The American International Health Alliance Partnership/Volunteer Program in the Newly Independent States and Central and Eastern Europe

Report of the Continuing Evaluation Panel

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Panel members:

Neal A. Vanselow, M.D., Chairperson

Linda H. Aiken, Ph.D., R.N., FAAN, FRCN

Ross Anthony, Ph.D.

Bright M. Dornblaser, MHA

Clifton R. Gaus, Sc.D.

Cornelius Hopper, M.D.

Mary Richardson, Ph.D., MHA

Mary Ann Micka, M.D.
Division Chief, EEUD/HRHA
U.S. Agency for International Development
Room 5.10-096
Ronald Reagan Building
1300 Pennsylvania Avenue, NW
Washington, D.C. 20523-6802

James P. Smith
Executive Director
American International Health Alliance
1212 New York Avenue, NW, Suite 750
Washington, D.C. 20005

Dear Dr. Micka and Mr. Smith:

On behalf of the Continuing Evaluation Panel (CEP) I am pleased to submit this evaluation of the American International Health Alliance (AIHA) program in the Newly Independent States (NIS) of the former Soviet Union and the countries of Central and Eastern Europe (CEE). The report contains the unanimous findings, conclusions, and recommendations of the seven CEP members.

During the past year, the CEP has visited 49 original and new AIHA partnerships in the NIS/CEE and has interviewed approximately 350 individuals. Interviewees include participants from both the NIS/CEE and U.S. partners, NIS/CEE government officials, USAID personnel from both the missions and the Washington office, and staff in the AIHA Washington and regional offices. CEP members have also attended AIHA conferences and workshops, visited the AIHA Washington office, and reviewed a large amount of written material.

My colleagues and I would like to express our thanks to the many people who assisted us with our work. These include all those in the categories listed above as well as Jane Donat and Alice Porter from the University of Washington who provided invaluable assistance with the preparation and editing of the report. We also wish to express our appreciation to those staff members in the USAID missions and Washington office who reviewed the report in draft form. Many of their comments and suggestions have been incorporated into this final document.

When the CEP was formed, most of its members had only superficial knowledge of the AIHA program and were not certain what would be found. We have been pleased to discover an exciting and vibrant program that has been successful in improving health and health care in the NIS/CEE. In our opinion, it is a program about which USAID, AIHA, the partners, and the American people can be very proud.

Sincerely yours,

Neal A. Vanselow, M.D.
Chairperson, Continuing Evaluation Panel

Table of Contents

Executive Summary

The collapse of the former Soviet Union and the will of its people to chart a new, more democratic course posed unique opportunities and challenges for the United States and its Agency for International Development (USAID). Stagnant and inefficient economic conditions in the Soviet era had resulted in an erosion of basic social services, substantial deterioration in the health services infrastructure, and declining health. USAID selected a partnership model as the ideal vehicle to engage educated and justly proud people, who had been closed off to information and innovation, in a cooperative effort with U.S. health care professionals and institutions to improve health and health care in the Newly Independent States (NIS) of the former Soviet Union and the countries of Central and Eastern Europe (CEE).

In 1992, USAID initiated a cooperative agreement with the American International Health Alliance (AIHA) to develop and implement partnerships linking hospitals in the NIS/CEE with U.S. hospitals. Over time, cooperative agreements between USAID and AIHA have been expanded and renewed to support community-based primary care partnerships and other initiatives. To date, AIHA has developed and supported 90 health care partnerships in 21 countries in the NIS/CEE.

This report documents the findings and recommendations of an independent panel, the Continuing Evaluation Panel (CEP), initiated under the direction of USAID, to conduct a comprehensive examination of the AIHA Partnership Program from its inception. A primary objective of the evaluation is to assess the progress of the most recently funded community-based primary care partnerships, which are at the midpoint in their funding cycle, to determine whether they are on the same trajectory toward success previously documented in the original partnerships. Moreover, the evaluation assesses the sustainability and extent of replication of programs funded through the original partnerships.

Overall Appraisal

The CEP spent a year evaluating the AIHA Partnership Program, including site visits to 48 partnerships in the NIS/CEE and structured interviews with more than 345 individuals associated with the program. The CEP concludes that the AIHA Partnership Program has been highly successful and is an exemplar of the use of the partnership model in international development. Previous evaluations have documented the success of the original AIHA hospital partnerships in achieving their programmatic goals. The current evaluation, reexamining these original partnerships at a later point in time, found that most of the original NIS/CEE partnership programs are continuing despite termination of AIHA program support. Many of them have expanded their work to additional sites and have become increasingly influential in the development of new health services, better education for health professionals, and improved governmental decision-making in health care. The continued success of the original partnership programs can be attributed in part to one-year sustainability grants made available to many of the programs, to cross-cutting initiatives targeted to common concerns across partnerships, and to the continuing efforts of AIHA to maintain the involvement of the original NIS/CEE partners in the ongoing Partnership

The CEP concludes that the AIHA Partnership Program has been highly successful and is an exemplar of the use of the partnership model in international development.

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Program. The new community-based primary care partnerships show evidence of being on the same trajectory for success established by the original hospital-based partnerships.

The difficulty of providing health care of acceptable quality in the countries of the former Soviet Union is so immense as to defy description. Numerous articles in the Western press have chronicled the problems of crumbling health care infrastructure, epidemics of preventable disease, below replacement level population growth, and declining life expectancy. The AIHA Partnership Program is creating sustainable and replicable programs that produce fundamental improvements in health care while sustaining hope and enthusiasm during trying times. As illustrated by the recent front page *New York Times* coverage given to the Dubna, Russia-La Crosse, Wisconsin AIHA partnership, success breeds more success. The AIHA Partnership Program has many examples of successes such as the Dubna-La Crosse partnership that are leveraging U.S. public and private resources in the pursuit of better health in the NIS/CEE. To date, U.S. institutions and communities have matched USAID funding for the AIHA Partnership Program on a l.5 to 1 basis with private contributions valued at close to $165 million. The CEP concludes that the AIHA Partnership Program is a success for which USAID, AIHA, the partners, and the American people can be justifiably proud.

The AIHA Partnership/ Volunteer Model

There are a number of important features to the AIHA partnership model that have proven successful in a complex program that extends across multiple countries and cultures. One of these is recruitment of highly trained and experienced U.S. volunteers who engage in peer relationships with NIS/CEE professionals. In many cases, both the U.S. and NIS/CEE institutions and key personnel are leaders in their fields. Substantial resource commitments on the part of both the U.S. and NIS/CEE partners are also expected. Mutual benefits to both partners are defined at the outset and pursued over the course of an extended relationship. The programmatic focus is on low-cost technology and training.

USAID's choice of the cooperative agreement mechanism to fund the AIHA Partnership Program has been instrumental in the program's success. It has provided needed flexibility for program planning and implementation. It allowed for non-prescriptive, peer-based approaches to decision-making that have been key to sustaining the programs when AIHA funding ends. Moreover, the cooperative agreement mechanism fosters the recruitment of distinguished, highly trained, and experienced U.S. volunteers who would be less likely to participate in contractual arrangements.

CEP Recommendations

1. *USAID should continue supporting the AIHA partnership/volunteer model and expand its use within the NIS/CEE.*
2. *USAID should continue to use the cooperative agreement as the mechanism for managing the AIHA Partnership/ Volunteer Program.*
3. *USAID should address the USAID missions' concern over lack of control of partnerships by devising an appropriate mechanism for reporting pertinent information without compromising program flexibility and encouraging unnecessarily detailed management of partnership activities.*

Partnership Program Achievements

Partnership achievements can be described within four broad areas.

- **Successful implementation of work plan goals and objectives:** Nearly all the original partnerships have met and generally exceeded their goals, and they are able to point to sustained improvements in care, more cost-effective use of resources, and in some instances, improved health outcomes. The new community-based primary care partnerships at the mid-point in their funding cycle have well-established trajectories that suggest the same level of success.
- **Reconnecting with contemporary medical science and practice:** All the partnerships have generated new collaborative relationships with international colleagues, regularly access scientific and professional materials, and participate in professional exchanges. As a result, new medical practices have been instituted that hold promise for improving health status over time.
- **NIS/CEE partners have become emerging leaders:** They develop cross-partner collaborations, promote dissemination and replication of partnership successes, participate in research and education, and promote democratic principles through the involvement of newly created professional groups and other non-governmental organizations in health care related decision-making.
- **NIS/CEE partners are influencing the development of health policies that promote continued advances in health care, lead to more cost-effective use of services, and engage consumers in efforts to advocate for their own health.**

CEP Recommendations

1. *The current cooperative agreement, budgeted for three years, should be continued for an additional two years to complete a five-year cycle. Concurrently, USAID should initiate a new five-year award cycle, ensuring sufficient overlap between the two cycles, so as not to disrupt ongoing programs. The new five-year award cycle should fund new partnerships and continue support for those partnerships and cross-cutting initiatives that focus on high priority areas and have the potential for replication.*

Cross-cutting Programs

AIHA supports two types of centrally funded cross-cutting programs. Programmatic cross-cutting initiatives emerge from the partners and address needs identified by multiple partnerships. Examples are infection control, women's wellness, and neonatal resuscitation training. AIHA's role is to coordinate a concerted response to such needs. The CEP finds the cross-cutting initiatives to be one of the most successful elements in the overall Partnership Program. Many have data supporting improved health outcomes. Proposals for cross-cutting initiatives are now emerging from the new primary care partnerships. The CEP views these as good investments for the future.

AIHA also supports centrally funded and managed communication and knowledge dissemination activities that inform the partnerships about advances in medical science and technology, create a network of partnerships that builds in-region expertise, and promotes program sustainability and replication. These include: learning resource centers and the Internet connectivity they provide, the AIHA web site,

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conferences and workshops, and AIHA publications. Although all of these efforts are valuable, the learning resource centers are especially important. The CEP is concerned about the financial viability of these centers.

CEP Recommendations

1. *USAID should continue to support, and consider increased funding for, cross-cutting initiatives.*
2. *AIHA should seek opportunities to use the cross-cutting initiative mechanism to advance the programmatic priorities of the new primary care partnerships.*
3. *AIHA should make every effort to maintain the viability of the learning resource centers. It should also support more Russian translations of English medical literature.*
4. *AIHA should continue to provide financial support to the NIS/CEE partners to maintain Internet access even beyond completion of the partnership.*
5. *The AIHA web site is an important enough resource that a special effort should be made to ensure its sustainability and continued excellent capability. AIHA should consider developing a comprehensive database to underlie the site's content and thereby improve the ability to archive, categorize, access, and retrieve information.*
6. *AIHA should continue its conferences and workshops and its publication program.*

AIHA Organization and Management

The CEP believes that the AIHA Board of Directors and CEO provide effective organizational leadership and that AIHA has a talented and hard-working staff. It applauds AIHA's plan to implement a strategic planning process. The CEP is concerned, however, that in the face of a rapidly expanding AIHA workload, the partners are experiencing undue delays in obtaining approval of their work plans and in the processing of financial transactions. It is also concerned that AIHA has placed too little emphasis on evaluating the impact of its program on health-related outcomes in the NIS/CEE.

CEP Recommendations

1. *The AIHA Board of Directors should move forward expeditiously with its plan to initiate a strategic planning process that encompasses a three to five-year time frame.*
2. *AIHA should consider hiring an external consultant to evaluate the adequacy of staffing, internal processes, lines of accountability, and procedural documentation for both current and projected workload.*
3. *AIHA should improve its monitoring and evaluation processes, placing increased emphasis on the collection and evaluation of outcome data.*

Relationships Between USAID and AIHA

The CEP found that the relationship between USAID and AIHA is complex and varies tremendously across organizational units. Although relationships between USAID/Washington and AIHA/Washington are positive and based on shared program objectives, relationships between USAID missions in the NIS/CEE and AIHA are characterized by poor communication, problems of staff turnover, lack of shared vision, little mission buy-in, and mediocre working relationships. The differences may be due in part to the broad regional perspective adopted by AIHA as compared with the country-specific focus of the USAID missions.

CEP Recommendations

1. *AIHA and USAID should seek ways to improve their working relationships. USAID Washington should bring participants together to address persistent concerns.*
2. *USAID should consider ways to improve the transition when there is a change in staff at its missions in the NIS/CEE. In the case of the AIHA program, new cognizant technical officers (CTOs) should be thoroughly briefed on past agreements by both USAID and AIHA and should be expected to honor them.*
3. *USAID missions and AIHA need to find ways to improve communication with the understanding that this does not empower the missions to engage in unnecessarily detailed management.*

Other AIHA Relationships

AIHA has been effective in developing and sustaining relationships with key organizational, political, and governmental leaders at all levels within the NIS/CEE. AIHA has also been successful in developing productive relationships with non-governmental organizations currently working in the NIS/CEE. It has not been as effective in identifying and reaching out to U.S. and other foundations that are not currently supporting programs in the NIS/CEE but might be interested in doing so. AIHA could also be more effective in publicizing its excellent program to a broad national and international audience.

CEP Recommendations

1. *AIHA should continue its current and effective efforts to develop good relationships with NIS/CEE government officials and with non-governmental organizations currently working in that part of the world.*
2. *AIHA should make a greater effort to obtain funding support from U.S. private foundations and other non-governmental organizations not currently working in the NIS/CEE.*
3. *In order to gain broader support for its programs, AIHA should place more emphasis on its public relations program.*

Summary and Future Prospects

The AIHA Partnership/Volunteer Program is highly successful and a credit to all who have participated. Its new community-based programs at the mid-term of their funding are following in the successful trajectory of the original hospital partnerships. The cross-cutting initiatives developed by the original partnerships have not only been successful but have provided a model that can be used effectively by the new primary care partnerships.

Soon after its creation, the CEP met with USAID's Dr. Don Pressley, who shared with it the vision of a 20-year funding commitment to health partnerships in the NIS/CEE. We concur with that vision. Although the AIHA Partnership/Volunteer Program has many achievements to its credit, the region is large and its problems are great. Sustaining the gains made by the partnerships and extending them into mainstream care so that all the people of the region can benefit will require USAID and AIHA to stay the course.

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1. Project Overview

A partnership model was chosen as an ideal vehicle to engage educated and justly proud people, who had been closed off to information and innovation, in a cooperative effort with U.S. health professionals and institutions.

The objective of this report is to provide a mid-term evaluation of a set of interlocking cooperative agreements granted by the United States Agency for International Development (USAID) to the American International Health Alliance (AIHA) to develop health sector partnerships in the Newly Independent States (NIS) of the former Soviet Union and Central and Eastern Europe (CEE). This report documents the findings and recommendations of a Continuing Evaluation Panel (CEP) initiated under the direction of USAID to conduct a comprehensive examination of the new health sector Partnership Program developed and managed by AIHA.

The evaluation occurs midway through the funding of the second group of AIHA partnerships. It will report on the current status of the new partnerships and assess their likely trajectory based upon predictors of success gained from assessing the current status and impact of the original partnerships. It will also report on the outcomes of sustainability funding to some of the original partnerships and provide an overall assessment of the Partnership Program since its inception in 1992.

1.1 Background

Dramatic changes occurred in Central and Eastern Europe and the former Soviet Union beginning in the late 1980s, as people threw off the yoke of communism to chart a new more democratic course. These changes challenged USAID to come up with fresh approaches to assistance where people were well educated and countries had already industrialized. Using the authorities granted under two congressional acts, the 1989 Support for East European Democracy Act (SEED) and the 1991 Freedom Support Act (FSA), USAID began an ambitious set of innovative programs originally in Central and Eastern Europe and later in the Newly Independent States.

In the late 1980s, USAID initiated a handful of partnerships between U.S. community hospitals and CEE hospitals. USAID decided to build on this successful model when the need to provide emergency humanitarian assistance to a crumbling NIS health system arose in 1991. A partnership model was chosen as an ideal vehicle to engage educated and justly proud people, who had been closed off to information and innovation, in a cooperative effort with U.S. health professionals and institutions. In 1992, USAID initiated this expanded partnership strategy through a cooperative agreement with AIHA, a non-profit, non-governmental organization created to develop and implement partnerships linking U.S. and NIS hospitals. Under the initial cooperative agreements, 25 hospital partnerships were created and funded for three years. By the mid-1990s, the original hospital partnerships began to serve as the platform for cross-cutting initiatives that were designed to focus on specific concerns common to many, if not all, of the countries within the NIS/CEE. The cross-cutting initiatives were funded through a series of amendments to the original cooperative agreement.

A 1995 amendment provided support for five university partnerships to create health management education (HME) programs and a leadership training capacity within CEE academic institutions. A subsequent cooperative agreement was awarded the Association of University Programs in

Health Administration (AUPHA) to develop three HME partnerships in Russia that included a subcontract for support services from AIHA. The HME partner - ships initially targeted physician leaders but were quickly expanded to include nurse leaders as well.

In 1998, AIHA competed for and was awarded renewed funding under a new series of cooperative agreements that replaced the original umbrella agreement with USAID. These new agreements were structured to enable USAID missions to interact directly with AIHA in order to reflect better their country-specific strategies in AIHA work plans. Currently, AIHA has seven cooperative agreements with USAID, including a non-fiscal agreement defining and covering the program broadly and six agreements with a fiscal component. These include four regional agreements covering partnership programs in Russia, the Caucasus, Central Asia, and West NIS, managed through USAID missions, and one NIS-wide agreement that supports cross-cutting initiatives and other AIHA-sponsored activities such as learning resource centers, conferences, workshops, communication support, and other infrastructure. A sixth fiscal agreement covers the entire CEE program, including region-wide activities, and USAID/ Washington manages it. Funding for this new set of agreements totals $61.6 million and is used to:

- Sustain cross-cutting initiatives and other AIHA Partnership Program support activities and infrastructure.
- Provide bridge support for those partnerships whose programs were clearly successful but needed some additional external support to assure long-term impact and promote replication.
- Create a series of partnerships with a focus on community-based primary care or primary care, linking a range of health, social service, and governmental organizations from U.S. communities with corresponding NIS/CEE health organizations and communities. There are cur rently 26 such new community-based, primary care partnerships. In addition, USAID and AIHA have supported the development of 15 other new partnerships through the new cooperative agreements to address key developmental needs such as the improvement of health management education, infection control, emergency care, and breast cancer screening.

Including these new partnerships, AIHA has since 1992 developed and supported 90 partnerships involving health care providers and educators in 21 nations in the NIS/CEE. More than 150 U.S. hospitals and health systems and 58 universities and schools of health professions and their communities in 37 cities and 27 states have now lent their resources to the program. NIS/CEE participants include 90 hospitals and health systems and 33 schools of health professions in 42 cities and 21 countries. The program has supported more than 10,000 exchanges between U.S. and NIS/CEE institutions.

Total USAID support of AIHA-managed partnership programs has been about $115 million since inception. Although this represents a modest share of the agency's total fiscal year 2001 budget, for all activities, of $7.5 billion, it constitutes a significant percentage of USAID health expenditures in the NIS/CEE region (see table on page 12). At the same time, volunteer contributions of professional time, supplies, and equipment from U.S. institutions and communities have totaled nearly $165 million for the program—matching USAID funding by about a 1.5 to 1 ratio.

AIHA has since 1992 developed and supported 90 partnerships involving health care providers and educators in 21 nations in the NIS/CEE.

Over time, AIHA partnerships and cross-cutting initiatives have formed a complex network linking NIS/CEE partners with their U.S. partners and with each other.

The table below shows AIHA outlays in the NIS as a share of total USAID health spending in that region..

Eurasia: Estimated Health Obligations, 1992 - 2001

Country	Total Estimated Obligations by USAID, 1992-2001	Total Estimated Obligations to AIHA, 1992-2001	AIHA as % Total USAID Funding
Armenia	$23,621,179	$6,986,096	30%
Azerbaijan	$12,450,242	$3,170,000	25%
Belarus	$4,160,858	$2,485,000	60%
Georgia	$19,303,247	$6,474,185	34%
Kazakstan	$41,146,519	$6,185,000	15%
Kyrgyzstan	$20,389,378	$2,455,000	12%
Moldova	$10,563,926	$3,100,000	29%
Russia	$136,413,890	$19,719,926	14%
Tajikistan	$7,504,256	$2,250,000	30%
Turkmenistan	$8,328,805	$1,950,000	23%
Ukraine	$67,718,114	$22,822,024	34%
Uzbekistan	$25,869,599	$2,683,543	10%
CAR Regional	$967,000	$0	0%
NIS Regionwide	$32,901,039	$31,304,836*	95%
TOTAL	$411,338,052	$111,585,610	27%

*This number includes $23.0m obligated under the original 1992-1995 Cooperative Agreement and for which AIHA was not given (or required to report on) a breakdown by country. We have chosen to show this entire amount under Regionwide, although in fact the money was intended for and spent on programmatic activities in several NIS countries. We do not have information as to how USAID chose to break out this amount by country in displaying their Estimated Obligations.

Additional background information about USAID and the AIHA Partnership Program is included in Appendix 5.

The CEP was appointed by AIHA with the concurrence of USAID as to both its charge and its membership and with the understanding that the USAID Washington office would be a primary recipient of the report and its recommendations. The CEP's responsibility differs from previous, more targeted and shorter-term evaluations[1] in that it is charged with providing a comprehensive assessment of the Partnership Program as a whole, with a particular emphasis on its policy, programmatic, and clinical impact. Focal issues for the CEP evaluation were:

- Accomplishments of the AIHA Partnership/Volunteer Program
- Contribution to USAID health sector goals
- Demonstrable impact in the field
- Value of contribution relative to level of investment
- Sustainability
- Replication

- Effectiveness of the USAID partnership model, including the use of the cooperative agreement as a contracting mechanism
- Effectiveness of AIHA implementation and management.

The CEP is comprised of senior academic and industry health service researchers and health professionals. Two of the panel members have some familiarity with AIHA programs through prior participation in AUPHA-sponsored and managed HME partnerships, although their contact with AIHA was limited. The remaining five had limited knowledge of the Partnership Program prior to their involvement with the CEP. The evaluation consisted of visits to 49 partnerships in the NIS/CEE selected to provide representation of different kinds of partnerships at different stages of development located in all regions. These visits and interviews with more than 350 individuals associated with the Partnership Program were guided by a common protocol developed by the CEP. A list of CEP members and their biographical sketches, together with a summary of the evaluation methodology employed, partnerships visited, and individuals interviewed appear in Appendices 1- 4.

Inasmuch as the current evaluation occurred at the midpoint of the present cooperative agreements, the CEP placed its greatest emphasis on assessing the progress being made by the community-based primary care partnerships funded in 1998 and thereafter. Visits were also made to the original partnerships funded between 1992 and 1998. There were several reasons for examining these original and mostly hospital-based programs. First and foremost, lessons could be learned from them regarding factors that enhance or inhibit success. This knowledge could help determine if the new partnerships were on a satisfactory trajectory. In addition, it was felt important to know if the original partnerships were still experiencing the progress noted in previous evaluations and the extent to which the sustainability grants some of them received under the current cooperative agreements have been used effectively.

As noted in subsequent sections of this report, the CEP's evaluation was hampered by the relative lack of quantitative outcome data measuring the impact of the AIHA program on health status in the NIS/CEE. As a result, it was forced to rely on a more qualitative assessment of the extent to which the various partnerships and cross-cutting initiatives had achieved the goals outlined in their work plans. Also impeding the CEP evaluation was the absence of clear definitions of program sustainability, partnership sustainability, and program replication agreed upon by AIHA and USAID.

1.2 The Health Care Context in NIS/CEE

The AIHA partnerships have been implemented under extremely difficult circumstances[2]. The Soviet era had created stagnant and inefficient economic systems that, in many areas, had not been able to support basic social services. While the population was well educated, and the countries industrialized, the physical infrastructure of the health care system was literally crumbling. Public health policies, previously enacted through coercive means, were no longer effective, leading to a deterioration in immunization coverage and subsequent outbreaks of preventable epidemics of diphtheria, polio, and other diseases. Isolation from advances in medical science and technologies resulted in non-scientific approaches to medical treatment and disease prevention, which has negatively affected health throughout the region. Widespread inappropriate use

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Since the Soviet Union collapsed in 1991, the share of gross domestic product in the NIS allocated to health care has dropped from 3-4% to 2%. Health status has worsened.

of antibiotics during the Soviet era created major residual problems of life-threatening drug resistant organisms, including drug-resistant tuberculosis, which is at epidemic levels in some areas.

Although the former Soviet Union trained large numbers of doctors, the quality of their training was well below western standards[3,4]. Similarly, the Soviets built many huge hospitals, often with more than 1,500 beds, but the hospitals were of poor construction, had outdated equipment, non-scientific and ineffective methods for infection control, and poorly trained nurses. Weak economies throughout the region have resulted in an acute shortage of supplies of all kinds, including syringes that are often reused without effective sterilization procedures, creating vectors for infection including HIV/AIDS and hepatitis. Electricity and heat are in short supply, unaffordable, and often inadequate in hospitals and clinics. Some countries are unable to provide wages to clinicians for extended periods of time.

Since the Soviet Union collapsed in 1991, the share of gross domestic product in the NIS allocated to health care has dropped from 3-4% to 2%[5]. Health status has worsened. In Russia, male life expectancy is now 59.9 years, compared with a U.S. rate of 74.1 years and with a Soviet-era life expectancy of 65 years[6]. Rising death rates now surpass decreasing birth rates[7]. Death rates are increasing due to infectious and chronic diseases, alcoholism, drug abuse, homicides, accidents, and suicides[8]. Parts of the NIS have the fastest growing rate of new HIV infections in the world. Should the trends of the 1990s continue, Russia's population could decrease to less than the population alive before the Bolshevik Revolution in 1917[9].

While a comprehensive examination of deteriorating health trends in the NIS is beyond the scope of this report, suffice it to say that creating new programs to stem these negative trends is a major undertaking. The AIHA Partnership Program seeks to improve health care systems and health and medical practices to enable the countries of the NIS to improve their people's health and well-being. As noted in the assessments that follow, the achievements of the Partnership Program are all the more impressive when viewed in the context of deteriorating health and health care that characterizes the region.

1.3 AIHA Background and Partnership Types

The AIHA mission is "to advance global health through volunteer-driven partnerships that place particular emphasis on economically viable, low-technology solutions that improve productivity and care." This mission is linked to USAID strategic goals that focused initially on creating "medical partnerships" that have evolved over time. Partnerships and cross-cutting initiatives are now expected to support the following key elements embodied in USAID's current strategic objectives and mission strategies:

- Develop care management
- Develop resource management
- Reorient toward primary care
- Align closer personal health and public health efforts
- Improve coordination with other community-based services
- Increase the quality and availability of information
- Promote democratic values.

While AIHA partnership programs can be categorized by type, the categories are not rigid or immutable. The first partnerships formed a platform from which many of the subsequent initiatives and new partnerships

have been launched. Some partnerships have a broad set of objectives, while others are more narrowly focused (e.g., emergency medical services, infection control, or blood banking). A number of the partnerships rightfully fit into more than one category. Over time, AIHA partnerships and cross-cutting initiatives have formed a complex network linking NIS/CEE partners with their U.S. partners and with each other. The major types of partnerships follow:

Hospital partnerships: The original partnerships were institutionally based. Partners from hospitals or hospital systems in a U.S. city were matched with counterparts in the NIS/CEE in order to assist in addressing significant mortality and morbidity issues, improve health care organization, and introduce market-oriented solutions to hospital and health system delivery and finance problems. Professionals from each partnership institution participated in a series of consultative and educational exchanges, shared training activities, and other capacity-building activities aimed at meeting the goals of negotiated work plans. These partnerships also worked to develop effective relationships with ministries of health, local and regional health system administrations, and academic programs in public health and clinical practice, including medicine and nursing. Generally funded for a three-year period, all of the initial hospital partnerships have "graduated" from USAID funding, but some have continued to receive support for cross-cutting initiatives or development of new partnerships under the provisions of the current cooperative agreements. Many of these "graduated" partnerships have successfully developed unique, self-sustaining strategies and remain viable.

Health management education partnerships: HME partnerships were developed in response to the scarcity of resource management skills necessary for addressing the structural problems within NIS/CEE health systems and institutions. AIHA's partnerships in the NIS/CEE were recruited with assistance from AUPHA. These interdisciplinary research and teaching programs, located in leading universities nationwide, were matched with academic institutions in the NIS/CEE for the purpose of developing undergraduate and graduate degree programs that can train practicing health managers as well as prepare a cadre of new leaders. Four of the five initial HME partnerships have "graduated" from USAID funding and one continues within the current agreement. In addition, there are five new NIS partnerships in HME, and HME is also provided more broadly through AIHA training initiatives, engaging a wide range of NIS/CEE partners.

