesus negative, common vaginal infections, identifying women who must see a gynecologist at the first visit, a care plan for women with a normal pregnancy, and conditions arising in pregnancy requiring gynecological assessment. Health promotion activities have now begun in the Prizren WWC with health education sessions being held for large groups of women, both young and old. Topics include healthy pregnancy, breastfeeding, contraception, and other general health topics.

The Tirana WWC developed and implemented clinical practice guidelines for pre-natal care, Pap smear, menopause, and breast self exam. The staff posted charts in each exam room showing and explaining each of the guidelines. Similarly, the Romanian Breast Health partners have translated American and European manuals of radiology quality assurance (QA) and these are available at every center that has been trained. Each center also has a QA kit (from the US which includes phantom films). They state that they are aiming for the same quality of radiographic studies as is obtained in the US.

Understanding that patient satisfaction is important to the ability to retain patients and make a successful medical facility in the wake of health reform, several of the WWCs surveyed their patients to find out how they felt about the service received. The Tirana WWC conducted a patient satisfaction survey of 39 patients in June 2003. The overall satisfaction level was 5.5 out of a maximum possible score of 7. The WWC was received its highest ratings for the cleanliness and comfort of the clinic, courtesy of the staff, competence of the physicians, and the availability of educational and counseling services. The center continues to administer patient satisfaction surveys every six months to use as internal guidance to improve service delivery.

The Gjilan and Prizren WWCs conducted patient satisfaction surveys of 103 and 107 patients, respectively, in September 2003. Gjilan received an overall satisfaction score of 6.1, with its highest ratings in the staff's willingness to answer questions, the competence of nurses and physicians, and the availability of educational and counseling services. Prizren received an overall score of 6.4 with its highest scores for the cleanliness of the clinic, the competence of nurses at the clinic, and the availability of educational and counseling services.

- ***Health Promotion, Disease Prevention, and Community Outreach***

Health education on-site and in their local communities was part of the activities of many of AIHA's women's health programs. Nurses and physicians from the Iasi WWC provided health education programs for pregnant couples. The inclusion of fathers made the program unique and it was met with a high demand. They also initiated a program to screen patients for domestic violence and provide the necessary counseling and referrals for victims of abuse.

The WWCs also continually provided patient education and health promotion materials to its clients. In Tirana, printed materials were prominently displayed throughout the Center, and many classes were offered by the clinic staff on breast self exam, family planning, childbirth, prenatal care, menopause, and STIs. The Center encouraged health promotion by showing educational videos to patients in the waiting area. In Iasi, the WWC staff set up an Internet-based chat line that local youth can use to ask physicians, nurses, and psychologists questions of concern to them.

To engage the community and gain interest from the local community about women's health issues, US and Albanian partners organized a first-ever women's health fair in conjunction with the opening of the Tirana WWC. The fair attracted over 80 women (along with some men) who came to get information about the Center and its services, to have a free blood pressure test, or to stop at one of the many information booths set up by AIHA partners and other local and international organizations. This was the first of four women's health fairs sponsored by the partners that combined attracted over 400 women and men.

The staff of the WWC in Iasi travel to local high schools to talk about health education, contraceptives, and STIs. Posters advertising the Center and their daily schedule of classes for adolescents are displayed in every participating high school. These two-hour health education classes are held at the Center three times a week and attended by approximately 20-25 teenagers from various backgrounds. The goal of these classes is to provide adolescents with basic information regarding their own bodies and health so they can make healthy lifestyle choices. The adolescents attending these courses come of their own free will and learn about the courses through the lectures, posters, or mobilization efforts of local volunteers.

- ***Sustainability and Replication***

Each WWC established through AIHA's program was designed to create sustainable, replicable health facilities. The Iasi WWC was successful in soliciting private funding and local support for its activities. Donations included $17,000 for renovations and laboratory supplies from the Insurance House of Health, $10,000 for renovations and equipment from the Public Health Department, and $3,000 of contraceptives from the Ministry of Health. In Albania, the Ministry of Health was so impressed with the Tirana WWC as a model, it opened a replication site using the staff of the original WWC to train the new staff.

CHALLENGES

Some of the main challenges that faced the partnerships in establishing and sustaining the WWCs were:

- Securing financing for renovations of the facility. While AIHA in a few cases contributed to infrastructure costs, it was typically the responsibility of local partners to find resources for the centers' physical infrastructure. In all cases, public, private or a combination of funding sources was secured;
- Changing providers' attitudes about how they provide services (e.g., following appointment schedules, eliminating under-the-table payments, ensuring patient privacy rights, adopting continuous quality improvement processes and paying attention to patient satisfaction);
- Securing a patient base without a catchment area (advertising in the community, reaching out to the community through health fairs);
- Addressing difficult societal issues, such as domestic violence and STIs; and
- Setting up reliable lab services and ensuring steady supplies of laboratory supplies.

III.E. EDUCATIONAL CAPACITY FOR HEALTH MANAGEMENT

BACKGROUND

The changes in healthcare delivery systems that were being realized throughout the CEE region in the 1990s placed a spotlight on the need for skilled administrators who could manage existing healthcare services and programs and develop new ones capable of meeting the constantly changing healthcare needs of their communities. Professional managers were needed to help meet the key reform goals of improved efficiency in the delivery of clinical services and, in particular, enhanced productivity of hospitals and related delivery sectors within the region's new democracies.

"The successful transformation of the Czech health system cannot be accomplished through the efforts of talented medical professionals alone. As market forces are introduced through new payment systems, professional managers with a strong knowledge of management science, practical skills and a thorough understanding of economics are necessary to maintain the health of the system as a whole." – Roman Prymula, *Purkyne Military Medical Academy, Hradec Kralove, Czech Republic*

However, the profession of health administration/management was non-existent in these countries, and most management positions (hospital directors and other leaders of health facilities) were filled by clinicians with little to no training in administration and management. This lack of management training among health professionals contributed to poor productivity and health outcomes below those of other countries with comparable industrialization. (RTI 2006)

Education and continuing research in modern management methods – both in-service and academic programs – was largely neglected in CEE under the former socialist structures. The result was not only a lack of trained mangers but also a lack of health services research and analytical expertise required by ministries of health and policymakers to drive sector transformation. Health reform highlighted the critical need for additional grounding in health policy for leaders throughout the region.

PROGRAM STRATEGY

As part of its strategy for advancing health sector reform in CEE, USAID in 1995 asked AIHA to establish and manage a program to develop and expand institutional capacity within CEE countries to train a cadre of health management professionals. USAID approved AIHA's proposal to adapt and apply its successful institution-based hospital partnership model to address the need for development of academic programs in health management. Funding was received to establish five health management education (HME) partnerships in four countries – Albania, Czech Republic (two), Romania, and Slovakia.

AIHA and USAID representatives introduced the new education partnership program at the annual meeting of the Association of University Programs in Health Administration (AUPHA) in June 1995 and solicited interest from AUPHA member institutions. At the same time, AIHA worked with USAID Missions in the targeted countries to identify influential, reform-minded educational institutions that could potentially participate in the partnership program. Using a competitive solicitation process, AIHA subsequently selected in the fall of 1995 leading US universities with programs in health administration willing to volunteer the time and energies of their faculty in partnering with counterparts in CEE.

Using a slightly different approach from the establishment of hospital partnerships, AIHA traveled to the HME partnership countries with representatives of the selected US institutions to conduct site assessment visits, meet with potential partners, and finalize the selection of the CEE partner institutions. This first group of five HME partnerships were all launched in late-1995 and graduated between 1998 and 1999. Two additional HME partnerships were established, one in 2000 and another the following year.

In 2000, USAID/Romania asked AIHA to manage a new partnership involving the former HME partners in Bucharest, Romania, and the University of Kentucky in Lexington, in order to further strengthen capacity in management training and in developing and implementing national health communication campaigns. A final HME partnership in the CEE region was launched in 2001 as the first-ever "intra-CEE" partnership without the involvement of US partners. The partnership between Bucharest, Romania, and Tirana, Albania, focused on improving the quality of primary healthcare services in Albania through health management training for general practitioners. As a Romanian partner commented, "By bringing together two Eastern European partners, AIHA supported a new type of collaboration, one in which knowledge gained within former partnerships with US specialists is disseminated, not only in the country, but also throughout the region." (Daniela Valceanu, National Institute for Research and Development in Health, Bucharest, Romania)

AIHA also provided a one-year grant to one of the Romanian partnership institutions in order to support the development of its legal framework and organizational structure, as well as a business plan to help guarantee its sustainability as it transitioned from a government-funded to an autonomous entity.

Each of the HME partnerships took into account the country's specific needs and existing capabilities through needs assessments that resulted in the design of a unique approach to developing health management education capacity. They focused on designing and enhancing the education of current and prospective administrators, policymakers, and clinicians at the undergraduate, graduate, and continuing education levels. Some partnerships worked with economics and management faculties to add a health management specialty to existing business and management degree programs. Others developed management courses for standard undergraduate medical and nursing curricula, or developed graduate-level programs in health administration. Finally, several partners developed innovative approaches to offer management training through specialized short courses, including through the use of distance learning technology.

All the HME partnerships worked closely with ministries of health and of education to assure the quality of the education they were providing, to obtain certification for the new degree programs, and to lobby for the creation of appropriate positions available for retrained and newly-trained health managers within the health systems.

The partnerships also concentrated on faculty development, teaching materials including country or region-specific case studies, government approval processes, implementation of accreditation standards, and other essential elements of establishing new educational programs. Some also addressed national health policy analysis, health services research, and strengthening relationships within the healthcare community at both national and international levels. An important component of the HME agenda was establishing libraries and resource centers to provide administrators, policymakers, students, and the healthcare community with accurate and timely information on health policy and management. Supporting professional associations for health management practitioners and developing professional journals of health management were also addressed.

In addition to the individual partnerships, AIHA applied its strategy of "partnership of partnerships" in order to create a supportive environment among the HME partners where they could share experiences and information, as well as receive supplemental technical assistance in a manner cost-effective to AIHA. Over the years, AIHA organized numerous opportunities for the HME partners to meet at workshops and conferences, both those organized by AIHA and others, including a special case method workshop offered to both active and graduated partners in 2000. In these efforts, AIHA collaborated closely with American experts at AUPHA.

AIHA also relied upon the CEE HME partners to serve as models for additional HME partnerships established in 1999 in the four NIS countries of Armenia, Georgia, Kazakhstan, and the Kyrgyz Republic. As a prelude to the launch of the new partnerships, NIS representatives participated in a study tour to four of the CEE HME partnership sites. NIS study tour participants reported that the trip not only greatly expanded

their vision, but also helped them to launch their new partnerships on a faster track than would otherwise have been possible. CEE HME partners also used the skills they had gained from their own partnerships to later serve as faculty during workshops for NIS partners.

PARTNERSHIP/PROJECT	YEARS	PARTNER INSTITUTIONS
Tirana, Albania/New York, NY	1995-1999	University of Tirana, Ministry of Health New York University
Tirana, Albania/Bucharest, Romania	2001-2004	Institute of Public Health National Institute for Research & Development in Health (formerly the Institute of Health Services Management)
Olomouc, Czech Republic/Richmond, VA	1995-1998	Palacky University Faculty of Medicine Virginia Commonwealth University
Bohemia, Czech Republic/Nevada	1995-1998	South Bohemia University Faculty of Management (Jindrichuv Hradec), Faculty of Health and Social Care (Ceske Budejovice), University of Education (Hradec Kralove); Purkyne Military Medical Academy (Hradec Kralove); Postgraduate Medical School (Prague); University of Nevada
Bucharest, Romania/Chicago, IL	1995-1998	Institute of Health Services Management University of Medicine & Pharmacy "Carol Davila" University of Chicago
Bucharest, Romania/Lexington, KY	2001-2004	Institute of Health Services Management University of Medicine & Pharmacy "Carol Davila" University of Kentucky School of Public Health
Organizational development grant	2003	National Institute for Research & Development in Health
Slovakia/Scranton, PA	1995-1999	Trnava University School of Public Health and Nursing (Trnava); University of Matej Bel Faculty of Economics (Banksa Bystrica); Health Management School (Bratislava) University of Scranton

RESULTS

The HME partnerships achieved significant results in building sustainable capacity to train health managers in the CEE region, often being the first in their respective countries to offer new courses and degree programs in health administration. They contributed greatly to advancing the profession of health management and to providing much-needed management skills to support healthcare reforms in their countries.

One of the main legacies of the HME partnerships is having created a new cadre of professionals trained to effectively lead and implement healthcare reforms through improved management knowledge and skills. The partnerships not only created educational programs at individual institutions that have been producing skilled management professionals, but they created a network of institutions and professionals committed to advancing the new profession in the region.

"The AIHA partnership was instrumental in establishing the concept of health management as an essential tool in improving the cost-effectiveness and efficiency of health service delivery." – RTI, 2006

In the Czech Republic, building on the momentum generated by the two HME partnerships, nine Czech partner institutions developed a network to promote education for healthcare management. This network jointly submitted proposals for and won two separate grants from the country's ministry of health and ministry of education (in 1998) to increase the exchange of expertise and information among Czech educational institutions in the area of health management education, and to develop uniform standards for health management education in the country.

Other areas of overall results of the HME partnerships are summarized below.

- ***Educators improve skills and develop new tools***

Key to building institutional capacity for management education was building the individual capacity of faculty members at the participating schools. Over 100 CEE educators and trainers gained skills in curriculum development (including developing program structure, individual course syllabi, teaching materials, and lesson plans) as well as strengthened their knowledge in specific content areas of health management.

A number of partnerships, including Bucharest/Chicago and Tirana/New York, enabled CEE faculty members to spend anywhere from two months to a year studying and working with faculty at the US institutions. Eighteen Romanian partners participated in three-month exchange programs at the University of Chicago, giving them in-depth exposure to health management topics, teaching methodologies, research, health policy design and analysis, and consulting. Two members of Albania's Ministry of Health spent one year at NYU to earn masters degrees in policy analysis.

All the HME partnerships focused on strengthening the pedagogical skills of the CEE faculty, who were introduced to a variety of interactive teaching methods and effective and new teaching/learning technologies such as teleconferencing, and distance learning. These tools continue to be widely used at many of the institutions and faculty members have received positive feedback from students about the effectiveness of the new pedagogical methods.

"Over the course of our partnership, we learned a number of highly effective teaching techniques. The classroom experience for our students is now much more interactive. We use a number of info-tech and online resources and also take groups to local hospitals and clinics where they can get a first-hand look at the administrative process in action." – Helena Kuvikova, *Matej Bel University, Banksa Bystrica, Slovakia*

A particularly important and useful teaching/learning tool was country-specific case studies developed by many of the HME partnerships. The Bucharest/Chicago partners, for example, completed five country-specific case studies during their partnership. The cases were incorporated into the partners' teaching activities and were very well received by trainees. The development of case studies required educators to work closely with practitioners to document and evaluate real life management situations. The Romanian partners subsequently presented the case study methodology to other AIHA partners in the region and co-taught a one-week training course held in 2001 for AIHA's NIS HME partners.

As in other types of partnerships, the HME partners in CEE benefited from the intensive exchanges and the peer-to-peer collaborative approach taken by US partners. As one Slovak partner commented, "Equally important, however, are the things that are less tangible—like the way our US colleagues shared their knowledge and experience so freely, never viewing us as competitors, but as true and equal partners." (Helena Kuvikova, Matej Bel University, Banksa Bystrica, Slovakia)

- ***Creation of new courses and degree programs in healthcare management***

The HME partnerships were at the forefront of creating educational capacity to train managers for the health sector. Programs created ranged from continuing and in-service management education for practicing physicians and nurses, to undergraduate and graduate degree programs for the education of future professional managers.

"Overall, the health management education partnerships helped to establish and strengthen the curricula for health management education programs by promoting modern principles and techniques of health care management education and increasing the availability of information for decision making." – RTI, 2006

Health management courses are now part of the standard curriculum at almost all of the HME partner institutions. Among the examples of partnership achievements in new courses and curricula are:

- The Institute of Social Medicine and Health Policy at Palacky University Medical Faculty in Olomouc introduced the first master's degree program in health administration in the Czech Republic. Accreditation was received in January 2000 and the first class enrolled in September of that year with 20 students admitted out of 80 applicants.
- The Faculty of Management at University of South Bohemia in Jindrichuv Hradec also developed a masters-level program introduced a three-year bachelors program in management of health services in 1997 and graduated the first class of 25 students in June 2000.
- The Institute for Theory and Practice of Nursing at Palacky University developed advanced management training for nursing administrators. The partnership efforts resulted in the accreditation of the first postgraduate master's program for nurses in the Czech Republic (in 1999), with a program capacity of 25 students per year.

"Sometimes change begins very quietly, such as the introduction of healthcare management curricula in Czech universities. The graduates will make a significant contribution to improving the quality of Czech health care." –Vladimir Spidla, *Chairman, Parliament's Health Care Committee (quoted in USAID's Czech Republic closeout report)*

- In Romania, the Institute for Health Services Management (renamed the National Institute for Research and Development in Health, NIRDH) and the Carol Davila University established master's programs in health management. As of 2005, the NIRDH reported approximately 200 students are enrolled each year in their Master's Course in Health and Social Services Management.
- The Romanian partners also introduced post-graduate teaching training, practical courses for hospital managers, and an accredited short course for people in and outside of Bucharest.
- The NIRDH developed hospital management short courses and continuing education programs for healthcare professionals, extending the health management curriculum to include new subjects like evidence-based medicine, social marketing and health research. New curricula have been developed on health economics and financial management, health promotion and prevention and managing general practice. The Institute reported in 2005 that over 400 students each year enroll in the program for "Certificate of Competence in Health Services Management."
- A master's degree program for nurse managers was established at Trnava University and accredited in 1998, as were health management programs.
- In Slovakia, the HME partnership, working with the ministry of education and the educational accreditation bodies in the country to achieve official recognition of health management as a professional discipline, allowing universities across Slovakia to offer advanced degrees and conduct research in this area.
- In Albania, the Tirana/New York partnership created a new management and economics course, the first of its kind in the country, for sixth year medical students. The course, introduced in the fall of 1998 at the University of Tirana, provides future clinicians and managers with basic skills necessary for successfully managing their practices and/or institutions.
- The Tirana/Bucharest partnership developed a health management training curriculum for general practitioners, adapted to the Albanian environment.

- ***Healthcare managers improve management practices***

HME partnerships also addressed the need to provide management training to practicing clinicians and managers and developed skills-based, practical short courses that ranged from one day to two weeks. Topics included core management competencies, finance reform, ethics, information systems, communication techniques, marketing and small business management, cost accounting, healthcare financing, and leadership. The goal was to bring managers up to date on internationally recognized practices and to provide them with the tools they need to improve their own practices.

For example, the Bucharest/Chicago partners developed a five-day health management course and first taught it in July 1997 to 40 newly-appointed district health directors. The Tirana/Bucharest partnership developed a three-day short course on practice management for primary care providers and jointly taught 60 general practitioners from the cities of Berat, Lezha, and Tirana. To further ensure close links with the participating clinicians, several partnerships recruited adjunct and guest faculty for their programs.

Some partnerships succeeded in implementing national continuing education requirements for managers and clinicians to help increase the minimum standards and implement new technologies. Several HME partnerships developed distance learning course offerings to provide additional opportunities for university-based study for those persons already working in the health care field. For example, the Bohemia/Nevada partnership developed "smart" classrooms for its partnership institutions, combining the information resources of the Internet with video and audio technology to bring the latest information on health and management into the classroom. The Bucharest partners, as a result of their partnership with Kentucky, developed the e-learning platform currently in use. At the National Institute for Research and Development in Health (NIRDH), a database of the institute's library collection has been put on-line to facilitate searches, and CD-ROM training courses for distance learning were introduced.

- ***Increased capacity for health communications***

Through the Bucharest/Lexington partnership, Romanian partners gained practical skills in developing and implementing a health communications campaign as well as in providing training in this area. In the process, they learned that communications skills are an important management tool for a broad range of issues including improving relations between professionals, educating and engaging patients and communities, promoting patient rights, advocating among policy makers, and engaging journalists and other media.

The Bucharest partners mastered communication skills and methods and successfully implemented several health communication and advocacy activities and developed a training package for health education and communications.

The partnership culminated with the implementation of a health communications campaign, to more effectively share updated and accurate information about available healthcare services and how the public can access these services. The partners crafted messages which were included in television and radio spots, newspaper and magazine advertisements, and brochures and posters. The printed materials were distributed to general practitioners, the local insurance houses, and public outpatient clinics throughout the country. In addition, the partners developed a Web site containing information about available health services and contact information of local public providers that was advertised in all of the media spots. From the launch of the campaign, on June 26, 2002 through October 7, 2002 there were an impressive 17,635 visits to the Web site.

The campaign was publicly launched on June 26, 2002 with a launch and press conference at the National Health Insurance House in Bucharest. The partners distributed a press kit containing all of the relevant information and printed materials to the media representatives covering the launch. National and local media outlets covered the campaign, including three television stations, two radio stations, and three newspapers.

- ***Capacity for consulting services***

HME partners applied their strengthened management, policy development and research skills to establish or expand consulting services for a range of clients from ministries of health to hospitals to private clinics. The provision of health management consulting services contributes to faculty development and provides HME partner institutions with the potential to generate income and increase sustainability of programs.

The Slovakia/Scranton partnership established a Center for Health Policy and Strategy at the University of Matej Bel which has developed a strong expertise in health policy analysis, and the Center for Training and Consultancy Skills Development at the Health Management Institute in Bratislava.

In the case of the NIRDH in Bucharest, through AIHA's sustainability grant, the Institute was able to establish a legal framework and structure for the restructuring of the institution; develop a business plan; and strengthen their training, consultancy, and research services. AIHA support to the Institute contributed to their ability to serve as Romania's leading institution supporting national health sector reforms.

- ***Information sharing, networking, regional collaboration***

To support the development of the new health management education programs, the HME partnerships developed comprehensive health management library resource centers to provide students and educators with access to modern literature and research on health management education and practice. AIHA provided general health management texts and journals in the English language, both in hard copy and electronic format, computers and Internet connectivity, and equipment such as photocopiers, LCD projectors, and overhead projectors to support teaching activities.

The CEE health management partners were also very successful in information sharing and collaborating among themselves, including sharing case studies and inviting one another to conferences and workshops. The Slovakia/Scranton partners organized and held three international healthcare conferences in Slovakia during their partnership years. They also developed a new international journal— *Journal of Health Management and Public Health*—to expand the available literature on healthcare management issues of relevance to their region (and in local languages). Ten issues were published and more than 80 manuscripts were prepared and/or published by the journal. The partners also successfully submitted seven articles on health management issues in Slovakia to the *Journal of Health Administration Education* in the US.

HME partners in the Czech Republic credited the two partnerships with having been significant for the long-term growth of health management education the country, particularly because of the ties that the partnership program created within the Czech Republic itself. By encouraging the sharing of faculty and resources among the partnership institutions, the US partners brought a sense of purpose and a common language to what was previously an uncoordinated effort. The partnerships created a nucleus of dedicated health management educators and professionals to jointly address the issues facing the profession.

The HME partnerships also benefited from numerous opportunities to network across countries and to gain additional knowledge at international and US-based conferences in health administration and at AIHA-organized topical workshops and meetings. In one example, 40 senior university educators from the US and CEE, CEE government officials, and representatives of private accreditation programs in the US and western Europe convened at an Invitational Forum on Quality Assurance for Health Management Education in Central and Eastern Europe organized by AIHA in April 1996. The forum was the first to address growing concerns for educational quality assurance in both the US and CEE. Through such events, AIHA encouraged and facilitated the development of professional ties and collaboration throughout the region.

KEY INTER-PARTNERSHIP ACTIVITIES

1996

- Invitational Forum on Quality Assurance for Health Management Education in Central and Eastern Europe, Budapest, Hungary, April
- Participation in annual meetings of the Association of University Programs in Health Administration (AUPHA) and the Association of Health Services Research (AHSR), Atlanta, GA, June

1997

- Participation in annual meetings of AUPHA and AHSR, Chicago, IL, June
- Graduation ceremony for two Czech Republic partnerships, Prague, September

1998

- AIHA conference, Shaping the Infrastructure of Health Professions, Budapest, Hungary, March
- Participation in annual meetings of AUPHA and AHSR, Washington, DC, June
- Case studies development workshop, Bucharest, Romania, September. (co-presented with AUPHA)

1999

- Hosting of study tour by new NIS HME partnerships to CEE partnership sites, April
- Special HME session at AIHA's annual conference in Washington, DC, November

2000

- Study tour for Albania HME partners to Czech Republic and Slovakia, February 21-26
- HME case method workshop, Almaty, Kazakhstan, May 22-26

2001

- Participation in annual meetings of AUPHA and AHSR, Atlanta, GA, June

III.F. COMMUNITY MOBILIZATION

BACKGROUND

As the countries in CEE began their transformation to democracy and addressed issues of healthcare reform, governments were interested in empowering municipalities and individuals to assume greater responsibility for their health and the health of their communities. The task of maintaining good health could not rely solely on a few decision-makers or healthcare professionals. Health and healthier communities became the collective responsibility of key stakeholders in all segments of the community.

The global movement to engage local governments in health development through a process of political commitment, institutional change, capacity building, partnership-based planning and innovative projects is reflected in what is called the "healthy communities" (HC) movement, popular in North America. healthy communities refers to a strategy and methodology that involves and empowers a community to effect change. WHO embraced this approach through the development of its Healthy Cities program, which promotes comprehensive and systematic policy and planning with a special emphasis on health inequalities and urban poverty, the needs of vulnerable groups, participatory governance, and the social, economic, and environmental determinants of health. It also strives to include health considerations in economic, regeneration, and urban development efforts.

While the recognition existed of the need for communities themselves to be involved in creating health and well-being for their citizens, they generally lacked the leaders, the experience and the tools to engage in this new type of community mobilization and building.

PROGRAM STRATEGY

AIHA, in 1995, adapted the healthy communities methodology to the CEE region and developed a new type of partnership. AIHA's healthy communities partnerships reflected a broad-based, community-to-community initiative that is a unique vehicle for developing skills in community health assessment, planning, and improvement. These partnerships engaged community leaders from CEE and their US counterparts in a systematic six-phase process. The process combined workshops and professional exchanges, typically over an 18- to 24-month period. CEE partners were exposed to strategies and skills for mobilizing their communities to focus on health. They also learned about research and epidemiology including conducting surveys to assess needs. In addition, they used organizational development skills to gain support from key community stakeholders. They succeeded in creating a well-trained cadre of community leaders who were empowered to develop solutions to problems that they identified.

A total of seven healthy communities partnerships were established, with the first two launched in Slovakia in late-1995. Additional HC partnerships were established in Romania (1998), Croatia (2001), Hungary (2001), and other cities in Slovakia (1997). In addition, two of the hospital partnerships (in Vác, Hungary, and Riga, Latvia) incorporated HC projects into their partnerships.

Each partnership focused on different issues, as appropriate to a healthy communities approach which is designed to enable each community to identify and address important obstacles to healthy living in their community. For example, in Slovakia, Martin focused on smoking cessation; Banska Bystrica focused on geriatric, hospice and chronic disease care; Turcianske Teplice (TT) provided community health screenings and improved emergency services; and Petrzalka made support available for drug users and victims of domestic violence. HC partnerships in Romania and two cities in Hungary addressed priority women's health issues. In Constanta, Romania, the main focus was on domestic violence. In the Hungarian city of Győr, which was selected by competition from member cities of the national healthy cities network, partners developed women's reproductive health intervention services and education programs. AIHA also sponsored

a partnership linking the entire Hungarian Network of Healthy Cities with a similar state-wide network in Pennsylvania, to increase the capacity of the Hungarian network to address women's health and other community health issues.

In Croatia, AIHA provided training in mobilizing communities for faculty from the Stampar School of Public Health and the coordinators of the member cities of the Croatian Network of Healthy Cities. AIHA then asked member cities to apply to participate in a healthy communities partnership, which was awarded to the city of Split.

The hospital partnership in Vác, Hungary, decided to expand their focus to address the needs of the greater community and initiated a healthy communities project in the last year of the partnership with Winston-Salem. Similarly, the Riga, Latvia/St. Louis, Missouri partnership reached out to the town of Tukums and worked with them to mobilize around priority issues identified by the community.

KEY RESULTS

➢ *Mobilization of Diverse Community Stakeholders*

As a first step, the HC partnerships worked to mobilize their local communities to plan and implement health interventions. They identified stakeholders, who ranged from health professionals to police and teachers and politicians, who could help provide a diverse view of what steps needed to be taken to improve the health of the community. In many cases, the communities created boards to formally convene the stakeholders.

- In Slovakia, the Turcianske Teplice healthy community project assembled a multi-faceted task force comprised of the town's mayor, town deputies, the town's environmental engineer, a teacher, a priest, a coach, a social worker, and interested community residents. Group leaders engaged residents in an open dialogue on their perspectives of community problems. Together with their American partners, they systematically compiled a list of priority health issues and the resources available to the community to address the problems.
- In Hungary, the Vác/Winston-Salem partnership created the Vác Healthy Community Task Force to coordinate the partnership's healthy community activities. Regular meetings of the task force helped to bring together the community and the municipal policymakers and stakeholders, and convinced them that they were doing significant work for the benefit of the community. These meetings demonstrated to the mayor and local policymakers that everyone must share the responsibility for the community's health and well-being.
- In Tukums, the Riga, Latvia/St. Louis, Missouri partners helped local leaders to establish a community coalition (or council) comprised of representatives of the municipal government, schools, child development center, churches, social workers, healthcare professionals, and the general community.
- The Hungarian partners in Győr established a multi-disciplinary Community Advisory Board to organize and implement the healthy communities process and subsequent interventions.

➢ *Community Needs Assessment*

An essential element of the healthy communities process is a community health assessment. The assessment is critical not only for planning and optimizing the use of community resources, but also to generate a genuine sense of collective ownership, individual responsibility, and shared accountability for creating a healthier community.

It provides an opportunity to establish baseline measures of health status, health practice and health-related perceptions of a population. The assessment draws on both quantitative and qualitative data on health status and use of health services. Factors that are examined include: the political, social, and economic determinants that impact on health; lifestyle factors such as smoking, exercise behavior, nutritional and dietary habits;

environmental factors including, for example, exposure to carcinogenic agents in the air, water and workplace; and relevant hereditary and physiological factors.

- Leaders in Turcianske Teplice conducted community surveys and analyzed data to determine community needs. The initial survey was administered to 1620 school-age children to assess the impact that the economic transformations was having on the family and to provide baseline data with which to assess and monitor the health of school-aged children and their parents in the district. A behavioral epidemiologist from Case Western Reserve University held workshops and discussed the methodology with the TT team in order to assist them in the development of a Family Stress Survey. A survey questionnaire was administered to over 1,600 school-aged children and 500 parents. Results were then used to design interventions.
- Partners in Petrzalka, with the help of a local research firm, administered a survey to over 800 students, addressing the lifestyle and risk of children and youth of that community. The results revealed rising rates of drug abuse among teenagers. An unexpected finding of the survey was that domestic violence was also an issue in Petrzalka where the unemployment rate was extremely high following the collapse of the old regime – 816 children and youth between the ages of 12 to 18 participated in the survey.
- In Romania, the Constanta partners also conducted a community health assessment to identify health needs. Twelve hundred local women were surveyed to identify perceptions and concerns related to women's health. The top three health concerns listed by those surveyed were STI's, domestic violence, and lack of health education.
- The partners in Győr, Hungary, conducted an initial assessment of women's health needs in the community through the use of focus groups representing the target populations. After receiving training from a research fellow at the Hungarian National Drug Prevention Institute and AIHA, the partners conducted eight focus groups with a total of 46 women. After analyzing the focus group interviews, the partners identified the priority women's health needs in the community and the target groups on which to focus intervention activities.
- Split/New Jersey partners conducted an initial needs assessment and identified high-risk behaviors among adolescents as the focus of the partnership. To determine the prevalence of risk-taking behaviors among adolescents, the Youth Risk Behavior Survey (YRBS, a data collection tool developed by the US Centers for Disease Control and Prevention) was conducted after the instrument was adapted culturally and translated. The survey was conducted in a sample of primary and secondary schools in Split, and approximately 987 students ages 12-17 completed the survey. Analysis of the YRBS results showed that alcohol abuse was an emerging issue among adolescents in Split. Overall the findings from the YRBS indicated that early onset of alcohol use, in conjunction with high-risk behaviors, was an emerging problem in Croatia. Based on the needs assessment and the findings of the Split/YRBS, the partnership focused on both the problem of alcohol abuse among adolescents and the need to strengthen primary and secondary prevention to empower adolescents and counteract negative societal change.

➢ *Successful Community-Based Interventions*

The HC partnerships implemented a wide variety of projects and programs based on the needs identified in the community assessments. US and CEE partners worked together to leverage funding for continued projects, create sustainable community organizations, and adapt various interventions to meet local needs.