Partnerships are charged with developing broad-based, community-oriented primary care services in a local jurisdiction that can serve as a model for national replication.

Sustainability partnerships: Under the current cooperative agreements, funding for sustainability grants was made available for up to a year for partnerships that had substantially met their objectives but that needed support for specific activities to assure one or more of the following:

- Sustainability of the Partnership Program
- Sustainability of the partnership relationship
- Increased replication and/or policy impact potential.

Activities funded under these partnerships have been completed.

Primary care partnerships: Funded under the current cooperative agreements in place since 1998, these new partnerships are intended to promote community-based primary care, reflecting USAID's priority for the region. Other areas of focus include improvement in

AIHA provides specialized support activities designed to facilitate and maintain essential communication, provide training, and facilitate interaction.

health professions education for primary care, development of health management education and training, and improvements in national infection control systems and policies. New partnerships are charged with developing broad-based, community-oriented primary care services in a local jurisdiction that can serve as a model for national replication. This often includes establishing model primary care centers, retraining and educating health care providers based in existing programs and facilities, and promoting community involvement. Health promotion, an important focus of many new partnerships, emphasizes topics such as smoking cessation and breast health. About a third of the new partnerships include previously involved U.S. partners, and many were leveraged from the initial NIS/CEE hospital partnership. There are currently 25 primary care partnerships, of which 23 are community-based.

Healthy community partnerships: Healthy Communities is an international movement and a methodology whereby citizens are given the tools to take charge of their own health as well as the health of their communities, bringing together diverse members of a community to identify and address key health challenges. There is currently one healthy community partnership, in Romania, and the primary care partnerships are using elements of the Healthy Communities methodology.

1.4 The Cross-cutting Initiatives

AIHA's original program design included support of inter-partnership activities, thus enriching their efforts. As its program has evolved, AIHA has supported two types of initiatives designed to address important common problems and facilitate communication between partnerships. These include programmatic cross-cutting initiatives and broad-based sustainability and support activities.

1.4.1 Programmatic Cross-cutting Initiatives:

As the original partnerships developed, interaction between participants made it obvious that many sites were identifying health-related problems that spanned multiple partnerships, communities and countries. AIHA has developed formal cross-cutting initiatives to address these common concerns. Initiatives that have arisen out of the original partnerships include:

- Emergency medical services (EMS) training
- Nurse leadership
- Women's wellness
- Breast cancer
- Infection control
- Neonatal resuscitation training
- Health management education
- Diabetes education.

A similar process of common problem identification is taking place among the partnerships funded under the current cooperative agreements. Examples are primary care education and training and the development of clinical practice guidelines. It is likely that these or other similarly targeted projects will evolve into a new set of programmatic cross-cutting initiatives.

1.4.2 Communications and Knowledge Dissemination

AIHA provides specialized support activities designed to facilitate and maintain essential communication, provide training, and facilitate interaction. These include:

- Learning resource centers, developed and staffed by an information coordinator in each of the partnership sites
- Information systems hardware and software
- Conferences and workshops
- Web-based and print publications
- Web site with information in English, Russian, and other NIS/CEE languages
- *CommonHealth*, a quarterly print journal
- Connections, a monthly on-line newsletter
- Periodic monographs
- Posters and certificates of recognition for training and other accomplishments.

2. Assessment of the Partnership Model

Both the U.S. and NIS/CEE partners are selected through a collaborative process involving AIHA and USAID.

2.1 The USAID Partnership Approach

USAID has successfully implemented partnership initiatives throughout the world, including the Partnership Program initiated by AIHA throughout the NIS/CEE. In a recent study of the partnership approach, USAID developed the following definition[10].

> *"USAID defines sustainable partnerships as lasting relationships between target countries and the United States and among countries within a region. The key elements of a partnership are: a) written agreement, b) goal of mutual benefit, c) resource transfers, and d) substantive purpose. An effective partnership is sustainable—generating resources equal to or greater than the cost of sustaining the relationship—and durable. It maintains over a period of time. Partnership benefits can be measured in a variety of ways including, for example:*
>
> - *Acquisition of new skills and technologies.*
> - *Increase in market share or dominance.*
> - *Enhancement of leadership and human resource capacities.*
> - *Addition of a new product line.*
> - *Improved strategic positioning.*
> - *A strengthened financial base."*

USAID further cites an important difference between the partnership relationship and the programs that result. The perpetuation of the partnership relationship is not in and of itself a satisfactory measure of success. Rather, a successful partnership may produce a benefit stream that exists beyond the life of the partnership.

2.2 The AIHA Partnership/ Volunteer Model

The AIHA partnership/volunteer model is an exemplar of the USAID partnership approach. AIHA has developed an organizational capability for assuring:

- Written contractual agreements between partners aimed at achieving USAID desired goals and objectives
- Defined mutual benefits, emphasizing the needs of the NIS/CEE partner based on the situation and needs within its service area
- A high probability for a well-matched partnership in which partners are able to develop mutual trust because they share common interests and purposes
- Substantive resource commitments on the part of both U.S. and NIS/CEE partners.

While the partnership approach is not unique to AIHA, the implementation of a collaborative Partnership Program has rarely been accomplished successfully when the program is complex and the sites extend across multiple countries and cultures. The AIHA partnership/volunteer model has been very successful in this regard. There are several essential features associated with this success. They include:

- Establishment of institutional relationships as the basis of the partnership—in many cases both the U.S. and NIS/CEE institutions are leaders in their field.
- Use of a "bottom up," non-prescriptive, peer-based approach to deci-

sion-making that generates ownership and commitment

- Flexibility within the partnership agreements and work plans, thus encouraging an entrepreneurial and opportunistic spirit
- Recruitment of distinguished, highly trained, and experienced U.S. volunteers, who engage in peer relationships with NIS/CEE professionals
- Requirement for substantive voluntary commitment of resources (human, financial, and technology) by U.S. and NIS/CEE partners. U.S. partners and corporations, for example, have contributed $1.50 for every $1.00 of USAID expenditures.
- Requirement for bi-directional partnership exchanges, introducing NIS/CEE partners to U.S. health care as well as U.S. partners to host country health care
- Commitment to an extended relationship by participants in order to build sustainable capacity within the NIS/CEE partner institution/community
- Empowerment of NIS/CEE partners, placing a high priority on NIS/CEE issues and concerns during the negotiation of the work plan
- Focus on lower-cost technologies
- Emphasis on the development of broad-based institutional and professional networks
- Use of partnership programs as platforms for developing innovative, more targeted initiatives (e.g., cross-cutting initiatives)

2.3 Stages of Partnership Development

Experience with the original and now "graduated" AIHA hospital-based programs has demonstrated that most partnerships evolve in a series of predictable stages. Some of these stages were planned in advance while others have become evident only through experience. The stages of partnership development are:

- Partnership selection
- Partnership orientation and work plan development
- Initial implementation of the work plan
- Expanding the scope of partnership activities
- A graduation period.

In general, the first four stages occupy the initial three years of the partnership and are supported by the initial grant award. The fifth takes place in the fourth year of funding for partners selected for award of a sustainability grant. The CEP found that the new community-based primary care partnerships appear to be following the same trajectory of staged development as did the original partnerships.

Under the current structure, the missions most often determine the health sector goals within their regions, choice of vendor, model for intervention, and management mechanism.

2.3.1 Partnership Selection

Both the U.S. and NIS/CEE partners are selected through a collaborative process involving AIHA and USAID. U.S. partners are solicited through a well-established network that was generated from many sources, including the organizations represented by the AIHA Board of Directors. At the inception of the AIHA program, the networks represented by board members provided rapid access to potential U.S. partners. AIHA has since developed a much broader network, well beyond the groups represented by board

Visits by U.S. partners to NIS/ CEE partnership sites are key to introducing health care administrators, physicians, nurses, and community stakeholders from the United States to the culture and normative practices of their partner.

members, for the selection of U.S. partners. Information about partnership opportunities and selection criteria are available to any interested party who contacts AIHA by telephone or electronically. Information is also maintained on the AIHA web site.

Criteria for partnership selection are based on the strategic goals for the USAID region and country in which the partnership will be located. Under the current USAID cooperative agreements, these goals include:

- Developing and delivering integrated, accessible primary and/or preventive care services.
- Aligning personal and public health.
- Developing and effectively managing clinical care systems.
- Managing human and other resources.
- Developing access to information networks and using them for effective clinical and organizational decision-making.
- Expanding civil society through democratic pluralism by decentralizing information and decision-making and empowering individuals to manage their own health better.

Interested U.S. parties are invited to AIHA-sponsored workshops that provide additional information and, secondarily, initiate informal contact between potential partners and AIHA staff. A review committee evaluates applications and often requires the applicants to provide additional information to ascertain their specific areas of interest and strength. Some of these requests for additional information originate in the USAID missions.This committee makes preliminary selections subject to concurrence by USAID.

AIHA senior leaders initially selected NIS/ CEE partners as they traveled throughout NIS/CEE countries forging relationships with national and regional health ministries. AIHA began this initial partnership development prior to the establishment of USAID missions. Now the NIS/CEE partner selection has become more routine and partners are selected with input from USAID's central office, USAID missions, health ministries from participating countries, and other similar informants. Final selections are made by AIHA senior management based on recommendations generated from the field with USAID mission review and comment.

2.3.2 Partner Orientation and Work Plan Development

Early in the process, partners are brought together for an orientation. This affords an in-depth introduction to the Partnership Program and an opportunity to participate in specific skill-building activities, such as working in teams. Work plan development is initiated during these meetings as well, using an AIHA-designed template and process. AIHA central office and regional program staff members provide guidance and technical assistance.

Work plans must address major health issues defined by the NIS/CEE partner. Partners work within budget parameters, provided ahead of time, that include items such as travel, purchase of equipment and supplies, and administration. Administrative expenses are limited to a percentage of the partnership award. The AIHA regional staff members assist the NIS partner in orienting appropriate government officials and obtaining their approval of the partnership work plans. On average, work plan development takes three to five months, and AIHA staff members assist during the entire process. Both partners must sign off on the work plan. The AIHA program officer reviews the final work plan, assess-

ing whether work plan goals and objectives are realistic. A "substantial involvement" clause in each of AIHA's cooperative agreements provides for USAID mission approval of AIHA work plans at the regional and country levels. But there is disagreement between AIHA and the missions as to whether this includes USAID approval of specific paretnership work plans. The language of the substantial involvement clause does not adequately clarify this issue.

Work plans are reviewed and revised annually. Most partnership awards are intended to cover a three to four-year period but are renewed annually.

2.3.3 Initial Implementation of the Work Plan

Once developed, work plans are initiated through partnership exchange visits. In addition to the customary exchange of resources such as technology, equipment, and supplies, AIHA requires an exchange of personnel between the partners very early in the process. Generally, NIS/CEE partners make an early visit to the U.S. partnership site. This exchange is intended to provide the NIS/CEE partner with an opportunity to observe clinical and administrative practices in U.S health care organizations at an early stage in work plan implementation. As a result of this visit, the NIS/CEE partner is more likely to envision viable clinical and managerial strategies not previously considered. Another important purpose of this visit is to initiate training designed to assist NIS/CEE partners in mastering specific clinical and managerial techniques. This initial visit often includes exposure to other health care organizations and to U.S. academic programs in medicine, nursing, and health management.

Visits by U.S. partners to NIS/CEE partnership sites are key to introducing health care administrators, physicians, nurses, and community stakeholders from the United States to the culture and normative practices of their partner and to see the particular circumstances in which new ideas and technology will be implemented. This lays the groundwork for the U.S partner to assist in developing culturally and organizationally appropriate applications as the work plan is implemented. Over time, both sides engage in regular professional exchanges.

In the case of the new community-oriented primary care partnerships, initial implementation of the work plan generally has focused on conducting assessments of community needs and establishing model primary care centers.

2.3.4 Expanding the Scope of Partnership Activities

As partners work together to implement their work plan, they often identify both problems and opportunities that may not have been evident in the early stages of their relationship. This process frequently leads to an expansion of partnership activities into one or more projects that facilitate the achievement of their original goals and enrich the overall project. These new activities may involve the creation of new education and training programs, the institution of outreach programs, a redefinition of the roles various health professionals play in care delivery, and participation in inter-partnership activities.

One example of the expansion of partnership activities is evident in the new community-based primary care partnership programs. As these programs have evolved, it has become obvious that there is a need for new education and training programs in primary care. No single U.S. or NIS partner has the capacity to mount these

As partners work together to implement their work plan, they often identify both problems and opportunities that may not have been evident in the early stages of their relationship.

The partnership model is valuable when there is a need for an extended process in order to assure that people are willing and able to sustain results achieved once the project is over.

programs alone. A number of the partnerships are beginning to discuss the possibility of establishing a common primary care training center to meet this need. Another example, evident in both the original and the new partnerships, is a redefinition and expansion of the role nurses play in the delivery of patient care.

2.3.5 The Graduation Period

Some but not all partnerships have found that they need additional time beyond the initial three years of funding to consolidate their achievements and develop ways to sustain and/or replicate their programs. USAID and AIHA have addressed this need by awarding an additional year of support to a subset of the original partnerships. Termed "sustainability grants," these awards are at a reduced level of funding. Based on its visits to several of the original partnerships that have graduated from AIHA funding, the CEP believes the sustainability grants have accomplished their purposes.

2.4 Managing the Partnership Model Effectively

The partnership model is one of several approaches employed by USAID throughout the NIS/CEE. Another is the consultation model. Typically, the partnership model is managed through a cooperative agreement, emphasizing broad goals and allowing flexibility in activities and the opportunities to modify anticipated outcomes or even change direction in the course of the work plan. The consultation model is typically managed through a contract mechanism that requires the contractor to develop and adhere to specific predetermined and pre-approved activities as well as goals, objectives, and outcomes.

USAID selected the partnership model as an intervention strategy for the former Soviet Union soon after Perestroika. One of the ways this was implemented was through a cooperative agreement with AIHA. This initial cooperative agreement was managed from the USAID Washington, D.C., office. As USAID has established missions throughout the NIS/CEE (subsequent to the implementation of the AIHA Partnership Program), and the USAID presence has grown, missions have assumed greater oversight responsibility for partnerships. They have also initiated other interventions in the health sector, using the consultation model and engaging other vendors. It is not unusual for multiple vendors to be working side by side, using the partnership model, the consultation model, or some combination.

Under the current structure, the missions most often determine the health sector goals within their regions, choice of vendor, model for intervention, and management mechanism. Missions vary in their approach. Some elect to use the partnership model extensively, while others are less inclined to do so. Criteria for selecting one model over another are not always clear. In some instances, missions enter into partnership cooperative agreements but subsequently express a desire to manage them like a contract, apparently believing that tighter controls are necessary. (The AIHA-USAID relationship is discussed in Section 6 of this report.)

The CEP believes there are strengths and weaknesses to each model and that best results are achieved when there is an alignment between the goals, desired outcomes, and model selected. For example, the partnership model is most appropriate when addressing broad, complex issues where desired outcomes are difficult to determine in advance, time is needed to develop the appropriate relationships and support, and there is low environmental stability. The consultation

model is most appropriate when the issues are more clearly defined, favorable outcomes can be specified in advance, and results are likely to be achieved without the need for sustained intervention.

The partnership model emphasizes the partnership process as a viable mechanism for defining needs and determining appropriate, sustainable results. Trust is established through this process, engaging both partners in learning about one another, while developing strategies that will produce results most suited to the needs and situation of the NIS/CEE partner. This model encourages flexibility and innovation and provides the opportunity to respond to needs, interests, and additional resources identified along the way. In contrast, the consultation model is generally a "top-down" approach and focuses more on specific results that are generally determined at the beginning of the relationship. Establishing a relationship is less important than clarifying desired results prior to beginning the project. A consultant is able to offer tested ideas and strategies, used by others, assuming that the recipient will have already assessed potential benefits and be prepared to readily adopt them.

The partnership model is valuable when there is a need for an extended process in order to assure that people are willing and able to sustain results achieved once the project is over. Health care providers, for example, when expected to adopt new methods of practice, generally require exposure to the new idea, an opportunity to see or experience it, training to learn how to use it effectively, and the opportunity to participate in deciding the best way to implement it. In the consultation model, there is general agreement in advance about desired results; the process is less important than achieving the desired result and meeting agreed-upon time deadlines.

The CEP believes that USAID's choice of a partnership model, managed through a cooperative agreement, was instrumental in the rapid and successful deployment of both the original hospital partnerships and the newer primary care partnerships. The architects of the program were farsighted in their understanding of the need for a model that was flexible and receptive to innovation. The initial partnership relationships were the mechanism for planting the seeds of change within NIS/CEE institutions and communities. Those changes were nurtured by interaction between partners, facilitated by AIHA staff, and supported by measured applications of equipment and technology. This approach resulted not only in the achievement of the initial goals set out by the partnerships, but once established, served as the platform for fundamental philosophical, political, and clinical changes extending beyond the initial partnership sites.

The CEP finds that the use of the cooperative agreement as the vehicle for managing the partnerships provided the needed flexibility to implement the AIHA/volunteer partnership model successfully. This mechanism provided many opportunities to experiment and adjust in an unpredictable political and economic environment. AIHA was able to move rapidly to organize and focus partners on producing significant and sustainable outcomes, while simultaneously creating and nurturing a process that established trust, even under the most difficult and uneven conditions. As a result, partners quickly engaged with one another, identifying and negotiating goals that were meaningful for both but best served the needs of the NIS/CEE partner.

The CEP finds that the use of the cooperative agreement as the vehicle for managing the partnerships provided the needed flexibility to implement the AIHA/volunteer partnership model successfully.

2.5 Conclusions and Recommendations

Conclusions

1. *The USAID partnership approach, as implemented by AIHA through its partnership/volunteer model, is successful.*
2. *Although the USAID missions are ambivalent about using the cooperative agreement to manage the AIHA Partnership/Volunteer Program, the CEP concludes that it is superior to the contract approach when managing a partnership/volunteer approach to health sector development in a rapidly changing part of the world. Use of contracts would reduce AIHA's flexibility and threaten the success of the program.*
3. *Differing interpretations between USAID mission staff and AIHA regarding the "subtantial involvement: clause are creating tensions within the work environment.*

Recommendations

1. *USAID should continue supporting the AIHA partnership/volunteer model and expand its use within the NIS/CEE.*
2. *USAID should continue to use the cooperative agreement as the mechanism for managing the AIHA Partnership/ Volunteer Program.*
3. *USAID should address the USAID missions' concern over lack of control of partnerships by devising an appropriate mechanism for reporting pertinent information without compromising program flexibility and encouraging unnecessarily detailed management of partnership activities.*

3. Assessment of the AIHA Partnership/ Volunteer Program

3.1 Impact of the AIHA Partnership/Volunteer Program

The AIHA Partnership/Volunteer Program faced great challenges and high expectations. The CEP finds that most of the initial partnership programs remain viable, and their accomplishments exceed initial goals. The CEP drew these conclusions from interviews, visits, and review of documentation—but generally not from reported verified outcomes. Despite the relative absence of outcome data, there are many examples that demonstrate the positive impact of the program. The Partnership Program remains a vital and vibrant work in progress.

AIHA partnerships include those ranging from earlier hospital-focused partnerships that have since graduated from USAID funding to those most recently formed under the 1998 cooperative agreement. Partnership goals and activities likewise cover a broad spectrum, ranging from institutional care focused more on specialty and subspecialty medical care, to community-based primary care, health promotion, and disease prevention.

Partnerships developed under the first cooperative agreement offer many examples of successful outcomes. The AIHA sustainability grants made to some of these original partnerships appear to have been successful in promoting both program sustainability and replication. Many of the partnership programs have been sustained even though the nature of the partnership relationship generally changes as USAID funding is terminated. This outcome is consistent with the USAID definition for sustainability that favors outcome or results of partnership activity over the perpetuation of the partnership relationship. Many partners report that, while physical exchange between the partners is problematic when USAID funding is no longer available, continued communications and consultations through the Internet are common. In some instances, partners have been awarded additional funding either through non-AIHA USAID sources or non-USAID sources. In a few cases, NIS/CEE partners have pursued new partnerships with different partners.

Based on what it has learned from the original partnerships, the CEP has found evidence that the new community-based primary care partnerships are on productive paths. New partnerships have successfully completed community assessments, remodeled space for clinics in many instances, and opened community-based primary clinics in urban and rural areas. They are now entering the fourth stage of partnership development in which they are initiating related but more complex activities such as defining new primary care delivery roles for health professionals, instituting new primary care education and training programs, and creating clinical practice guidelines. There is evidence of the establishment of linkages between primary care partnerships, and where both types of programs exist in the same locale, linkages between hospital and community-based partnerships. Finally, the primary care partnerships have not only exploited the cross-cutting initiatives that grew out of the original partnerships but are generating new cross-cutting initiatives themselves.

Despite the relative absence of outcome data, there are many examples that demonstrate the positive impact of the program. The Partnership Program remains a vital and vibrant work in progress.

Nearly all of the original partnerships have been implemented successfully and are able to report sustained results in achieving the goals and objectives contained in their work plans.

Partnership achievements can be described within four broad areas:

1. Implementations of work plan goals and objectives
2. Reconnecting with contemporary science and practice
3. NIS/CEE partners as emerging leaders
4. NIS/CEE partners as policy makers.

These four areas apply to all of the partnership types. All partnerships can demonstrate achievements in at least one area and many in several. The examples presented here are highlights rather than a comprehensive compilation of all achievements.

3.1.1 Implementation of Work Plan Goals and Objectives

3.1.1.1 The Original Partnerships

Nearly all of the original partnerships have been implemented successfully and are able to report sustained results in achieving the goals and objectives contained in their work plans. Those partnerships that failed did so early in the process, often during the negotiation of partnership goals and objectives and prior to their implementation.

Accomplishments observed in the most successful partnership programs include:

- An upgrade in clinical practice throughout the partnership site. Clinical practices, widely available throughout western nations but unknown in NIS/CEE countries, have now been introduced and replicated throughout the NIS/CEE. EMS, mammography, and infant resuscitation are three of many examples. As part of this process, NIS/CEE partners have undergone remarkable changes in clinical philosophy, practice, and mindset.
- Changes in the roles and relationships of physicians, nurses, and other clinical practitioners resulting in more efficient care delivery. Rigid authoritarian models of clinical practice and education have given way to democratic pluralism. Interdisciplinary, team-based models of care are one example.
- Introduction of consumer-focused care.
- Improvements in education and training of health care personnel. High-level U.S. health care leaders and clinical professionals have become engaged and deeply committed to supporting knowledge transfers by providing technical assistance, developing and delivering training, redesigning curriculum and academic programs, and hosting extended educational visits to U.S. sites.
- A visible effort to improve outcome measurements by NIS/CEE partners at several partnership sites, and in a few cases, within the community or region. This has occurred despite the fact that systems for measuring the impact of new practices are not generally available and data collection is spotty at best.
- NIS/CEE partners have been instrumental in the redesign of health care policy and regulatory mechanisms aimed at system-wide improvements such as improved access to care, higher clinical standards, and enhanced professional training.
- Promotion of the principles of democracy through the development of professional associations, advocacy groups, foundations, and other nongovernmental organizations.
- Development of successful strategies for replicating and sustaining programs.

The CEP was able to identify numerous specific examples of impressive accomplishment of work plan goals and objectives by the original partnerships. These were obtained through interviews of program participants and were evident in partnership reports. It should be noted, however, that for the most part the CEP did not have access to reliable data that would confirm the reported outcomes. In addition, although the reported outcomes occurred after the introduction of partnership initiatives, appropriate studies have not been conducted to establish statistically a causal relationship between these outcomes and the Partnership Program. Establishing causal relationships is made especially difficult because the reported changes occurred during a time of multiple inputs and substantial environmental change.

Improved clinical outcomes reported by the original partnerships include:

- A 200% increase in survival of sick infants in the first two days of life resulting from improved care in outlying maternity hospitals and the availability of the Regional Neonatal Center in L'viv, Ukraine.
- A reduction in neonatal mortality in Kiev, Ukraine, from 14.2 /1,000 live births in 1992 to 8.0 /1,000 live births in 1999.
- A reduction in infant mortality from 31.9/1,000 in 1993 to 22.7/1,000 in 1999 in Bishkek, Kyrgyzstan.
- A 23% reduction in the abortion rate in a women's wellness center catchment area of about 5,000 women in Almaty, Kazakhstan, and a similar reduction in Odessa, Ukraine.
- A two-thirds reduction in transfusion-related hepatitis infections in Almaty, Kazakhstan.
- An approximate 10% reduction in infections occurring at the site of insertion for central venous transfusions at the Oncology Institute in Bishkek, Kyrgyzstan.
- A remission rate of 90% in acute leukemia, compared with 30% reported before 1994 by the Oncology Institute in Bishkek, Kyrgyzstan.

Reports from the original partners also suggest that care is being delivered in a more cost-effective manner. These include:

- Over a one-year period, a reduced length of hospital stay for diabetic patients in Vac, Hungary, from 11.7 to 6.6 days.
- Following the introduction of laparoscopy, a reduction in length of stay for surgical patients from 20 days to 6-7 days at the Regional Hospital in Odessa, Ukraine.
- Reduction in length of stay from 21 days in 1993 to 12 days in 1999 at TashMI II in Tashkent, Uzbekistan.
- Reductions of nearly 1,000 beds at Erebouni Hospital in Yerevan, Armenia, based on implementing U.S.-style planning and care processes.
- Reduction in beds at Zhovka Rayon Hospital in L'viv, Ukraine, by 30% since 1992.
- Substantial downsizing of beds in Bishkek, Kyrgyzstan, and Semipalatinsk, Kazakhstan.

Although most of the original partnerships are hospital-based, several have emphasized community-based services. Examples of successful community-based efforts include:

- The healthy communities' partnership in Bratislava, Slovakia, engaged in a community needs assessment of Petrzalka, an economically depressed

The CEP was able to identify numerous specific examples of impressive accomplishment of work plan goals and objectives by the original partnerships.

Many of the original partners have been successful in their efforts to generate internally or to secure from external sources the resources required for program sustainability.

area of the city. Initially, high reported rates of teen drug and alcohol abuse focused partnership activities on drug and alcohol abuse prevention. As the partnership developed, domestic violence began to emerge as a significant underlying problem, and a new program was designed to deal with it. Modeled after the Hope House in Missouri, this program served 500 clients the first year. A shelter for abused women is in the planning stages.

- In Constanta, Romania, partners assessed community problems by conducting surveys and focus groups. Based on the results, domestic violence programs were created to address their top priority, and programs aimed at reducing sexually transmitted disease were developed to address the next highest priority. To develop these programs, a team with broad professional and citizen representation was formed and a public awareness campaign was launched using TV and other news media. Citizen participants include young student volunteers who are heavily involved in promoting the programs. One positive result of this campaign is the passage of a domestic violence law and a reporting system in Romania. With help from the U.S. partner, a foundation has been created for the purpose of securing continuing funding.
- The Citizens for Health Association in Vac, Hungary, developed an extensive set of health promotion/ disease prevention activities including self-help clubs for diabetic, ostomy, and oncology patients. The association also persuaded a local grocery chain to develop a separate "healthy foods" section in its markets, with accompanying educational materials of high quality.

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

Many of the original partners have been successful in their efforts to generate internally or to secure from external sources the resources required for program sustainability. Following are some examples:

- The Oncology Institute in Bishkek, Kyrgyzstan, has secured more than $450,000 in funding from the City of Hope and other foundations.
- The chief nurse at the Ministry of Health in Tashkent, Uzbekistan, has obtained training funds from the government of Japan.
- A women's wellness center in Almaty, Kazakhstan, has obtained grants from multiple agencies, including the Soros Foundation.
- A women's clinic in Semipalatinsk, Kazakhstan, has obtained funding from the Methodist Church Council and the Soros Foundation.
- A satellite women's wellness center in Tashkent, Uzbekistan, is generating 100% of its budget from fees-for-service, having implemented a physician payment scheme based on measures of productivity.