- The Turcianske Teplice community recognized the need to provide reliable emergency transportation and chose to initiate a voluntary community fundraising drive to purchase an ambulance. A Citroen ambulance was purchased and equipped, which now serves a wide catchment area (12-20 km). Within 10 minutes everyone within that area can get emergency services. Through the process of raising funds, the community learned the importance of approaching new donors, establishing a system to recognize contributors, and changed the tax laws to encourage charitable contributions.
- Petrzalka's Citizen's Association of Aid to Children at Risk (CAACR), with the help of Truman Medical Center in Kansas City, worked to prevent drug abuse among teenagers and domestic violence. It designed and implemented an extensive drug awareness campaign for teenagers and trained teachers to recognize

signs of drug or child abuse. Approximately 30 to 50 community residents participate in the monthly anti-drug forums. The CAACR has also opened a crisis hotline and the Hope Center for battered women to provide counseling and self-help activities for women and children fleeing domestic violence or confronted with drug abuse crises. The Center provides services to approximately 500-600 clients each year. In addition to the services provided to clients who visit the center, over 40 volunteers were trained to respond to calls to the Crisis Hot Line. Approximately 1,600 calls are received per year for consultation, counseling and referral. In 2004 the Crisis Hotline received 1,850 calls, a drastic increase over 2001, when they only had 60 calls.

- The Constanta community developed an integrated approach to responding to the problem of domestic violence. In 2000, the Constanta-Louisville Healthy Communities Partnership founded the Constanta Community Foundation and immediately opened an Office for Women which has served over 1,200 victims of domestic violence. Since the Office for Women was opened in December 2000 and the first case of domestic violence was recorded, more than 1,200 victims sought serves from the center.
- In April 1998, the Hungarian partners established the Association for the Health of the Citizens of Vác, a task force consisting of local government officials, educators, public health officials, and leading businessmen. The Association was created in order to develop and implement a community health program in Vác municipality. The association continues to remain active after the end of USAID/AIHA funding, with support of the Vác municipal government. In December 1998, the partners celebrated the opening of the Healthy Community Center in Vác. The Center serves as a venue for community education programs and as a resource center and meeting place for the Healthy Community Task Force.
- Győr/Pittsburgh partners celebrated the grand opening of For Women's Health, the women's health information and resource center in Győr. The center provides women in the community with access to important information about issues such as family planning, healthy childbirth, healthy lifestyles, and mental health. The partners report that in its first six months of operation, For Women's Health held 54 health classes attended by 1,146 people. Over 150 additional individual visitors visited the center. Center staff loaned resource materials to 183 people and distributed 10,900 leaflets on a variety of topics.
- In Martin a Promotion of Non-Smoking Center was established and since then there has been a 6% decline in daily smoking. In the US they were introduced to the concept of using mass media to communicate about public health and learned how to do it. These skills enabled them to reach the entire Slovak population with their messages in newspapers, radio shows, and press conferences. There is a stop smoking day every year and semi-annual press conference on the smoking cessation program. They have established a Web site which has information about tobacco control and they have a Web site and a "Quick Line" for people to call who want advice on how to quit. They also have published evidence-based guidelines for smoking cessation in the Slovak language.
- In Banska Bystrica, a new city department for health care was established, the regional hospital designated a 20-bed ward as a geriatric care unit, and a municipal 18-bed unit was established for pensioner care. The city also began a program that encouraged self-management of chronic disease that included the initiation of the area's first ambulance service, a family stress reduction program and a city clean-up campaign.

➢ *Sustainability*

By building capacity within the local communities for mobilizing resources, the healthy communities partnerships placed great emphasis on the sustainability of initiatives started under the partnerships. AIHA and US partners helped the CEE partners connect with other organizations with which they could collaborate and provided training and tools for fundraising and, in the case where new NGOs were created, for applying for legal status within their countries.

- The Slovakian partners were able to develop a viable ongoing marketing/promotional plan to increase the awareness of Citizen's Association of Aid to Children at Risk's efforts, and to create methods for fundraising activities to sustain the viability and continuation of CAACR with the assistance of a US Peace Corps volunteer. The CAACR received a 600,000 Sk grant ($17,200 approx.) from EUPHARE and

the City of Petrzalka in the Fall of 1998. The grant enabled the foundation to hire four full-time employees to work on Domestic Violence issues and the Hope Center's Fundraising and Public Awareness campaign.

- Since 1995 the Petrzalka partners have initiated numerous promotional activities/media campaigns to inform the Bratislava/Petrzalka community about the seriousness of drug abuse and mental health problems/issues of Petrzalka teenagers and adolescents (e.g., newspapers, radio, television, and drug forums). The founder of CAACR conducts a special radio talk show two to four times per month, and a special television show on an average of once a month, both on local Petrzalka stations. She discusses topics such as social issues, domestic violence, and drug abuse and gives listeners an opportunity to call in and ask questions.
- Hungary's partnership which linked networks of cities embracing the healthy communities approach, provided guidance on women's reproductive health services HAHC's 23 member cities and improved the networking capabilities among the member cities in addressing women's reproductive health and other issues. The partners identified current and potential opportunities for addressing women's health in Hungary, including US models that might be applicable to the Hungarian situation. IHC shared a range of resources to help communities build capacity and collaborative partnerships, including materials related to assessing and improving health status, implementing community health improvement programs, engaging the business community, developing community health policy, and a variety of brochures and newsletters.
- In Croatia, partners implemented a translated version of the American program, Project Northland in 13 local schools. Project Northland is a school-based curriculum designed as a multilevel, multiyear program proven to delay the age at which young people begin drinking, reduce alcohol use among those who have already tried drinking, and limit the number of alcohol-related problems of young drinkers. Designed for sixth, seventh, and eighth grade students (10 to 14 years old), PN uses an ecological framework to address both individual behavioral change and environmental change. PN also strives to change how parents communicate with their children, how peers influence each other, and how communities respond to young adolescent alcohol use. The program includes: active parental involvement and educational programs, behavioral based curricula, peer participation activities, and comprehensive involvement of the community.

➢ *National Impact*

Many of the communities involved in the HC partnerships also had an impact beyond their individual communities by lobbying their governments to pass laws or by demonstrating successful models for replication. Examples include:

- As a result of lobbying by Martin, the haemophillus influenza is now fully reimbursed by insurance, and in 2004 Martin was successful in getting legislation that had been pending for seven years passed which prohibited smoking in public buildings. And as a direct result of the advocacy of the Petrzalka partners, there is now national legislation to protect victims of domestic violence.
- The Constanta experience is being used as a model in six different counties in Romania and for the ministry of health's National Strategy to monitor, prevent and combat domestic violence. In April 2002, the national strategy on fighting domestic violence was approved. It includes provisions for all levels of government to be active. The law created an inter-ministerial committee of the Departments of Health, Justice, Youth, Police, Education, and Sports, etc. with responsibility for improving the laws to protect victims. It also calls for a National Commission for monitoring and preventing domestic violence and it requires counties to establish an Office for Women and a shelter for victims.
- The Hungarian Association of Healthy Communities worked on a national level to 1) better engage business leaders in the Hungarian communities in garnering their support for programs addressing women's health and other issues, and 2) increase the capacity and effectiveness of HAHC coordinators in organizing and implementing community-based programs. To meet these needs, the partners held two meetings in Budapest in February 2004. The Business Leaders Summit engaged Hungarian business

leaders in critical dialogue with executives from leading Pennsylvania businesses regarding their corporate responsibility for improving health and quality of life in their own communities.

CHALLENGES

- The healthy communities partnerships were generally funded for too short a duration to be able to fully support the community interventions being implemented by the partnerships. Healthy communities partnerships were ending just as they were at the point of being able to effectively administer programs. While some activities could not be implemented, AIHA and the partners focused on issues of sustainability during the partnerships, providing the local CEE partner communities with the ability to secure their own future funding. For example, community foundations and other NGOs were established by CEE partners which were able to apply for grants and conduct other fundraising activities.
- In some cases, funding agencies and other entities were expecting immediate results from the healthy communities process. The healthy communities process is most effective when allowed to work over a period of time. Expecting communities to be galvanized and addressing health issues in the first three to six months of a partnership was unrealistic, and created strains on the partners who were trying to navigate through the process. To address this issue, AIHA instituted the idea of "early wins," suggesting that partnerships plan some sort of activities early on in the process which addresses health needs in the community while at the same time galvanizing the public about the healthy communities project.

III.G. ACCESS TO HEALTH INFORMATION & COMMUNICATIONS

BACKGROUND

In the early 1990s, health professionals in the countries of Central and Eastern Europe found themselves increasingly isolated from the global body of medical literature. The transition from centrally-planned to market-based economies wreaked havoc with finances for their primarily public-funded health systems. As a result, in addition to shortages of pharmaceuticals and medical supplies, access to the latest medical research became a scarce commodity as well. In the face of funding shortages, medical libraries were unable to maintain subscriptions to international medical journals and domestic medical publishing houses were forced to cut back the number of journals they published. Because of this isolation, many CEE health professionals, educators, and policymakers were not always aware of new advances in medicine, which led to oftentimes outdated and less effective clinical practice and healthcare policy.

At the same time as CEE health professionals were facing this crisis, the international medical community was witnessing the growth of a grassroots movement in support of "evidence-based practice" (EBP), which aims to ensure effective integration of research evidence with clinical practice. This growth was prompted in part by studies by the Institute of Medicine and others, which found that medical errors were far more prevalent in patient care in the US and Europe than many had assumed. The "errors" cited not only included misdiagnoses or incorrect treatment, but also the frequent use of less effective or ineffective therapies. In other words, physicians were too often *not* prescribing the treatments that were proven to be most effective in treating a particular disease. Many adherents to the discipline of EBP therefore began working from the premise that physicians need to balance their own knowledge and experience with the most current research evidence as well as patient preference when deciding on a course of treatment. EBP provides a methodology that helps clinicians find and interpret research that will better inform their decision-making.

A third developing trend in the 1990s was the rapid growth on an international scale of the Internet, and more specifically, of the World Wide Web. As local markets for Internet access developed around the world, it was becoming more affordable for institutions and individuals to get connected. Furthermore, by the mid-to-late 1990s, it was becoming increasingly apparent that the model of medical publishing was going to be transformed as more and more journals and other sources of research became available online. Thus, for health organizations in CEE, the Internet offered an opportunity to at least partially address their information access problems.

The convergence of these three trends—the breakdown in access to health information for CEE health professionals, the rise of evidence-based practice, and the rapid growth of the Internet—presented AIHA with a unique opportunity to help address the capacity-development needs of its CEE partnerships. It was within this context that the Learning Resource Center project emerged and evolved over the past 12 years.

PROGRAM STRATEGY

To address the dual challenges of helping its partners access health information and to tie standards of practice to the latest research evidence, AIHA began complementing the activities of its ongoing partnerships by investing directly in the information infrastructure of the CEE partner institutions. Between 1996 and 2004, AIHA began to routinely purchase computers, modems, Internet connectivity, and a package of medical CD-ROMs and online databases for each of its new CEE partner organizations. The unifying concept behind these investments was the Learning Resource Center (LRC). The LRC model was designed to ensure that partners saw these investments not only as improvements in their infrastructure, but also as a focal point to encourage their staff to adopt quality improvement and evidence-based approaches to care, treatment, education, and policy.

Through the LRC project, AIHA incorporated a combination of strategies to begin to overcome barriers to accessing information. One of the distinguishing features of AIHA's approach is that the LRCs were designed to give health professionals access at the point of care and thereby improve the convenience of using information. Another element of the project involved active staff outreach and education. To accomplish this, AIHA promoted the development of a cadre of staff at partnership institutions to serve as "change agents" or "opinion leaders" at their institutions. These change agents, referred to as Information Coordinators, were charged with the task of getting their colleagues to begin using information and communication integrally in their day-to-day practice. The salaries of Information Coordinators and any other LRC staff were always supported entirely by the CEE partner institutions.

In establishing each LRC, AIHA's approach was grounded in the belief that partners must be prepared to commit their own resources to the project. This commitment was formalized through the signing of a project agreement that outlined the responsibilities of AIHA and the partner institution. In exchange for the above-mentioned resources provided by AIHA, each institution was required to establish a separate, secure room for the center that must be open and accessible to all staff. The institution also had to designate an Information Coordinator to maintain this center and to devote a minimum of 15 hours per week to various project activities. Information Coordinators designated by the partnership institutions were typically medical librarians, physicians, or nurses. In addition to the Information Coordinator, after 2002 the institutions also began to assign an Evidence-Based Practice (EBP) Specialist and an Information Technology (IT) Specialist who were responsible for managing these specialized components of the project.

The equipment and infrastructure investments were complemented with a series of training workshops, initially delivered to the Information Coordinators over the course of 2-3 years, but later delivered to three different staff at three separate workshops during the first year of the project. These workshops were designed to introduce a range of skills and themes that help LRC staff and their colleagues to develop a more sophisticated attitude toward information. These training workshops cover the following core set of skills:

- Basic and advanced Internet tools and applications;
- Medical searching techniques, including use of MEDLINE and other databases;
- Principles of evidence-based practice and critical appraisal of information;
- Training and outreach (training-of-trainers, presentation skills);
- Strategic planning (how to build support for the LRC, budget management, and grant proposal writing);
- Presentation skills, marketing and promotion;
- Web site development and design; and
- Basic database design, computer networking, and information systems planning.

The workshops also served as a forum to provide an orientation for LRC staff relating to their roles and responsibilities and provide an opportunity for AIHA staff to meet individually with each participant to discuss issues and problems specific to their institution.

Following the workshop, LRC staff undertook the tasks of setting up the LRC, getting better acquainted with the tools and resources available, and working with AIHA regional staff on establishing (or improving) their Internet connectivity. AIHA developed annual project workplans to help guide the development of the LRCs while at the same time providing the flexibility to allow the partner institutions to adapt the LRC model to meet their needs. Project workplans addressed the following key areas:

Staff Outreach and Training: One of the primary responsibilities of LRC staff was to educate health professionals on the benefits of using the Internet. To accomplish this, they organized outreach activities such as lectures, presentations, and training sessions. Some met with physicians during or after their morning rounds to discuss problems the physicians encountered and what information might be useful to them. Many LRCs created information bulletins, brochures, reference guides, and other printed materials to make staff

aware of new resources. LRC staff was also responsible for providing assistance to health professionals in searching for information and research materials.

Evidence-based Practice: After receiving formal instruction on EBP, including search methodologies and critical appraisal skills, LRC staff were responsible for providing training on these skills to other health professionals and working with them to help them integrate the latest evidence into clinical practice, education, and policy. LRC staff also periodically worked with groups of staff to review and appraise the literature on various topics identified as important to the institution, using a template developed by AIHA called a Practice Standard Review (PSR). The PSR was intended as a tool to demonstrate the value of EBP as well as to engage a wider cross-section of staff from the partner institution into the activities of the LRC.

Communications and Information Exchange: During training workshops, LRC staff learned about a variety of Internet communications tools—including e-mail, mailing lists, chat, audio conference, and application sharing—that enable conferencing and teleconsultation with other health professionals from around the world. LRCs were thus able to serve as communications centers for health professionals within their institutions—allowing staff to solicit input on difficult patient cases and other problems, participate in on-line international medical conferences, post their own research findings, and communicate with professional colleagues via the Web.

Building Support and Sustainability for the LRC: Throughout the program, Information Coordinators were faced with the task of thinking about how their institution will be able to continue to support the capabilities provided by the LRC after AIHA funding ends. The LRC model was intended to provide built-in sustainability by investing in the core equipment and information/communications infrastructure as well as developing staff skills so that the recurring costs of supplies, equipment maintenance, and Internet connectivity are all that is required for an institution to sustain the LRC on its own. During training workshops, LRC staff discussed various methods for building sources of support within the institution and ensuring that the LRC becomes an integral resource for health professionals. AIHA also provided LRC staff with training on LRC budget development, cost-recovery approaches, and grant proposal writing.

Web Site Development: One of the initial tasks of the LRC was to begin developing an identity for their institutions on the World Wide Web (for those institutions that do not already have a Web site). By creating a Web site, partner institutions were able to reach out to both local and global communities in order to market their institutional and staff capabilities and to share information (including research, conference reports, etc.).

Information Systems Planning and Database Development: Building on the IT infrastructure provided through the LRC, many LRC staff become engaged in thinking about the institution-wide flow of information. LRC staff learned that in addition to impacting patient care, information affects resource utilization and costs for the institution as a whole. For example, the introduction of computerized or electronic patient record systems and databases can help physicians, nurses, and administrators to access patient information, including a patient's previous medical history, more easily. This helps physicians and nurses to make more informed decisions about treatment. It also makes it easier for physicians, nurses, and administrators to evaluate aggregate data about patient treatments and costs. LRC staff received training on basic database development and information systems planning so that they learn how to develop applications that allow health professionals and administrators alike to organize and evaluate patient and financial information. They also learned some basic computer network management skills to help them expand the reach of LRC resources within the institution.

Reaching Out to Local Communities: After each of the CEE partners successfully established its LRC as a central hub for information access, training, and communications, many LRCs became involved in activities that extended outside of the boundaries of their institution—for example, by sharing health education materials and other resources with local NGOs, community groups, and other healthcare providers. Some

LRCs also served as resource centers for patients in addition to their own staff. A majority of the most successful LRCs have been actively engaged in serving their local communities by providing resources to health professionals and supporting other institutions in their efforts to establish similar capabilities.

KEY RESULTS

"Modern communications technology catalyzed rapid change. AIHA's initiatives to provide CEE partners with modern communications and training enabled them to engage with the global medical community. These initiatives were especially innovative in the early years of the program when Web-based communications were only recently widely available even in the U.S. Access to these technologies accelerated the use of evidence-based medicine and quality improvement systems by as much as 10-15 years according to CEE partners." – RTI, 2006

Through the healthcare partnership program, AIHA supported the establishment and maintenance of a total of 42 Learning Resource Centers in CEE between 1996 and 2005. Of these, 37 continue to be active and functioning. Altogether, this group of LRCs provided support to a community of over 19,000 health professionals.

AIHA measured the achievements of the LRCs according to a set of indicators linked to four key objectives, which themselves were tied to the overall project goal of promoting improved healthcare practices through increased access to, use of, and understanding of available health and medical information resources. These four objectives were:

1. To increase access to up-to-date health and medical information resources;
2. To promote the knowledge and application of evidence-based practice;
3. To sustain access to knowledge resources independent of AIHA funding; and
4. To increase CEE partners' development and use of information and communication technology tools and applications.

The analysis below provides an overview for the 42 CEE LRCs as a group; specific achievements and success stories for individual LRCs are included in the country summaries.

➢ *Increased Access to Up-to-date Health and Medical Information Resources*

The LRCs increased access to information in a variety of ways. First, they provided training to health professionals to enable them to use computers and the Internet to find health and medical information on their own. Altogether, the 42 CEE LRCs trained a total of 9,314 health professionals while they were being funded by AIHA, nearly half of their targeted user audience of 19,152.

Second, the staff of the LRCs performed information searches on behalf of their colleagues who were either too busy or reluctant to use the LRC computers to obtain the latest research evidence on their own. CEE LRCs responded to an average of 481 information requests each month, or a total of 18,362 during the period of funding.

In terms of the user base, the LRCs collectively received an average of 2,413 visitors each month.

In addition to service statistics, AIHA tried to measure trends and changes based on surveys among the target user audience for the LRCs. With the first surveys conducted in 1997 (approximately one year after many of the LRCs had been set up), about 40% of surveyed health professionals were using the Internet to access health and medical information. By the time of the last round of staff surveys conducted in 2002/2003, this had grown to 91% of all health professionals surveyed.

Aggregated statistics hide many of the greatest success stories in terms of improving access to and use of information resources. In Lezha, Albania, for example, the LRC represented the first opportunity for most health professionals there to be able to access the Internet. In May 2002, prior to the official opening of the LRC, less than 10% of the staff at the Town Health Center and Central Polyclinic had used the Internet to access health and medical information. One year later, nearly 60% of staff surveyed was using the Internet to obtain such information. Even at institutions that already had access to the Internet prior to the LRC project, usage rates grew tremendously. For example, at both the Institute of Postgraduate Medical Education in Prague and Palacky University in Olomouc, Czech Republic, the percentage of health professionals surveyed who were using the Internet to access information grew from about 50% in 1997 to 70% and 95%, respectively, in 2003.

- ***Knowledge and Application of Evidence-based Practice***

In measuring the knowledge and application of evidence-based practice, AIHA tracked CEE partner usage of EBP resources as well as their ability to demonstrate an understanding of its principles. Aside from the Internet itself, two of the most significant resources that AIHA provided to the LRCs during the scope of the project were the Cochrane Library and the Ovid Full-Text Medical Library databases. The Cochrane Library includes the well-known Database of Systematic Reviews, which provides a periodically updated synthesis of the latest research on a wide range of clinical topics. The Ovid Full-Text Medical Library (provided to partners from 1996 through 2002) included a collection of over 30 full-text major medical journals as well as an easy-to-use MEDLINE interface. Together, these resources provided partners with access to a valuable set of peer-reviewed information resources. According to annual surveys of AIHA partner institutions conducted in 2002, 43% of LRC staff in CEE were using the Cochrane database and 65% utilized Ovid database. Prior to the LRC project, the number of partners with access to these resources was negligible.

As part of efforts to promote evidence-based practice, AIHA in 2001 began requiring each LRC to produce something called a "Practice Standard Review" (PSR). The objective was to change the way individual health professionals think about their own practice and the evidence which may or may not support it. The activity was designed to help partners to critically evaluate the literature on a particular topic related to clinical practice, health and social policy, or educational methodologies. AIHA sought to create a simple step-by-step process that would guide partners through the process of posing an appropriate query, finding and reviewing the available evidence, and determining whether the evidence is consistent with existing practice.

Although all LRCs produced at least one PSR, these were not always prepared in a manner consistent with evidence-based practice. In making this evaluation, AIHA reviewed each PSR to determine whether (a) the literature selected by the partners demonstrates that they have done a critical quality assessment, (b) the partners showed an ability to tie the evidence to an existing practice, and (c) at least one individual outside the staff of the LRC was involved in conducting the review. By 2005, around 46% of all LRCs in CEE (up from 41% in 2002) were able to demonstrate their ability to apply evidence-based methodologies using the PSR template.

In addition to evaluating the PSRs, AIHA sought to enhance its qualitative assessment of its EBP activities by contracting with two researchers from the University of Wisconsin/Eau Claire in 2002. In order to measure the impact of the LRC project on the understanding, acceptance, and implementation of EBP among partner institutions, the researchers surveyed participants at two AIHA LRC dissemination conferences and conducted individual and group interviews with information coordinators. The evaluators also performed textual analysis of documents and training curricula developed by AIHA. The evaluators were satisfied with AIHA's efforts to provide material conditions (infrastructure and information resources) and to promote "how-to knowledge" among LRCs. However, they also concluded that to achieve fully rational practice of EBP at partnership institutions, the staff need to master the "principles knowledge" of evidence-based practice. The researchers suggest that this can be accomplished through: a) additional training on EBP fundamentals and critical appraisal skills, b) the development and dissemination of an EBP guide book to

partnership institutions, and c) the designation of an additional staff as an "EBP point person." The last recommendation was addressed through a new division of LRC responsibilities that AIHA began introducing in 2003. The Information Coordinator should now have a designated EBP Specialist and a Technical Specialist who are responsible for various aspects of the LRC project requirements. AIHA staff also compiled an EBP reference manual in 2003 that included a number of information resources to aid EBP specialists in the understanding and the implementation of evidence-based practice at their institutions.

- ***Development of ICT Tools and Applications***

The LRCs often have the effect of stimulating or supporting the adoption of other information and communication technologies that can help to improve the quality and efficiency of health care delivery. This includes the development of local area networks (LANs), databases, and the use of e-mail and the Internet to support telemedicine, including consultations related to the diagnosis and treatment of individual patients. Partner institutions have also been encouraged to develop an institutional Web page which, in addition to improving visibility and access for patients, can serve to promote the overall reputation and prestige of the institution. As a result of LRC efforts among CEE partnership institutions, 54% of them developed databases to manage administrative and/or health care information; 59% set up local area networks that enable expanded access to knowledge resources; 81% used their LRCs for telemedicine; and 86% established institutional Web sites.

- ***Sustainability***

From the beginning of the project, all partner institutions covered the costs of staffing the LRCs as well as furniture, office space, and most supplies. During the period of funding for the partnerships, AIHA provided ongoing support in the form of monthly Internet payments, office supplies (mostly just paper and printer toner), and equipment repairs. AIHA tried to support monthly Internet connections at a cost that would be affordable to CEE partners after funding ended. By the end of 2005, 36 of 37 (97%) of the still functioning LRCs were maintaining Internet connectivity on their own, and the last one (Lezha Town Health Center/Central Polyclinic) anticipated being able to secure funding within the next year. With 37 of 42 total CEE LRCs still functioning, the project had an overall sustainability success rate of 88%.

Another common approach to attaining sustainability for LRCs in CEE was seeking grants from local and international foundations and other organizations. In part as a result of the grant proposal writing training modules provided by AIHA during various LRC workshops, 65% of partnership institutions in CEE applied for grants that would specifically support continued access to knowledge resources and other LRC functions, and 43% of all CEE LRCs have had at least one successful grant proposal.

KEY ACTIVITIES

1996

- 1st CEE Information Coordinator Training Workshop, Tallinn, Estonia, September 2-6

1997

- 2nd CEE Information Coordinator Training Workshop, Krk, Croatia, July 21-25

1998

- 3rd CEE Information Coordinator Training Workshop, Kosice, Slovakia, July 12-16

2000

- Medical Informatics Study Tour for CEE Information Coordinators, Palo Alto and Los Angeles, CA; Portland, OR; Cleveland, OH, October 30-November 11

2002

- CEE Regional LRC Dissemination Conference and Site Visit, Zadar, Croatia, June 2-7

2004

- LRC Training Workshop for Information Coordinators, Evidence-Based Practice Specialists, and Information Technology Specialists, Pristina, Kosovo, May 24-29

After 1999, AIHA launched several rounds of new partnerships in CEE. Two new LRCs were established in Romania in 1999. In 2002, LRCs were established in Lezha, Albania; Split, Croatia; and Gjilan, Kosovo. In 2004, one new LRC was opened in Gjakova, Kosovo. Between 1999 and 2002, AIHA sent representatives from these LRCs to participate in the NIS information coordinator workshops—mostly held in Almaty, Kazakhstan.

III.H. KNOWLEDGE TRANSFER, DISSEMINATION & NETWORKING

BACKGROUND/PROGRAM STRATEGY

One of the ways that AIHA's partnership program distinguished itself from other technical assistance and partnership programs was its emphasis on collaboration, networking, and the sharing of information among partnerships. In seeking to maximize program outreach, AIHA actively promoted inter-partnership communications and synergy, supported technical initiatives which cut across partnerships, and collected and disseminated partner-produced information resources as well as information about successful partnership activities and lessons learned. Through its "partnership-of-partnerships" philosophy, AIHA actively promoted the integration of partnerships into a region-wide network through conferences, seminars, on-line networks, and cross-partnership exchanges and replication of successful activities. This important program element successfully and cost-effectively enhanced partnership achievements by allowing partners to draw upon each other's experiences. In addition, such events and efforts served as opportunities to gain high-level attention for partnership programs, on both the US and CEE sides, which often led to official endorsement of the programs and/or financial support.

AIHA supported conferences and workshops to reinforce and disseminate the successes of CEE partnerships both individually and regionally. These activities were designed to assure that (1) the individual exchanges were as effective as possible and build on the experience of others; (2) that emphasis was placed on sustainability of the program outcomes; and (3) that systems were in place to disseminate clinical and administrative changes beyond the direct participants in the AIHA partnerships. By sharing information, the partnerships were able to learn from each other's successes and failures, thus allowing each individual partnership to achieve considerably more than it could alone.

AIHA's information and communication technology (ICT) and publications programs have contributed to significant successes on the part of partners and other CEE health professionals in updating their knowledge and skills. Through the AIHA Web site as well as through *CommonHealth, Connections*, and other professional publications, AIHA provided partners and other CEE health professionals with information about program successes and models of best practice. AIHA also developed the EurasiaHealth Knowledge Network, a separate Web site that aims to provide and develop native-language educational materials and to serve as a forum for CEE and NIS health professionals to communicate and consult with each other. In addition to supporting knowledge dissemination through print and electronic media, AIHA also helped each CEE partner institution to establish a Learning Resource Center (LRC), which functions as an evidence-based practice training center and library for health and medical information. Taken together, the 135 LRCs that AIHA has established in CEE and the NIS, have evolved into a networked community, which supports greater cross-partnership collaboration as well as the sharing and dissemination of knowledge to other health professionals and institutions in the region.

KEY RESULTS

As the Continuing Evaluation Panel (CEP) noted in its 2001 mid-term evaluation report, AIHA's knowledge transfer, dissemination, and networking activities helped to improve the effectiveness of partnership activities by "speed[ing] the rate of adoption of new practices, often introduced first by the individual partnerships, to a wide cross-section of providers and consumers and thus contribute to measurable improvements in local or regional health outcomes." For example, partners working together in regional groups with local and national policy-makers to develop primary care clinical practice guidelines have demonstrated success in getting updated, evidence-based practice standards adopted at the national level.

- ***Annual Conferences***

Regionwide conferences and workshops provided an opportunity for partners to meet with and share information. Each year from 1996 to 2003, AIHA provided CEE partners an opportunity to meet for an annual meeting. These meetings not only provided a networking opportunity, but also offered sessions about topics relevant across partnerships.

The first CEE annual meeting, held in Budapest, Hungary, in 1996 gave AIHA's 15 CEE hospital, health management education and healthy communities partnerships, health ministry officials, and other senior healthcare professionals an opportunity to explore the progress and challenges of healthcare and health reform. Presentations by US and CEE partners provided an overview of the clinical areas of focus for the hospital partnership program, an introduction to the healthy communities partnerships established in Slovakia, and the health management education partnerships in CEE. Partners were also introduced to AIHA's Technology and Information Resources programs and special initiatives such as the Nursing Task Force and an invitational forum on quality assurance in international health management education programs. International organizations working on CEE health sector strategies, including WHO, EU/PHARE, and the World Bank, presented information on their funding capabilities and programs in the region. Representatives from USAID, AIHA, and the partnerships used the conference as an opportunity to discuss methodologies for assessing community health status and measuring partnership impact. Smaller breakout sessions reviewed cross-cutting issues being addressed by multiple partnerships, including home care and hospice; management of the pregnant patients; leadership and teambuilding; fundraising and volunteerism; and continuous quality improvement.

More than 230 partners, government officials, and other healthcare leaders from CEE and the US attended the second partnership conference in Zagreb in 1997. The conference gave its attendees the opportunity to present partnership initiatives and to highlight ways that the partnerships were having a regional impact. All 17 hospital, health management education, healthy communities, and community health partnerships participated. The conference included plenary sessions, smaller workshops, site visits to Zagreb partner hospitals, round table discussions, and hands-on technology demonstrations. The Nursing Task Force for CEE conducted a two-day annual meeting prior to the conference and shared its results with the general assembly.

AIHA's Third Annual Partnership Conference for Central and Eastern Europe was held in Bucharest, Romania, in 1998. Seventeen active and graduated CEE partnerships, government ministries, USAID missions, and other organizations sent a total of 176 representatives to Bucharest for this conference "about partnerships." Sessions and activities were developed to help improve the partnerships' ability to share successes, to replicate programs, to disseminate lessons learned and maximize impact, and to better evaluate programs. The conference had a special focus on helping partners to sustain relationships and achievements. Partners also had the opportunity to participate in site visits to St. John Hospital, a 700-bed general hospital in Bucharest and Polizu Maternity Hospital, Romania's largest maternity hospital where Holt International, with the support of USAID, has developed and implements a pregnancy-counseling program that teams social workers with medical professionals.

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

Over 250 healthcare professionals from CEE, the NIS, and the US participated in AIHA's 2000 partnership conference in Budapest, Hungary, on "Developing Common Strategies for Improving Primary Care and

Community Health." The conference offered plenary presentations and breakout sessions focusing on community mobilization, health promotion strategies, and practical skills-building for primary care providers. Partnerships also met in sub-regional sessions to share best practices and facilitate coordination on issues related to workplan implementation, primary healthcare clinical practice guidelines, and performance indicators and outcomes. Throughout the conference, partnerships had opportunities to meet and work on their respective workplans, and US partners attended meetings specially designed for partnership coordinators on administrative and financial issues and AIHA's evaluation activities.

AIHA hosted the 2001 annual partnership conference in Washington, DC. The theme of the conference, "Primary and Community-based Healthcare Solutions: Building on Models of Change," was in keeping with AIHA's programmatic emphasis on developing community-based approaches to improving the quality of primary healthcare in the NIS and CEE. Conference participants included key healthcare leaders from 18 countries, including the Ministers of Health of Kazakhstan and Tajikistan, and more than 500 health professionals from the NIS, CEE, and US. AIHA partners participated on panels throughout the conference to present their successful healthcare models and ways they have met the challenge of providing primary healthcare services and training family physicians. Additional topics included health promotion and education, effective methods to conduct needs assessments, the development of clinical practice guidelines, methods to encourage community involvement, infection control and multi-drug resistant strains of infections, integrated approaches to women's health services, and mother-to-child transmission of HIV/AIDS.

AIHA organized and held its 2002 annual partnership conference in Washington, DC. In addition to celebrating the organization's 10-year anniversary, the conference focused on disseminating partnership successes and discussing the emerging health challenges created by HIV/AIDS. Over 500 health professionals representing current and graduated partnerships, as well as numerous VIPs and other guests, participated. Graduating partnerships were recognized during a ceremony on the conference's first day, and special recognition awards were presented to three individuals for their contributions to the partnership program.