- The home health care program in Vac, Hungary, has been successfully organized as a private company. It employs a staff of 15 and is financed by health insurance.
- Every ward at the Institute for Pediatrics in Almaty, Kazakhstan, has a private practice area where medical staff provides fee-for-service care, returning 50% of the revenue to the institute.
- Hospital #122 in St. Petersburg, Russia, provides space to a private business making dental prostheses in return for a percentage of net profit that is then used to subsidize other services.
- The Almaty Kazakhstan Institute of post Graduate Medical Education trains and certifies 60 Emergency Medical Services Specialists from around the country annually on a self-sustaining educational fee basis.

There are several other examples of success in the original partnerships that involve the categories outlined above. Three of these are mentioned here, although others could be cited as well:

- An outstanding example is the Dubna-La Crosse Partnership, which was recently featured in a front page article in *The New York Times*[11]. This very successful partnership resulted in a number of effective programs that continue to be supported by the city government and other international agencies. During the past year, the partnership hosted 70 La Crosse citizens who traveled at their own expense to Dubna to celebrate Dubna Day. Together, they put on a health fair for the citizens of Dubna that included programs in women's wellness, diabetes education, alcohol and substance abuse, and cardiac care. As a direct result of the partnership, the city of Dubna has assumed fiscal responsibility for many new, health-related programs. Some of these have been replicated in other sites.
- Hospital #122 in St. Petersburg, Russia, created a 42-bed, American-style "mini-hospital" by renovating a section within its large, rundown, regional hospital originally built to serve the health care needs of atomic industry workers. The entrepreneurial partners recognized the opportunity to obtain funding for renovating the first units as a means of assuring efficient, high-level care for participants in the 1995 Goodwill Games in St. Petersburg. This renovation was supported in part by U.S. partners and the Turner Foundation. Once the Goodwill Games were over, not only did the hospital director maintain the original improvements, but also the hospital continued to renovate old units, creating more efficient, American-style facilities as resources became available. The director has been successful in obtaining support from government sources, grants, and fees-for-service, and he has negotiated more than 100 referral agreements with industries and businesses throughout the region. Physical renovations were accompanied by significant changes in clinical practice. Nursing roles were expanded to include more care management and clinical leadership, and the ratio of nurses to patients was increased. Currently, there are 55 nurses assigned to the mini-hospital, making for a nurse-patient ratio significantly higher than that of the rest of the hospital and providing comprehensive, more cost-effective care with less reliance on higher paid physicians.

Because the CEP evaluation was conducted at the midpoint of the current cooperative agreements, it was not realistic to expect that the new partnerships would successfully have achieved all of the goals and objectives contained in their work plans.

Of the 23 community-based primary care partnerships in the NIS, 11 have completed their community needs assessments.

- Reflecting U.S. hospital standards, the Erebouni Medical Center in Yerevan, Armenia, also made major changes in an effort to improve care and achieve greater efficiency. The director invited the U.S. partner to assist in determining a realistic number of beds for the center and followed this by significantly reducing bed capacity. Physician and nursing roles were restructured, and care processes were reformed throughout the hospital. The hospital director is also involved in the creation of the first private insurance company in Armenia.

More difficult to quantify, but important nonetheless, is the extent to which the AIHA program has changed attitudes among NIS/CEE participants. Prior to initiation of the original partnerships, some had lost hope as resources dwindled dramatically, and it became difficult to maintain what they believed to be acceptable standards of care. In many cases, this has changed as a result of the partnership. An example was provided to the CEP by one of the participants in the Bishkek, Kyrgyzstan-University of Kansas partnership who described his participation in the AIHA program as a life-changing experience, noting how his own spirits were lifted. He described how he and his colleagues are now able to do things better and more effectively, even though they still have relatively few resources available to them.

3.1.1.2 The New Partnerships

Because the CEP evaluation was conducted at the midpoint of the current cooperative agreements, it was not realistic to expect that the new partnerships would successfully have achieved all of the goals and objectives contained in their work plans. The five-stage cycle observed in the original partnerships included time for partnership selection, orientation of partners, and work plan development. In addition, time was required for the partners to learn about each other through exchange visits and other means and to develop mutual trust. All of these steps were essential preliminaries to the actual achievement of specific work plan goals and objectives.

The CEP has found evidence, however, that the new partnerships are actively at work and are on a trajectory that should lead to success. Of the 23 community-based primary care partnerships in the NIS, 11 have completed their community needs assessments. These assessments are in progress in an additional three partnerships. Eleven primary care centers have been opened and 10 other primary care centers are undergoing renovation. These steps are essential prerequisites to the initiation and implementation of additional programs such as health promotion, outreach activities, education and training of primary care providers, and a redefinition of the roles various providers will play in patient care.

The CEP also found evidence that some of the primary care partnerships are identifying common problems and beginning to work together to solve them. As an example, many of the new partnerships in Ukraine have recognized the need for improved education and training in primary care. Because no partnership has the sole capacity to develop these programs, a number of them are considering the possibility of joint training activities—including the possible creation of a common primary care training center.

A joint effort to improve medical education and training and to address common health care workforce problems has emerged from an AIHA-sponsored workshop held in Almaty, Kazakhstan, in October 2000. Attended by the rectors of the medical universities in Central Asia as well as by

representatives of Central Asian health ministries, the attendees agreed to establish a Rectors' Council that would meet on a regular basis to discuss mutual problems and develop joint solutions to them.

Another example of beginning interpartnership activities is the joint development of clinical practice guidelines. The new partnerships are also re-examining the role of nurses in the delivery of primary care and taking steps to upgrade nursing practice. In this effort, as well as in the development of clinical practice guidelines, they are building on similar activities undertaken by the original partnerships. The CEP believes that several of these joint undertakings could lead to the development of new cross-cutting initiatives involving the primary care partnerships.

Other examples of accomplishments by the new partnerships follow:

- The Sakhalin, Russia-Houston Partnership has conducted a survey of teenagers, and based on the findings, developed public education programs for use in Sakhalin and the neighboring city of Korsakov.
- The Georgia Mtskheta-Mtianeti Regional Health Administration received through its partner (The Milwaukee International Health Training Center) a $100,000 grant from the Meehan Family Foundation for a new Public Health Center, which led to a $120,000 grant from the World Bank, land from the municipality, and U.S.-developed architectural plans. A competitive bidding process for construction is planned for spring of 2001.
- Following the establishment of a family medicine center in the village of Rudno, Ukraine, both ambulance calls and visits to district polyclinics have decreased.
- At the School of Public Health of the Mechnikov State Medical Academy, a graduate program in epidemiology has been established and textbooks developed. This program is being replicated at universities in Russia and other NIS/CEE countries. The school is also serving as a training site for U.S. students.
- The health management education program in Tbilisi, Georgia (Scranton, Pennsylvania-Tbilisi partnership), has begun a new two-year MHA program in health management, conducted management courses for physician and nurse administrators, and established satellite training centers in Kutaisi and Batumi. A third satellite center is planned for Telavi.
- The School of Public Health in Almaty, Kazakhstan (partnered with Virginia Commonwealth University), is completing course syllabi for its master's in public health and master's in health administration programs. Faculty development activities are also underway via exchange visits and attendance at conferences and workshops.
- The State Medical Academy in Bishkek, Kyrgyzstan (partnered with the University of Nevada), has opened its family medicine clinic. Building upon prior efforts by the Kansas City-Bishkek partnership, it is also working to upgrade nursing practice through the development of a nursing baccalaureate program. Educational programs in health management education and preventive medicine are also being offered.
- The Pereyaslavka Social Services Department (Khabarovsk-Lexington

The CEP observed or was given numerous examples of the extent to which health professionals in the NIS/CEE were sequestered from modern medical science and technology.

As was the case with the original partnerships, some of the new partners also report that participation in the AIHA program helps renew hope and optimism.

Partnership), with encouragement from the U.S. partner coordinator, was successful in having local orphanages included in the partnership service network and work plan.

As was the case with the original partnerships, some of the new partners also report that participation in the AIHA program helps renew hope and optimism. Some relate that, along with many of their colleagues, they lost hope as resources dwindled dramatically and the ability to maintain what they believed to be acceptable levels of care became impossible. As an example, the director of the primary care clinic in Lori, Armenia (Lori-UCLA partnership), cites hope as key to maintaining the community's only clinic in the face of dire shortages of even the most basic resources—heat and water. She and her staff report that they have not received any salary for more than a year, but they report daily to the clinic, study English, take advantage of any training opportunities that are made available, provide health education to their community, and deliver what care they can within their limited resources. They recently sponsored a well-attended community health fair.

3.1.2 Reconnecting with Contemporary Science and Practice

Centralized control of health care resources and the system of delivery within NIS/CEE hospitals during the Soviet era resulted not only in poorly designed and misaligned resources but also the sequestering of health care professionals from the international scientific and practice communities. This occurred at a time of rapid intellectual and technical development in medical research elsewhere and its translation into clinical care delivery. As a result, the devastation left by an almost overnight collapse in existing resource and decision-making systems was further exacerbated by the lack of managers and practitioners with the capacity for rebuilding or replacing them. Perhaps most dangerous of all was the inability of those who did assume leadership positions in the aftermath to understand how far they had been left behind.

The CEP observed or was given numerous examples of the extent to which health professionals in the NIS/CEE were sequestered from modern medical science and technology. In the Republic of Georgia, for example, it learned that there had not been a single paid subscription to a peer-reviewed medical journal since 1990. Site visits also demonstrated that many of the NIS/CEE medical libraries are not only small by international standards, but they have collections that consist largely of theses written by previous students.

Reconnecting NIS/CEE health professionals to modern science and technology can occur in a number of ways including:

- Generating new collaborative relationships with international colleagues.
- Providing regular access to and use of professional materials, via printed or electronic media, that supply state-of-the-art information on health related issues.
- Visits to U.S. partners, during which NIS/CEE health professionals observe and participate in contemporary clinical and management practices.
- Contributing to knowledge development through publication of research and practice experience in literature, such as refereed journals, professional publications, and the popular press.
- Participating in professional exchanges by attending conferences, workshops, and professional study groups.

From the beginning, the AIHA program has emphasized exposing the NIS/CEE partners to current practices. Its learning resource centers provide exposure through Internet connectivity as well as through their collections of journals and CD-ROMs (see Section 4 of this report). Visits to U.S. partner institutions, AIHA conferences and workshops, the AIHA web site, and AIHA publications are also designed to accomplish this goal.

As a result of visits to the United States, several NIS/CEE physicians and nurses quickly recognized the gravity of their situation and became instant reformers. They described the ability to see and experience the tremendous disparity of knowledge and technology as a life-changing experience. Many returned to their respective positions with an absolute commitment to bring about change within their organizations and their countries. Initially, they involved large numbers of their staff in an effort to jump-start the reform. Many quickly moved beyond their own organizations, promoting advanced education for physicians, nurses, and other health care professionals within other institutions and organizations in their communities.

Listed below are some specific examples of what has been accomplished through visits by NIS/CEE partners to the United States. Although the examples listed are from the original partnerships, there is every reason to be confident that a similar process is taking place in the new partnerships since the exchange visits are continuing:

- The director of the Almaty, Kazakhstan, women's wellness center described her first visit with her Tucson partners as an "epiphany." She observed, for the first time, a painless obstetric delivery and vowed to bring that change to the women in her country. Her center is now a model of compassion, patient amenities, utilization of modern techniques, and entrepreneurial creativity. Her activism has resulted in the creation of policy mandating the use of obstetric anesthesia, where appropriate.
- The head neonatologist for Ukraine's health ministry described how she visited U.S. health systems early in the partnership process. She became convinced that changes could be made in health policy and practice throughout Ukraine. Since her first visit in 1992, she has been tireless in her efforts to improve the survival rate among infants, engaging professionals throughout the Ukraine. She has been instrumental in obtaining equipment from others, such as the Swiss government and UNICEF.
- The director of the Center for Maternal and Child Health Care in Kiev described his visit to a museum in Detroit during a partnership exchange. He saw exhibits denoting U.S. advances in technology between 1928 and 1953. He pointed out that Ukraine did not make the same advances during this period and emphasized the importance of reducing the gap and rapidly upgrading clinical practice in his country.
- The director of the Emergency Medical Center in Kiev recalled watching the American television show *911* in 1990 and realizing the possibilities that existed for improving emergency care. Subsequently, she was able to visit and observe emergency medicine in the United States. Since that time, she has been instrumental in establishing emergency medicine training programs for professionals throughout Ukraine. Adopting the American entrepreneurial spirit, she is marketing training to

Several NIS/CEE partners have reported that, despite the importance of their initial visits to the United States, they now prefer a continuing relationship based on visits by U.S. experts to their respective organizations.

AIHA-sponsored conferences and workshops also provide excellent opportunities for NIS/CEE clinical professionals, scientists, and government officials to meet and engage with their counterparts from other countries.

private security companies, the tourist industry, and others as a means of maintaining the center.

- The director of the Regional Hospital in Odessa, Ukraine, noted the challenge of introducing innovation in his hospital. He cites the importance of visiting the United States and actually participating in surgical practice, experiencing the remarkable difference in technology. He had never before seen laparoscopy, for example, and was quick to solicit funds for equipment in order to implement such procedures. After completing 100 procedures, he and his colleagues sponsored a conference for the medical community from throughout Ukraine and also invited U.S. partners. This conference helped create the momentum for adopting and using this technology at other sites. Laparoscopy is particularly valuable in this part of the world because it contributes to the reduction of infection rates.

Several NIS/CEE partners have reported that, despite the importance of their initial visits to the United States, they now prefer a continuing relationship based on visits by U.S. experts to their respective organizations. In other words, once they truly understand the scope of the problem and the potential for correcting it, they want their U.S. counterparts to help them adapt new knowledge and technology on-site, working with their staff and within their respective organizations and communities.

AIHA-sponsored conferences and workshops also provide excellent opportunities for NIS/CEE clinical professionals, scientists, and government officials to meet and engage with their counterparts from other countries. Many of these connections would not occur solely through partnership exchanges. Several partners described the importance of attending these conferences and workshops and provided examples of continuing collaboration based on the relationships that developed. Ideas for cross-cutting initiatives, for example, have grown out of cross-partnership discussions that have taken place at AIHA-sponsored conferences. In other cases, government leaders who participated in AIHA-sponsored conferences returned home and initiated significant policy changes in order to implement ideas they had been exposed to at the conference or workshop.

3.1.3. NIS/CEE Partners as Emerging Leaders

Emerging leadership by NIS/CEE partners is expressed through:

- Developing and implementing cross-partner collaborations.
- Actively promoting dissemination and replication of partnership successes.
- Continually seeking opportunities to advance health and medical care through participation in research and education.
- Initiating and/or participating in system-wide changes.
- Promoting democratic principles by assuming leadership in the development or management of professional groups and other non-governmental organizations that work toward improved clinical practice and care delivery.
- Developing strategies for program sustainability.

The enhancement of nursing education and practice is perhaps the most striking example of emerging leadership. Nurses—traditionally poorly trained, underutilized, and held in low esteem by physicians and others —are finding their own voice and engaging in substantive reform of nurse education and practice. They have been

quick to adopt initiatives, participate in advanced training, and strive toward reforms throughout the profession and health systems in which they work. Nursing associations have been established in many NIS/CEE countries. The Semipalatinsk, Kazakhstan, nurse association, for example, has a membership of 1,500 nurses. It has successfully lobbied with the authorities to reverse a negative employment action involving one of its members.

Nurses come together from many partnerships and NIS/CEE countries to participate together in AIHA-sponsored nurse leadership conferences and workshops. With assistance from AIHA, they have developed an affiliation with Sigma Theta Tau International, a professional nursing organization that promotes evidence-based practice. At the most recent nurse leadership conference held in St. Petersburg, Russia, nurse leaders from NIS/CEE countries were inducted into that organization. Inductees included the chief nurse for the Tashkent ministry of health, who is also the head of the Uzbek nursing association, and the minister of health from Russia, who was trained initially as a nurse and then as a physician. Another example of a nurse leader is the director of public health in Vac, Hungary, who is the driving force behind the successful creation of Vac Citizens for Health, a non-governmental organization.

The examples listed above are from the original partnerships. Although the new partnerships are still in a relatively early phase of development, they too are producing leaders in the health professions. For example:

- A demonstration of the advancement of nursing education is found at the Kyrgyz State Medical Academy (KSMA) in Bishkek, Kyrgyzstan (Bishkek-Reno partnership). Beginning with broad goals focused on primary care, the program has emphasized faculty development in primary care medicine, nursing, and health management. As the partnership developed, it became clear that there was a great need to upgrade nursing. Building on the accomplishments of a previous partnership (University of Kansas Medical Center), the partners engaged faculty from the University of Nevada's Orvis School of Nursing. KSMA is now offering a four-year bachelor of nursing curriculum and preparing graduates to teach, serve as nurse managers, and provide clinical care. The KSMA partners were successful in securing funding from the Soros Foundation to support a visit by nursing faculty to the Orvis School.
- Leadership within the Kazakhstan School of Public Health in Almaty (Almaty-Virginia Commonwealth University partnership) resulted in the development of certificate programs for practicing administrators, health department staff, and physicians in the Central Asian Republics. One of the priorities is the training of chief nurses. Participants are identifying nurse leaders and training them as trainers in order to reach a broader group of nurses and upgrade nursing, initially in Kazakhstan and with plans to include the other republics later.
- Georgia's Kutaisi Center (Georgia-Atlanta partnership) is emerging as the hub for a regional, countrywide women's health care system supported by the ministry of health. In this model, the Kutaisi Center will conduct the training programs, provide technical assistance for the satellite centers, and receive and treat high-risk patient referrals. The

A number of original and new NIS/CEE partners have been successful in engaging local and national health officials in the development of innovative approaches to health-related problems.

Representatives from the ministries of health in Hungary and the Central Asian Republics provided examples to CEP members of partnership innovations that affected development of national policies.

regional health administration has adopted the concept and pledged to help finance system development.

Leadership from both the United States and NIS/CEE partners formed the basis for the development of AIHA's cross-cutting initiatives. For example, NIS/CEE participants in the Partners Health System/ Magee Women's Care partnership began the first women's wellness center, which became the model for the AIHA initiative in women's health. There are now 16 women's wellness centers. Moreover, the initial partnership has been successful in attracting external funding and in creating a foundation to raise money.

3.1.4 NIS/CEE Partners as Policy Makers

Elements of policy leadership observed by the CEP include:

- Influencing the development of policies and regulations that improve health care, increasing the quality of health professions education, and promoting a more efficient use of the health care workforce.
- Promoting advocacy by clinician groups for the purpose of improving health care access and delivery.
- Developing or participating in efforts to encourage consumers to advocate for and preserve their own health.

A number of original and new NIS/CEE partners have been successful in engaging local and national health officials in the development of innovative approaches to health-related problems. By doing so, they gain substantial influence, increasing their ability to sustain and replicate the innovations they are introducing in their own organizations through the development of new policies and regulations. Because some ministries have experienced significant turnover, partnership participants are often able to gain significant influence as acknowledged "experts," thus maintaining a more continuous involvement in policy formulation.

Examples of policy leadership from both the original and new partnerships follow:

- The head of the women's wellness center in Odessa, Ukraine, has become a recognized expert on reproductive health care nationally and internationally, and working with the Ukraine health ministry, has developed national guidelines for reproductive health that will be introduced during 2001.
- The deputy health minister of Ukraine described the importance of the Partnership Program, citing her visit to the United States as influential in her subsequent efforts to change health policies throughout Ukraine. She pointed out, for example, that the Prime Minister had signed in the previous week a decree establishing family medicine as a legal practice.
- In Ukraine, physicians, nurses and other health professionals have banded together to organize a national advocacy group (Pulse of the Ukraine) for the purpose of sharing information among the membership and working with local and national political leaders to improve health and health care. A number of the members are involved in AIHA partnership programs. They view this organization as an important avenue for promoting health policies that will improve clinical practices and workplace conditions in health care facilities.
- The Tbilisi-Atlanta Partners invited Georgian health ministers to AIHA-sponsored workshops. As a result,

these governmental leaders learned about the major features of health care markets and were introduced to the importance of promoting health care as a productive sector of the economy. They also gained new perspectives on the importance of more customer-focused systems. As a result of their participation in AIHA-sponsored conferences, governmental leaders are showing greater concern over specific health issues.

- As an outgrowth of the Tbilisi-Atlanta partnership, a Georgian Nursing Association has been created. The president of the nursing association also serves as chief adviser to the minister of health on nursing matters, a new government position created as a result of the partnership.
- Representatives from the ministries of health in Hungary and the Central Asian Republics provided numerous examples to CEP members of partnership innovations that affected development of national policies. Among these examples were nursing role reforms and the adoption of new clinical practices standards for women's health care, emergency medicine, infection control, and neonatal resuscitation.
- An important effort of the Bishkek-Reno primary care partnership is to support the goals of health care reform in Kyrgyzstan and strengthen the Kyrgyzstan State Medical Academy's role as a consultant to the government. The Kyrgyz minister of health is the former chair of the Kyrgyzstan State Medical Academy's Department of Family Medicine. He and the state secretary of Kyrgyzstan are very supportive of the AIHA Partnership Program. The state secretary characterized the AIHA program as the most successful component of USAID's efforts in Kyrgyzstan.

3.2 Factors Contributing to Successful Partnerships

As a result of its visits to both the original and new partnerships, the CEP was able to identify several factors that contribute to partnership success. They include:

- Strong champions in both the NIS/CEE and U.S. partner organizations
- Close relationships between key individuals in the partner organizations and government officials, leading to the active involvement, support, and commitment of local, regional, and national governments
- Prior international involvement of the U.S. partner coupled with a commitment to social activism
- Congruent goals between partners
- Size of organizations or communities involved in partnership arrangements. Large organizations and communities may be less flexible and more complex to deal with.
- Preexisting relationships, such as Sister City designations. Examples are the sister city relationships between Dubna, Russia and La Crosse, Wisconsin and between Tbilisi, Georgia and Atlanta, Georgia.

Another important element of a successful partnership is the presence of reciprocal benefits for the U.S. partner. U.S. partners reported a number of such benefits:

- Participation sensitizes U.S. organizations and communities to the importance of global issues and concerns and builds support for international assistance in health care among U.S. citizens who might otherwise not be exposed to such programs. One partner reported the involvement of

The greatest challenge to partnership success and sustainability is the availability of public and private resources. This challenge has been exacerbated by the deepening fiscal crisis in many NIS/CEE countries.

U.S. participants are able to observe clinical situations not generally seen in the United States, some of which may develop into global problems.

more than 300 churches from its state. Another described the role of volunteers, including a governor. School children in Kansas City participated in a "Heart to Heart" collection, producing more than $8 million worth of supplies and equipment for Bishkek, Kyrgyzstan. Church women from throughout North Dakota, South Dakota, and Montana prepared 8,000 layettes for the women of Turkmenistan.

- U.S. partners, observing what their NIS/CEE counterparts are able to accomplish with limited resources, return home and reexamine ways to eliminate wasteful practices in their own health care system.
- Several U.S. partners report that collaboration with an NIS/CEE partner inspired collaboration back home, changing previously competitive relationships. The consortium of health centers and systems from Tucson, participating in a partnership with Almaty, are now collaborating more effectively with each other. As a result of the partnership, they are now working together to install a World Health Organization WHONET Program in hospitals in Southern Arizona and Northern Mexico that will track antibiotic sensitivity. Another example is in La Crosse, Wisconsin, where the two major health systems that have collaborated on the Dubna project have begun to collaborate on health care delivery in La Crosse.
- The program has resulted in improved understanding of cultural factors that may be encountered with populations in the United States with NIS/CEE ancestry (e.g., Ukrainian or Armenian communities).
- The program has generated professional opportunities to teach and share knowledge. Participants experience a refreshed sense of professional mission, stating, "This reminds me of why I went into [nursing or medicine] in the first place. With the pressures, you forget why you became a practitioner and this helps us remember."
- U.S. participants are able to observe clinical situations not generally seen in the United States, some of which are may develop into global problems. An example is drug-resistant tuberculosis.
- Some U.S. partners note that they have an opportunity to participate in implementing program improvements not yet adopted in the United States. The women's wellness centers, for example, integrate an array of women's health care and educational services in one location and represent a state-of-the-art not yet achieved within many U.S. organizations. Community-based primary care programs in some of the NIS countries have better integration of services than is found in many U.S. communities.

3.3 Factors that Threaten Success of the Partnerships

The greatest challenge to partnership success and sustainability is the availability of public and private resources. This challenge has been exacerbated by the deepening fiscal crisis in many NIS/CEE countries, which has sometimes made it difficult to obtain government financial support to continue AIHA-initiated programs. In view of this problem, the success of most of the partnerships in sustaining and expanding their programs is quite remarkable and provides evidence of the strength of the AIHA partnership model. The CEP believes the success of

the partnerships despite severe resource constraints in the NIS is reason to take a longer-term view toward support of the AIHA program and the innovations that it has introduced.

Political uncertainty and frequent changes in leadership often exacerbate the negative impact of the underlying economic crisis. The Pirogov-Boston partnership has been constrained by Russia's worsening economic crisis, lack of interest in the partnership by the Moscow Health Care Committee, and poor support from a majority of physicians practicing at the hospital. City Hospital #2 in Tbilisi, Georgia, was undergoing remodeling as part of the partnership plan when Abkhazian refugees who occupied the building halted construction. The Khabarovsk -Lexington partnership experienced a temporary setback when the region's head of public health and the Khabarovsk partnership coordinator were replaced.

A less obvious but still important threat is increasing competition in the U.S. health care environment. A critical feature of the AIHA Partnership Program is the ability of U.S. partners to provide in-kind contributions to their NIS/CEE partners. A number of U.S. partners told the CEP that, as a result of heightened competition and budget pressures, their institutions increasingly were reluctant to grant leave time to members of their staffs and provide equipment and supplies for use in the NIS/CEE.

Resistance to change on the part of both government officials and health professionals in the NIS/CEE has also been cited as a factor inhibiting success. In the case of health professionals, resistance to innovation is most commonly exhibited by physicians and appears to be especially pronounced in some of the premier NIS/CEE institutions. An example, as noted above, is the Pirogov-Boston partnership, in which lack of support from Pirogov physicians was one of the factors that forced the partnership to narrow its goals significantly. Conservative attitudes on the part of both physicians and health care administrators were also listed as factors that prevented the Moscow-Chicago partnership from attaining all of its goals.

Another problem for some of the partnerships is the inability to maintain and replace equipment. Even though AIHA has successfully emphasized the use of lower cost technology, equipment is difficult to maintain. The learning resource centers, for example, depend on the continued availability of communication technologies. NIS/CEE partners find it difficult to replace USAID support for these centers. If funding is phased out at the end of a partnership period, the centers are at risk of losing their effectiveness or even disappearing. Even when equipment is donated, it may be underutilized if learning resource center staff is not knowledgeable about its use or it breaks down and parts are difficult to replace.

The large oversupply of physicians and the variation in physician competency in many NIS/CEE countries has posed a threat to some components of the AIHA program, especially attempts to upgrade nursing. As the role of nurses is expanded, there is a decrease in the need for physicians. This creates physician anxiety and produces resistance to change in spite of the fact that the more effective use of nurses has the potential to affect favorably both the quality and cost of care.

Other factors that the CEP believes have the potential to undermine the Partnership Program include:

- Tensions between AIHA and the USAID missions (see Section 6)
- Cultural and language differences

The CEP believes the success of the partnerships despite severe resource constraints in the NIS is reason to take a longer-term view toward support of the AIHA program and the innovations that it has introduced.

The current cooperative agreement, budgeted for three years, should be continued for an additional two years to complete a five-year cycle.

- Poor management skills and systems within the NIS/CEE.

3.4 Conclusions and Recommendations

Conclusions

1. *CEP review of the original partnerships established under the initial cooperative agreement between AIHA and USAID indicates that most of them have continued on a successful course. There is evidence of:*
   - *Program sustainability and replication.*
   - *A more rational approach to resource use. Health care providers not only have improved skills but have also allocated responsibility and workload more efficiently, particularly between physicians and nurses.*
   - *More positive provider attitudes resulting from their inclusion in decision-making through the "bottom up" partnership approach.*
   - *An emphasis on the use of relatively inexpensive low technology as contrasted with expensive high technology.*
2. *Sustainability grants have been used effectively by the original partnerships and have contributed to their continuing success.*
3. *There is evidence that the new partnerships funded under the current cooperative agreements are following the same successful course evident in the original partnerships.*

Recommendation

1. *The current cooperative agreement, budgeted for three years, should be continued for an additional two years to complete a five-year cycle. Concurrently, USAID should initiate a new five-year award cycle, ensuring sufficient overlap between the two cycles, so as not to disrupt ongoing programs. The new five-year award cycle should fund new partnerships and continue support for those partnerships and cross-cutting initiatives that focus on high priority areas and have the potential for replication.*

4. Assessment of Cross-cutting Initiatives

AIHA supports centrally funded initiatives of two types: (1) programmatic cross-cutting initiatives addressing needs identified by multiple partnerships, and (2) communication and knowledge dissemination activities. The impetus for the programmatic cross-cutting initiatives arises from the partnerships. AIHA's role is in coordinating a concerted response in each initiative, drawing on the knowledge of the partners, and often establishing replicable protocols, institutional structures, and delivery models.

AIHA has initiated and maintained communication and knowledge dissemination activities to reconnect the NIS/CEE partners to advances in medical science, facilitate communication between NIS/CEE partners and their U.S. counterparts, establish communication among partners within the NIS/CEE, and disseminate information on successful programs to promote sustainability and replicability.

The cross-cutting programs are an essential feature of the success of the AIHA Partnership/Volunteer Program.

4.1 Programmatic Cross-cutting Initiatives

Programmatic cross-cutting initiatives emerge from identification by partnerships of common health problems and health care infrastructure needs that can be most effectively and efficiently addressed by programs established specifically for that purpose. The programmatic cross-cutting initiatives supported to date include nursing leadership, women's wellness and breast cancer detection, infection control, neonatal resuscitation training, diabetes education and control, EMS training, and health management education.

Some of the cross-cutting initiatives focus on developing new approaches to major health problems, such as early detection of breast cancer and more effective treatment of diabetes. Others address clinical and infrastructure needs that require cross-institutional and cross-jurisdictional cooperation, such as EMS training, infection control, neonatal resuscitation training, and nursing leadership development. The programmatic cross-cutting initiatives develop resources that benefit multiple partnerships and engage a wide network of health care providers and government officials. They have often been developed in collaboration with regional health authorities. The linkage of local, regional, and national governmental entities with the Partnership Program through sponsorship of the cross-cutting initiatives has been important in sustaining programs following AIHA support.

The programmatic cross-cutting initiatives evaluated by the CEP emerged primarily from since-graduated hospital partnerships, but they have served as important resources for the new primary care partnerships. The nursing leadership program, for example, is contributing to the development of more clinically relevant professional roles for nurses in primary care settings. The EMS training centers are providing training in urgent care for primary care personnel, and in one case in Ukraine, rural primary care providers are receiving training from a neonatal resuscitation training center in case they are involved in emergency deliveries. Because there are few examples of comprehensive,

Some of the cross-cutting initiatives focus on developing new approaches to major health problems, such as early detection of breast cancer and more effective treatment of diabetes. Others address clinical and infrastructure needs.

Nursing is substantially underdeveloped in the NIS/CEE, which limits possibilities for moving to cost-effective, evidence-based, patient-focused health care.

patient-focused health care in the NIS/CEE, the women's wellness centers have been an important model for emulation by those designing new primary care settings.

Just as some of the hospital partnerships received sustainability grants, cross-cutting initiatives also receive modest ongoing support from AIHA, primarily to restock training supplies and maintain communication links with the Partnership Program. The CEP believes modest investments in these initiatives have a high rate of return in terms of moving innovations into everyday medical practice. Some of the cross-cutting initiatives that had their origins in the hospital partnerships are continuing, as they were funded late in the original cooperative agreement or under the present cooperative agreement. The more recently funded cross-cutting initiatives are well ahead of earlier such programs in terms of employing entrepreneurial strategies to develop multiple revenue sources that will ultimately give them staying power. A number of women's wellness centers, for example, have revenue enhancement strategies, including the development of non-governmental organizations to raise funds from non-patient care resources and marketing of services to privately insured populations such as foreign nationals.

The new primary care partnerships appear to be on a similar trajectory to the original partnerships in terms of identifying initiatives that need to be developed across partnerships. One initiative is underway and a second is in the formative stages of development. The former cross-cutting initiative involves the development of clinical practice guidelines on both a NIS-wide basis as well as on a sub-regional and national basis to promote evidence-based primary care practice. The latter focuses on the development of medical residency training in primary care in Ukraine, which is viewed to be essential to the full implementation of primary care practice because few physicians have received formal education in primary care. None of the U.S. partners has the capacity alone to develop residency training for its Ukrainian partner. Thus, discussions are underway about how residency training could be developed across multiple partnerships. The CEP predicts on the basis of the past success of the cross-cutting initiatives that funding for those evolving from the new primary care partnerships will be equally important to the ultimate success and sustainability of the new partnership programs.

4.1.1 Brief Assessments of Targeted Cross-cutting Initiatives

A brief assessment of each of the cross-cutting initiatives funded to date follows. Detailed descriptions of each initiative are available on the AIHA web site (www.aiha.com).

Nursing leadership

Nursing is substantially underdeveloped in the NIS/CEE, which limits possibilities for moving to cost-effective, evidence-based, patient-focused health care. Nursing was identified early by the hospital partnerships as a resource that required strengthening in order to achieve partnership goals. Quality of care deficits in inpatient settings such as high infection rates, preventable deaths among newborns, and high patient and family dissatisfaction could not be effectively addressed without improving nursing. Nursing in the NIS/CEE, like medicine, has been isolated from advances in care and services administration that are widespread elsewhere in the world. The CEP believes the nursing leadership initiative has been one of the most successful AIHA investments. It has contributed to the development of more relevant roles for nurses in a range of settings including direct clinical care in inpatient and primary

care as well as in administration. The nursing leadership initiative has encouraged and supported changes in mainstream nursing education, generating new baccalaureate and postgraduate nursing programs in multiple sites in the NIS/CEE. Thus, subsequent cohorts of nurses will be better prepared to take leadership roles in improving care. The nursing leadership initiative has reconnected nurses in the NIS/CEE to the world nursing community through the establishment of professional nursing organizations that are networked worldwide.

These professional international connections have generated substantial volunteer investments beyond those of the U.S. partners by nurses from developed countries and will provide a continuing source of support for the advancement of nursing in the region. Because the nursing leadership program has been so successful in laying the groundwork for major improvements in nursing care in the region, the CEP is particularly concerned that some USAID missions do not see a need for continuing support that we believe is required to institutionalize further the changes that have begun.

Women's wellness

The women's health initiative began in 1997. Nineteen women's wellness centers have been established in nine NIS/CEE countries, several under the new cooperative agreements. These centers were created to demonstrate the feasibility and value of comprehensive, consumer-focused care models, which for the most part were absent in the region, where most health services were provided in impersonal, fragmented, multi-specialty polyclinics. Women's wellness centers provide health care to women of all ages; services include family planning, well baby care, new parent education, adolescent health services, STD screening and treatment, mental health and substance abuse treatment and referral, cancer screening, and health promotion.

The women's wellness centers have been highly successful in changing professional mindsets about the importance of comprehensive care and consumer satisfaction. Moreover, the women's wellness centers are influencing the organization of services in inpatient units and polyclinics toward more comprehensive, consumer-focused services. Consumers have responded very positively to the women's wellness model, and the programs have exploited opportunities for various entrepreneurial activities that provide supplemental revenue that should enhance their sustainability following cessation of AIHA financial support.

Nineteen women's wellness centers have been established in nine NIS/CEE countries… to demonstrate the feasibility and value of comprehensive, consumer-focused care models.

Breast cancer initiative

Closely aligned with the women's wellness initiative, the breast cancer initiative develops comfortable, easily accessible outpatient centers that provide breast cancer screening, including, in four instances, mammography and a full range of educational materials related to breast cancer prevention, detection, and treatment. Breast cancer is a major health concern in the NIS/CEE but modern technology for the early diagnosis of breast cancer was largely lacking during the Soviet era. An emphasis in this initiative is to teach breast examination to physicians and nurses and breast self-examination to women. Data available in several programs visited by the CEP show that a higher proportion of cancers are detected at earlier and more treatable stages since the introduction of mammography and routine breast exams. Anecdotal evidence suggests a significant decline in radical mastectomies. All 19 women's wellness centers have adopted clinical breast exams and breast self-exam programs. With USAID/AIHA support in Ukraine and Moldova, four of the women's wellness centers have adopted mammography-based screening

AIHA recognized the importance of complementing the exposure of NIS/CEE participants to management processes through their partnership exchanges with basic coursework and workshops in leadership, team-building, and management techniques.

and early detection programs. A new partnership in Armenia is focused exclusively on breast cancer screening and diagnosis. Each of these programs in turn is providing breast disease screening, training of health care providers, and community-based consumer education in support of the new primary care partnerships, including outreach to remote sites.

Infection control

Nosocomial infections are a major problem in the NIS/CEE. Infection control programs in place at the fall of the Soviet Union were not science-based and were ineffective. Widespread use of prophylactic antibiotics to prevent hospital-acquired infections contributed to serious problems with drug-resistant bacteria. Most of the original 25 hospital partnerships identified improved infection control as a high priority. Partnership activities that focused on introducing improved surgical and trauma techniques as priorities could not effectively begin these activities without first improving infection control practices. Hospitals lack trained epidemiologists and uniform data collection systems, and national infection control standards and surveillance mechanisms were inadequate. The AIHA infection control task force, comprised of representatives from the hospital partnerships, focused on developing a training program that could be replicated across partnerships and integrated as part of the philosophy of patient management. Currently, 22 partnerships in seven countries have infection control as a major focus, including two centers (in two countries) dedicated to infection control and patterned after the U.S. Centers for Disease Control and Prevention. The CEP found evidence that these programs have been influential in engaging national health authorities in setting higher standards and improving national infection control surveillance.

Neonatal resuscitation

Population growth in the NIS is below replacement levels and infant mortality is high. In response to this problem, nine partnerships initially identified neonatal mortality as a clinical focus and then came together to form the neonatal resuscitation task force. Their efforts led to the creation of a targeted cross-cutting program that has introduced basic elements of newborn care to maternity hospitals and created regional centers for improved care of high-risk infants. There are currently 15 neonatal resuscitation training centers in six countries. Three centers have opened since 1998 under new cooperative agreements. Consistent with the AIHA philosophy, low-technology, affordable approaches are emphasized. Data maintained at individual centers suggest that the program has been successful in improving infant outcomes in maternity hospitals and in the regional neonatal centers.

Diabetes education and control

This cross-cutting initiative is designed to improve the medical treatment of diabetes, to engage patients and their families in more effective self care, and to reduce costs through reduction in the need for hospital care. The CEP believes this cross-cutting initiative is an excellent example of the development and use of practice guidelines and patient education and is a model that could be replicated to improve the care of other prevalent chronic diseases in the new primary care partnerships.

EMS

Potentially preventable morbidity and mortality result from the lack of training of physicians and ambulance, police, and fire personnel in basic emergency care. Moreover, the region lacks planning for mass emergency responses to mass casualty disasters, including radiation and chemical exposure and natural disasters such as earthquakes. This initiative concentrates

on developing EMS training centers that offer a standardized curriculum in pre-hospital emergency care to ambulance personnel, police, and firefighters and others who are called upon to provide emergency care. There are currently 15 EMS centers located in 12 countries. Four have been created since 1998 under new AIHA cooperative agreements, two as part of new partnerships. Several are working on plans for managing large scale medical disasters including Ukraine, which still suffers the health aftermath of the Chernobyl nuclear power plant disaster. The CEP rated this initiative highly in terms of its widespread impact on changing basic emergency medical practices.

HME

Transition to a market economy in health care requires the acquisition of knowledge and management techniques that are new to the NIS/CEE. AIHA recognized the importance of complementing the exposure of NIS/CEE participants to management processes through their partnership exchanges with basic coursework and workshops in leadership, team-building, and management techniques. AIHA and AUPHA developed and conducted a series of "101" management courses for NIS/CEE partner staff. This work included basic and follow-up courses in financial management and cost accounting for the original partnerships as well as train-the-trainer courses to develop faculty capacity in management education.

The results of this effort gave rise to the development of HME partnerships focused exclusively on development of university-based health management education programs in Albania, the Czech Republic, Romania, and Slovakia, and more recently under new cooperative agreements, Armenia, Georgia, and Kazakhstan. Alongside the exclusive HME partnerships and with their participation, AIHA continues to conduct basic management courses for its new primary care partnerships. An important focus of the training continues to be the train the trainers component, and there is a growing cadre of NIS/CEE faculty and practitioners who participate regularly in this activity. A professional association for health care managers, patterned after AUPHA. was formed in Russia; a similar association is being developed in Armenia. These associations play a dual role of connecting managers and management educators in the NIS/CEE to a larger world community and developing self-supporting management training activities that can be sustained after AIHA support. HME partnership representatives (both current and graduated) meet twice a year in AIHA-sponsored workshops to develop and share case studies. AIHA also supports faculty participation from the NIS/CEE in annual meetings of AUPHA and the Academy for Health Services Research, through which they maintain important linkages with professional counterparts and continue to develop their faculty and curricula.

Cross-cutting initiatives have a larger geographic population target by design than do partnerships located at particular hospitals, polyclinics, or medical practices.

4.2 Assessment of the Programmatic Cross-cutting Initiatives

The CEP finds that the cross-partnership programs serve several functions that collectively promote the effectiveness, sustainability, and replicability of health reforms fostered by the overall AIHA Partnership Program, and it notes with concern that missions have often not been supportive of this part of the AIHA program. The CEP believes these initiatives have contributed in the ways described below.

1. **They speed the rate of adoption of new practices, often introduced first by the individual**

The cross-cutting programs provide an excellent opportunity for conducting outcomes evaluations about the impact of changes in health practices associated with AIHA programs.

partnerships, to a wide cross-section of providers and consumers and thus contribute to measurable improvements in local or regional health outcomes. The cross-cutting initiatives generally include a substantial training component. An initial investment is made in training a small number of NIS/CEE practitioners, often in the United States or by U.S. partners, in new practices and techniques. Modest training or resource centers are established in host countries to facilitate those that have been trained to train a large number of other providers—a train the trainer approach. The ongoing costs of the programs are modest and consist primarily of maintaining the training and resource centers and their equipment and replenishing educational materials and supplies. Examples include emergency medical care training and infant resuscitation training.

These initiatives have data documenting improved outcomes arising from greater recognition of problems in front-line medical facilities. For example, EMS and infant resuscitation programs have data documenting that patients now arrive at emergency hospitals and neonatal intensive care units in better condition, thus improving the probability of a good outcome. The L'viv-Detroit neonatal program, established as the first high-risk neonatal care center within the former Soviet Union, (and as noted in Section 3), has demonstrated a 200% increase in survival of infants in the first two days of life because of better care provided at maternity hospitals prior to transport of sick infants to the regional neonatal care center.

2. **Cross-cutting initiatives have a larger geographic population target by design than do partnerships located at particular hospitals, polyclinics, or medical practices. Thus, they are well positioned to collaborate with city, regional, and national government entities to tackle problems that require cross-jurisdictional cooperation.** Examples of this include the successful establishment by EMS programs of emergency response plans to radiation disaster and other mass casualty incidents and the influence of infection control initiatives on new governmental policies and standards for hospitals.
3. **The cross-cutting initiatives also link individual partnerships to one another within regions and countries, creating a synergy that helps partners pursue similar objectives and efficient use of technology.** For example, the breast health program in Yerevan, Armenia, brings mobile mammography services to outlying polyclinic-based primary care partnerships, thus bringing a new service to consumers, heightening awareness of the need for self breast examination, and creating a source of referrals for the AIHA-supported women's wellness centers. The cross-cutting initiatives provide a natural network that connects individual partnerships to one-another, promotes a Partnership of Partnerships, the sharing of problems and solutions, and judicious resource use, and that fosters the continued pursuit of program objectives in an environment that is often discouraging of innovation. The women's wellness and breast health programs within countries and between

countries are in close communication via AIHA e-mail connections and meetings. The three Ukrainian programs in Kiev, Odessa, and L'viv participate in joint training and problem-solving and also train nurses from as far away as Uzbekistan. Once a few good programs are established in the NIS through the cross-cutting initiatives, new NIS partnership personnel are trained in the region rather than in the United States.

4. **The cross-cutting initiatives break down the natural barriers to broad health reform created by language barriers, geographic distance, nationalism, cultural differences, and professional isolation.** The nursing initiative has very successfully brought together nurses from different countries and cultures in pursuit of common objectives. Women's wellness and infant resuscitation programs now routinely train nurses from across the NIS with great success. Health management education also serves to bring together leaders from across partnerships, creating an interdisciplinary training opportunity.
5. **The cross-cutting initiatives create a broad platform for launching the next generation of health reforms because they have established relationships with a cross-section of health care providers, institutions, and government entities. The graduates of their training programs are widely dispersed throughout the health care system.** The success of community-based primary care programs to date is due, in part, to the infrastructure created by the cross-cutting programs. The nursing initiative paved the way of acceptance of more responsible roles for nurses in primary care. The existence and success of women's wellness centers laid the groundwork for a more accepting environment for one-stop primary care as an alternative to multi-specialty polyclinics.
6. **The cross-cutting initiatives have created services with commercial potential to subsidize ongoing operations.** The EMS program has a commercially valuable training program to market to private sector companies, private security businesses, and the tourism industry. The women's wellness programs have developed a constellation of services in health promotion, counseling, and infant growth and development that can potentially tap new revenue sources. Several women's wellness centers have created non-governmental organizations to market their services and collect revenues supplemental to those provided from government resources.
7. **Finally, the cross-cutting programs provide an excellent opportunity for conducting outcomes evaluations about the impact of changes in health practices associated with AIHA programs.** The cross-cutting initiatives by design use a similar model of service delivery and education, and the programs collect data on similar markers of changes in processes of care and associated health outcomes. An outcomes evaluation could be designed to aggregate information on a common set of indicators across sites. For example, the breast health programs collect comparable information by year on the number of mammographies conducted, the demographic characteristics and medical histories

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The CEP observed that the relatively modest investment in maintaining Internet connections for graduated partners …has a significant return to the overall Partnership Program.

of the patients screened, the number of positive tests for breast disease, and the stage of cancer detected. While these data tend not to be computerized at present, breast screening sites have trend data suggesting that a higher proportion of breast cancers are being detected at an earlier stage in every year since the introduction of mammography. Similar kinds of data are available in the neonatal resuscitation program, as noted in the L'viv example. The infection control programs have an excellent database showing declines in infection. It would be possible to design and introduce some fairly non-obtrusive data collection instruments into the cross-cutting programs to monitor changes over time in key health outcomes

4.3 Communications and Knowledge Dissemination

Communication and knowledge dissemination activities are designed to provide the NIS/CEE partners with access to scientific knowledge and health-related literature, improve communication between partners, create an information network within the NIS/CEE, and disseminate the activities and results of AIHA partnerships. AIHA communication and knowledge dissemination initiatives include learning resource centers, Internet connectivity, the AIHA web site, conferences and workshops, and publications, as described below.

Learning resource centers

Each partnership has a learning resource center, and there are together about 140 in the NIS and CEE. In addition, there are 22 nursing resource centers located in 13 countries. Learning resource centers are designed to make available the "global library of information" by proving Internet access and act as an information clearinghouse and hub for partnership communication. The costs are shared by AIHA and each partnership, with the NIS/CEE partner supporting an information coordinator and AIHA providing computer hardware, software, Internet access, etc. Each center must be open at least 20 hours per week. The centers' basic components are computer and Internet and e-mail connectivity, together with periodicals and tools to search medical literature. Also, key health care resources are available in textbook or CD-ROM form, including medical and nursing journals. These information sources are in English, and some materials have been translated into Russian. Some partnerships (e.g. Mtshketa-Mtianeti, Georgia-Milwaukee, Wisconsin, Lori, Armenia-UCLA Medical Center) are providing English language training to physicians and other staff. The centers are usually housed in a NIS/CEE partner institution. When a partnership ends, AIHA in most cases continues to provide Internet connectivity and scientific journal subscriptions if the partner continues to report its activities.

The centers were evaluated in 1998 and identified as key factors in successful, sustainable partnerships[12]. The CEP visited a number of learning resource centers in graduated partnerships and found that the centers are still playing a vital role in sustaining programs begun under the first cooperative agreement. The nursing resource centers have contributed significantly to building momentum in the nurse leadership program by providing vital communication networks necessary for the formation of professional organizations and for communications with the international nursing community. The learning resource centers in the new primary care partnerships are heavily used and are key to implementing clinical practice guidelines and other innovative clinical and adminis-

trative practices. The CEP believes the investment in the learning resource centers has been key to the continuing programmatic growth in the graduated partnerships and is a vital and necessary element in the implementation of the new primary care partnerships.

Internet connectivity

Internet connectivity is an essential feature of the Partnership Program as it is the primary source of communication between U.S. and NIS/CEE partners and between the partners and AIHA. Moreover, as noted previously, the Internet offers the best and sometimes only access to knowledge since current written scientific information is scarce in the NIS/CEE. Internet connectivity is absolutely required for active partnerships and cross-cutting initiatives. Moreover, the CEP observed that the relatively modest investment in maintaining Internet connections for graduated partners (many of whom reported to us that they could not afford to maintain these connections without AIHA assistance) has a significant return to the overall Partnership Program. The newly funded partnerships benefit by the continuing involvement of graduated partners, who provide a source of information, consultation, and technical assistance within the NIS/CEE that contributes to building critical capacity within the region.

AIHA web site

The AIHA web site acts as a coordinating point, a portal and data repository for AIHA and partner activities and functions. The site contains a great deal of content, including goals, history, administrative structure, and staff. Background pages describe the health care history of the region. Program sections present extensive documentation of the partnerships and the cross-partnership activities. Information sections concern "lessons learned" and advice about "best practices" contributed by earlier partnerships. Technical fact sheets assist partners in learning about how to use the web site and other Internet resources and how to set up their own web sites and other technical initiatives. Partnership descriptions link to individual partnership web sites. The partnership web sites are eclectic, each developed by the partner, and represent their specific interests and type and levels of expertise. AIHA has maintained simultaneous and identical English language and Russian Internet sites that are accessible to the public. AIHA keeps track of the numbers accessing the site and reports that most are from NIS/CEE. A major priority for AIHA has been the quality of translation of English information resources into Russian, and AIHA continues to work to increase the quality and quantity of Russian language materials. The CEP believes the web site is excellent and serves to advance the objectives of the overall Partnership Program in numerous ways.

AIHA has maintained simultaneous and identical English language and Russian Internet sites that are accessible to the public.

Conferences and workshops

AIHA sponsors or holds several conferences and workshops each month that serve a variety of purposes. The annual AIHA meeting provides an opportunity for partners from both the United States and NIS/CEE to interact with one another, with AIHA and USAID personnel, and often with ministers of health from the NIS/CEE. The annual meeting enables partners to gain perspective on the big picture, to become aware of both progress and achievements, and to obtain technical assistance. Most workshops are held in the NIS/CEE, and they are targeted to achieve specific cross-partnership goals such as training in health management techniques and development of curricula for medical and nursing education programs in primary care. These conferences also serve an important networking function among NIS/CEE partners. Experts who speak at

The AIHA maintains several publications that provide additional means of communicating new information as well as showcasing successful programs.

the workshops are recruited from partnerships and NIS/CEE regions whenever possible. The CEP attended a sample of workshops and two annual meetings. These meetings, we believe, are an important element in the success of the Partnership Program and should be continued.

Publications

The AIHA maintains several publications that provide additional means of communicating new information as well as showcasing successful programs. Given the scarcity of Internet connections and poor library resources in the NIS/CEE, print media are important. The CEP observed that the partners and government officials in the NIS/CEE were putting these publications to good use. U.S. partners also use these publications to inform their institutions about their activities. The publications provide useful background for potential non-governmental funders and for mass media press coverage. All publications are featured and archived on the AIHA web site. Current publications are:

- *CommonHealth,* originating in 1992 and published two to four times a year, a semi-glossy magazine of about 40-50 pages that is distributed to partnerships, regional offices, and interested others. Its purpose is to keep health care practitioners and officials informed about partner activities and advances in health care and to help partnerships feel pride that they are part of a valued, quality endeavor. Issues focus on concerns specific to the NIS/CEE. AIHA has returned to publishing the magazine on a consistent quarterly basis.
- *Connections*, a monthly online newsletter featuring recent newsworthy events of AIHA and the partnerships. NIS/CEE partners are the main audience. The newsletter offers summaries of stories about health in the CEE//NIS, including articles on the rise of infectious diseases in Russia and associated health care statistics. Partnership solicitations, job openings, and grants available are also announced.
- Special publications are related to specific subjects and/or conferences, especially of cross-partnership interest. Over the years, AIHA has published several of these, including: "Safer Streets, Longer Lives: Creating A Healthy Community (1997)," "Nurse Leaders Creating Change: A Revolution in Progress (1997)," and "Health Care Without Borders: Promoting Partnerships Through Technology (1998)." These articles are also available and archived on the web site, where they are called the "AIHA Booklet Series."
- Educational poster series address single topics among the cross-cutting initiatives: communications, emergency medical services, health management education, infection control, neonatal resuscitation, nursing programs, primary health care, and women's health. The CEP observed widespread use of the posters in clinics and program sites throughout the NIS/CEE.

The CEP finds AIHA communications and knowledge dissemination activities to be a strong and important element of the AIHA partnership/volunteer program.

4.4 Conclusions and Recommendations

Conclusions

1. *Cross-cutting initiatives represent one of the most valuable and effective parts of the AIHA partnership/volunteer program.*
2. *The learning resource centers are a critical part of the AIHA program and are*

essential to improving health care in the NIS, but some are experiencing financial difficulties and have unmet needs. Following the end of the partnership, the NIS/CEE partner may lack resources to maintain computer systems.

3. *Hardware and Internet connections provide an effective vehicle for NIS/CEE health care providers to keep up with advances in their fields and to network with the world-wide medical community.*
4. *The AIHA web site is outstanding.*
5. *AIHA uses its convening function and resources very effectively to provide technical assistance and new knowledge in a peer-to-peer format that promotes ownership of programs and enhances their chances for success.*
6. *In addition to their excellent content, AIHA conferences and workshops provide opportunities for essential networking of partners and attract governmental officials who have the capacity to change national health care policy.*
7. *AIHA publications are valuable.*

Recommendations

1. *USAID should continue to support, and consider increased funding for, cross-cutting initiatives.*
2. *AIHA should seek opportunities to use the cross-cutting initiative mechanism to advance the programmatic priorities of the new primary care partnerships.*
3. *AIHA should make every effort to maintain the viability of the learning resource centers. It should also support more Russian translations of English medical literature.*
4. *AIHA should continue to provide financial support to the NIS/CEE partners to maintain Internet access even beyond completion of the partnership.*
5. *The AIHA web site is an important enough resource that a special effort should be made to ensure its sustainability and continued excellent capability. AIHA should consider developing a comprehensive database to underlie the site's content and thereby improve the ability to archive, categorize, access, and retrieve information.*
6. *AIHA should continue its conferences and workshops and its publication program.*

Hardware and Internet connections provide an effective vehicle for NIS/CEE health care providers to keep up with advances in their fields and to network with the world-wide medical community.

5. Assessment of AIHA Internal Management

Some board members are concerned about the capacity of the AIHA staff to accommodate the demands of an organization that has grown from an annual budget of $9 million to $29 million.

5.1 Governance

The AIHA Board of Directors, the organization's governing board, was initially composed of representatives of constituent organizations who provided access to major U.S. health care delivery and educational institutions. In recent years, new members have been recruited and membership has been diversified beyond the initial founding organization (See Appendix 2 for list of board members). Board responsibilities have also changed. Initially, board members were substantially involved in the review of partnership selection. During the past few years, their focus has shifted to AIHA's financial status and future and the review of AIHA overall work plans.

Board members report that they view AIHA as a unique organization that has blossomed in recent years, and they have great faith in Executive Director Jim Smith. They are particularly proud of the role they have played in the following:

- Structuring relationships between partners and assuring the development of realistic work plans.
- Entering into numerous partnerships simultaneously and working in multiple countries with diverse laws and regulations.
- Managing a smooth transition from hospital-based partnerships, emphasizing acute care, to community-based primary care partnerships.

Some board members are concerned about the capacity of the AIHA staff to accommodate the demands of an organization that has grown from an annual budget of $9 million to $29 million. They identified several issues that need to be explored in the months ahead:

- Expansion of AIHA's funding base to include other U.S. and international sources.
- Broadening the geographic scope of the program beyond the NIS/CEE.
- Supporting the growth of program infrastructure, particularly staff.