The focus of the 2003 CEE Regional Meeting held in Budapest was to examine current issues surrounding HIV/AIDS issues in CEE and to help partners develop community-based strategies to cope with the epidemic, affect change within vulnerable populations, and fight stigma associated with the disease. The second day of the meeting consisted of partnership presentations. The meeting concluded with a half-day workshop on engaging the business community in health projects.

- ***Other Conferences and Workshops***

AIHA also organized meetings, conferences, and workshops around specific topics, such as *healthy communities*, nursing, and health management education. Approximately 150 community health experts from across Central and Eastern Europe met in November 1997 during the region's first Healthy Communities-Healthy Cities Dissemination Conference in Banska Bystrica, Slovakia. The conference, co-sponsored by AIHA and the Association of Healthy Cities of Slovakia, brought together leaders from AIHA's three community health partnerships in Slovakia, USAID representatives from throughout the European region, partners from Latvia, Hungary, and Romania, and representatives from several Slovak cities participating in WHO's Healthy Cities project. Over three days, participants discussed the achievements of AIHA's healthy communities initiatives, as well as the building blocks of an effective healthy community/healthy city program: community needs assessment, community leadership strategies, multi-sectoral cooperation, fundraising, and city health planning.

Other conferences and meetings related to AIHA's inter-partnership programs in nursing and health management – such as a regionwide workshop on nursing association building and a case studies workshop for HME partnerships – are described in other sections of this report.

In addition to AIHA-sponsored meetings and events, AIHA also occasionally supported CEE partners' participation in other international conferences, including events for the World Organization of Family Doctors (WONCA) and WHO. In addition to the learning and networking opportunities, these conferences provided CEE partners with a forum to present their own successes and lessons learned.

- ***Information and Communications Technology***

AIHA's Information and Communication Technology (ICT) programs focused on improving access to reliable health and medical information for health professionals worldwide, as well as developing the capacity for health professionals to interpret and apply this information using the principles of evidence-based practice. With greater access to information, physicians, nurses, educators, policymakers, and other health professionals are equipped with greater capability to improve the quality and effectiveness of the healthcare they deliver. AIHA's ICT programs aimed to both improve the availability of appropriate native-language health information resources and build upon the infrastructure and capacity of healthcare institutions to access and use these resources.

AIHA recognizes the importance of promoting information exchange and communication among its networked partner institutions and has captured the capabilities of the Internet, including electronic mailing lists and the Web, to support this goal. During the CEE Health Partnerships Program, AIHA maintained two Web sites in support of CEE partners. The main AIHA Web site (www.aiha.com) focused on providing information about AIHA programs and partnership activities. The EurasiaHealth Knowledge Network (www.eurasiahealth.org) has served as an online community for the exchange of knowledge and resources on medicine and healthcare focused especially on the Eurasia (Central and Eastern Europe and the former Soviet Union) region. The site offers searchable databases of downloadable resources and links as well as interactive forums. The site's content is particularly rich in subject areas that represent critical and common concerns facing the region, such as HIV/AIDS, infection control, and women's health. These resources are made available for free to AIHA partners, other CEE/NIS health professionals, and the broader international community through a network of Internet mailing lists and World Wide Web links to key medical sites.

Since its inception in 2001 as an independent Web site (separate from the AIHA Web site), the usage of the site has increased dramatically. In the fourth quarter of 2001 the average number of visits to the site per month was 6,900. By 2006, the average is 27,399 visits per month, a 297 percent increase. About 800 healthcare professionals list their contact information and professional interests in the site's EurasiaHealth Community directory. Four EurasiaHealth-affiliated e-mail discussion and dissemination lists support the exchange of knowledge and news about new health and medical resources and events in the Eurasia region, and the lists range in membership from 200 to 500 subscribers.

The site offers free access to about 1,700 downloadable documents (articles, conference proceedings, presentations, clinical practice guidelines, patient education materials, etc.), many of which are available in Russian or other languages of the Eurasia region, or even in several languages. About 175 documents are in languages of Central and Eastern Europe, especially Polish, Romanian, Hungarian, Bosnian, and Croatian. AIHA has been responsible, through its partnership programs and collaboration with other healthcare organizations, for the translation of hundreds of these resources from English into other NIS/CEE languages, while others have been contributed directly by EurasiaHealth community members [i.e., users] or offered by other organizations. AIHA continues to package resources into instructional toolkits covering particular subject areas, such as healthy communities, health management education, women's health, and nursing, and made them available on the Web site.

Over 40 cases have been posted to the site's teleconsultations forum (and also sent out via the EurasiaTeleconsult e-mail list) by clinicians in the NIS/CEE requesting information and recommendations for treatment.

A survey of EurasiaHealth site users in 2004 indicated that 86 percent of respondents felt the site meets their needs. About 40 percent of respondents had been using the site regularly for more than two years.

AIHA staff principals of the EurasiaHealth project have made presentations about the Knowledge Network at conferences in Prague and Bratislava, at which many participants were in attendance from countries in Central and Eastern Europe, thereby increasing the awareness about the site within the CEE region.

- ***Publications and Media Relations***

AIHA's Publications and Media Relations (PMR) department disseminated information about partnership successes, highlighted relevant medical information, and documented partnership activities. AIHA regularly produced a journal, electronic newsletter, and special publications featuring regional collaborative activities. These publications were designed to keep partners, USAID, ministry officials, healthcare practitioners, and the general public informed about partnership activities and healthcare issues throughout the NIS and CEE.

Publications staff also worked to support and facilitate information exchange, a key component of partnership collaboration and an essential component of capacity building and "scale-up." CEE partners benefited from this exchange by receiving, for example, information on best practices, evidenced-based medicine, and successful models that help partners use resources effectively and promote sustainability. AIHA's approach created a framework for information sharing and capacity-building among partners and the worldwide community through the production of a wide range of high-quality publication and educational products that are disseminated on the Web and in hard-copy format.

AIHA produced regular publications documenting partnership successes and other relevant healthcare advances. The journal, *CommonHealth*, was published in both English and Russian since 1992 and distributed extensively through partnerships and regional offices. *CommonHealth* offered articles of interest to a broad range of healthcare professionals working in and with the NIS and CEE, offering a forum for exploring cross-partnership issues and initiatives. Most issues of *CommonHealth* focused on a special clinical or healthcare area.

AIHA also produced an electronic newsletter, *Connections,* which updated partners on the latest news and activities of its partners across the region.

In addition to the regular publications, AIHA published brochures and posters about various program areas, and a series of booklets that covered areas of cross-partnership interest such as healthy communities and information technology. AIHA also supported the production of a variety of curricula, manuals, and other educational materials that were developed through AIHA cross-partnership programs. The following list highlights some of these products:

AIHA Partnership Products
(by program area)

Clinical Practice Guidelines

- Clinical Practice Guidelines (CPG) Process Manual
- Chest Pain: Clinical Practice Guideline for Primary Health Care Physicians
  Protocol for Diagnosis and Treatment of Peptic Ulcer in Adults
- Bronchial Asthma: Clinical Practice Guideline for General Practitioners
- Cervical Screening: Clinical Practice Guidelines for Primary Care Providers
- Common Diagnoses of Primary Care
- Healthy Lifestyle During Menopause-Training Manual
- Clinical Practice Guideline for General Practitioners: Community-Acquired Pneumonia Diagnosis and Treatment Protocol
- Community Acquired Pneumonia (CAP)-Diagnosis and Treatment Protocol

Emergency & Disaster Medicine

- First Responder EMS Curriculum for Training Centers in Eurasia: Instructor Manual
- First Responder EMS Curriculum for Training Centers in Eurasia: Student Manual
- Pre-Hospital EMS Curriculum for Training Centers in Eurasia, 2nd Edition

Health Management Education

- HME Toolkit

Infection Control

- Infection Control Manual

Learning Resource Centers

- Lessons Learned & Best Practices Report

Neonatal Resuscitation

- Neonatal Resuscitation-Student Manual
- Neonatal Resuscitation-Instructor Manual
- Neonatal Resuscitation-Train the Trainer
- Neonatal Resuscitation-Train the Trainer Audiovisual Book
- Neonatal Resuscitation Slide Presentation Kit

Primary Health Care

- Youth Risk Behavior Survey
- Youth Risk Focus Group Questions
- Women's Health Needs Assessment Survey
- Women's Health Needs Focus Group Questions

III.I. US PARTNER IMPACT

Often overlooked among the outcomes of AIHA's partnership program, which are usually measured in terms of improvements within the CEE partner institutions and communities, is the personal, professional, and institutional impact of the program on the US participants. This impact, not fully anticipated when the program was initiated, has been documented over the years in both formal and informal surveys of US partners who have consistently and unanimously described the dramatic enrichment their personal and professional lives received from their participation in the program.

The benefits cited by US healthcare professionals range from a deeper understanding of the meaning of and appreciation for democracy, to improved teamwork with colleagues, to new clinical approaches that arise from looking at approaches to treatment from a different cultural perspective. Many US partners also cited changes in their way of thinking, similar to the mindset changes noted among CEE partners. The US partner profiles contained in this report reflect such impact, and a special report on this topic prepared in 1998 has been adapted and reproduced below:

THE VALUE OF PARTNERSHIP: *An American Perspective*

Physicians, nurses, educators, and administrators who have taken part in the partnership program say cross-cultural exchange has prompted them to rethink the mechanics of healthcare delivery and practice in the US, resulting in more efficient use of time and resources, and a new outlook on their profession.
Elaine Borawski, PhD, assistant professor of epidemiology and biostatistics at Case Western Reserve University in Cleveland, Ohio and participant in the Turcianske Teplice, Slovakia/Cleveland healthy communities partnership, is representative of the US perspective. "Having to speak about what we do in our health system to the Slovaks challenged the reasons why we perform our tasks or administrate," she said. "Realizations such as this came about by the Slovak partners asking questions and attempting to understand why we do what we do. It has been healthy self-analysis for many traveling [US] partners."

Fostering Teamwork and Creating Networks

For many US partners, the opportunity to work with CEE colleagues has yielded a renewed sense of purpose that translates into better working relationships, not only within their home institutions but with other health care professionals in their cities and with the community at large.

Bill Munley, administrator of rehabilitation at St. Francis Hospital in Greenville, South Carolina and team leader for orthopedics and rehabilitation with the Zadar, Croatia-Franciscan Sisters of the Poor Health System, Inc. partnership, said his hospital has forged stronger ties with several local universities and health care institutions by soliciting their help with partner activities.

"I think it has built a better camaraderie between our staff and other health care professionals in the area. For example, when Clemson University came to do a presentation on their orthopedic research projects, we learned a lot from them, and I think it helped our staff refine some of our rehabilitation techniques" he said. "People have changed their attitudes about a lot of things," he added. It made an impression to see [the Croatians] perseverance and fortitude through war, yet they still have a positive attitude and are still willing to pitch in and work as a team. It has given us a different picture of what teamwork means."

Stronger professional relationships also resulted at the University of Nevada School of Medicine in Reno, Nevada when partners launched a project to install upgraded technology in health management classrooms at several universities in the Czech Republic.

"The SMART classroom project involved individuals from the medical school, the campus education media office, AIHA program staff, instructional media staff at our partners' campuses, and partner faculty," noted Mary Paterson, PhD, director of the school's Office of Health Care Policy Research. "During this collaboration many people learned about these technologies and established informal networks that support continued learning. These networks, sustained by e-mail, will persist long after the project's completion."

Barbara Bogomolov, RN, MS, manager for community health and international services at Barnes-Jewish Hospital in St. Louis, Missouri and coordinator for the Riga, Latvia/St. Louis partnership, said the partnership experience has created a new sense of teamwork among several St. Louis health care institutions that are often at odds over local issues.

"At any major US medical center where you have a hospital and a university and several components there are always political issues to be worked out," she noted. "This partnership has given us the opportunity to put that aside and go to a different country to work with people who have given up everything. It is a real wake-up call. It has allowed team-building on neutral turf, where there are no political agendas for the [US] players involved."

The health management education partnership between Scranton, Pennsylvania and universities in Slovakia has helped "develop a very strong sense of cooperation within the health care and university communities in Pennsylvania," said Daniel West, PhD, chairman of the Department of Health Administration and Human Resources at the University of Scranton in Scranton, Pennsylvania. Fourteen US health care providers have worked on the partnership. "This has really opened doors to new opportunities for research in addition to field work," West said of the institutions' new bonds, which include regular exchanges of students and faculty across the facilities.

Partnership can also serve as an effective tool for building better relationships with the broader community: In Cleveland, Ohio, the MetroHealth System has reached out to the city's sizeable Slovak-American community for support with its community health partnerships with the cities of Turcianske Teplice, Martin and Banska Bystrica, Slovakia. The partnership has also drawn on the work of the Cleveland-Bratislava Sister Cities organization.

"The community health partnership has been good advertising for The MetroHealth System," said Cecilia Huffman, director of community affairs at MetroHealth. Cleveland is a town of immigrants, primarily from Eastern Europe, so it has been a program that the populace was pleased to see MetroHealth become involved with. As the Berlin Wall crumbled and became a symbol of the end of an old, totalitarian regime, our activities with Slovakia have been a positive sign of our assistance in a new democracy."

Exploring New Clinical Approaches

While the hospital partnerships focus on implementing clinical improvements at CEE health care institutions, CEE medical expertise has contributed to improved outcomes in US health care settings as well.

In St. Louis, for example, Bogomolov has successfully applied the Latvian concept of "a birth year" to her work in women's and infants' health among the city's refugee population. As soon as a pregnancy is diagnosed in Latvia, she explained, a one-year clock starts and one care provider is assigned as a case manager to oversee the pregnant woman through several months after delivery. This approach provides an alternative to the Western model of maternal and child care, which often incorporates different care providers for mother and child at different stages of pregnancy, delivery, and infancy.

Because refugee women can "fall through the cracks" of the Western system, Bogomolov said, the "birth year" model's supervisory strategy has been remarkably effective within St. Louis's refugee population, more than doubling their "adequate prenatal and birth care rate" in one year.

OB/GYNs at Dartmouth-Hitchcock Medical Center in Lebanon, New Hampshire have learned from clinical advances made by their partners at Sveti Duh General Hospital in Zagreb, Croatia. Doctors at Sveti Duh are among the first in the world to use Doppler ultrasound to help diagnose ovarian cancer. The technique uses ultrasound equipment to evaluate the speed and characteristics of blood flow in the blood vessels of the ovaries to help make the distinction between benign and malignant tumors.

Harte Crow, MD, a professor of radiology and obstetrics and gynecology at Dartmouth-Hitchcock Medical Center, and colleagues have studied Sveti Duh's techniques and tried to replicate them with their own patients. However, they have not been able to diagnose ovarian disease as accurately as their colleagues. Crow attributes this mainly to the larger volume of patients at Sveti Duh and, thus, their greater experience with using ultrasound for the procedure. Because of the reputation of Sveti Duh's OB/GYN Department, women from across Croatia with ovarian problems visit the hospital. However, several other high-volume US hospitals, including Columbia Presbyterian in New York City and Vanderbilt University Medical Center in Nashville, Tennessee, have used the technique successfully. Physicians at Vanderbilt have also collaborated with doctors at Sveti Duh.

The experience has "given us the opportunity to work with world-renowned OB/GYNs [at Sveti Duh] and really led us to appreciate the skill they have in scanning."

Another area of clinical collaboration has been in-vitro fertilization. A technique used at Sveti Duh injects a single sperm into an egg. Doctors at Dartmouth-Hitchcock had been mixing the sperm and egg together, but have now adopted the injection technique, "with promising results," Crow said.

"Sometimes I think, here we are in war-torn Croatia and we're learning cutting-edge methods for OB/GYN problems," he said. "That has really enhanced the experience for us."

A New Appreciation

Traveling to countries that are struggling to navigate the social and economic pitfalls along the road to democratization has been an eye-opening experience for Americans involved in the partnership program, many of whom say they have come away with a new appreciation for the privileges of life in the US.

One example of this metamorphosis can be found at the National Perinatal Information Center (NPIC) in Providence, Rhode Island, where more than three years of partnership with Faculty Hospital in Kosice, Slovakia, has changed the outlook of many of the staff.

"In many cases, US partners have gotten as much out of [the partnership] as the Slovaks," said NPIC executive director David Gagnon, MPH. They learned about working with a group of professionals who have the same knowledge base, but are applying it in [adverse] conditions.

"We have learned a lot about making the best of an imperfect world. [Our staff] come back and sees that they're basically spoiled. It makes it so much easier when they examine whatever problems they might have on the job here."

Frances Hutchison, RN, director of Forsyth Memorial Home Care in Winston-Salem, North Carolina and coordinator for the Vác, Hungary-Winston-Salem partnership, has seen a similar change in attitude among partners at NovantHealth. "The [US] employees who have had an opportunity to visit and work with our partners have a greater appreciation for the abundance of resources that we take for granted," she said. In this era of managed care, we are being challenged to not sacrifice quality as we reduce cost, and they have taught us how to stretch our resources."

West said his university's work with Slovakia in health management education has given him and other faculty members "a strong appreciation for democratization." When the partnership began, he explained, the [Slovak] Ministry of Education was moving to curtail certain elements of academic freedom, from writing to teaching. "They were talking about setting up laws on the appointment of rectors. We began to realize how powerful the government was," West said. "I began to appreciate more the importance of plurality of opinion, how important it is for faculty to have the freedom to teach what they think is necessary and not be restricted....We take so many things for granted in our country, press, voting, even making changes in curriculum."

The impact of trans-Atlantic collaboration is evident in many of the participating American hospitals, communities, and universities. Improved teamwork, more effective clinical practices and a broader understanding of the global practice of medicine are just a few examples of how the partnership experience has dramatically enriched the personal and professional lives of US participants.

IV. CONCLUSIONS

A. BEST PRACTICES & LESSONS LEARNED

Lessons learned and resulting best practices from AIHA's 12-year CEE partnership program can be grouped into three broad categories – the first relates to lessons about the partnership methodology and approach, the second to lessons about program implementation, and the third to lessons about the key ingredients or factors that contributed to successful partnerships. Findings from the RTI evaluation have been incorporated wherever applicable.

1) THE PARTNERSHIP METHODOLOGY

"The partnership fostered creativity and innovation. Through exchanges people on both sides of the Atlantic were exposed to new experiences, new approaches, and new ideas. Through open inquisitive minds; clinical, administrative, and governmental personnel forged new innovative approaches to improving the health of the people of Bosnia."
– C.J. Urlaub, *US Partnership Coordinator*

Two-way Exchanges

American and CEE experts traveled in both directions (US to CEE and vice versa) while participating in AIHA partnerships. This two-way exchange of expert partners was a crucial element of the AIHA partnership program in CEE. It played an important role in fostering a sense of true partnership between Americans and CEE partners and was also instrumental to the partnership process and in the success of the program. Rudolf Stritecky, a Czech partner, explains: "For us, these exchanges provided guidance both on how to structure curricula and to change people's attitudes. Really, it's difficult to put into words the enthusiasm that typified these meetings." Americans traveling to CEE were able to learn first-hand the situation on the ground that the CEE partner institutions faced. Exchanges to CEE were also important since the CEE institutions were the ones implementing programs being developed by the partnerships. In-country training provided by the American partners enabled a higher number of participants and better dissemination of information.

But one cannot underestimate the importance of CEE partners having an opportunity to travel to the US. By traveling to America early in the partnership, CEE partners were able to get a sense of the experience, skills, and resources of the US partners and their institutions. "If we had not been in America to see what they had done, we would have been more quiet. We wouldn't know what to ask…" explains Pellumb Karagjozi, an Albanian partner. Exchange visits to the US were imperative because they allowed the CEE partners to see American procedures and approaches to healthcare with their own eyes. Aldis Gailis, a Latvian partner admits: "I had done some ultrasound training for one month before I went to the US. But there, I could see with fresh eyes how it works in practice. I learned a lot and saw new and better ways of dealing with problems related to ultrasound." Fellow Latvian Liga Drukalska notes: "Before going to (the) States I thought that I had everything that I need here in Latvia, but when I went there I realized that people here don't know what we can have. It was important for me, because I realized that my future plans have to be on a higher level than before." Another common example was the case of nurses who observed their US colleagues in daily practice and gained a much better understanding about what the nursing profession should be like. The matching of CEE partner needs to US partner capacity was very important in the development of realistic and appropriate partnership workplans. Experiences in the US also exposed the CEE partners to American styles of community involvement that would have been hard to grasp otherwise.

"I have experience from before the war. There were no community-based programs—nothing was done. And after the war we are trying—we are especially motivated by visits to the US—community based-projects a lot. We are getting commitment from the community and you are feeling more satisfied with yourself and pushing yourself more."
– Jashar Ramadani, *Gjilan, Kosovo Municipal Government Representative, Gjilan/Hanover partnership.*

One concern about CEE partners traveling to the US was that what they would see in resource-rich US institutions was not always relevant, affordable, or otherwise replicable for their own institutions. However, AIHA and the US partners were careful to plan appropriate exchanges to the US which would be relevant for their CEE partners. While expensive pieces of equipment in a US hospital might not be available for a CEE partner institution; the clinical skills, organization, and management of care were ideas that could be shared and transferred. Exchange visits to the US were also limited in their scope because most of the trips consisted of short-term exchanges and informal training, rather than longer-term, intensive training courses. Additionally, because travel to the US was considered a perk, sometimes politics and favoritism drove the selection of participants, limiting the effectiveness of the delegation to utilize what they learned upon their return.

Demand-driven and flexible process

"During a period of rapid change, flexibility allowed the partnership focus to evolve. When opportunities arose to influence national policy, the partners were free to pursue them. The program had infinite possibilities, limited only by participants' imaginations." – RTI Evaluation

Another important element of the AIHA partnership methodology is its demand-driven partnership process. Any partnership interventions implemented would be successful only if they reflected the needs of the CEE partner institutions. Instead of imposing solutions devised in a vacuum, US partners shared ideas and worked together with their CEE colleagues to implement appropriate and effective programs. The partners were also empowered to address more than one health concern in the same project, unlike many other international programs that focused only on one targeted area.

AIHA managed the partnerships with a rigorous approach to process, developing policies, procedures, and tools to help facilitate the work of the partnerships, while fostering partner-driven results. However, the demand-driven nature of the partnerships meant a certain degree of flexibility in allowing partners to adjust to changing situations and priorities, resulting in changes in workplan objectives and outcomes. For example, the Vác/Winston-Salem hospital partnership shifted its focus in its last year to implement a healthy communities program, as the Hungarian partners realized that while improvements in care at the hospital were important, there was also a need to more effectively engage the greater Vác community in health-related issues.

The use of a cooperative agreement helped AIHA have the flexibility to fund partners' activities based on individual partnerships' needs assessments. This allowed for flexible planning and allowed partners to set and modify objectives as needed to meet the goal of the program. This flexibility, while beneficial to the programs, made mapping to USAID indicators difficult.

"The lovely thing about the first three months of the partnership with Gjilan was that we really didn't know what we were going to do! It was wide open. We did not know if we were going to be working on an acute care issue, a chronic care issue, or what. All we knew was that the partnership was going to improve health by working in family medicine. That was really a wonderful opportunity." – Don Kollisch, *Associate Professor and Family Physician, Dartmouth Medical School*

Peer-to-Peer Relationships

"Once the US partners escorted their CEE partners into the global medical community, the CEE clinicians became active participants, seeking out collaborations with other institutions and thriving on the depth and breadth of new knowledge they could access." – RTI Evaluation

By focusing on the development of relationships between CEE and US partners as peers and colleagues, the AIHA partnerships were able to foster a true sense of teamwork among partners. The US partners were experts in their field, but the CEE partners were involved from the start as equal partners in the process. While the Americans could share their expertise and experience, this peer-to-peer approach empowered CEE partners to become change agents in their institutions and to take ownership of the programs being implemented.

Involving the CEE partners as equals to their American counterparts in the assessment and planning phases also ensured that the partnership workplans developed addressed local needs and that the interventions suggested would be appropriate to the local context. It also enabled the US partners to learn from the CEE partners. One example was when the Romanian partners were able to participate in the process of the US partners planning to reopen a closed rural hospital. The Romanians were able to participate in key meetings, activities, and planning sessions and observe firsthand the strategies employed and skills used that led to the reopening of the hospital.

"Dr. Barsic read us the riot act for our inability to use our [medical equipment] more discriminately; we were using whatever and not being frugal; we wasted so much in our system; it was said and received with great respect." – Pamela Thompson, *CEO, American Organization of Nurse Executives*

The partners on both sides have noted that the personal relationships that they've established through the program have been one of the lasting impacts of the program. They stress that while work was the main purpose of the exchanges, developing personal relationships where they were able to share their personal lives and see their shared values greatly strengthened the program.

Voluntarism

A crucial element of the AIHA program in CEE has been the voluntary aspect of the partnerships. US partners donated their expertise by volunteering their time, during professional exchanges to CEE and in hosting CEE partners in their US institutions. US partner institutions also donated equipment and supplies in support of the work of the partnerships in CEE. By galvanizing US institutions and American experts to participate in the partnership program, AIHA has been able to leverage substantial amounts of in-kind donations. AIHA's partners generated a total of $137,302,121 in in-kind contributions to the partnership program balanced against $70,983,219 of funding from USAID.

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

The CEE partners also benefited from this voluntary approach. The idea of volunteerism was new in the CEE countries during the partnership program, and some CEE partners started to utilize volunteers to support their own partnership work, particularly the Healthy Communities partnerships.

A drawback of the use of volunteers was that AIHA had to be more flexible and understanding of the partners when they did not address certain issues in a timely or effective manner. Since the US partners had full-time jobs, the partnership work was above and beyond their usual work obligations. Some areas, such as

effective data collection, suffered because of this. The US partners were also constrained by the varying levels of organizational support. As US healthcare institutions faced cost-reduction pressures, they were less able to justify the donation of paid time to the partnership program. The fact that many had not traveled internationally or worked on international assistance programs did not pose a barrier to the success of the program, but the Americans did find that developing an understanding of USAID's policies was one of the more challenging aspects of their work.

2) PROGRAM IMPLEMENTATION LESSONS

Language barriers

One of the ongoing challenges in supporting the partnership program was bridging the language barriers, both between US and CEE partners and among the CEE partners during inter-partnership events. In order to prevent language being a factor in excluding CEE partners from being able to participate in the program. AIHA provided funding to partners for interpreters during partnership exchanges and for the translation of written materials and educational resources. However, when working with interpreters, the value of the program is limited by the quality of the interpretation or translation. Partners had to work hard to find translators who understood the program and related politics, had the appropriate medical backgrounds, and who were able to bring across the appropriate message. That is one reason why some US partners felt that CEE partners who traveled to US on professional exchanges should have at least a workable knowledge of English. The Buffalo partners held intensive English language courses in Bosnia for the Tuzla partners who were going to be traveling to Buffalo on partnership exchanges. "We didn't want to send people to the US who couldn't speak English well. The courses were very effective in bringing them to using English at a workable level," explained one of the Buffalo partners.

The partners also found that when the CEE partners had English-language skills it made it easier for them to have an ongoing relationship by e-mail or phone. And because of the variety of languages spoken by partners in the CEE region, whenever meetings were held with participants from more than one country, English was the common language that they could use to share common challenges and accomplishments.

Another issue was the lack of educational materials in local CEE languages. An assessment of the Nursing Resource Centers found that many of the resource handbooks and other written materials were used less because of a lack of English-language proficiency. However, the cost of translating whole textbooks into the local language was cost-prohibitive given the funding levels of the partnerships.

Whenever possible, the selection of CEE partners with English-language proficiency for professional exchanges would be optimal. And when possible, funds should be made available for the translation of resource materials into the local language. However, the value of including a wider array of individuals in the partnership experience (with interpreter support) is a larger consideration which should not be ignored. Many CEE partners with no English-language ability effectively participated in partnership activities, and more importantly, became important change agents in their institutions as a result of the partnership experience.

As an unexpected benefit, the American partners noted that learning to deal with language barriers within the context of their partnerships brought insight to issues that they had as an organization dealing with non-English-speaking customers in the US. The partnerships also helped encourage partners to learn a new language. According to Hotic Nesad, pediatric surgeon from University Clinical Center Tuzla (Bosnia), he did not speak English at all prior to the partnership. Participation in the partnership provided the impetus for learning English, to be a more effective partner, and to better communicate with US counterparts and new friends. Hotic now speaks English very well.

Selection of exchange participants

One very important aspect of the partnership was the involvement in its activities of people of different professions and levels of experience. It created an opportunity for them to work together in a neutral environment outside the hospital. For many nurses, the partnership gave them the very first occasion to work with physicians as a team. This nurse-physician teamwork helped to improve the perception of nurses among physicians.

Many partners also found that a higher number of participants in the exchange trips to the US meant better odds for success. Partners who returned to their country with new ideas and knowledge very often meet with resentment and skepticism among their colleagues. A group of professionals from the same institution, or even from the same department, who are exposed to international practices can rely on each other for support in implementing changes at their home institution.

The Tuzla partners said that it was important to have a partnership coordinator/director who would select the right people to participate in exchanges to the US. In Tuzla, there was a focus on younger staff participating in partnership exchanges, almost all of whom have stayed at the hospital. In many partnerships, there were times, especially in the initial exchanges, when politics or favoritism influenced the selection of delegates who were not as appropriate as other staff. AIHA tried to avoid such selections by working closely with partnerships in identifying staff and asking partners to identify specific objectives and follow-up items for each traveler.

Training methods and settings

The partners utilized a variety of different methods and settings for the training that took place during partnership exchanges. Depending on the subject matter, partners designed hands-on as well as didactic training courses, and they organized both group and one-on-one sessions. Generally, partners found that hands-on in-clinic training worked better for clinical topics, while training courses using adult learning methodologies worked better for management training.

Exposure to new teaching methodologies in many ways helped to teach CEE partners to think differently, which turned out to be just as important as the content being taught. Osman Sinanovic from Tuzla noted: "The management workshops were important in helping us to find the potential in each individual in the organization. They not only introduced important theoretical concepts, but also helped us learn practical skills in working with each other. While we were playing with a ball, we were really learning very important problem-solving skills."

Monitoring and evaluation

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

There were many challenges in trying to effectively monitor and evaluate the program outcomes of the AIHA partnerships in CEE. While many of the CEE partnerships and projects instituted systems to collect and share data regarding their interventions, the partners faced many challenges in collecting timely, accurate, and useful information. In some of the CEE institutions, there was simply a lack of capacity to efficiently collect the needed data. In hospitals and clinics where there was a lack of human and material resources, it was difficult to find someone who could be dedicated to the task of data collection and analysis.

For instance, in Kosovo, primary care facilities were able to track the number of patients visiting clinics and being screened for hypertension (in Gjilan) or receiving antenatal care (in Gjakova). The Kosovar partners understood the importance of tracking this information to develop and refine interventions, improving the quality of primary care offered to patients. However, these data collection measures focused on the processes being implemented, not on the expected outcomes. With the limited timeframe and resources available for these partnerships, perhaps these process measures were all that could effectively be developed during the partnership funding period.

However, AIHA did take concerted steps to make sure the CEE partnerships focused on monitoring and evaluation. AIHA became more rigorous with partners in making sure they included measurable indicators to track outcomes. A monitoring and evaluation unit was established at AIHA to better track outcomes of the partnerships and cross-partnership programs. AIHA developed indicator frameworks for its major program areas and provided partners with expertise in monitoring and evaluation efforts, such as the implementation of patient satisfaction surveys.

Despite the challenges in developing monitoring and evaluation capacity in CEE institutions, through the partnership program a data collection capacity has been developed within many CEE partner institutions that can be used by partners to measure the effectiveness of new interventions they will be implementing in the future on their own.

Role of information and communications technology

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

For many of the CEE partner institutions, the introduction of information and communication technologies through the Learning Resource Center (LRC) program had a transformational effect. One Romanian partner noted: "I will never forget the first e-mail messages sent to the US saying 'We are connected' which meant that we are connected to the world. For me I felt like — to use a metaphor — like the change from candlelight to the light of knowledge, which was the computer, modern technology, which we were not able to use in the past, in the years of communism." Aside from some of the universities, most CEE partner institutions had very limited IT infrastructures when the partnerships started, and in many cases computers were seen as irrelevant to healthcare. The LRC helped to plant a seed in helping healthcare professionals see the value of computers and the Internet to connect them to the outside world, so much so that the overwhelming majority of partner institutions have been able to maintain the LRC functions and capabilities on their own without external funding.

One of the difficulties AIHA faced with the LRC program's implementation was that training was often generalized to clinical content because the majority of partners were clinical institutions. While AIHA allowed partners to select specific information resources relevant to them, some of the healthy communities partner organizations (government offices or NGOs) and universities involved in the health management education partnerships felt the level of training was sometimes too high or too low for their needs.

Information and communications technology also had an impact in facilitating communication within and between partnerships. E-mail was instrumental in keeping the partners in contact with each other in between exchanges. And AIHA-managed Internet discussion lists allowed US and CEE partners to communicate with each other as a group. One of these lists developed into a resource for partners who wanted to consult with other colleagues when having difficulty in diagnosing and treating a patient. In these cases, US partnership coordinators on the list would track down a relevant specialist to provide feedback and support.

Inter-partnership conferences and other regional activities

In order to foster a "partnership of partnerships," AIHA sponsored activities that brought together partnerships from different countries in the region to foster collaboration and dissemination of knowledge. Task forces not only helped steer partnership directions in topic areas, but also became a useful tool for building long-lasting relationships and sharing experiences. Regional conferences and workshops enabled partners to share experiences in common program areas and make connections with their colleagues who are going through a similar process.