Another important area of board responsibility is strategic planning. There has been a great deal of preoccupation during the past few years with establishing and implementing new partnerships, and as a result, a formal strategic planning process has not been developed. Both the AIHA senior staff and its Board of Directors are aware of the importance of strategic planning, and they are taking steps to develop such a plan. The CEP was informed that an outside firm is being employed to coordinate development of a strategic plan during March to October 2001. The firm will solicit input from a variety of sources, and both the board and senior staff will be closely involved throughout the process. The following issues will be among those addressed:

- Programmatic expansion into new areas (e.g., HIV-AIDS).
- Geographic expansion, applying AIHA Partnership/Volunteer Program models in countries other than the NIS/CEE.
- Diversification of the funding base and reducing dependence on USAID support.

The CEP applauds the decision to initiate a strategic planning process, encouraging careful attention to developing a viable plan for broadening the financial, programmatic, and geographic base. AIHA has been very successful in obtaining in-kind contributions from U.S. partners and corporations, but as a matter of choice, it has not been particularly aggressive in exploring alternative funding sources such as World Bank and U.S. and international foundations.

5.1.1 Conclusions and Recommendations

Conclusions

1. *The AIHA Board of Directors is comprised of knowledgeable members and functions effectively.*
2. *The CEO has the confidence and respect of the board.*
3. *Effective and timely strategic planning is essential to AIHA's future success.*

Recommendations

1. *The AIHA Board of Directors should move forward expeditiously with its plan to initiate a strategic planning process that encompasses a three to five-year time frame. The planning process should include a review of AIHA's programmatic, geographic, and financial bases.*
2. *In addition to the development of a strategic plan, the AIHA Board of Directors should pay special attention to the following:*
   - *Developing an enhanced evaluation capacity program-wide that captures impact and outcome data on national policy changes, improvements in health, and reductions in disease and trauma.*
   - *Formulating strategic growth and funding options, including the application of AIHA's successful partnership model in other geographic areas.*
   - *Assuring that poor internal management does not hamper USAID and partnership relationships and reporting systems.*
3. *The board and the CEO need to engage in succession planning in order to ensure that the high quality of leadership that has characterized AIHA to date will continue if the need arises.*

5.2 Program Organization and Management

The AIHA senior management team is made up of a CEO, deputy executive director who is also chief financial officer, and an associate executive director for partnership programs. This team assumes responsibility for program planning and direction, fiscal and operations management, periodic evaluation, and the maintenance of effective relationships with USAID and other key organizations and individuals.

The CEO, recruited very early in the development of AIHA, has been intimately involved in all aspects of the design and implementation of the AIHA partnership/ volunteer model.

The CEO, recruited very early in the development of AIHA, has been intimately involved in all aspects of the design and implementation of the AIHA partnership/ volunteer model. His vision resulted in the development of a unique and powerful partnership concept, and his charismatic leadership has been instrumental in the rapid launch and continuing viability of the Partnership Program. The CEO is valued and respected by the AIHA Board of Directors, U.S. and NIS/CEE partners, national health ministries, and regional and local health administrators throughout the NIS/CEE. Much of the success of the AIHA program can be attributed to his leadership. But the CEP notes a lack of succession planning—important in any organization—for the CEO position, and especially so when the CEO is uniformly viewed as exceptionally strong and capable.

Five Washington D.C.-based program officers each have responsibility for a portfolio of partnerships and cross-cutting

AIHA staff members are professional, well trained, and dedicated. AIHA has been very successful in recruiting skilled and effective host country nationals and placing them in senior positions within the regional offices.

initiatives including work plan development and monitoring and budget oversight. They also share responsibility for a host of AIHA support activities and daily management of the central office. A senior program officer is responsible for conceptual design. Each program officer works with a team comprised of a program analyst and a program associate. The program officers spend approximately 35% of their time in Washington, 20% visiting U.S. partners, and 45% visiting regional offices and partnerships in the NIS/CEE. All of the program officers have master's degrees or higher, and program analysts and associates have bachelor's degrees or higher. The CEP notes the absence of a career ladder program for program analyst and associate levels, which may be a factor underlying considerable staff turnover.

Four regional offices are each staffed by a director and program and fiscal support staff. The regional offices vary in size, depending on the region and the level of AIHA activity within that region. Regional office staff is responsible for partnerships and cross-cutting initiatives in their regions, maintaining effective relationships with USAID, and managing the logistics of travel for both U.S. and NIS/CEE partners along with a host of other visitors. They assist in the development of partnership work plans, obtain appropriate approvals from NIS/CEE officials and AIHA senior staff, provide oversight and technical assistance to partners as needed, and work with partners to assure timely completion of annual updates and submission of reports.

AIHA staff members are professional, well trained, and dedicated. AIHA has been very successful in recruiting skilled and effective host country nationals and placing them in senior positions within the regional offices. This has been important in the development of good relationships with key leaders in the NIS/CEE countries and the selection of viable partners.

Board members have expressed concerns about the capacity of AIHA staff and partners to keep up with a growing volume of work as the organization grows. They cite, and the CEP noted, that inadequate delegation by senior staff to program officers is creating delays in processing even small requests. Board members and several U.S. partners reported that heavy senior staff travel schedules—which are aggravated by limited decision-making authority among mid-level staff—often makes it difficult to get questions answered or concerns addressed.

U.S. partners are dissatisfied with information made available to them regarding current financial status of their partnerships and the lack of timely financial reimbursement to themselves and their organizations for budgeted expenditures, as well as the last minute receipt of airplane tickets and other travel documents such as visas. They expressed concern about undue delays in obtaining approval of the initial work plan and subsequent revisions. Partners characterize this as a "hurry up and wait" process under which they must adhere to a strict AIHA-imposed deadline but then are left to wait indefinitely. They also feel that, once reviewed, AIHA staff members demand revisions in an unrealistically short time frame. AIHA senior staff partly attributes approval delays to the large number of work plans to be reviewed at the same time and the poor quality of some of the work plans. Senior staff members believe that some U.S. partners want exceptions to AIHA rules and procedures. There is also a notable lack of procedure manuals and written guidelines.

The complex financial requirements imposed by the federal procurement regulations, coupled with the fact that

there are six separate cooperative agreements (each with its own budget) also creates a management challenge for a small organization such as AIHA. The process is even further complicated by the presence of more than 70 separate projects and budgets within the cooperative agreements and the need to process so many international transactions at great distances with underdeveloped, technology-poor foreign partners.

The CEP found that since the last evaluation, AIHA has implemented several new procedures and controls to track and account for the expenditure of funds. An analysis of these expenditures shows indirect and program management spending, as a percentage of total expenditures, that might be considered high if the complex financial management is not fully understood. Thus, questions may be raised about the seemingly high level of indirect or program management costs. Yet there remains inadequate numbers of staff to accomplish management and support activities efficiently. Management has tried to hold the staff at its current size, even though the scale of projects and transactions will be substantially increasing in 2001.

There were a number of concerns expressed about the amount and percentage of total project funds devoted to program management. Program management costs include both direct management costs and indirect overhead costs. AIHA provided the CEP with an analysis of administrative costs, noting that a significant amount of the costs charged as "program management" are actually direct program expenses. For example, program manager's time is generally charged fully to program management although a significant amount of the manager's time may actually be devoted to direct program activities. Based on the AIHA report to CEP, true administrative costs in 2001 were $4.3 million or 18.5% of total program funding, not including in-kind and voluntary contributions from the U.S. partners. If the dollar value of of in-kind and voluntary contributions were countedin total program funding, the program management share would fall from 18.5% to 8.%

Percentages for 1999 and 2000 were somewhat larger as a result of the contraction in total program funding that occurred at the expiration of the previous five-year contract and the delay of the award for the current five-year cooperative agreement. AIHA has worked hard to keep administrative spending stable while overall program funding has increased since 1999. In evaluating the appropriateness of program management costs, the panel considered its experiences with other federal procurement programs as well as the particular characteristics of the AIHA program. Circumstances that contribute significantly to AIHA's program management costs are:

1. Complexity of managing more than 100 sub-budgets for the partnerships
2. The often detailed administrative approvals required by USAID for individual expenditures of funds within a line item of the budget
3. The fact that extensive non-federal, voluntary direct and in-kind funds from U.S. partnering institutions require management resources but are not counted or scored in calculating the program management percentage. For example, many professionals from U.S. partners are not paid by USAID funds, but AIHA program management resources cover administrative support and travel arrangements.

In our experiences with federal funding of both non-profit and for-profit organizations, program management costs of 18.5% appear reasonable in this case.

The CEP found that since the last evaluation, AIHA has implemented several new procedures and controls to track and account for the expenditure of funds.

The CEP is also concerned about the overall balance between federal and private funding for AIHA and the potential effect on the organization of losing USAID funding.

The stringent oversight on capital purchases imposed by USAID is a further complication. All capital transactions of more than $5,000 require USAID central office approval. Thus complex paper work is initiated in order to justify and receive approval for requests. Requests are made from the partners to the regional office, and then referred to the AIHA central office where they are reviewed. The central office transmits its decisions back to the regional offices, which in turn respond to individual projects. This approval process is required even if the particular purchase has been previously budgeted and approved. The result is an unnecessary amount of back-and-forth paperwork and substantial time delays that prevent any reasonable delegation of authority within AIHA.

The CEP notes that senior management has already taken some steps to improve the operation of the Washington office. A task force, comprised of three U.S. partner representatives, has been appointed and charged with advising on strategies for reengineering internal procedures in both the financial and program areas. To date, a new and less cumbersome financial reporting form has been created and a new grants manager appointed. The program staff is being reorganized into teams, and revised procedures are being developed to provide senior management with a weekly update on current issues and problems. These issues and problems will be discussed in a series of weekly "Friday memos" that will then be discussed at weekly Monday morning staff conferences.

5.2.1 Conclusions and Recommendations

Conclusions

1. *The leadership provided by the CEO is exceptional, resulting in the creation of a successful and important program.*
2. *AIHA is an effective organization with a talented and hard-working staff in both the central and regional offices, but it is showing the strains of rapid growth and success. The CEP is concerned that the added workload without additional resources will only add to more delays and dissatisfaction on the part of the partners.*
3. *The absence of a "career ladder" program contributes to frequent turnover among staff at the program analyst and program associate levels.*
4. *The CEP believes federal approval at the $5,000 level within the confines of a cooperative agreement is not reasonable and consistent with other procurement programs with which panel members are familiar.*
5. *The CEP is also concerned about the overall balance between federal and private funding for AIHA and the potential effect on the organization of losing USAID funding.*
6. *Financial control systems are sufficient.*
7. *Financial management systems are unnecessarily slow with respect to providing appropriate reimbursements and financial information to U.S. partners in a timely manner.*
8. *The partnership selection process in both the United States and the NIS/CEE is appropriately inclusive, effective, and well-adapted to a program of this type.*
9. *AIHA has been remarkably successful in finding strong, influential leaders and recruiting them to lead both the U.S. and NIS/CEE sides of the partnership.*
10. *While work plan development is generally well supported by AIHA staff, there are two areas of concern: undue delays in obtaining work plan approvals; and inadequate attention during work plan development to issues of sustainability and replicability.*

Recommendations

1. *AIHA is now a large, mature organization that needs to delegate more responsibility and disperse authority (e.g., to program officers and regional staff) so that decision-making can occur in a more timely and efficient manner. (A recommendation of this type was included in the 1998 evaluation of AIHA.)*
2. *AIHA should consider hiring an external consultant to evaluate the adequacy of staffing, internal processes, lines of accountability, and procedural documentation for both current and projected workload.*
3. *AIHA should develop a set of performance standards (e.g., approval of work plans) and add additional resources should performance goals not be achieved.*
4. *AIHA should develop procedural remedies such as staggering dates for work plan review and approval, delegating lower levels of decision making, and developing prototypes of well-written program work plans that emphasize sustainability and replicability.*
5. *AIHA should develop a career ladder, particularly for junior staff.*

5.3 Program Monitoring and Evaluation

As noted in the preceding sections, the CEP believes the accomplishments of the AIHA Partnership Program are numerous and impressive. There is clearly a high level of activity associated with the partnerships. Substantial numbers of health care providers are receiving training in new techniques that have been shown by prior research to improve health care outcomes. Large numbers of patients are receiving care in much-improved clinical settings, and many examples of clinical excellence were observed, especially in the women's wellness centers and in the new comprehensive primary care centers. Extensive communications via international and regional meetings and internet connections have done much to reconnect the NIS/CEE with advances in medical science and technology that will inevitably improve health care and outcomes. To date, AIHA has relied substantially on its quarterly reports to create a record of these accomplishments. As the program has expanded and matured, the need for greater emphasis on impact evaluation has been raised by program evaluations and by USAID.

AIHA should develop a career ladder, particularly for junior staff.

The 1998 evaluation of the AIHA Partnership Program, performed for USAID by a team led by Malcolm Butler[13], concluded that "AIHA has no monitoring and evaluation system; instead, it is monitored largely through partnership reports." In response, AIHA has made efforts to expand its evaluation activities but is still lacking a consistent evaluation strategy that provides ongoing decision-making data to management and accumulates evidence that would demonstrate the impact of the partnership program on improving health and health care in the various countries in which partnerships are located.

AIHA continues to monitor partnership activity through:

- Quarterly reports from each partnership
- Monthly reports from regional offices
- Service statistics from the various centers
- Event reports

Partnerships are required to include indicators for defined goals and objectives within the work plan, and they must report progress quarterly. Regions compile partnership reports and measure progress against regionally determined indicators that must correspond with AIHA program indicators.

An evaluation strategy that includes impact evaluation and that is feasible for AIHA to implement given its resources should be developed.

Quarterly reports consist primarily of program-related activities and some utilization statistics (e.g., the numbers of individuals attending workshops and conferences, the number of patients seen in various programs).

The CEP concurs with AIHA management that creating a record of activities of each partnership is necessary for program accountability. The quarterly reports could be strengthened by the addition of an overview or summary of a more analytic and reflective nature, which would focus on the links between activities and accomplishments.

AIHA has increased its evaluation activity in recent years. Targeted evaluations include the assessments of women's wellness centers[14], emergency medical services training programs[15], the learning resource centers, and a 1999 evaluation of AIHA activities in the Slovak Republic[16]. Overall evaluations of the AIHA partnership program include the Butler Report in 1998 and the Continuing Evaluation Panel Report in 2001. Nevertheless, insufficient quantitative data are available on the outcomes and impact of AIHA programs to satisfy USAID needs and to enable the partners and AIHA to take well deserved credit for their accomplishments.

USAID mission personnel have expressed serious concerns about the lack of outcome data. They have stressed the importance of being able to demonstrate to Congress the impact of the AIHA partnership program on improving health in the region. The CEP agrees with the USAID mission perspective that impact-oriented program evaluation is important and should be pursued. An evaluation strategy that includes impact evaluation and that is feasible for AIHA to implement given its resources should be developed.

The CEP urges USAID and AIHA to take a realistic approach to outcomes evaluation. The CEP believes it is not necessary or feasible for AIHA to undertake research that demonstrates that partnership programs lead to better health. Such research generally requires expensive randomized controlled studies that are beyond the scope of program evaluation and the resources available to AIHA. Such research is more appropriately carried out by universities and other health services research organizations that have appropriately trained staff and adequate research resources targeted specifically for that purpose. AIHA can, however, engage their staff and the partnerships in ongoing impact evaluation and quality improvement activities, consistent with the current state of the art in U.S. health care institutions, which rely on the systematic collection of data on indicators that have been demonstrated in previous research to lead to improved health.

5.3.1 Evaluation Strategies

Over the years, health services researchers have developed methods and carried out large scale research initiatives aimed at defining the determinants of population health, with special focus on describing sub-populations that are at risk for health problems because of environmental, social, or genetic factors. During the past decade, a particular emphasis has been placed on identifying measures of clinical outcomes that are directly associated with health and health status. As a result, there is now a growing array of commonly accepted clinical indicators that are feasible to measure by health care provider organizations and that can be causally linked, based on the established research, to changes in health status in specific populations. This advance in health services research has occurred at the same time information and communication technologies have made it possible for individuals to gain access to

current research and practice information, fueling the development of "evidence based" medical and nursing practice.

These advances in research and technology have been the basis for the introduction of quality improvement processes using existing research and clinical evidence as a basis for decision making. Many U.S. health care providers develop clinical protocols (or care pathways) based on clinical evidence and best practice assessment, requiring that clinical staff modify their practice according to these protocols. Using teams of clinicians and administrators, systems of observation and measurement are implemented that are designed to continually assess the outcomes of that practice. For example, there may be an effort to measure the number of women who receive mammography services, based on clinical guidelines that specify specific time intervals and ages at which mammography should occur. The desired outcome is to improve early detection of breast cancer. This measure does not specifically assess the impact of mammography on the population served, but it is linked to improved health status by prior health services research. Thus the health care provider organization can say, with some confidence, that they are indeed improving the health status of women in their target population.

AIHA has already begun to establish many of the elements of quality improvement in their partnerships including, for example, the development of clinical care pathways based on clinical evidence and established best practices. The CEP believes that with some additional effort and "fine tuning," it is possible to introduce quality improvement methods that can constitute a form of program evaluation. It is also possible to link these quality improvement activities across partnerships, providing a more systematic measure of outcome within a country or region. The cross-cutting initiatives, with their common clinical focus, offer an ideal opportunity. Although each partnership may develop its own internal quality improvement focus, it is feasible to get agreement on a small number of key indicators that like programs report on, to each other and to AIHA.

A model for this method has been developed by Dr. Donald Berwick and his colleagues at the Institute for Health Care Improvement; it is titled the "breakthrough" method. Berwick and colleagues bring together a number of delivery organizations wishing to work on a common clinical issue or "target." Together they identify the gap in clinical practice they wish to reduce in order to achieve a higher quality of service. Once a gap or focal point is identified, the team searches for indicators that will best assess the progress as efforts are undertaken to achieve an ideal level of performance/ practice. Participants remain in communication electronically and through periodic meetings, much as the participants in the AIHA cross cutting initiatives do. They report periodic progress, using an agreed upon format and clinical measure, sharing their learning along the way.

While the CEP was not charged with developing a detailed strategic plan for monitoring and evaluation of the AIHA partnership program, its members have expertise in program evaluation and offer the following suggestions for consideration as a strategic plan is developed. The plan must be feasible to implement within the resources available and without undue burden on the partnerships, the clinicians, or the patients. Thus we believe that it would be wise to undertake multiple targeted evaluation activities that could be synthesized into a comprehensive assessment of program impact. A combination

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of the following types of initiatives could comprise an overall evaluation strategy:

1. **Periodic independent summative evaluations using the National Academy of Sciences model.** That model entails assembling a panel of internationally recognized health care experts who assess the program context, conduct interviews and site visits, synthesize available program monitoring and outcomes data, and render an informed assessment of overall program effectiveness as well as recommend strategic directions for future program enhancement. The Continuing Evaluation Panel is an example of this form of program evaluation. Independent summative evaluations are most effective when the results of targeted, in-depth, quantitative assessments of particular program elements are available.
2. **Ranking like programs using defined criteria of effectiveness.** The Learning Resource Center Evaluation[17] is an example. This strategy is useful for program monitoring purposes to strengthen or eliminate poorly performing sites in a multi-site initiative in which the program elements are standard across sites and the criteria for ranking are clear and measurable. This form of evaluation is more of a management tool than a vehicle to assess program impact.
3. **Health outcomes indicators.** This strategy is best suited to programs whose interventions are designed to affect specific markers or indicators that have been demonstrated by prior research to be associated with improved individual health or population health, and the indicators can be recorded in the course of ususal clinical care activities. Examples include stage of cancer detected in breast or cervical screening programs; infant death rates within two days of transfer to neonatal centers (an indicator of effectiveness of infant resuscitation training in maternity hospitals); and death rates within two days of hospitalization following emergency medical treatment (indicator of effectiveness of emergency medical services training). This strategy would be particularly applicable to the cross-cutting initiatives. Primary care partnerships could easily adopt measures, such as immunization rates, well established as proxy measures for assessing prevention activities. The CEP observed these types of indicators being collected currently but not computerized and not in a standard form that would allow for trends to be tracked over time and across similar programs in different sites.
4. **Benchmarking against standards.** In an age in which the demand for accreditation and commendation for excellence has increased, various performance standards have been developed that have an evidence base suggesting that institutions or practices that meet the standards have superior patient outcomes. Such standards exist both for hospitals and primary care. An evaluation strategy could employ benchmarking of programs against established standards and against one another, a common practice among U.S. health care organizations. American Nurses Association's CredentialingInternational offers accreditation for nursing care excellence against a set of standards that have been evaluated by independent researchers. Similarly, standards have

been developed in the United States for federally qualified community health centers. As noted above, quality improvement processes using existing research and clinical evidence as a basis for decision-making is a form of evaluation employing benchmarking.

5. **Survey-based community assessments.** Some of the community-based primary care programs have undertaken community assessments, often with the assistance of local academic institutions. With some modest standardization of community assessment instruments, they could be employed to evaluate and compare access to care issues experienced by the different populations served by various partnerships. Community surveys could also be employed to assess patient satisfaction, immunization coverage, patient reported health status and functional limitations, and other measures of health status, access, and care quality. If repeated at several year intervals, community assessments could provide invaluable information about the impact of AIHA programs within their communities. AIHA could potentially provide central technical assistance in the design of surveys, computerization of results, and analysis. This strategy should be used judiciously because of its potential costs and logistical challenges, and probably limited to comprehensive primary care partnerships that have interventions of sufficient magnitude to expect change that could be detected in community surveys.
6. **Health system change.** Changes in utilization of certain kinds of services have been shown to be markers for improved patient outcomes as well as potentially reducing health care expenditures. Selective indicators such as reductions in hospitalizations and use of emergency services among diabetics are widely accepted indicators of improved health outcomes and more cost effective care. The opening of a satellite primary care center/family practice in a rural area should reduce visits to central polyclinics and hospitals, as has been demonstrated by research on utilization patterns following the opening of the rural satellite family practice clinic near L'viv, Ukraine.

AIHA's Board of Directors and senior management are aware of the evaluation deficiencies noted above. They recognize that the evaluation component must be strengthened and include outcome as well as process data. Several options to achieve this objective are being explored. Board members note, however, that the AIHA program has grown rapidly, and the organization is "so caught up in action" that it has not had adequate time to document fully what has been accomplished. AIHA program officers have also stressed the difficulties inherent in getting unpaid volunteers from the U.S. partners to collect either process or outcome information. They believe that an internal staff member with evaluation expertise will be required if quantitative outcome data are to be collected and analyzed. The program officers favor an internal evaluation coordinator because "the partners get very suspicious when someone from the outside comes to evaluate them."

AIHA's Board of Directors and senior management are aware of the evaluation deficiencies.... They recognize that the evaluation component must be strengthened and include outcome as well as process data.

Monitoring and evaluation of outcomes should be concentrated in those areas where reliable data are relatively easy to obtain.

5.3.2 Conclusions and Recommendations

Conclusions

1. *AIHA's current monitoring and evaluation process is weak and oriented more toward process than outcomes.*
2. *AIHA lacks a senior staff member with formal evaluation training and expertise. It has collected little quantitative data on the impact of its program on health status in the NIS/CEE and has no organized method for collecting qualitative evaluation information such as anecdotes on program successes or failures.*
3. *Senior management and the AIHA Board of Directors are aware of the program's monitoring and evaluation deficiencies and are exploring ways to improve the situation.*

Recommendations

1. *AIHA should improve its monitoring and evaluation processes, placing increased emphasis on the collection and evaluation of outcome data.*
2. *AIHA should revise the content of its quarterly reports to include, in addition to USAID requirements for financial reporting and a list of key activities, a brief synthesis of accomplishments with a focus on linking project activities to program results.*
3. *AIHA needs to dedicate resources to:*
   - *Hiring a senior staff person, reporting directly to the Executive Director, with evaluation expertise to create and manage the monitoring and evaluation process. This person must be provided with an appropriate budget for evaluation activity.*
   - *Enabling AIHA regional staff and NIS/CEE partners to develop adequate skills and capacity to engage in data collection and program evaluation.*
   - *Contracting out for specific evaluation projects to organizations with evaluation expertise to assure objectivity, with monitoring and coordination provided by the AIHA staff person in charge of the evaluation function.*
4. *Monitoring and evaluation of outcomes should be concentrated in those areas where reliable data are relatively easy to obtain. Examples would be cross-cutting initiatives such as neonatal resuscitation, women's wellness, and emergency medical services.*
5. *The increased emphasis by AIHA on developing and reporting program outcomes and impact should be adequately supported by USAID.*

6. Relations between USAID and AIHA

Upon meeting with USAID mission staff and in particular the health officers … it quickly became apparent that relationships with AIHA were not optimal.

The CEP found that the relationship between USAID and AIHA is complex and varies tremendously across organizational units. There are four sets of important bilateral relationships:

- AIHA Washington with USAID Washington
- AIHA Washington with USAID regional and country missions
- AIHA regional offices with USAID missions
- USAID Washington with USAID missions.

6.1 AIHA Washington with USAID Washington

In all its interactions with USAID Washington and AIHA Washington, the mutual shared vision and close working cooperation exhibited impressed the CEP. Don Pressley, the Assistant Administrator, USAID Bureau for Europe and Eurasia (Acting USAID Administrator at the time this report was prepared), was supportive and complementary of the AIHA health Partnership Program while seeking ways to enhance its performance. Pressley also emphasized to the CEP that partnership programs were a key component of his overall regional strategic vision. In the recently published "A Decade of Change: Profiles of USAID Assistance to Europe and Eurasia," this commitment was expressed as follows:

> *As the world moves into the 21st century, USAID will continue to be a catalyst for change in Central and Eastern Europe and Eurasia. To meet the challenges of the next decade, USAID is modifying its approach in ways that will build lasting relationships that sustain and further progress long after formal assistance programs have ended. USAID calls this approach Sustainable Partnerships. Simply put, USAID believes that partnerships between nations, communities, institutions, and individuals are the best way to help this region overcome the isolation of the past and participate fully in international markets and institutions.*

The CEP met several times with the USAID project officer responsible for the AIHA programs, who provided many insights. Again, there appeared to be a mutually respectful working relationship based on trust and shared objectives. Issues that have arisen seem to have been handled in a timely and proper manner. A review of the past indicates that this close cooperation in Washington is not new. Historically USAID Washington and AIHA Washington have had good working relationships across a series of project officers, bureau directors, and Administrations.

6.2 AIHA Washington with USAID Missions

Upon meeting with USAID mission staff and in particular the health officers in the Central Asian Republics, West NIS and the Caucasus, it quickly became apparent that relationships with AIHA were not optimal. They have different perspectives on many issues. It is not the purpose of this report to assess who is "right or wrong" but only to lay out the situation as each party perceives it in order to encourage improvement in a relationship that the CEP feels endangers project performance.

Tensions seem to center on a number of key issues, including interpretations of the "substantial involvement understandings clause," communication, and differing views of the country-specific strategic direction.

In general, the USAID mission staff feels that AIHA is not sensitive to their needs, is too autonomous, takes too long to provide scheduled reports or respond to requests for current information, and does not appreciate its need to coordinate all health sector projects within a country. USAID mission staff described AIHA staff as poor communicators and inflexible in what they are willing to do. Mission staff indicate that they are often surprised by AIHA staff because they meet with government officials even at the minister level without informing or debriefing the USAID mission staff. They also do not feel that AIHA appreciates their need to make decisions across all vendors as they seek to achieve maximum impact on the health sector within their countries. They described the approach of cross-cutting initiatives as so rigid in structure that it is irrelevant as a broad-based strategy.

AIHA staff members often feel frustrated. They feel that USAID mission staff participated in the establishment of AIHA goals and objectives for the region and were included when new partnerships were implemented. Mission staff agreed to partnership projects and program objectives. Yet when changes in the USAID cognizant technical officer (CTO) occur in the midst of a project period, new CTOs may not always be aware of previous agreements. AIHA also feels that the mission staff does not appreciate the synergistic effect created by a Partnership Program that stretches across the NIS and beyond the jurisdiction of the mission. Missions, not understanding how achieving overall Partnership Program objectives may be relevant to the partnerships and improvement of health care in their individual sectors, sometimes ask AIHA to justify individual partnership attendance at conferences and workshops.