One challenge to the success of the regional activities were the varying levels of economic and social status of the various countries in the region, which made the content of the meetings more general than many partners would have liked. Another downside to the use of the regional meetings was that it was costly to convene them.

External pressures on the program

Despite the best efforts of the partnerships to plan their programs, they were often hindered by challenges that were beyond their control. Many partnerships faced changes in leadership. Sometimes partnership coordinators or key personnel left the partnership organization, causing changes in direction with new leadership. In other cases, partnerships faced political changes on the local, regional, or national level that affected the progress of the partnership by changing healthcare priorities.

Another challenge for partners was when healthcare reforms had not yet caught up to the progress of the partners. For example, when nurses learned about the roles of their American counterparts and wanted to take on new responsibilities within their own systems, they frequently encountered resistance when they went back home. Similarly, graduates of the CEE partner institutions' newly created healthcare management programs were often unable to find positions as healthcare managers because the positions were still appointed politically.

The partners also faced financial constraints when trying to implement their programs. Because the national Ministries of Health were underfunded, and the healthcare institutions were working with very sparse resources, the partners had to work hard to solicit funding for their new programs and bring in external funding though grants or by instituting fee-for-service.

3) KEY FACTORS FOR SUCCESS

CEE change agent/champion

In many cases, the success of the program was at least partially attributable to the single contributions of a key leader, who served as a champion of the project and an agent for change. Partners with magnetic personalities, important political connections, or simply intense dedication were able to sway reluctant decision-makers and clinicians to support the program. Some partners also found that the encouragement and moral support provided during interactions with their American partners helped them to grow more confident and discover the leadership potential in themselves.

"The [AIHA partnership] approach opened doors for naturally gifted social entrepreneurs with vision and energy, empowering them to take action." – RTI Evaluation

The US partnership coordinator was also a key element contributing to the overall success of the partnership. As volunteers, many partnership coordinators worked on the project above and beyond their daily job responsibilities and did so because they believed in the work they were doing. Dynamic and dedicated

partnership coordinators were able to garner the support they needed from their institutions, recruit a wide variety of volunteers, and help their CEE partners lobby for political change.

Local ownership

By being involved in true peer-to-peer relationships with their American counterparts and involving them in a demand-driven process, the CEE partners took ownership of the partnership and the changes being implemented in their institutions. For example, in Kosovo, the US partners at Dartmouth Medical School relied on their counterparts in Gjilan and Gjakova to implement the primary care-based hypertension screening and antenatal care programs. The US partners provided key technical assistance and mentoring, but the actual delivery of services was managed and provided by the Kosovar partners. The US partners were not even in Kosovo in February 2004 when the antenatal care program was launched in two pilot centers in Gjakova. By placing ultimate responsibility for the success of the interventions squarely on the shoulders of the Kosovar partners, the CEE partners became owners of the process, helping ensure its sustainability well after the partnerships graduated.

Political support

"The success of the program depended on the personal interactions. When we started, the local government changed the director of the hospital. You can have the champion (and Agnes was that champion), but if she is not supported by the top management of the organization, it makes it really hard on that day-to-day champion to do something. The administrator/executive doesn't need to be involved all that time, but has to be intellectually committed." – Paul Wiles, *CEO, Novant Health*

Support from the national and local governments was integral to the eventual success of the partnership programs. AIHA partners were encouraged to keep the Ministries of Health updated on the partnership's progress, and funding limitations made securing the financial support of the MOH imperative. Because AIHA's subgrants would generally only fund training and a limited amount of supplies, CEE partners had to gain the support of their Ministries of Health to fund salaries, renovations, and most equipment. The Lezha partners, for example, were able to secure approximately $130,000 in funding from the MOH to support the physical renovation of the space for the new Town Health Center.

"Despite difficulties in getting stakeholders from different political parties to work together, we learned how to strategically find and nurture support of key individuals."
– Daniel Verman, *Head, Health Promotion Department, Constanta Public Health Authority*

Partnership timing

"It would have taken us five more years to get to the point we are now, without the partnership with Buffalo. We had cooperation with others before the Buffalo partnership, but Buffalo came at an important time at the end of the war. The partnership helped us keep people here. The partnership helped us realize that we cannot be a small closed hospital. The partnership opened up the hospital to work more on education and training, and to new ways of learning."
– Nedret Mujkanovic, Director, University Clinical Center Tuzla

Timing was also one of the main factors for the partnerships' successes. The partnerships were initiated at a time of structural changes in the healthcare systems of CEE countries, when hospitals began to be accountable for their financial stability, for example. The training and exchanges offered by the partnerships helped the CEE partners to ground themselves in the countries' new economic reality. With their partners' support, they learned new management skills and important competencies that enabled them to jump ahead in the new market economy.

B. THE LEGACY

As a result of 12 years of USAID funding and the dedicated efforts of hundreds of CEE and US partners, AIHA's Health Partnership Program in CEE contributed in myriad ways to strengthening healthcare in the nine countries and Kosovo. As the country summaries, program area summaries, success stories, and partner profiles illustrate, the program has had an impact that goes far beyond the immediate individuals and institutions involved. Not only were a wide range of new, improved, and sustainable solutions to healthcare problems introduced, but as a result of deep and significant shifts in thinking and new paradigms for approaching problems, a legacy of enduring and ongoing changes remains throughout the region.

"USAID's investment in the partnerships program has produced important results in the CEE that have had cascading impact in the years since program support ended. The collaborative and participatory approach of the AIHA model has brought meaningful, lasting changes at the personal, professional, institutional and policy levels in the CEE. By contributing to USAID Bureau goals and strategic objectives, the approach also fulfilled foreign policy goals that have accelerated the movement of the local medical communities, including hospitals, academic institutions and social service organizations, out of isolation and into the international medical community. Most importantly, it has fostered widespread friendship and good will among partners."
– RTI, 2006

The key contributions of the program as a whole can be summarized in eight main broad areas of impact that cut across individual partnerships, countries, and program areas. These areas (some of which overlap) are: 1) changes in thinking and mindset; 2) new and/or improved health professions; 3) institutional/organizational changes; 4) focus on individual patient and personal responsibility; 5) community-building; 6) regional and national-level impact; 7) impact on US partners; and 8) sustained benefits of initial investment

1) CHANGES IN THINKING AND MINDSET

Perhaps the single most profound legacy of the partnership program, cited by both CEE and US partners, is a "change in mindset." While such an outcome is difficult to measure and quantify, it is arguably the most significant and lasting legacy of the program. In surveys and interviews, CEE partners spoke of a newfound ability to think critically, to look at problems differently and find solutions, and to be more collaborative and work as teams.

The mindset changes partners describe range from the very personal—such as the Kosovar physician who said, "The partnership experience made me realize that I needed to live healthier. I run an hour a day, eat less, and eat healthier….My life changed because of the partnership."—to the way in which colleagues learned to interact with one another more as equals. Partners also describe how they began to perceive and therefore treat patients differently. Such changes, by their nature, not only precipitated the achievements of the partnerships, but also have been responsible for influencing ongoing achievements by the CEE partners. While numerous examples appear through this report, a few highlights are provided below:

The experience of the director of Albania's Trauma Hospital was not unusual. When he began his partnership with Bronx, New York, he felt all the Albanians needed was equipment and argued that USAID funds would be best spent on simply upgrading their medical technology. After several years of the partnership and participating in a series of leadership and management seminars organized by AIHA and the partners, this physician confessed in a lengthy and heartfelt letter to AIHA's executive director he that he had been "absolutely wrong" in his initial dismissal of the partnership. He apologized profusely for his negative attitude and said he now realized that "the new way of thinking my colleagues and I

gained was far more important than money or any equipment we could have received from the US."

"You didn't teach us how to do a lot of 'things'; you taught us how to think differently about our work. Now we will be able to use that on any project, not just the ones we are working on now."
– Bruno Barsic, MD,Zagreb, Croatia/Lebanon, NH partnership

"The project [Riga/St. Louis partnership] helped to change our post-Soviet type of thinking and let us work more freely." *– Ainars Civcs, MD, Ministry of Health, Latvia*

"My life changed. I am not the same person. I became more committed to the community's problems, to listening to the voice of the community. I enlarged my family to the community level."
– Daniel Verman, MD, Constanta, Romania/Louisville, KY partnership

"The most valuable result of the partnership program is surely the change in the behavior and attitudes of healthcare workers in all structures, to be more responsible for their particular job, to have better relationships and collaboration as part of a healthcare team. This led to significant improvement in the quality of work." *– Tatiana Jeren, MD, Zagreb, Croatia/Lebanon, NH partnership*

"It was useful to see how practical Americans are. I became also very practical. It's not just talking but you go and do something." *– Ulo Kivistik, MD, Tallinn, Estonia/Washington, DC partnership*

"A 'change in mindset' was described at almost every hospital partnership visit. This consequence of the visits to the U.S. and the collaboration with the U.S. partners clearly enabled—and in some instances appeared a necessary requirement for—many of the other partnership goals to be achieved. It played a critical role in building human capacity….Underlying all of these gains was the shift in mindset that resulted from the CEE partners being able to envision doing things differently." *– RTI report, 2006*

2) NEW AND/OR STRENGTHENED HEALTH PROFESSIONS

The partnership program contributed significantly to human capacity building among healthcare professionals in the CEE countries. Thousands of CEE doctors, nurses, and other professionals received training through voluntary, peer-to-peer exchanges and other programmatic activities. The interaction with their counterparts in the United States and other countries in the region, as well as their exposure to new ideas and ways of approaching the provision of care, enabled these professionals to rethink their roles as healthcare providers and become educators and agents of change at their institutions and in their communities. The increased skills and knowledge of the health practitioners translated into clear improvements in healthcare, better preventative medicine, and healthier lifestyles for the public.

While increased knowledge and skills in specific clinical areas were evident among the partners, one of the greatest areas of impact was in the area of health management and leadership. Both through AIHA-organized central management training workshops and the work of each individual partnership, the CEE partners unanimously pointed to their newfound management and leadership skills as among the most valuable and important.

Nurses, in particular, embraced the new educational opportunities the partnerships afforded them and assumed greater roles and responsibilities, gaining the respect of physicians and patients alike who gradually came to view them as an integral part of the healthcare delivery system. Nurses and nursing made great strides in many CEE countries through the efforts of partnerships and AIHA's inter-partnership nursing initiative. As the USAID evaluation team found, "The elevation of the nursing profession in the region is a clear success story…."

Not only did individual healthcare professionals gain new skills; in several instances, entirely new specialties were created as a result of partnership work, such as in health management, emergency medicine, hospice, palliative care, home care, occupational health, nurse educator, infection control nurse, among others.

Whether in a new or existing areas of healthcare, many CEE health professionals used their new knowledge and skills to become nationally-renowned specialists or champions in their particular fields. Some have expressed that they owe their dedication to and achievements in specific areas of medicine and public health to their involvement in the partnerships. Among them are:

- Peter Krcho, neonatologist from Kosice, now president of the Slovak Neonatology Society and a leader in creation of Union of European Neonatal and Perinatal Societies;
- Anda Jansone, and palliative care;
- Aldis Gailis, an ob/gyn, who became a renowned ultrasound specialist in Latvia;
- Daniel Verman, who has become Romania's leading expert and advocate on domestic violence issues;
- Liga Drukalska, a microbiologist at the Children's Hospital in Riga, Latvia, who said, "Without this project [salmonella outbreak investigation], I wouldn't be a microbiologist today;
- Elena Kavcova, who has become a smoking cessation champion and expert in Slovakia;
- Andrus Remmelgas, an anesthesiologist, who developed an EMS training center in his current position as Chief of Medical Service/Surgeon General for the Estonian Defense Forces;
- Dana Farcaseanu, a Romanian healthcare policy expert who says she was nurtured in her professional growth as a healthcare management specialist and "grew up with AIHA;" and
- Ramize Ibrahimi, a nurse who found her calling as a leader in nurse education and patient outreach in Kosovo.

3) <u>INSTITUTIONAL/ORGANIZATIONAL CHANGES</u>

Because AIHA's partnership program was built on a foundation of institution-to-institution relationships, some of the greatest legacies of the program can be found at the organizational level. Each of the CEE partner hospitals introduced multiple and permanent improvements that included implementing quality improvement processes; creating new departments or restructuring them; establishing new committees to deal with issues such as infection control; developing new staffing and human resource policies; and instituting cost-accounting and other financial measures, such as the improvements in pharmacy management that resulted in a 35 percent reduction in drug-related costs at one Croatian hospital. These changes led to better and more efficient services and ultimately to higher quality patient care.

One indicator of improved efficiencies and quality of care in hospitals is average length of hospital stay (ALOS). Among the many hospitals that reported dramatic reductions in ALOS as a result of partnership efforts was the Orthopedic Hospital in Biograd, Croatia, where ALOS for arthroscopy patients fell from 30 days in 1995 to zero by 1998, when the procedure was handled as same-day surgery.

Many partner hospitals also introduced entirely new or significantly improved services in areas such as cardiac catheterization, emergency medicine, hospice and palliative care, and post-traumatic stress disorder.

Beyond hospitals, organizational changes also occurred within educational institutions as new courses and curricula were developed, new departments were created, and new capacity was built for conducting healthcare policy analysis and research and for providing consulting services.

4) FOCUS ON INDIVIDUAL PATIENT AND PERSONAL RESPONSIBILITY

For the individual patients and members of communities served by the CEE partnerships and projects, a dramatic change occurred as a result of the partnership program. For the first time in the CEE countries and healthcare institutions, the delivery of care became truly "patient-centered" – focus was on how best to meet the needs of the individual patient while achieving systemic changes. So, for example, patient satisfaction surveys were conducted for the first time in many of the partner hospitals; a customer service department was established at Mustamae Hospital in Estonia; patient consent forms were introduced at the Women's Clinic in Tallinn; and family-friendly policies were instituted at the Infectious Disease Hospital in Zagreb and at Children's Hospital in Riga.

This shift in thinking towards patient-centered care and the new practices instituted as a result were described by numerous CEE physicians and nurses. While some had heard of the concept before, partners described the importance of seeing the practice first-hand in the US and understanding the policies and procedures that support its implementation. This shift in delivery of care influenced the institutions at many levels – affecting hospital visitation policies (i.e., increased family visiting hours), requiring restructuring of some physical facilities (e.g., creation of mini-apartments to allow parents to stay near their children in intensive care units), down to the level of patient-provider interactions (e.g., respecting patients' privacy during examinations).

At the same time as healthcare professionals focused more on the individual patient, the individual was asked to play a more active role in their own health, by participating in health promotion and health education activities. This, too, represented a major shift in thinking, given the historic lack of public engagement and personal responsibility and accountability in the health arena. Patient support groups were established in Vác for diabetes and colostomy patients, and patients were given information to enable them to play a more active role in decision making about treatments and procedures.

Each of the healthcare partnerships – whether hospital, healthy communities or primary healthcare – incorporated and promoted approaches to disease prevention and health promotion. Through partnership efforts at patient education, community outreach programs including media campaigns and health fairs, and various community-based interventions, populations learned about the importance of taking responsibility for one's own health as well as the health of their community. In Zadar, for example, public education campaigns and health fairs were held to encourage for early detection of heart disease and cancer.

5) COMMUNITY BUILDING

The partnerships, through their embracing of the importance of inclusiveness and community engagement as a foundation for improving health in the communities, also leave behind a legacy of strengthened communities able to work together across conflicting backgrounds, professions and ethnicities in the interest of creating health.

Perhaps the most vivid examples of how a healthcare partnership helped bridge divides within communities and bring people together can be found in those communities rocked by inter-ethnic strife –Bosnia, Kosovo, Croatia—and, to a lesser extent, in Hungary with its sizeable Roma community, where healthcare partnerships reached out and embraced disparate groups around the common goal of improved health.

"In Gjilan the Serbs are in a better position than in other places in Kosovo, because when the American partners were here we tried to integrate the Serbs into our system. The partnership made connections between us and the family physicians in the Serb areas." – Hajriz Ibrahimi, *former Director, Main Family Medicine Center*

The nine communities where partnerships applied the healthy communities methodology, engaging multi-sectoral stakeholders, there have been permanent shifts in how stakeholders come together to solve common problems. By learning how to utilize tools of community mobilization, consensus-building, and conflict resolution, for example, these communities developed a newfound capacity for working together to find solutions to their community's problems. Partners in Vác created a Healthy Community Task Force and the Association for the Health of the Citizens of Vác in Gyor, partners established a Community Advisory Board that has been implementing numerous educational programs in the community on priority women's health topics; and in Turcianske Teplice, partners assembled a multi-faceted task force that included the town's mayor, environmental engineer, a teacher, and a priest.