Tensions seem to center on a number of key issues, including interpretations of the "substantial involvement understandings clause," communication, and differing views of the country-specific strategic direction.

Like all cooperative agreements, the current one includes a substantial involvement understandings clause. It specifies the mission's involvement in the strategic planning process, including approval of work plans, their right to approve the AIHA country director, and to receive quarterly reports from AIHA. As noted in Chapter 2, AIHA and the missions' interpretation of the substantial involvement understandings clause differ greatly.

In the new contracts, missions sought better coordination on decisions about country program objectives, partner selection, and work plans. The AIHA proposal for the current cooperative agreement described the "mission-centered approach" was intended to address mission concerns by specifically including them in a strategic planning process. The CEP finds that AIHA has followed through with this plan and has been successful in including mission staff in the strategic planning process. AIHA believes that it has met every level obligation of the substantial involvement clause and is seeking to work cooperatively with USAID missions.

Although inclusion of mission staff in the planning processes is mutually viewed as an improvement over past practices, tensions remain. Missions feel that annual work plans should better reflect their perspective on coordination with other programs and be more focused on country-specific conditions. Some missions feel that their efforts to ensure that the program is strategic, not duplicative of other efforts, and with a well-coordinated country perspective is why they are characterized as

engaging in unnecessarily detailed management. Some missions also believe that the best way to enhance sustainability is through greater efforts to mainstream successful models through government roll-out of new sites rather than establishing new partner demonstration sites for models that have been shown to work, i.e., women's wellness centers.

Communication is another area where improvement is necessary. Both parties believe the other could communicate better with them. AIHA does not feel it is always well-informed on mission activities and evolving strategic goals and priorities. Missions, on the other hand, feel they are often surprised and find out after the fact about important meetings with country officials and that they do not receive the amount and type of information they need both to oversee projects and to support them in the R-4 budget process.

The CEP has the following observations:

- At the beginning of the new cooperative agreement, AIHA seems to have made a concerted effort to address concerns of regional missions and implement programs consistent with country-strategic plans. AIHA also seems to have appropriately tried to consult with USAID in the early implementation of the new partnerships, at which time program objectives were mutually agreed upon.
- Historically, AIHA was present in many regions before USAID offices were established. During visits, CEP members were frequently told that AIHA has better relationships than USAID missions with the country ministries of health. What seem to be strong and direct relationships between AIHA and country ministries of health appear to cause some tensions and may explain the desire of the regional officers to have greater control over the program.
- Turnover in USAID mission staff and particularly the CTOs is problematic. New CTOs inherit responsibility midway in a long-term program. Often, the new officers do not agree with or appreciate commitments made by previous USAID staff and do not feel bound by these earlier commitments. Where USAID staff has been more stable, such as in Russia, better understanding and improved working relationships appear to exist.
- Not all mission staff visit partnerships often enough to gain a better understanding of them. On the other hand, U.S. partners rarely appear to debrief mission staff when they are in-country.
- AIHA has not been able to provide the evaluation data that the missions have requested to document success. AIHA does supply current information about partnership activities, but this has not met the needs of USAID missions. AIHA fears that increased demands for information by mission staff are reflective of the desire of missions to manage the program with a level of specificity that is beyond that which is appropriate in a cooperative agreement.
- AIHA appears to be in compliance with its substantial involvement clause in the cooperative agreements, and the kind of additional operational control that some missions seek appears to go beyond USAID's own guidelines for administering cooperative agreements.
- There appears to be a lack of appreciation of the AIHA partnership model at the USAID mission level. By its very nature, this model will

AIHA has not been able to provide the evaluation data that the missions have requested to document success.

The differences in perspective between AIHA Washington and USAID missions may be due in part to the broad regional perspective adopted by AIHA as compared with the country-specific focus of the USAID missions....

involve give and take, and it can only be structured through a cooperative agreement. USAID mission staff do not always agree with or support the legal requirements of cooperative agreements.

- Communication could and should be improved between AIHA and USAID missions.

6.3 AIHA Regional Offices with USAID Missions

The CEP was impressed with the AIHA host country national staff. (See Section 5.) It was also our impression that good working relationships exist with USAID mission staff in most of the regions. The CEP notes the relationship established by the AIHA regional director in the Caucasus with USAID mission staff is a model for appropriate interaction and information exchange. Differences have sometimes arisen when missions staff for whatever reason try to exert greater operational authority over program operations. Communication, although usually good, could be improved. Missions often do not inform AIHA regional and country director's information about activities of other USAID mission funded health organizations, thereby encouraging synergy. AIHA has not always been forthcoming with information in a timely fashion that could enhances the CTOs' ability to do their jobs. The CEP also found there were large differences in the amount of understanding and visitation to the partnership programs on the part of CTOs. It also observed that the greater the actual hands-on experience with the program, the greater is program appreciation and acceptance. Some mission staff feel that giving AIHA regional directors more decision-making responsibility would improve relationships.

6.4 USAID Washington with USAID Missions

Although it is not the purpose of this report to evaluate internal USAID management relationships, they are clearly relevant to the AIHA evaluation. The CEP was surprised to find that not only might regional officials not share the vision expressed in the USAID bureau plan, they also appear willing to chart an independent course without feeling obligated or bound by decisions made by USAID in Washington. This results in mixed messages and difficulty in efficiently implementing the Partnership Program.

6.5 Conclusions and Recommendations

Conclusions

1. *The relationships between USAID Washington and AIHA Washington are positive and based on shared program objectives.*
2. *The relationship between AIHA Washington and USAID missions is not optimal. There is a lack of shared vision, little mission buy-in, and mediocre working relationships. In particular, working relationships have not evolved in a manner that produces smooth operational interaction.*
3. *The differences in perspective between AIHA Washington and USAID missions may be due in part to the broad regional perspective adopted by AIHA as compared with the country-specific focus of the USAID missions and to differing interpretations of the substantial involvement understandings clause in the cooperative agreements.*
4. *The relationships between AIHA regional offices and USAID mission staff are moderately good but could be improved.*

Recommendations

1. *AIHA and USAID should seek ways to improve their working relationships. USAID Washington should bring participants together to address persistent concerns.*
2. *USAID should consider ways to improve the transition when there is a change in staff at its missions in the NIS/CEE. In the case of the AIHA program, new CTOs should be thoroughly briefed on past agreements by both USAID and AIHA and should be expected to honor them.*
3. *USAID missions and AIHA need to find ways to improve communication with the understanding that this does not empower the missions to engage in unnecessarily detailed management.*

7. Assessment of Other AIHA Relationships

Partnerships that were developed where sister city relationships already existed, such as the successful Dubna-La Crosse partnership, demonstrate the potential power of governmental involvement.

AIHA has worked hard and been successful at developing good working relationships with local, regional, and national governmental personnel in the NIS/CEE. These relationships have been important factors in the success and sustainability of the individual partnerships and in the replication of successful programs to other sites. Governmental relations have also been a major factor in expanding the impact of cross-cutting initiatives to a broader audience. In the future, these relationships will be essential in incorporating AIHA innovations into the mainstream of health care services. Partnerships that were developed where sister city relationships already existed, such as the successful Dubna-La Crosse partnership, demonstrate the potential power of governmental involvement. This is also demonstrated by examples in which relationships with government officials and policy makers led to substantive policy changes.

AIHA staff has also been creative in seeking out additional relationships with non-governmental organizations, such as American and international nursing organizations, corporations, and foundations, already active in the NIS/CEE. For example, AIHA has:

- Promoted a successful collaboration with the U.S. Centers for Disease Control and Prevention and facilitated the establishment of several WHONET and EPI-INFO sites.
- Supported a collaboration between WHO and the World Bank by assisting them in establishing a beta site at a primary care partnership site in Donetsk, Ukraine, for the purpose of testing the feasibility and effectiveness of the directly observed therapy short course (DOTS) for the treatment of tuberculosis, a significant and growing health problem in the NIS.
- Promoted the involvement of the Partnership for Peace Information Management System, NATO, World Bank, World Health Organization, UNICEF, Kiwanis, and the Soros Foundation with the Tbilisi-Atlanta partnership.
- Assisted the partnership between the Armavir, Armenia, Regional Health Care Administration and the University of Texas Medical Branch at Galveston to make connections with the Armenia-American Association in Detroit. As a result of fund-raising efforts, the small, rural clinic in Armavir now has a heating system—the only public building in the town to have heat. Townspeople come to sit in the clinic during the day to warm up and be exposed to health education and a different way of delivering health care services.

AIHA also leverages existing relations. In Yerevan, Armenia, a relationship between the non-profit Armenian-American Cultural Association and the Armenian-American Mammography University Center predated the AIHA partnership. Under the initial relationships, plans were underway to renovate a facility, donated by the Armenian government, for a women's health center. Recognizing the opportunity to build on the existing relationship, AIHA worked with the partnership to provide technology and develop training that would assist in improving clinical,

screening, and community education services. Additionally, AIHA has assisted in evaluating and revising management, administrative, inventory, and accounting procedures for the cultural association, the women's health center, and the university center's staff. In addition, the AIHA involvement resulted in the creation of a WHCA Satellite Clinic in the small, rural town of Gavar, Armenia.

AIHA has not been proactive, to date, in trying to interest non-governmental organizations and foundations that are not already active in the NIS/CEE to move into the region. Often, non-profit organizations and foundations have insufficient staff resources to expand their funding into new areas of the world. Moreover, international assistance is thought by many organizations to be fraught with too many complexities and risks to represent a viable investment strategy.

The U.S. has experienced the largest growth of private foundations and philanthropic organizations in its history over the past decade. The Bill and Melinda Gates and Turner Foundations are examples. Many of these new organizations have substantial payout requirements of millions of dollars annually in order to retain their non-profit status. AIHA has an established infrastructure and platform in the NIS/CEE that could be used very effectively by the newly emerging large philanthropies and is in a good position to encourage them to invest in this important part of the world. But they have not fully developed strategic plans nor acquired the appropriate level of staff to expend these dollars judiciously.

Additionally, AIHA is in the position to initiate a more organized approach in the United States for seeking access to the resources of the diaspora from NIS/CEE countries. Groups such as the Armenian-Americans are demonstrating their willingness to invest. The Armenian-American group in Providence, Rhode Island, for example, has raised $3,000 toward the cost of a heating system for the community-based primary care clinic in Sevan, Armenia. AIHA is in a central position to organize more such activities in the United States, assisting Americans who are proud of their heritage to reach out financially and support important health programs in their native countries.

Finally, the success of the AIHA Partnership Program throughout the NIS/CEE can be more effectively communicated to a broader audience. This could include a more targeted campaign aimed at the popular press as well as a more systematic effort to write and publish the results of partnership programs in appropriate professional publications. To date, AIHA has missed opportunities to focus public attention on its achievements. For example, the page one *New York Times* article in December 2000 that featured the accomplishments of the Dubna-La Crosse partnership did not mention AIHA, even though agency staff provided information for the story.

AIHA has not been proactive, to date, in trying to interest non-governmental organizations and foundations that are not already active in the NIS/CEE to move into the region.

7.1 Conclusions and Recommendations

Conclusions

1. *AIHA has developed excellent relationships with government officials in the NIS/CEE.*
2. *For the most part, relations with other non-governmental organizations working in the NIS/CEE have been good.*
3. *AIHA has placed inadequate emphasis on the development of cooperative relationships with private foundations and other U.S. non-governmental organizations that are not currently working in the NIS/CEE but might be interested in doing so and providing support for AIHA programs.*

4. *AIHA does not emphasize publicizing the achievements of its programs to the outside world.*

Recommendations

1. *AIHA should continue its current and effective efforts to develop good relationships with NIS/CEE government officials and with non-governmental organizations currently working in that part of the world.*
2. *AIHA should make a greater effort to obtain funding support from U.S. private foundations and other non-governmental organizations not currently working in the NIS/CEE.*
3. *In order to gain broader support for its programs, AIHA should place more emphasis on its public relations program.*

8. Summary of Conclusions and Recommendations

The AIHA Partnership/ Volunteer Model

Conclusions

1. The USAID partnership approach, as implemented by AIHA through its partnership/volunteer model, is successful.
2. Although the USAID missions are ambivalent about using the cooperative agreement to manage the AIHA Partnership/Volunteer Program, the CEP concludes that it is superior to the contract approach when managing a partnership/volunteer approach to health sector development in a rapidly changing part of the world. Use of contracts would reduce AIHA's flexibility and threaten the success of the program.
3. Differing interpretations between USAID mission staff and AIHA regarding the "substantial involvement" clause are creating tensions within the work environment.

Recommendations

1. USAID should continue supporting the AIHA partnership/volunteer model and expand its use within the NIS/CEE.
2. USAID should continue to use the cooperative agreement as the mechanism for managing the AIHA Partnership/Volunteer Program.
3. USAID should address the USAID missions' concern over lack of control of partnerships by devising an appropriate mechanism for reporting pertinent information without compromising program flexibility and encouraging unnecessarily detailed management of partnership activities.

The AIHA Partnership/ Volunteer Program

Conclusions

1. CEP review of the original partnerships established under the initial cooperative agreement between AIHA and USAID indicates that most of them have continued on a successful course. There is evidence of:
   - Program sustainability and replication
   - A more rational approach to resource use. Health care providers not only have improved skills but have also allocated responsibility and workload more efficiently, particularly between physicians and nurses.
   - More positive provider attitudes resulting from their inclusion in decision-making through the "bottom up" partnership approach
   - An emphasis on the use of relatively inexpensive low technology as contrasted with expensive high technology.
2. Sustainability grants have been used effectively by the original partnerships and have contributed to their continuing success.
3. There is evidence that the new partnerships funded under the current cooperative agreements are following the same successful course evident in the original partnerships.

Recommendation

1. The current cooperative agreement, budgeted for three years, should be continued for an additional two years to complete a five-year cycle. Concurrently, USAID should initiate a new five-year award cycle, ensuring sufficient overlap between the two cycles, so as not to disrupt ongoing programs. The new five-year award cycle should fund new partnerships and continue support for those partnerships and cross-cutting initiatives that focus on high priority areas and have the potential for replication.

The Cross-cutting Initiatives Conclusions

1. Cross-cutting initiatives represent one of the most valuable and effective parts of the AIHA Partnership/ Volunteer Program.
2. The learning resource centers are a critical part of the AIHA program and are essential to improving health care in the NIS, but some are experiencing financial difficulties and have unmet needs. Following the end of the partnership, the NIS/CEE partner may lack resources to maintain computer systems.
3. Hardware and Internet connections provide an effective vehicle for NIS/ CEE health care providers to keep up with advances in their fields and to network with the worldwide medical community.
4. The AIHA web site is outstanding.
5. AIHA uses its convening function and resources very effectively to provide technical assistance and new knowledge in a peer-to-peer format that promotes ownership of programs and enhances their chances for success.
6. In addition to their excellent content, AIHA conferences and workshops provide opportunities for essential networking of partners and attract governmental officials who have the capacity to change national health care policy.
7. AIHA publications are valuable.

Recommendations

1. USAID should continue to support, and consider increased funding for, cross-cutting initiatives.
2. AIHA should seek opportunities to use the cross-cutting initiative mechanism to advance the programmatic priorities of the new primary care partnerships.
3. AIHA should make every effort to maintain the viability of the learning resource centers. It should also support more Russian translations of English medical literature.
4. AIHA should continue to provide financial support to the NIS/CEE partners to maintain Internet access even beyond completion of the partnership.
5. The AIHA web site is an important enough resource that a special effort should be made to ensure its sustainability and continued excellent capability. AIHA should consider developing a comprehensive database to underlie the site's content and thereby improve the ability to archive, categorize, access, and retrieve information.
6. AIHA should continue its conferences and workshops and its publication program.

Governance

Conclusions

1. The AIHA Board of Directors is comprised of knowledgeable members and functions effectively.

2. The CEO has the confidence and respect of the board.
3. Effective and timely strategic planning is essential to AIHA's future success.

Recommendations

1. The Board of Directors should move forward expeditiously with its plan to initiate a strategic planning process that encompasses a three to five-year time frame. The planning process should include a review of AIHA's programmatic, geographic, and financial bases.
2. In addition to the development of a strategic plan, the AIHA Board of Directors should pay special attention to the following:
   - Developing an enhanced evaluation capacity program-wide that captures impact and outcome data on national policy changes, improvements in health, and reductions in disease and trauma.
   - Formulating strategic growth and funding options, including the application of AIHA's successful partnership model in other geographic areas.
   - Assuring that poor internal management does not hamper USAID and partnership relationships and reporting systems.
3. The board and the CEO need to engage in succession planning in order to ensure that the high quality of leadership that has characterized AIHA to date will continue if the need arises.

Program Organization and Management

Conclusions

1. The leadership provided by the CEO is exceptional, resulting in the creation of a successful and important program.
2. AIHA is an effective organization with a talented and hard-working staff in both the central and regional offices, but it is showing the strains of rapid growth and success. The CEP is concerned that the added workload without additional resources will only add to more delays and dissatisfaction on the part of the partners.
3. The absence of a "career ladder" program contributes to frequent turnover among staff at the program analyst and program associate levels.
4. The CEP believes federal approval at the $5,000 level within the confines of a cooperative agreement is not reasonable and consistent with other procurement programs with which panel members are familiar.
5. The CEP is also concerned about the overall balance between federal and private funding for AIHA and the potential effect on the organization of losing USAID funding.
6. Financial control systems are sufficient.
7. Financial management systems are unnecessarily slow with respect to providing appropriate reimbursements and financial information to U.S. partners in a timely manner.
8. The partnership selection process in both the United States and the NIS/CEE is appropriately inclusive, effective, and well-adapted to a program of this type.
9. AIHA has been remarkably successful in finding strong, influential leaders and recruiting them to lead both the U.S. and NIS/CEE sides of the partnership.
10. While work plan development is generally well supported by AIHA staff, there are two areas of concern:

undue delays in obtaining work plan approvals; and inadequate attention during work plan development to issues of sustainability and replicability.

Recommendations

1. AIHA is now a large, mature organization that needs to delegate more responsibility and disburse authority (e.g., to program officers and regional staff) so that decision-making can occur in a more timely and efficient manner. (A recommendation of this type was included in the 1998 evaluation of AIHA.)
2. AIHA should consider hiring an external consultant to evaluate the adequacy of staffing, internal processes, lines of accountability, and procedural documentation for both current and projected workload.
3. AIHA should develop a set of performance standards (e.g., approval of work plans) and add resources should performance goals not be achieved.
4. AIHA should develop procedural remedies such as staggering dates for work plan review and approval, delegating lower levels of decision-making, and developing prototypes of well-written program work plans that emphasize sustainability and replicability.
5. AIHA should develop a career ladder, particularly for junior staff.

Program Monitoring and Evaluation

Conclusions

1. AIHA's current evaluation process is weak and oriented more toward process than outcomes.
2. AIHA lacks a senior staff member with formal evaluation training and expertise. It has collected little quantitative data on the impact of its program on health status in the NIS/CEE and has no organized method for collecting qualitative evaluation information such as anecdotes on program successes or failures.
3. Senior management and the AIHA board is aware of the program's evaluation deficiencies and are exploring ways to improve the situation.

Recommendations

1. AIHA should improve its evaluation process, placing increased emphasis on the collection and evaluation of outcome data.
2. AIHA should revise the content of its quarterly reports to include, in addition to USAID requirements for financial reporting and a list of key activities, a brief synthesis of accomplishments with a focus on linking project activities to program results.
3. AIHA needs to dedicate resources to:
   - Hiring a senior staff person, reporting directly to the CEO, with evaluation expertise to create and manage the evaluation process. This person must be provided with an appropriate budget for evaluation activity.
   - Enabling AIHA regional staff and NIS/CEE partners to develop adequate skills and capacity to engage in data collection and program evaluation.
   - Contracting out for specific evaluation projects to organizations with evaluation expertise to assure objectivity, with monitoring and coordination provided by the AIHA staff person in charge of the evaluation function.
4. Monitoring and evaluation should be concentrated in those areas where

reliable data are relatively easy to obtain. Examples are crosscutting initiatives such as neonatal resuscitation, women's wellness, and emergency medical services.

5. The increased emphasis by AIHA on developing and reporting program outcomes and impact should be adequately supported by USAID.

AIHA - USAID Relationships

Conclusions

1. The relationships between USAID Washington and AIHA Washington are positive and based on shared program objectives.
2. The relationship between AIHA Washington and USAID missions is not optimal. There is a lack of shared vision, little mission buy-in, and mediocre working relationships. In particular, relationships have not evolved in a manner that produces smooth operational interaction.
3. The differences in perspective between AIHA Washington and USAID missions may be due in part to the regional perspective adopted by AIHA as compared with the country-specific focus of the USAID missions and to differing interpretations of the substantial involvement clause in the cooperative agreements.
4. The relationships between AIHA regional offices and USAID mission staff are moderately good but could be improved.

Recommendations

1. AIHA and USAID should seek ways to improve their working relationships. USAID Washington should bring participants together to address persistent concerns.
2. USAID should consider ways to improve the transition when there is a change in staff at its missions in the NIS/CEE. In the case of the AIHA program, new CTOs should be thoroughly briefed on past agreements by both USAID and AIHA and should be expected to honor them.
3. USAID missions and AIHA need to find ways to improve communication with the understanding that this does not empower the missions to engage in unnecessarily detailed management.

Other AIHA Relationships

Conclusions

1. AIHA has developed excellent relationships with government officials in the NIS/CEE.
2. For the most part, relations with other non-governmental organizations working in the NIS/CEE have been good.
3. AIHA has placed inadequate emphasis on the development of cooperative relationships with private foundations and other U.S. non-governmental organizations that are not currently working in the NIS/CEE but might be interested in doing so and providing support for AIHA programs.
4. AIHA does not emphasize publicizing the achievements of its programs to the outside world.

Recommendations

1. AIHA should continue its current and effective efforts to develop good relationships with NIS/CEE government officials and with non-governmental organizations currently working in that part of the world.
2. AIHA should make a greater effort to obtain funding support from U.S. private foundations and other non-governmental organizations not currently working in the NIS/CEE.

3. In order to gain broader support for its programs, AIHA should place more emphasis on its public relations program.

References

[1] Butler M, Buzzard S, Mathies A, Mason J, Ferri J. Evaluation of the American International Health Alliance (AIHA) partnerships program. USAID/ENI/ DGSR Technical Assistance Project, BHM International, Arlington, Virginia, January 30, 1998.

[2] Barr DA, Field MG. The current state of health care in the former Soviet Union: Implications for health care policy and reform. American Journal of Public Health 86:307-312, 1996.

[3] Barr DA, Schmid R. Medical education in the former Soviet Union. Academic Medicine 71(2): 141-145, 1996.

[4] Ryan TM, Thomas R. Trends in the supply of medical personnel in the Russian Federation. JAMA 276(4): 339-342, 1996.

[5] Garrett Laurie. Betrayal of Trust: The Collapse of Global Public Health, Hyperion, New York, 2000.

[6] National Center for Health Statistics. Vital and Health Statistics: Russian Federation and United States, Selected Years 1980-93. U.S. Dept of Health and Human Services Pub No (PHS), Hyattsville, Maryland: 95-1485, June 1995.

[7] Bobadilla JL, Costello CA, Mitchell F (eds). Premature Death in the New Independent States. National Academy Press, 1997.

[8] Leon DA, Chenet L, Shkolnilov VM, Zakharov S, Shapiro J, Rakhmanova G, Vassin S, McKee M. Huge variation in Russian mortality rates 1984-94: Artifact, alcohol, or what? Lancet 350: 383-88, 1997.

[9] Garrett, Ibid.

[10] Durable Partnerships – Phase II, Desk Study. USAID, 2000.

[11] Wines, Michael. New York Times, December 3,4,5,16,22, & 31, 2000.

[12] Daniels JK and Starke-Meyerring D. The Diffusion of Medical Information Technology in Central and Eastern Europe and the New Independent States: An Assessment of the AIHA Learning Resource Center Project. University of Minnesota, 1998.

[13] Butler, Ibid.

[14] Flores L, Greenan R, Huang A, Zafiriadis. Making women's wellness sustainable. Robert F. Wagner School of Public Service, New York University, May 2000.

[15] Bannon R, Fleming S, Palsdottir B, Ting J. Evaluation of the emergency medical services training program: An initiative of the American International Health Alliance. Robert F. Wagner School of Public Service, New York University, May 2000.

[16] Aaronson WE, Blumhagen DW. Evaluation of AIHA activities in Slovak Republic: Final draft report. October 18, 1999.

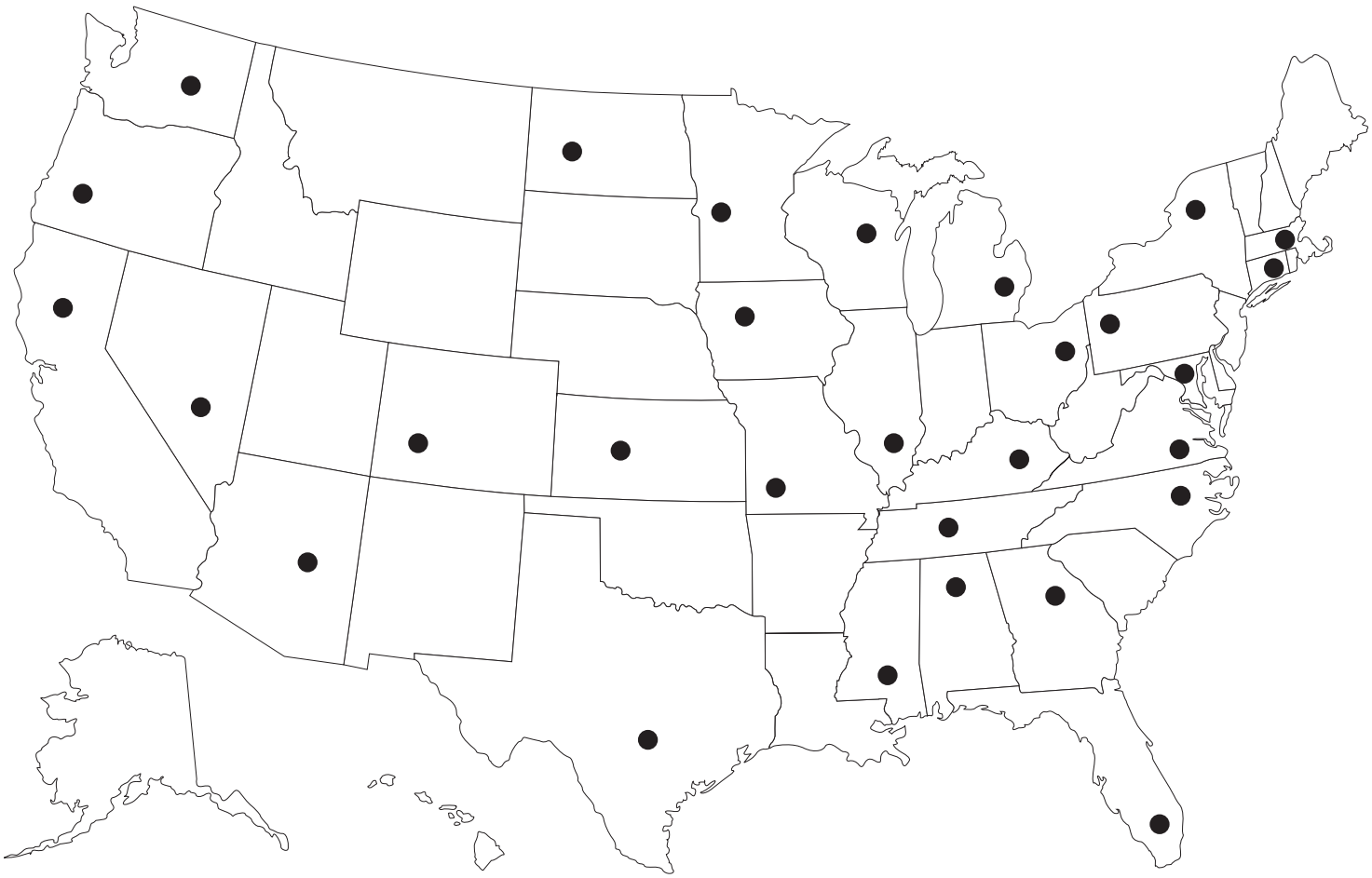
[17] Daniels JK and Starke-Meyerring D. The Diffusion of Medical Information Technology in Central and Eastern Europe and the New Independent States: An Assessment of the AIHA Learning Resource Center Project. University of Minnesota, 1998.