Another aspect of community-level impact was in the growth of non-governmental organizations and related voluntarism. Health-related NGOs were created where none existed before, such as the Association for the Health of Women in Gyor; the foundation and community relations program in Zadar; and the Community Foundation in Constanta. The US partners helped introduce the concept of voluntarism into these communities, resulting in CEE partners initiating their own volunteer programs that have been attracting young people into unpaid community service roles.

"The volunteerism spawned by the CEE partnerships reflects an important culture change….This reflects a higher acceptance of personal social responsibility than existed under the old regime and serves as a measure of the increased role of civil society organizations in these countries." – RTI, 2006

6) REGIONAL & NATIONAL IMPACT

AIHA partnerships also generated changes and impact beyond the individual institutions and communities involved. Although the partnerships did not always set out with broader ambitions, they were often at the forefront of local and national health reforms by initiating or influencing legislative and policy changes, demonstrating successful interventions that served as models for replication or rollout, and introducing new clinical guidelines and processes for adoption nationally. The USAID/RTI evaluation found that "Success at the institutional level was leveraged to create system-wide impact." Examples include:

- Influenced passage of laws such as requiring sexually transmitted infections (STIs) testing for pregnant women (Romania), designating drug use and domestic violence as crimes (Slovakia), prohibiting smoking in public buildings (Slovakia), establishing standards for workplace protection (Romania), and creating a national committee for control and surveillance of infectious diseases, and adopting the WHO Framework Convention on Tobacco Control (Slovakia)
- Developed model programs that were replicated in other cities such as palliative and hospice care in Latvia, Vác's home care model (Hungary), Constanta's domestic violence program (Romania), Split's school-based program to reduce alcohol use (Croatia), Gjilan's family medicine center's patient flow system (Kosovo), breast health radiology quality assurance program (Romania) children's asthma in Croatia, post-traumatic stress disorder in Croatia
- Produced guidelines that were approved for national dissemination such as on hypertension (Kosovo), microbiological testing (Latvia), and diabetes patient education (Hungary)
- Established a regional referral system for perinatal care in eastern Slovakia
- Designed health communications campaigns that served as a model for use by Romania's national health insurance house
- Established degree programs in health management in the Czech Republic and Romania
- Contributed to development of curricula for new baccalaureate and master's degree nursing programs in Estonia
- Initiated national interdisciplinary efforts to address stigma and discrimination around HIV/AIDS in Croatia

- Spearheaded creation of nationally recognized specialties such as occupational health (Romania), and clinical social work (Latvia).

In addition, several of the partner institutions gained national prominence as a result of partnership activities. These include:

- The University Hospital for Infectious Diseases in Zagreb, Croatia, was tapped to serve as a national resource center for infection control microbiology
- Partners from Mustamae Hospital in Tallinn, Estonia, spearheaded the establishment of a national rescue team with health professionals from other hospitals
- The University Clinical Center in Tuzla, B&H, became the country's leading hospital for state-of-the-art cardiac care and one of two national referral centers for pediatric surgery
- Bikum Holim Hospital in Riga, Latvia**,** with the country's first fully-functioning hospice program became a clinical training site for hospice care
- Children's Hospital for Respiratory Disease in Zagreb became known for its model asthma control program.

7) IMPACT ON US PARTNERS

The partnership program also greatly benefited participating American healthcare institutions and health professionals by providing them with a global perspective, an opportunity to build bridges within their own communities around an international service project, and critical insights into the solution of healthcare issues back home. The personal, professional and institutional impact of the program on the US participants, while not fully anticipated when the program was initiated, has been profound, as US partners have testified and as reflected in the partner profiles and elsewhere in this report.

8) SUSTAINED BENEFITS OF INITIAL INVESTMENT

USAID's investment in the AIHA partnership program has continued to sustain ongoing benefits and bear new fruit in the years since funding ended. Numerous examples point to partners who have continued to maintain relations (both institutional and personal) and work together, often expanding into new areas of collaboration. (Of the 30 AIHA partnerships established in the region, three-quarters have reported some type of continued relations.) In some cases, the relationships are more personal and simply serve to nurture ongoing cultural understanding and international relations; in other cases, the partnerships seeded what have become new areas of collaboration and achievements. Even when partners have moved on to new jobs at new institutions, often they have taken their relationships with them to grow new collaborations or simply to apply the knowledge and skills gained through their partnerships in new ways that benefit their countries. Examples include:

- Rhode Island partners, with funding from a local Albanian NGO, are working with their partners in Albania to train nurses at the Maternity Hospital on early childhood education.
- A physician from Buffalo, NY, moved to Tuzla, Bosnia, after the end of the partnership and has dedicated his life to continuing to help strengthen the hospital there.
- A US nurse executive is using the relationships she forged during the partnership with Zagreb, Croatia, to continue to help advance the nursing profession in that country.
- Partners from Missouri and New Jersey received funding for projects with their respective Latvian and Croatian partners that built upon partnership activities. Other US partners continue to seek outside funding for a variety of collaborative projects.
- Partners from North Carolina have continued to send printed health education and clinical materials to their partners in Vác, Hungary.

- Health management education partners in Scranton, Pennsylvania, and Trnava University in Slovakia have continued to work together and inspired doctors at Trnava to start their own partnerships in the countries developing of Kenya, Sudan and Cambodia.
- US partners at the Humana Foundation maintain active ties with and provided small grants to their partners in Constanta, Romania. In addition, the former Romanian partnership coordinator has been applying the knowledge and skills gained through the partnership in several positions at the ministry of health.

"Although USAID funding ended in 1999, the partnership concept took root and the Slovakian partner now implements its own health partnership program in Kenya (primary health care services, HIV/AIDS services, and a university-level degree program in social work), South Sudan (operates only full-service hospital in South Sudan), and Cambodia (home for HIV/AIDS positive orphans and street children, and antiretroviral therapy for children and parents). This legacy is an excellent example of a USAID gift that "keeps on giving."
– USAID/E&E Bureau's Weekly Report (August 25, 2005)

ADDENDUM TO II.F. HUNGARY (1995–2004)

KEY RESULT

- ***Access to Health Information and Communications***

AIHA supported the development of a Learning Resource Center (LRC) at Javorsky Odon Hospital in Vac from September 1996 through September 2004. Originally included as part of the hospital's library, the administration decided to give the LRC a separate room in October 1997 in order to raise the LRC's profile and encourage its use by staff. The LRC was heavily used by the hospital's 110 physicians and 130 other health professionals on staff to do research and to support communications with colleagues in Budapest and from other countries. Physicians reported finding useful new information on topics such as nasopharyngeal tumors, radiocarpal instabilities, and the use of a device known as the carpal box.

In 2002, the LRC was able to negotiate with a local Internet provider to improve the speed and quality of its connection by agreeing to place the provider's satellite equipment on top of the hospital building.

During the funding period, the LRC provided formal training on how to use Internet and Medline to over 60 health professionals on staff at the hospital. The LRC also responded to an average of seven information requests each month.

ADDENDUM TO II.J. SLOVAKIA (1995–1999)

KEY RESULTS

- ***Access to Health Information and Communications***

From 1996/97 through 2004, AIHA supported the development of eight Learning Resource Centers (LRCs) in Slovakia, including:

- Municipal Government Office – Banska Bystrica
- University of Matej Bel – Banska Bystrica
- Health Management School – Bratislava
- Faculty Hospital – Kosice
- Comenius University, Jessenius Faculty of Medicine – Martin
- Aid to Children at Risk Foundation – Petrzalka
- Trnava University – Trnava
- Municipal Government Office – Turcianske Teplice

These eight LRCs provided access to health information, training and teleconsultation services, and research support to a community of over 3,800 health professionals in Slovakia (this includes over 1,400 students at the three university sites). Collectively, they trained 1,427 health professionals on how to use computers and the Internet to access medical information during the period of funding.

The LRC information coordinator (director) at Faculty Hospital in Kosice was one of the most active in supporting the use of teleconsultations as well as in his promotion of evidence-based practice (EBP). Using digitized photos and X-rays, neonatologists, including the information coordinator himself, consulted with their US partners as well as other specialists on dozens and dozens of difficult cases, with diagnoses ranging from femoral facial syndrome to nemaline rod myopathy. Physicians at the hospital credit these consultations with saving the lives of several neonates in Kosice. In the area of EBP, the LRC launched an Open Medical Club, which brought together health professionals throughout Slovakia to discuss various clinical topics online (through chat and e-mail) on a monthly basis.

At Comenius University in Martin, the LRC information coordinator and his colleagues used the LRC's resources to conduct extensive research in the area of smoking cessation programs in support of the partnership's health promotion efforts. This research resulted in the publication of a review article in the *Bratislava Medical Journal*. The article, which compared the effectiveness of different smoking cessation approaches, was used to develop practice guidelines that were implemented by the Martin Non-Smoking Promotion Center established by the partnership.

Unlike most of the hospital-, clinic-, and university-based LRCs, the Banska Bystrica Municipal Government Office faced the challenge of needing to reach out and support a broad community of local hospitals, NGOs, schools, and other community groups. To accomplish this, in April 1998 LRC staff sent out letters to over 100 organizations throughout the city to let them know about the resources and services of the LRC. Within the first month, over 103 requests for information had been submitted. The LRC staff also worked with several hospitals and other local institutions to advise them on how they could set up their own Internet access and to share the LRC's CD-ROMs and print resources. The Banska Bystrica LRC also partnered with the Slovak Humanitarian Council to develop a Web- and CD-ROM-based resource for the disabled, which provides detailed information on benefits, services, and resources available to the disabled in Slovakia.

The eight Slovak LRCs received an average of 725 visitors and 59 information requests each month. While AIHA has not been in communication with several of these LRCs for a number of years, AIHA is aware that all eight institutions have been able to sustain Internet connectivity and access to medical information resources on their own. Three of the eight (Bratislava, Kosice, and Martin) continue to be active in AIHA's LRC Network Association, and at least two of the others (Trnava and the University of Matej Bel) are believed to be maintaining the LRC functions and capabilities. AIHA considers the remaining three LRCs to be non-functioning, though they do maintain at least a basic communications capacity.

AMERICAN INTERNATIONAL HEALTH ALLIANCE, INC.

List of Partnerships

Institutions and Areas of Focus

Partnership	U.S. Partnership Institutions	NIS/CEE Partnership Institutions	Areas of Focus
Albania			
Lezha/Pittsburgh	Magee Women's Hospital	Primary Care Directorate of Lezha District	Community-Based Primary Health Care
Tirana/Providence	Women and Infants Hospital of Rhode Island National Perinatal Information Center	University Maternity Hospital, Tirana Tirana Women's Wellness Center	Women's Health
Tirana-Grand Rapids	Spectrum Health	University Hospital Center of Tirana, Trauma Hospital, Maternity Hospital	Trauma Services, Emergency Medical Services, Nursing, Neonatology, Women's Health, Infection Control, EMS
Tirana-New York	Robert F. Wagner Graduate Scholl of Public Service at New York University	University of Tirana (Faculties of Medicine and Economics), Ministry of Health, National Institute of Public Health	Health Management: Curriculum Development, Faculty Development
Tirana-Bronx, NY	Jacobi Medical Center Butterworth Hospital (now Spectrum Health) Cook Institute for Research and Education Kirkhof School of Nursing	"Mother Theresa" Univ.Hospital Center Univ. Hospital of Obstetrics & Gynecology	EMS, Infection Control, Neonatology, Nursing, Women's Health, Trauma
Bosnia			
Tuzla-Buffalo	Buffalo General Hospital	Tuzla Clinical Center	Cardiology, Women's Wellness, Pediatric Surgery, NRC
Croatia			
Split/Piscataway	University of Medicine and Dentistry of New Jersey - Robert Wood Johnson Medical School	Split Zdravi Grad – Healthy City	Healthy Communities
Zadar-Franciscan	Franciscan Sisters of the Poor Health System, Inc.	Zadar General Hospital, Orthopedic Hospital of Biograd	Leadership Development, Cardiology, Oncology, Orthopedic Trauma, Geriatrics, Post Traumatic Stress Disorder, Infection Control, Total Quality Management, Fundraising & Development, NRC
Zagreb-Lebanon	Dartmouth-Hitchcock Medical Center	"Sveti Duh" General Hospital, "Srebrnjak" Children and Youth Hospital for Respiratory Diseases, "Dr. Fran Minaljevic" University Hospital for Infectious Diseases	Leadership Development, Nursing, Pharmacy, Infection Control, Respiratoy Diseases, Micro Invasive Surgery, Neonatology, Collaborative Practice, NRC

AMERICAN INTERNATIONAL HEALTH ALLIANCE, INC.
List of Partnerships
Institutions and Areas of Focus

Partnership	U.S. Partnership Institutions	NIS/CEE Partnership Institutions	Areas of Focus
Czech Republic			
Bohemia-Las Vegas	University of Nevada, Las Vegas	South Bohemian University, Postgraduate Medical School, University of Education, Purkyne Military Medical Academy	Health Management: Curriculum & Faculity Development
Moravia- Richmond	Virginia Commonwealth University	Palacky University	Curriculum Development, Nursing, Faculty Development
Estonia			
Tallinn-Washington, DC	George Washington University	Tallinn Central Hospital	Nursing, Women's Health, Family Practice, EMS
Kosovo			
Gjakova/Hanover	Dartmouth Medical School in Hanover	Municipality of Gjakova	Reproductive Health, Ante-natal Care
Hungary			
Gyor/Pittsburgh	Magee Women's Hospital, Family Health Council, University of Pittsburgh Graduate School of Public Health	Gyor Healthy Cities	Healthy Communities and Women's Health
Pecs/Harrisburg	Institute for Healthy Communities	Hungarian Network of Healthy Cities	Healthy Communities and Women's Health
Vac/Winston-Salem	Novant Health	Vac Municipal Hospital	Management, Diabetes, Oncology, Home care, Community Health, NRC, Healthy Community Center
Latvia			
Riga/St. Louis	Barnes-Jewish Hospital	Riga Maternity Hospital, "Bikur Holim" Jewish Hospital, Clinical Children's Hospital	Pediatric Infectious Disease, Hospice, Maternal & Child Health, Gerontological Cardiology, Healthcare Leadership, Community Health, NRC
Riga/Little Rock	University of Arkansas Medical School	MDR-TB Center of Excellence	Business Development, Tuberculosis
Romania			
Bucharest/Tirana (Cross-Border)		Romania: Institute of Health Services Management Albania: Institute of Public Health	Health Management Education
Cluj-Philadelphia	Thomas Jefferson University	Clinic for Occupational Diseases; Center for Medical Research, Health Services and Management, Inspectorate of Public Health	Occupational & Environmental Health, Health Management
Iasi-Minneapolis	Hennepin County Medical Center	Center for Reproductive Health & Family Planning	Women's Health

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List of Partnerships
Institutions and Areas of Focus

Partnership	U.S. Partnership Institutions	NIS/CEE Partnership Institutions	Areas of Focus
Romania (continued)			
Bucharest-Chicago	University of Chicago	Institute of Health Services Management, Department of Public Health and Management at the University of Medicine and Pharmacy "Carol Davila"	Health Management: Case Studies Development
Bucharest/Kentucky	Univ. of Kentucky School of Public Health Univ. of Kentucky Center for Excellence for Rural Health, Appalachian Regional Healthcare Inc., Kentucky Area Health Education Centers, Univ. of Louisville, Jefferson County Health Dept. Veteran Hospitals	Institute of Health Services Management Department of Public Health and Management of the University of Medicine and Pharmacy "Carol Davilla"	Health Management and Communications Partnership Health Management Education, Communications, Community Mobilization
Constanta/Louisville	The Humana Foundation University of Louisville	Directorate for Public Health Constanta City Hall "Odidius" Medical School County School Inspectorate Direction for Labor and Social Protection County Police Inspectorate	Healthy Community: Women's Health, Domestic Violence, STI
Slovakia			
Banska Bystrica and Martin-Cleveland	The Metro Health System	The City of Banska Bystrica, The City of Martin	Community Health, Hospice, Social Work, Smoking Cessation
Turcianske Teplice-Cleveland	MetroHealth System	Citizens Association of the Town of Turcianske Teplice	Community Health Education
Petrazalka-Kansas City	Truman Medical Center	Aid to Children at Risk, The Institute of Preventative and Clinical Medicine	Prevention of Domestic Violence & Drug Use Among Youths
Slovakia-Scranton	University of Scranton Graduate Program in Health Administration	Trnava University, University of Matej Bel, Health Management School	Health Management: Faculty Development, Accreditation, Nursing
Kosice-Providence	Women & Infants Hospital of Rhode Island, Hasbro Children's Hospital	Kosice Faculty Hospital	Neonatology, Pediatrics, Nursing, Health Promotion and Disease Prevention, Patient Care Management, Obstetrics, Gynecology, Domestic Violence, Child Abuse

OTHER SPECIAL PROJECTS*:*
Croatia: HIV/AIDS Project, completed 2005
Romania: USAID/Susan G. Komen Breast Cancer Foundation Radiology Project

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