Appendices

Map of partnerships in the United States and in the NIS/CEE

1) CEP Membership and Evaluation Methodology
2) AIHA Founding Organizations and Current Board of Directors
3) Partnerships and Site Visits
4) Interviews
5) USAID and The AIHA Partnership Program

Partners in the United States



Partnerships are listed in Appendix 3.

NIS/CEE Participants in the AIHA Partnership Program*

Map shows participating countries. Several countries have more than one partnership.

Appendix 1

CEP Membership and Evaluation Methodology

Panel Members

Neal A. Vanselow, M.D., (Chairman) is Chancellor-emeritus and Professor-emeritus of Medicine at Tulane University Health Sciences Center. He also holds appointments as Professor-emeritus of Health Systems Management in the Tulane School of Public Health and Tropical Medicine and as an Adjunct Professor in the School of Health Administration and Policy at Arizona State University. Dr. Vanselow served as Chancellor of Tulane University Health Sciences Center from 1989-94 and as a Senior Scholar-in-residence at the Institute of Medicine during the 1994-95 academic year. He has served as Chairman of the Department of Postgraduate Medicine and Health Professions Education at the University of Michigan, Dean of the University of Arizona College of Medicine, Chancellor of the University of Nebraska Medical Center, and Vice President for Health Sciences at the University of Minnesota. He is an allergist who received his training in internal medicine and allergy/immunology at the University of Michigan.

Linda H. Aiken, Ph.D., R.N., FAAN, FRCN, is the Claire M. Fagin Leadership Professor of Nursing, Professor of Sociology, and Director of the Center for Health Outcomes and Policy Research at the University of Pennsylvania. Prior to joining the faculty in 1988, Dr. Aiken was Vice President of the Robert Wood Johnson Foundation and directed its research and evaluation program. She is a member of the Institute of Medicine of the National Academy of Sciences, a fellow and former president of the American Academy of Nursing, and an elected fellow of the American Academy of Arts and Sciences, the National Academy of Social Insurance, and a Distinguished Fellow of the Academy for Health Services Research and Health Policy. Dr. Aiken received her bachelors and master's degrees in nursing from the University of Florida, Gainesville, and her Ph.D. in sociology and demography from the University of Texas at Austin. She was a postdoctoral research fellow in medical sociology at the University of Wisconsin, Madison.

Ross Anthony, Ph.D., is a Senior Economist at RAND and Director of the Center Military Health Policy Research. To date, the center has conducted research related to Gulf War Illnesses, evaluations of demonstrations to test alternative ways of delivering benefits to TRICARE beneficiaries over the age of 65, clinical practice guideline implementation, and cost of organization of military medicine. Dr. Anthony previously served as Vice-President and Director of the International Health Services Group at IPAC, Director of the Office of Development Resources for Europe at the United States Agency for International Development, and as Associate Administrator for Program Development of the Health Care Financing Administration, where he oversaw the development of program policy, regulations, and health services research. Earlier, he was a faculty member in health economics at the University of Oregon. Dr. Anthony received his Ph.D. in economics from the University of Pennsylvania and was a Robert Wood Johnson Fellow.

Bright M. Dornblaser, MHA, is Emeritus Professor of the Carlson School of Management at the University of Minnesota. He received his BBA and MHA degrees from the University. After serving as Secretary of the Board of Health of Philadelphia, Chief Executive Officer of a hospital, and consultant, he returned to the University as Chair of its Department of Healthcare Management. He has served as a member and Chair of numerous committees and organizations within and outside of the University, including President of the University Programs in Health Administration and as a health care company board member. His international experience includes serving as a member of a UNDP/PAHO mission to Latin America and as a consultant in Uruguay, Egypt, and Bahrain. He has been Director or Coordinator of health management development programs in the Kingdom of Saudi Arabia, Iran, and Russia.

Clifton R. Gaus, Sc.D., is President of The Gaus Group, Inc., which provides strategic planning, technical assistance, and policy analysis in managed care, Medicare and Medicaid, and e-business. Previously, Dr. Gaus was Executive Vice President and Chief Administrative Officer of WellPoint Health Networks Inc., Senior Vice President for Research and Development of the national Kaiser Permanente Health System and (from 1994 to 1997) Administrator of the Agency for Health Care Policy and Research, the lead federal Agency in studying health care organization, financing, quality, and technology. In the late 1970s, Dr. Gaus was Associate Administrator for Policy, Planning, and Research for the Health Care Financing Administration. He has held faculty positions at The Johns Hopkins University School of Public Health and at Georgetown University Medical School.

Cornelius Hopper, M.D., is the recently retired emeritus Vice President for Health Affairs of the University of California, featuring the nation's largest university health sciences system, which encompasses 14 health professions schools on six campuses and an enrollment of more than 13,000 students**.** A neurologist, Dr. Hopper has held faculty positions at the University of Wisconsin, Madison, Tuskegee University, and the University of Alabama, Birmingham. He introduced the national Health Services Corps into the southeastern United States, organized one of the nation's first rural-based Area Health Education Centers, and pioneered a unique multi-county primary care system in south central Alabama. He has served on numerous federal, state, and private boards and commissions and currently serves on the Health Manpower Policy Commission for the State of California.

Mary Richardson, Ph.D., MHA, is an Associate Professor in Health Services within the University of Washington's School of Public Health and Community Medicine. She currently directs the Center for Disability Policy and Research, and for 10 years was the Director of the UW Graduate Program in Health Services Administration. She conducts policy research on issues of health and health care delivery for persons with chronic conditions and disabilities, and she evaluates public and private sector health related programs for this population. Dr. Richardson served as the Joseph P. Kennedy Jr. Fellow in Public Policy, working for U.S. Senator Tom Harkin on issues of health and disability policy from January 1989 to June 1990. More recently, she was a Fellow in the Office of the President of the University of California, working with the Vice President for Clinical Services Development. Dr. Richardson is a past Chair of the Board of Directors of the Association of University Programs in Health Administration.

Evaluation Methodology

The CEP was organized to conduct a comprehensive, cross-sectional, and longitudinal assessment of the effectiveness of AIHA programs carried out under a series of cooperative agreements with USAID beginning in 1992. Its work was carried out from March 1, 2000, to February 28, 2001. The evaluation methodology followed standard practices for a USAID project. Methods used were principally qualitative and included:

- Site visits to a sample of partnerships in the NIS/CEE.
- Telephone interviews with U.S. partners.
- Interviews with AIHA regional office personnel.
- Attending conferences and annual meetings of the partners.
- Site visit to AIHA Washington.
- Interviews with representatives of USAID Washington and USAID missions.
- Review of written materials submitted by AIHA and USAID. (These included general background materials, administrative, managerial, and budgetary documentation, quarterly reports, partnership work plans, educational or training meeting schedules, publications, and information presented on the AIHA web site).

Team members visited partnership sites, USAID missions, and AIHA regional offices in the NIS/CEE during two sets of visits in the summer and late fall of 2000. Sites were representative of missions and regions and provided a geographic and economic mix. Mediating influences in site selection were relative isolation of some partnerships and practicality of coordinating travel to sites. The sites visited in the summer were primarily partnerships initiated under the initial hospital Partnership Program cooperative agreements and those receiving bridge funding after the completion of the initial funding cycle. Sites visited in the late fall were primarily new community-based, primary care partnerships. Cross-cutting initiatives and other AIHA support programs were reviewed during both summer and late fall. Locations of the partnership visits and the people with whom the CEP met and conducted interviews are shown in Appendices 3 and 4.

AIHA regional office staff, based on CEP direction, arranged interviews in advance and the interviews generally occurred over a three-day site visit. Those interviewed typically included USAID mission staff, partnership directors and staff, other relevant hospital and health service administrators, and local government and health officials. The AIHA regional director and appropriate staff were also interviewed. In addition, CEP members attended the AIHA Annual Meeting, held in July 2000 in Budapest. They met with staff from USAID-Washington and the missions, NIS/CEE and U.S. partners, and AIHA Washington and regional staff. U.S. partners were also interviewed by telephone. AIHA central management and program support, located in Washington D.C., were assessed by CEP visits to the agency's Washington site.

The CEP report was prepared in draft form and submitted to AIHA for corrections of factual errors. It was also circulated in draft form to USAID personnel in the NIS/CEE missions and the Washington office. Comments were received from USAID offices in Washington, D.C., Armenia, the Caucasus, Ukraine, Russian, the Central Asian Republics, and Romania., These comments and suggestions were considered by the CEP when it finalized the report.

Appendix 2

AIHA Founding Organizations and Board of Directors

Founding Organizations

American Hospital Association

American Medical Group Association

Association of Academic Health Centers

Association of University Programs in Health Administration

National Association of Public Hospitals and Health Systems

National Public Health and Hospital Institute

Premier, Inc.

VHA, Inc.

Current Board of Directors

Dennis P. Andrulis, MPH, Ph.D., is Research Professor in the Department of Preventive Medicine, State University of New York Health Science Center, Brooklyn. He has served on the AIHA Board since 1992. He was previously Director of the Office of Urban Populations at The New York Academy of Medicine; professional associate at the Institute of Medicine, National Academy of Sciences; a senior program analyst at the Office of the Secretary in the U.S. Department of Health and Human Services; and President of the National Public Health and Hospital Institute. He is a trustee for the Hospital for Sick Children.

Daniel P. Bourque, MBA, (Past Chairman) is Senior Vice President of Corporate and Public Affairs at VHA Inc. He served as Chairman of the AIHA Board from 1992-1998. Previous positions have included President, National Committee for Quality Health Care; Deputy Administrator, Health Care Financing Administration; and Deputy Executive Secretary, U.S. Department of Health and Human Services. He serves on the Board of Hospital Research and Educational Trust, National Committee for Quality Health Care.

Roger J. Bulger, M.D., is President and CEO of the Association of Academic Health Centers (AHC). He has served on the AIHA Board since 1992. Previous positions include President of the University of Texas Health Science Center; Chancellor, University of Massachusetts Medical Center; and Executive Officer, Institute of Medicine, National Academy of Sciences. He has received the President's Award of the American Academy of Family Practice and the Distinguished Service Award from the Association of Schools of Allied Health Professions. Dr. Bulger was elected to the National Academy for Social Insurance and is a Fellow of the Infectious Disease Society of America, American

College of Physicians, and the Royal College of Physicians. He is a member of the Institute of Medicine, Association for Health Services Research.

Henry A. Fernandez, J.D., is President and CEO of the National Catholic Development Conference. He has served on the AIHA Board since 1993. His previous positions include Managing Director at KPMG-Peat Marwick LLP and counsel for the Association of University Programs in Health Administration; President and CEO, AUPHA; Deputy Commissioner for the Professions, New York State Board of Regents; hospital administrator; and labor counsel, New York State Office of Mental Health. He is a Fellow of the New York Academy of Medicine.

Donald W. Fisher, Ph.D., (Secretary) is CEO of the American Medical Group Association (AMGA); Treasurer of the American Medical Group Association Political Action Committee; and Chairman of the American Medical Group Services Corporation. He has served on the AIHA Board since 1992, previously as its treasurer. He currently chairs the AIHA Finance and Audit Committee. From1973-1980, Dr. Fisher was the Executive Director of the American Academy of Physician Assistants.

Larry S. Gage, J.D., (Chairman) is president of the National Association of Public Hospitals and Health Systems and a partner at Powell, Goldstein, Frazer & Murphy, LLP. He has served on the AIHA Board since 1992. Previous positions include Deputy Assistant Secretary for Health Legislation, U.S. Department of Health and Human Services, and staff counsel for the U.S. Senate Labor and Human Resources Committee.

Sheila A. Ryan, Ph.D., R.N., is Professor at the School of Nursing, University of Nebraska. She has served on the AIHA Board since 1999. Her previous positions include Dean and Professor, School of Nursing, University of Rochester, and Associate Professor and Dean of Creighton University. She is a Fellow of the American Academy of Nursing, a member of the Institute of Medicine, and Treasurer of the National League for Nursing.

Louis W. Sullivan, M.D., is President of the Morehouse School of Medicine. He has served on the AIHA Board since 1999. His previous positions include Secretary of Health and Human Services; Dean and President, Morehouse School of Medicine; Professor of Biology and Medicine, Morehouse College; and Founding Dean and Director, Medical Undergraduate Program at Morehouse; Professor of Medicine, Boston University School of Medicine; founder of the Boston University Hematology Service at Boston City Hospital; Co-Director, Hematology, Boston University Medical Center; Assistant Professor of Medicine, Seton Hall College of Medicine; and Instructor in Medicine, Harvard Medical School.

Alan Weinstein, MBA, is a consultant. He has served on the AIHA Board since 1992. His previous positions include President of Premier Inc., President of the Premier Health Alliance; and Executive Vice President, Illinois Hospital Association.

Appendix 3

Partnerships and CEP Visits

AIHA partnerships in the NIS/CEE are shown on the following 11 pages; those visited by the CEP are shaded.

Appendix 3 AIHA Partnerships and Visits By the CEP

Partnership Location	NIS/CEE Institutions	US Partner Location	Type of Institutions	Type of Partnership	Years
Tirana, Albania	University Hospital Center, University Maternity Hospital, Central Trauma Hospital	Grand Rapids, Michigan	Spectrum Health	Hospital	1996-2000
Tirana, Albania	Albanian Ministry of Health and Environmental Protection	New York, New York	New York University's Robert F. Wagner School of Public Service	Health Management Education	1996-1999
Tirana, Albania	The Maternity Hospital	Providence, Rhode Island	Women and Infants Hospital of Rhode Island	Women's Wellness Center	1999-Present
Armavir, Armenia	Armavir Region Health Care Administration, Armavir Polyclinic	Galveston, Texas	University of Texas Medical Branch at Galveston, School of Nursing & School of Allied Health Sciences, Partnership for Better Living	Community-Based Primary Health Care	1999-Present
Gegarkunik, Armenia	Gegargunik Region Health Care Administration, Sevan Polyclinic	Providence, Rhode Island	Care New England and Lifespan Health Systems, Brown University School of Medicine, New England Medical Center	Community-Based Primary Health Care	1999-Present
Lori, Armenia	Lori Marz Region Health Care Administration, Vanadzor Polyclinic #5	Los Angeles California	University of California, Los Angeles & UCLA Medical Center, Santa Monica Hospital, Mattel Children's Hospital, Neuropsychiatric Institute Hospital, Jules Stein Eye Institute and Doris Stein Eye Research Center	Community-Based Primary Health Care	1999-Present
Yerevan, Armenia	School of Health Care Management and Administration	Birmingham, Alabama	University of Alabama at Birmingham, Creighton University, Omaha, Nebraska	Health Management Education	1999-Present

Partnership Location	NIS/CEE Institutions	US Partner Location	Type of Institutions	Type of Partnership	Years
Yerevan, Armenia	Erebouni Medical Center & College of Nursing	Los Angeles, California	University of California at Los Angeles Medical Center	Hospital	1993-1999
Yerevan, Armenia	Emergency Medical Scientific Center, Yerevan Emergency Hospital, Armenian Ministry of Health	Boston, Massachusetts	Boston University Medical Center & School of Medicine, University of Massachusetts Medical Center	Hospital	1993-1999
Yerevan, Armenia	Armenian-American Mammography University Center	Washington, DC	The Armenian-American Cultural Association Primary Health Care with Emphasis on Breast Health	Community-Based	2000-Present
Baku, Azerbaijan	Narimanov District Health Administration, Pediatric Polyclinic #7, Polyclinic #8	Portland, Oregon	Oregon Health Sciences University	Community-Based Primary Health Care	2000-Present
Baku, Azerbaijan	Republican Hospital "Mir Kasimov"	Houston, Texas	Baylor College of Medicine	Emergency Obstetrics, Maternal and Newborn Care	1999-Present
Baku, Azerbaijan	Binagadi District Health Administration, Pediatric Polyclinic #20	Richmond, Virginia	Virginia Commonwealth University	Community-Based Primary Health Care	2000-Present
Minsk, Belarus	Ministry of Health of Belarus, City Council Health Committee, City Clinic Ambulance Hospital	Worcester, Massachusetts	Institute for Disaster and Emergency Medicine University of Massachusetts Medical School	Emergency Medical Services	1999-Present
Minsk, Belarus	Belarus Ministry of Health, Minsk City Health Administration, Polyclinic #36	New Brunswick, New Jersey	Robert Wood Johnson Medical School & Health Network, Brown University Center for Primary Care	Community-Based Primary Health Care	1999-Present
Minsk, Belarus	Children's Hospital No.4, Institute of Radiation Medicine, Minsk State Medical Institute, Maternity Hospital No.2, Belarus-American Child Health Foundation	Pittsburgh, Pennsylvania	Magee-Women's Hospital, University of Pittsburgh Medical Center, Children's Hospital	Hospital	1993-Present

Partnership Location	NIS/CEE Institutions	US Partner Location	Type of Institutions	Type of Partnership	Years
Tuzla, Bosnia & Herzegovina	University Clinical Center of Tuzla	Buffalo, New York	Buffalo General Health System	Hospital	1996-1998
Zadar, Croatia	Zadar General Hospital, Orthopedic Hospital of Biograd	Kentucky, New Jersey, New York, Ohio, South Carolina, & Pennsylvania	Six Area Systems of the Franciscan Sisters of the Poor Health System, Inc.	Hospital	1995-1998
Zagreb, Croatia	Children and Youth Hospital for Respiratory Diseases, University Hospital for Infectious Diseases, Sveti Duh General Hospital	Lebanon, New Hampshire	Dartmouth-Hitchcock Medical Center	Hospital	1994-1998
Bohemia, Czech Republic	University Faculty of Management, Jindrichuv Hradec, University of Education Faculty of Management and Information Technology, Hradec Kralove	Las Vegas & Reno, Nevada	University of Nevada	Health Management Education	1996-1997
Olomouc, Czech Republic	Palacky University Faculty of Medicine and Nursing	Richmond, Virginia	Virginia Commonwealth University Department of Health Administration	Health Management Education	1995-1997
Tallinn, Estonia	Mustamae Hospital, Tallinn Central Hospital	Washington, DC	George Washington University Medical Center	Hospital	1994-1996
Kutaisi, Georgia	Kutaisi Regional Health Administration	Atlanta, Georgia	Grady Health System, Emory & Morehouse Universities Schools of Medicine, Georgia State University, Kaiser Permanente Medical Care, Rollins School of Public Health	Healthy Communities & Women's Wellness	1999-Present
Mtskheta-Mtianeti, Georgia	Mtskheta-Mtianeti Regional Health Administration, Primary Health Care Center	Milwaukee, Wisconsin	Milwaukee International Health Training Center, Children's Hospital of Wisconsin, Froedtert Memorial Lutheran Hospital, Medical College of Wisconsin, University of Wisconsin Medical School	Community-Based Primary Health Care	1999-Present

Partnership Location	NIS/CEE Institutions	US Partner Location	Type of Institutions	Type of Partnership	Years
Tbilisi, Georgia	Polyhaema Blood Bank	San Francisco, California	Global Healing	Blood Bank	1999-Present
Tbilisi, Georgia	City Hospital No. 2, National Information Learning Center, Tbilisi State Medical University	Atlanta, Georgia	Emory University School of Medicine	EMS; Hospital	1992-1999
Tbilisi, Georgia	National Center for Disease Control, International Hospital Infection Prevention and Quality Assessment Program	Minneapolis, Minnesota	Association for Professionals in Infection Control and Epidemiology, Society for Healthcare Epidemiology of America, Minneapolis Department of Health	Infection Control	1999-Present
Tbilisi, Georgia	National Health Management Center	Scranton, Pennsylvania	University of Scranton	Health Management Education	1999-Present
Vac, Hungary	Javorszky Odon Hospital	Winston-Salem, North Carolina	Novant Health	Hospital	1995-1998
Almaty, Kazakstan	Institute for Pediatrics & Children's Surgery, Almaty City Emergency Hospital, Almaty Medical College, Republican Medical College	Tucson, Arizona	Tucson & University Medical Centers, Arizona Health Sciences Center, Columbia NW Hospital, El Dorado Hospital, Veterans' Affairs Medical Center, Tucson General Hospital	EMS; Hospital	1993-1999
Almaty, Kazakstan	Kazakstan School of Public Health	Richmond, Virginia	Virginia Commonwealth University —Health Administration Department	Health Management Education	1999-Present
Astana, Kazakstan	City of Astana, Model Family Practice Center	Pittsburgh, Pennsylvania	Pittsburgh Mercy Health System, Sto-Rox Health Center, Allegheny County Health Department, University of Pittsburgh Graduate School of Public Health	Community-Based Primary Health Care	1999-Present
Semipalatinsk, Kazakstan	Consultative Learning Center/East Kazakstan Regional Rehabilitation Center, Emergency First Aid Hospital, Kurchatov Center	Houston, Texas	Methodist Hospital, Baylor College of Medicine	Hospital	1995-Present

Partnership Location	NIS/CEE Institutions	US Partner Location	Type of Institutions	Type of Partnership	Years
Bishkek, Kyrgyzstan	Institutes of Obstetrics & Pediatrics and Oncology & Radiology, Kyrgyz State Medical Academy	Kansas City, Kansas	University of Kansas Medical Center	Hospital	1992-1999
Bishkek, Kyrgyzstan	Kyrgyz State Medical Academy	Reno, Nevada	University of Nevada School of Medicine, State of Nevada Division of Health, Clark County Health District, Nevada Rural Hospital Project,Washoe Medical Center	Community-Based Primary Health Care, Emphasis on Health Professions Education	1999-Present
Riga, Latvia	Clinical Children's Hospital, Riga City Maternity Hospital	St. Louis, Missouri	Barnes-Jewish Hospital, Washington University Medical Hospital	Hospital	1995-1998
Cahul, Moldovia	Cahul Women's Consultation	Norfolk Virginia	Eastern Virginia Medical School, Portsmouth Health District, Portsmouth Community Health Center Inc.	Women's Wellness Center	2000-Present
Chisinau, Moldova	Republican Clinical Hospital, City Ambulance Hospital, Moldova Medical and Pharmacy University	Minneapolis, Minnesota	Hennepin County Medical Center	Hospital 1999	1994-
Chisinau, Moldova	Botanica Medical District, Moldova Medical and Pharmacy University	Norfolk/ Portsmouth, Virginia	Eastern Virginia Medical School	Community-Based Primary Health Care	2000-Present
Bucharest, Romania	University of Medicine and Pharmacy "Carol Davila," Institute of Health Services Management	Lexington, Kentucky	University of Kentucky	Health Management Education	1996-1999
Cluj-Napoca, Romania	Institute of Public Health, the Inspectorate of Sanitary Police, Hospital & Clinic for Occupational Diseases	Philadelphia, Pennsylvania	Thomas Jefferson University and Hospital	Hospital	1995-1997
Constanta, Romania	Public Health Directorate of Constanta County	Louisville, Kentucky	The Humana Foundation, Humana, Inc., University of Louisville	Healthy Communities	1998-Present

Partnership Location	NIS/CEE Institutions	US Partner Location	Type of Institutions	Type of Partnership	Years
Iasi, Romania	Center for Reproductive Health and Family Planning	Minneapolis, Minnesota	Hennepin County Medical Center	Hospital	1998-Present
Buryatia, Russia	Ministry of Health, City Maternity Center & Republic Maternity Hospital, Ulan Ude	Rhinelander, Wisconsin	Baikal-Great Lakes United Medical Program, Lutheran Social Services, Sacred Heart-Saint Mary's Hospital	Hospital	1998-2000
Chelyabinsk, Russia	Chelyabinsk Regional Health Administration, City Clinical Hospital No. 1, City Children's Hospital No. 8, Ural State Medical Academy for Postgraduate Education	Tacoma, Washington	Mary Bridge Children's Hospital and Health Center, Multicare Medical Center, Tacoma-Pierce County Health Department, Tacoma General Hospital	Hospital	1998-1999
Dubna, Russia	Hospital No. 9, Central City Hospital, Bolshaya Volga Hospital	La Crosse, Wisconsin	Lutheran & Franciscan Health Systems, Gunderson Clinic, Skemp Clinic, La Cross Visiting Nurses Association	Hospital	1992-1999
Khabarovsk, Russia	Khabarovsk Krai Health Department, Pereyaslavka Rayon Hospital and Polyclinic	Lexington, Kentucky	University of Kentucky and its Center of Excellence for Rural Health, Kentucky Department for Public Health	Community-Based Primary Health Care	1999-Present
Kurgan and Schuche, Russia	Kurgan Oblast & Schuche Districts Administrations, Kurgan Maternity House, Schuche Rayon Central Hospital	Fox Cities, Wisconsin	ThedaCare, Physicians for Social Responsibility, Fox Valley Technical College, University of Wisconsin, Lawrence University	Community-Based Primary Health Care	1999-Present
Moscow, Russia	Medical Center of the General Management Department of the President of the Russian Federation	Chicago, Illinois	Premier, Inc.	Hospital	1993-1999
Moscow, Russia	Pirogov First Municipal Hospital	Boston, Massachusetts	Brigham and Women's Hospital	Hospital	1993-1998
Moscow, Russia	Savior's Hospital for Peace and Charity, Main Medical Administration of Moscow	Pittsburg, Pennsylvania	Magee-Women's Hospital, Pittsburgh	Hospital	1992-Present

Partnership Location	NIS/CEE Institutions	US Partner Location	Type of Institutions	Type of Partnership	Years
Moscow, Russia	Scientific Research Institute of Pediatric Hematology	Memphis, Tennessee	Methodist Health Systems	Hospital	1998
Moscow, Russia	Institute of Continuing Education of the Federal Directorate for Biomedical Problems and Disaster Medicine	Austin, Texas	City of Austin, Travis County	EMS; Hospital	1995-Present
Moscow, Russia	Institute of Pediatrics and Children's Surgery	Norfolk, Virginia	Children's Hospital of the King's Daughters	Hospital	1995-1998
Murmansk, Russia	Murmansk Health Care Department & Regional Hospital, City Ambulance Hospital	Jacksonville, Florida	St. Vincent's Medical Center	Hospital Present	1992-
St. Petersburg, Russia	St. Petersburg Medical University in the Name of Pavlov	Atlanta, Georgia	Georgia Baptist Healthcare System	Hospital	1995-1999
St. Petersburg, Russia	Medical Center of St. Petersburg in the Name of Sokolov	Louisville, Kentucky	Jewish Hospital HealthCare Services, University of Louisville School of Medicine	Hospital	1995-2000
St. Petersburg, Russia	St. Petersburg Infection Control Training Center & Medical Academy in the Name of I.I. Mechnikov	Boston, Massachusetts	International Hospital Infection Prevention and Quality Assessment Program, Society for Healthcare Epidemiology of America, Association for Professionals in Infection Control and Epidemiology	Infection Control	1999-Present
Sakhalin, Russia	Sakhalin Oblast Health Department, Korsakov Rayon Hospital and Polyclinic	Houston, Texas	Baylor College of Medicine	Community-Based Primary Health Care	1999-Present
Sarov, Russia	Sarov City Duma, Office of the Mayor, Medical-Sanitary Unit #50	Los Alamos, New Mexico	County of Los Alamos, Los Alamos Medical Center & National Laboratory, State of New Mexico Department of Public Health, University of New Mexico School of Medicine	Community-Based Primary Health Care	1999-Present

Partnership Location	NIS/CEE Institutions	US Partner Location	Type of Institutions	Type of Partnership	Years
Snezhinsk, Russia	Central Medical Unit No.15	Livermore, California	Alameda County Public Health Department, Chabot-Las Positas Community College District, Lawrence Livermore National Laboratory, Valley Care Health System	Community-Based Primary Health Care	1999-Present
Stavropol, Russia	Stavropol Regional Hospital, City Hospital No.2, Stavropol Krai Oncological Center, Women's Health Center Essentuki	Cedar Rapids, Iowa	Iowa Hospital Education and Research Foundation (IHERF), Association of Iowa Hospitals and Health Systems	Hospital Present	1993-
Stavropol/ Samara, Russia	Stavropol Krai Ministry of Health, Samara Oblast Health Administration Medical Information-Analytical Center, Polyclinic No. 5	Iowa	Iowa Hospital Education and Research Foundation, Central Iowa Health System, Iowa Department of Public Health	Community-Based Primary Health Care	1999-Present
Tomsk, Russia	Central Regional Hospital in Timiryazevo	Bemidji, Minnesota	North Country Health Services	Community-Based Primary Health Care	2000-Present
Vladivostok, Russia	City Clinical Hospital No.2, Vladivostok Medical Institute	Richmond, Virginia	Medical College of Virginia, Virginia Commonwealth University	Hospital	1993-Present
Volgograd, Russia	Volgograd State Medical Academy	Little Rock, Arkansas	University of Arkansas for Medical Sciences	Hospital	1998-1999
Banska Bystrica, Bratislava, & Trnava, Slovakia	Trnava University, Health Management School, Bratislava University of Matej Bel, Banska Bystrica	Scranton, Pennsylvania	University of Scranton International Health Care	Health Management Education	1996-1999
Banska Bystrica and Martin, Slovakia	Jessenius Faculty of Medicine Comenius University, Martin Faculty Hospital, Municipal Government	Cleveland, Ohio	MetroHealth System	Healthy Communities	1997-1999

Partnership Location	NIS/CEE Institutions	US Partner Location	Type of Institutions	Type of Partnership	Years
Kosice, Slovakia	Faculty Hospital and Polyclinic	Providence, Rhode Island	Women and Infants Hospital of Rhode Island, Hasbro Children's Hospital	Hospital	1995-1999
Petrzalka, Slovakia	Aid to Children At Risk Foundation	Kansas City, Missouri	Truman Medical Center Communities	Healthy	1996-1998
Turcianske Teplice, Slovakia	Municipal Government Office	Cleveland, Ohio	The MetroHealth System	Healthy Communities	1996-1998
Dushanbe, Tajikistan	City Medical Center, Dushanbe Medical College, Tajik Medical University	Boulder, Colorado	Boulder Community Hospital	Hospital	1994-1998
Dushanbe, Tajikistan	Tajikistan Ministry of Health, Republican Center of Family Medicine	Boulder, Colorado	Boulder Community Hospital	Community-Based Primary Health Care	1999-Present
Ashgabat, Turkmenistan	Turkmenistan Ministry of Health and Medical Industry	Grand Forks, North Dakota	University of North Dakota College of Nursing, School of Medicine, Department of Health, Dakota Association of Community Health Centers	Primary Health Care Training, Family Medicine Education	1999-Present
Ashgabat, Turkmenistan	Medical Consultative Center in the Name of President Niyazov	Cleveland, Ohio	Cleveland Clinic Foundation—International Center	Hospital	1993-1998
Ashgabat, Turkmenistan	Tiz Komek Medical Center	Richmond, Virginia	Richmond Ambulance Authority	Hospital	1997-1998
Donetsk, Ukraine	Donetsk Trauma Center	Orlando, Florida	Orlando Regional Healthcare System	Hospital	1995-1999
Donetsk, Ukraine	Donetsk Oblast Health Administration, City Hospital #25, Kramatorsk Central City Hospital	Pittsburgh, Pennsylvania	Magee-Womens Hospital, Allegheny County Department of Public Health, United Mine Workers of America, University of Pittsburgh School of Public Health & Medical Center	Community-Based Primary Health Care	1999-Present

Partnership Location	NIS/CEE Institutions	US Partner Location	Type of Institutions	Type of Partnership	Years
Kharkiv, Ukraine	Kharkiv City and Oblast Health Administration, Kharkiv Oblast Student Polyclinic, Chuguev Rayon Hospital	La Crosse, Wisconsin	La Crosse International Health Partnership, Gundersen Lutheran Medical Center, Franciscan Skemp Healthcare, University of Wisconsin, Western Wisconsin Technical & Viterbo Colleges, Medical College of Wisconsin	Community-Based Primary Health Care	1999-Present
Kiev, Ukraine	EMS Training Center, Ministry of Health, Emergency & Disaster Medical Training Center	Coney Island, New York	Coney Island Hospital, New York City Fire Department	EMS; Hospital	1995-1998
Kiev, Ukraine	Children's Hospital No. 2, Center for Maternal and Child Health Care	Philadelphia, Pennsylvania	Children's Hospital of Philadelphia, University of Pennsylvania School of Medicine	Hospital	1992-1998
Kiev, Ukraine	Kiev City Health Administration, Kharkiv Rayon Polyclinic	Philadelphia, Pennsylvania	Temple & Widener Universities, Health Federation of Philadelphia, Crozer-Keystone Health System, Elwyn, Inc.	Community-Based Primary Health Care	1999-Present
L'viv, Ukraine	L'viv Oblast Clinical Hospital, Regional Neonatal Center & Medical Institute	Detroit, Michigan	Henry Ford Health System	Hospital	1993-Present
L'viv, Ukraine	Western Ukrainian Clinical Railway Hospital, L'viv Regional Perinatal Center	Buffalo, New York	Millard Fillmore Hospitals, Buffalo School of Medicine and Biomedical Sciences	Hospital	1993-1999
L'viv, Ukraine	L'viv Oblast Administration, L'viv City Polyclinic No. 5, Zhovkva Rayon Hospital	Cleveland, Ohio	Cleveland International Program, Federation for Community Planning, Cuyahoga County Board of Health, Case Western Reserve School of Medicine, Cleveland State University, MetroHealth, Department of Health	Community-Based Primary Health Care	1999-Present

Partnership Location	NIS/CEE Institutions	US Partner Location	Type of Institutions	Type of Partnership	Years
Odessa, Ukraine	City of Odessa, Oblast Health Administration, State Medical University, Sea Port Polyclinic	Boulder, Colorado	Community Hospital, University of Colorado School of Medicine, County Health Department, Beacon Clinic, County Healthy Communities Initiative	Community-Based Primary Health Care	1999-Present
Odessa, Ukraine	Odessa Oblast Hospital	Coney Island, New York	Coney Island Hospital	Hospital	1992-1998
Uzhgorod, Ukraine	Uzhgorod Oblast Clinical & Central Velikobereznianskaia Regional Hospitals, Zakarpatska Oblast Health AdministrationCare	Corvallis, Oregon	Oregon Health Sciences University, Corvallis Family Medicine, Western Oregon University, Benton County Health Department	Community-Based Present Primary Health	1999-
Tashkent, Uzbekistan	Second State Medical Institute	Chicago, Illinois	University of Illinois Hospital	Hospital	1992-Present
Tashkent and Fergana, Uzbekistan	National Republican Center for Emergency Medical Care, Fergana Affiliate of the National Republican Center for Emergency Medical Care	Atlanta, Georgia	Grady Health System, Rural/Metro Ambulance Service, Atlanta, Emory University & School of Medicine, Morehouse University School of Medicine, Rollins School of Public Health	Urgent Care/ Trauma Services	2000-Present

Note: Partnerships visited by CEP members are in "shaded" boxes.

Appendix 4

CEP Interviews

Partnerships

Partnership: Armavir, Armenia — Galveston, Texas

U.S. Interviews

Cissy Yoes, US Partnership Coordinator, University of Texas Medical Branch at Galveston

Partnership: Gegarkunik, Armenia — Providence, Rhode Island

NIS/CEE Interviews

Rita Zhamgarian, Partnership Coordinator, Director, Sevan Polyclinic

Partnership: Lori, Armenia — Los Angeles, California

U.S. Interviews

Salpy Akaragian, US Partnership Coordinator, Director, International Nursing Center

Cynthia T. Barrett;

Pam Thompson;

Sharon Weinstein; UCLA Medical Center

Partnership: Yerevan, Armenia — Birmingham, Alabama

NIS/CEE Interviews

Mihran Nazaretian, MD, PhD, MPH, Partnership Coordinator, Director, School of Health Care Management and Administration

U.S. Interviews

S. Robert Hernandez, DrPH, US Partnership Coordinator, Professor and Chair, Department of Health Services Administration, University of Alabama at Birmingham

Partnership: Yerevan, Armenia — Los Angeles, California

NIS/CEE Interviews

Alina M. Kushkyan, MD, PhD, Head Specialist in Nursing of the Ministry of Health of RA, Director of Erebouni State Medical College

Haroutioun Koushkian, MD, PhD, Partnership Representative, Director, Erebouni Medical Center

Tigran Khachatryan, MD, President of ErMed Medical Insurance Company, Deputy of General Director of Erebouni Medical Center

Partnership: Baku, Azerbaijan — Portland, Oregon

NIS/CEE Interviews

Dr. Saadat Mahmodova, Head;

Dr. Sevinj Bakhishova, Chief Pediatrician; Narimanov District Health Administration

Sevinj Ilashimova, Nurse, Pediatric Polyclinic #14

Dr. Rena Alakparova, Head, Polyclinic #8

Dr. Azar Abdullaev, Information Coordinator, Dermatologist

Professor Kamal Gakjyiev, CPG Steering Committee member

U.S. Interviews

Steve Kliewer, US Partnership Coordinator, Assistant Professor, Director of Community Medicine and Outreach, Oregon Health Sciences University

Partnership: Baku, Azerbaijan — Houston, Texas

NIS/CEE Interviews

Dr. Yagif Jafarov, Partnership Representative, Head Physician;

Firangiz Zeynalova, Chief Nurse;

Nahayat Mammadova, Nurse, Ophthalmology Department; Mir Kasimov Republican Clinical Hospital

Jeyhoun Y. Mamedov, JD, MS Program Coordinator

U.S. Interviews

Armin D. Weinberg, PhD, US Coordinator for Baku, Sakhalin, and Semipalatinsk Partnerships, Director, Center for Cancer Control Research;

Susan Miller, Trainer; Baylor College of Medicine

Partnership: Baku, Azerbaijan — Richmond, Virginia

NIS/CEE Interviews

Sevil Saforova, MD, Partnership Coordinator, Head, Pediatric Polyclinic #20

Nazeem Ildirim-zadeh, MD, Head, Binagadi District Health Administration

Dr. Rafael Mehdiyev, MD, Head, City Joint Hospital/Polyclinic #6

Dr. Gulshan Kerimova, Information Coordinator, Deputy Head, Pediatric Polyclinic #20

Sanubar Atamoglanova, Area Nurse, Pediatric Polyclinic #20

U.S. Interviews

Stephen M. Azres, MD, US Partnership Coordinator, Dean Emeritus and Director of International Health Programs;

David Marsland; Medical College of Virginia, Virginia Commonwealth University

Partnership: Minsk, Belarus — New Brunswick, New Jersey

U.S. Interviews

Andrew Green, US Partnership Coordinator, CEO, Robert Wood Johnson Health Network

Dr. Stephen Kairys, Associate Dean, Robert Wood Johnson Medical School

Partnership: Kutaisi, Georgia — Atlanta, Georgia

U.S. Interviews

Laura Hurt, Grady Health System

Partnership: Mtskheta-Mtianeti, Georgia — Milwaukee, Wisconsin

NIS/CEE Interviews

Ketevan Loria, MD, Partnership Coordinator, Director;

Khatuna Gogichaishvili, Information Coordinator; Regional Health Administration

Partnership: Tbilisi, Georgia — San Francisco, California

NIS/CEE Interviews

Levan Avalilshvilil, MD, Director, Polyhaema Blood Bank

Partnership: Tbilisi, Georgia — Atlanta, Georgia

NIS/CEE Interviews

Archil Kobaladze, Partnership Representative, Chief Advisor, Ministry of Health

Ketevan Nemsadze, Clinical Director,

M. Guramishvili, Pediatric Clinic

Zviad Kirtava, Director, National Information Learning Center

David Zhorzholiani, Technical Director, National Information Learning Center

Ioseb Bregvadze, lst Deputy Director, Georgia State Health Insurance Co.

Maia Gogashvili, Coordinator of Continuing Nursing Education, National Health Management Center of Continuing Medical Education

Dimitri Makhatadze, Director, EMS Training Center

U.S. Interviews

H. Kenneth Walker, MD, US Partnership Representative, Professor, Department of Medicine, Emory University School of Medicine

Partnership: Tbilisi, Georgia — Minneapolis, Minnesota

NIS/CEE Interviews

Paata Imnadze, J.D., Partnership Coordinator, Director;

Ekaterina Giorgobiani, Information Coordinator; National Center for Disease Control

Partnership: Tbilisi, Georgia — Scranton, Pennsylvania

NIS/CEE Interviews

Otari Vasadze, Partnership Coordinator, Director, National Health Management Center

U.S. Interviews

Daniel J. West, PhD, US Partnership Coordinator, Associate Professor, University of Scranton

Partnership: Vac, Hungary — Winston-Salem, North Carolina

NIS/CEE Interviews

Dr. Magdolna Nagy, Public Health Director, Professional Advisor;

Monika Forberger, Chairperson;

Dr. Tibor Silling, Head Physician, Vice Chairman;

Dr. Laszlo Ujhelyi, Pediatrician;Vac Citizens for Health Association

Dr. Ervin Szentgyorgyi, Director of Medical Care;

Zoltan Karpati, Management of Nursing;

Dr. Agnes Katona, former Partnership Coordinator, Head of Neurology Department;

Dr. Henrik Osgyan, Information Coordinator;

Zsuzsa Orosi, Head, Nursing Learning Resource Center,

Katalin Dxubak, Nurse, Matrix Surgical Unit;

Laszlo Kiss, Head Nurse, Emergency Unit;

Dr. Anna Licht, Surgeon,

Melinda Kiss, Stoma Therapy Nurse, Stoma Patient Club;

Ella Molnar, Home Care Director; Vac Municipal Hospital

Dr. Janos Both, Vice Mayor

U.S .Interviews

Frances C. Hutchison, RN, US Partnership Representative, Director of Forsyth Memorial Home Care, NovantHealth

Partnership: Almaty, Kazakstan — Tucson, Arizona

NIS/CEE Interviews

Vasiliy N. Devyatko, Chief of Department of Public Health of Almaty, Head of Almaty City Administration

Amantai Birtanov, MD, PhD, Partnership Representative, Chief Physician, First Aid Hospital

Auken K. Mashkeyev, MD, Professor, Deputy Director;

Dr. Zhanna Sekenova, Chief Doctor, Clinical Work;

Zhumabike Romashova, Chief Nurse;

Dr. Zhuldyz Abdrakhmanova, Information Coordinator;

Dr. Madina Sharipova, Acting Chief Doctor;

Dr. Kalsim Bilialova, Head,

Dr. Aygul Zhartieva, Clinical Diagnostics Laboratory; Institute of Pediatrics and Children's Surgery

Dr. Tamara Jusubalieva, Director;

Dr. Alia Anesova, Obstetrics-Gynecology;

Dr. Galina Grebennikova, Obstetrics-Gynecology;

Elena Kotiay, Nurse; Women's Wellness Center

Dr. Vassily Deviatko, Head, City Health Administration

Dr. Yury Silachev, Director;

Dr. Nadezhda Volkova, Information Coordinator, Instructor; EMS Center

U.S. Interviews

Emily Jenkins, US Partnership Coordinator, Tucson Medical Center

Jodi Brown, Theaa Care

Partnership: Almaty, Kazakstan — Richmond, Virginia

NIS/CEE Interviews

Nurlan Abdikaliev, First Deputy Rector;

Saule Kozhabekova, Information Coordinator;

Natalya Kukhazeva, faculty member;

Suljakham Kaiafutdinova, faculty member;

Anelia Juganova, Instructor of Health Economics;

Vitaliy Reznik, Head of the Department of Epidemiology & Hygiene;

Aetan Aringazina, Assistant Professor, Department of Health Promotion;

Kazakstan School of Public Health

U.S. Interviews

Yasar Ozcan, PhD, US Program Coordinator, Professor & Director, International Development, Virginia Commonwealth University Health Administration Department

Partnership: Astana, Kazakstan — Pittsburgh, Pennsylvania

NIS/CEE Interviews

Dr. Roza Abzalova, Partnership Coordinator, Model Family Medicine Center

Dr. Petukhova

U.S. Interviews

Mary Carrasco, US Partnership Coordinator, Director of International and Community Health, Mercy Children's Medical Center, Mercy Health System

Partnership: Semipalatinsk, Kazakstan — Houston, Texas

NIS/CEE Interviews

Dr. Galia Zhuasbayeva, President, Semipalatinsk Nursing Association

Elena Abrarova, Head, Department of Post-Graduate Training, City Health Administration

Lyudmila Kolesnikova, Chief Nurse, Kidney Center

Toleu Cheldybayeva, Chief Nurse, Oncology Center

Tamara Kozinskaya, Chief Nurse, Oblast Hospital

Lyudmila Zabolotnaya, Chief Nurse, Narcology Hospital

Bakhyt Alzhanova, Chief Nurse, Diagnostic Center

Khamzia Khasanova, Chief Nurse, Rehabilitation Center

Larisa Alekseyeva, Chief Nurse, Ambulance Service Center

Elena Timoshevskaya, Chief Nurse, Polyclinic #3

Kamal Toghyzbayeva, Chief Nurse, Dermato-Venerology Hospital

Dr. Saule Smakova, Head of Department, Nursing College

Dr. Marat N. Sandybayev, Chief Doctor;

Dr. Nurlan Ibrayeva, Deputy Chief Doctor;

Gulmira Abralina, Cancer Registry Specialist;

Anar Kulmanova, Cancer Registry Specialist;

Telman Aygozhin, Head of Department; Pavlodar Oncology Hospital

Zhanar Abeyeva, Director;

Dr. Svetlana Kamneva, Deputy Director;

Dr. Svetlana Lisitsina, Head of FP Department; Women's Clinic "Zhamilya"

Dr. Kaynolla Musin, Director;

Dr. Altay Nabiev, Deputy Director;

Galina Bakayeva, Chief Nurse;

Dr. Nadezhda Chernova, Head of Lab;

Andrey Allik, Information Coordinator; First Aid Hospital

Dr. Muktar Tuleutayev, Director;

Nurlan Rakhimzhanov, Deputy Director;

Sholpan Eskendirova, Nurse Trainer; Combined Hospital

Dr. Sh. Ospanova, Head of Cardiology Department

Dr. Maria Alimkhanova, Head of Laboratory

U.S. Interviews

Armin D. Weinberg, PhD, US Partnership Representative, Director, Center for Cancer Control Research, Baylor College of Medicine

Partnership: Bishkek, Kyrgyzstan — Kansas City, Kansas

NIS/CEE Interviews

Dr. Indira Kudaibergenova, MD, Partnership Representative, Director; Tynchy Borbashev, MD, Deputy Director;

Dr. Roza Zhyrgalbekova, Head,

Mrs. Mukadas Asylbekova, Chief Nurse, Hospice;

Dr. Damira Bayzakova, Head, Department of Children's Oncology;

Dr. Ayvar Toygonbekov, Head, Department of Thoracic Surgery;

Galina Sergeeva, Information Coordinator; Institute of Oncology and Radiology

Dr. Tulegen Chubakov, Director, Institute of Post-Graduate Training

Dr. Toktogazy Kutukeev, Director, National Blood Bank

Chubakov Fulegen, MD, and Professor, Republican Center of Uninterrupted Training of Medical and Pharmaceutical Workers

U.S. Interviews

Louise Redford, RN, Project Coordinator, University of Kansas Medical Center

Partnership: Bishkek, Kyrgyzstan — Reno, Nevada

NIS/CEE Interviews

Iskander Akylbekov, Rector;

Arsen Aidaraliev, MD, Partnership Coordinator, Vice Rector for International Relations;

Zhyldyz Ismailova, Information Coordinator;

Galya Nanaeva, Family Medicine Center;

Zhyldyz Isakova, Director of Nursing Center; Kyrgyz State Medical Academy

U.S. Interviews

Kathleen Conaboy, US Partnership Coordinator, Assistant Dean of Planning and Development;

Robert Daugherty, MD, Dean Emeritus;

Gerald Ackerman; University of Nevada School of Medicine

Partnership: Chisinau, Moldova — Norfolk/ Portsmouth, Virginia

U.S. Interviews

Francine C. Lutz, US Program Coordinator, Executive Assistant, VP Office;

Robert Alpina; Eastern Virginia Med School

Partnership: Bucharest, Romania — Lexington, Kentucky

NIS/CEE Interviews

Dan Enachescu, MD, PhD, Partnership Representative, Director, Department of Public Health and Management, Professor, University of Medicine and Pharmacy

Daniela Valceanu, MD, Institute of Health Services Management

Partnership: Constanta, Romania — Louisville, Kentucky

NIS/CEE Interviews

Daniel Verman, MD, Partnership Coordinator, Coordinator for Domestic Abuse;

Loti Popescu, MD, Coordinator for Sexually Transmitted Diseases;

Health Promotion and Health Education Department, Public Health Authority

U.S. Interviews

Virginia Kelly Judd, Humana Foundation

Partnership: Dubna, Russia — La Crosse, Wisconsin

NIS/CEE Interviews

Yury Komendantov, Deputy Mayor of Dubna

Irina Makarova, Deputy Head of Dubna City Health Department and Dubna Partnership Coordinator

Julia Muravievskaya, Leading Specialist, Dubna City Health Department. and Partnership Information Coordinator

Valerie Prokh, Mayor of Dubna

Sergey Riabov, Head of Dubna City Health Department

Olga Tarasova, Director of Dubna Diabetes School

Sergei Udin, Chief Physician, Krasnogorsk City Clinical Hospital #2 (replication site)

U.S. Interviews

Patrick Killeen, Director of Managed Care, Gundersen Lutheran, La Crosse

Sandra McCormick, US Partnership Representative, Vice President, Lutheran Hospital

Kermit Newcomer, MD, President Emeritus, Gundersen Lutheran, La Crosse

Barbara Pretasky, La Crosse

Lisa Radtke, La Crosse

Partnership: Khabarovsk, Russia — Lexington, Kentucky

NIS/CEE Interviews

Dr. Igor Zubanenko, MD, Chief Physician;
Ludmila V. Ipgefer, MD, Deputy Head;
Valentina Efremova, Chief Nurse;

Evgeniy Asachenko, MD, Deputy Chief Physician on In-hospital Work;
Albert A. Kanchuga, MD, Deputy Chief Physician on Out-patient Work;
Antonina Goryunova, Information coordinator; Pereyaslavka Rayon Hospital and Polyclinic

Natalia Rebova, MD,

Elena Poplevskeya, MD, Obstetrics and Gynecology;

Svetlana Polyakova, MD, Psychiatry;

Elena Tokareva, MD, General Practice Clinic;

Tatiane Yelizarova, MD, General Practice; Khor Hospital

Irinia Olovyamniokova, Midwife

U.S. Interviews

Elizabeth Schulman, PhD, US Partnership Coordinator, Assistant Professor, Department of Health Services, College of Allied Health Professions, University of Kentucky

Partnership: Kurgan and Schuche, Russia — Fox Cities, Wisconsin

NIS/CEE Interviews

Michael Faerberg, MD, Partnership Coordinator (Kurgan), Chief Doctor, Kurgan Maternity House

Ludmila Mitina, MD, Partnership Coordinator (Schuche), Deputy Chief Doctor, Central Rayon Hospital

Partnership: Moscow, Russia — Chicago, Illinois

NIS/CEE Interviews

Yuri Perov, First Deputy General Director, Medical Center of the General Management Department of the President of the Russian Federation

Alexander Nikolaev, MD, Partnership Representative, Chief Physician;

Marina Ugryumova, Partnership Coordinator, Head of the International Patient Department;

Marina Ayvazyan, Administrative Assistant, International Patient Department;

Central Clinical Hospital #1

Tatiana Blinoxvatova, Chief Nurse, Director, Nursing Learning Resource Center

U.S. Interviews

Sharon Weinstein, US Partnership Representative, Executive Director, The Premier Foundation, Premier, Inc.

Partnership: Moscow, Russia — Boston, Massachusetts

NIS/CEE Interviews

Oleg Rudkovsky, Chief Physician;

Andrei Lishansky, MD, Partnership Coordinator, Deputy Chief Physician;

Galina Gvozdeva, Chief Nurse;

Larisa Spirina, Nurse Educator;

Alexander Turchev, Infection Control Physician; Pirogov First Municipal Hospital

U.S. Interviews

Diane Hanley, RN, MS, US Partnership Representative, Nursing Research and Development, Brigham and Women's Hospital

Partnership: Moscow, Russia — Pittsburg, Pennsylvania

NIS/CEE Interviews

Alexander Marachev, Head, Women's Wellness Center, Chief of Pathology, Savior's Hospital for Peace and Charity

Vadim Lopukhin, Chief Physician, Obstetrics-Gynecology Service, Birth House

Chestova Iana, Representative, Magee Womencare International

U.S. Interviews

Jeanne Cooper, US Partnership Coordinator, Community Outreach Coordinator, Magee Womencare International

Partnership: St. Petersburg, Russia — Atlanta, Georgia

NIS/CEE Interviews

Larisa Kochorova, MD, Partnership Representative, Director, Medical Center;

Professor Al-Shukri Salman, Vice Rector for International Relations;

Nikolay I. Vishnjakov, MD, PhD, Chief of the Department of Social Medicine and Management;

Edwin E. Zvartau, Professor, MD, PhD, Research Director, Valdman Institute of Pharmacology, Head, Department of Psychopharmacology; St. Petersburg State Medical University in the name of Pavlov

Irina Bakhtina, MD, Dean, St. Petersburg Postgraduate School of Nursing

Partnership: St. Petersburg, Russia — Louisville, Kentucky

NIS/CEE Interviews

Jakov A. Nakatis, MD, Partnership Coordinator, Professor, President;

Rimma N. Grigorieva, MD, Information Coordinator, Vice-President;

Farit N. Kadyrov, Doctor of Economy, Vice-President of Economy;

Gallina Orlova, Chief of Nursing;

Farit Kadirov, Chief Financial Officer; Medical Center of St. Petersburg in the Name of Sokolov

U.S. Interviews

Jane Younger, US Partnership Representative, Vice President, Clark Memorial Hospital, affiliate of Jewish Hospital

Partnership: St. Petersburg, Russia — Boston, Massachusetts

NIS/CEE Interviews

Ludmila P. Zueva, Partnership Coordinator, Vice Rector for Postgraduate Studies, St. Petersburg State Medical Academy in the name of I.I. Mechnikov

Partnership: Sakhalin, Russia — Houston, Texas

NIS/CEE Interviews

Alla Lyubimova, MD, Partnership Coordinator, Chief Doctor;

Anatoliy V. Bourdasov, MD, Deputy of Chief Doctor; Korsakov Central Rayon Hospital

Gehhady Golodnekov MD, Deputy Director, Crisis Center
Elena Osatova, psychologist, Crisis Center

U.S. Interviews

Sara Rozin, US Partnership Coordinator, Baylor College of Medicine, Houston

Partnership: Sarov, Russia — Los Alamos, New Mexico

NIS/CEE Interviews

Sergey Okov, Partnership Coordinator, Chief Doctor, Central Medical-Sanitary Unit #50

U.S. Interviews

Phil Hertzman, US Partnership Coordinator, Medical Director, Los Alamos Medical Center

Partnership: Snezhinsk, Russia — Livermore, California

NIS/CEE Interviews

Sergey Skorobogatov, MD, Partnership Coordinator, Chief Doctor, Central Medical Unit #15

Partnership: Stavropol, Russia — Cedar Rapids, Iowa

U.S. Interviews

Phil Latessa, President, Iowa Hospital Education and Research Foundation

Partnership: Stavropol/Samara, Russia — Iowa

NIS/CEE Interviews

Vassily Pavlov, Partnership Coordinator, Deputy Head, Oblast Health Administration
Olga Chertukhina, Head;
Valentina Brovchenko, Deputy Head; City Health Administration, Samara
Lidia Fedosyeeva, Chief Physician, Samara City Out-Patient Clinic #15
Vladimir Adaikin Chief Physician, Samara City Qut-patient Clinic #9

Partnership: Petrzalka, Slovakia — Kansas City, Missouri

NIS/CEE Interviews

Dr. Jana Cadyova, PhD, Administrative Board, Citizen's Association of Aid to Children at Risk

Sona Docolomanska, Manager, Hope Center

Beata Dobova, Social Worker

U.S. Interviews

Ross Marine, MHA, US Partnership Coordinator, Senior Vice President, COO, Trinity Lutheran Hospital/Health Midwest

Partnership: Ashgabat, Turkmenistan — Grand Forks, North Dakota

U.S. Interviews

Lonna Milburn, PhD, RN, US Partnership Coordinator, University of North Dakota College of Nursing

Partnership: Donetsk, Ukraine — Pittsburgh, Pennsylvania

U.S. Interviews

Irma E. Goertzen, CEO, Magee-Womens Hospital

Partnership: Kharkiv, Ukraine — La Crosse, Wisconsin

NIS/CEE Interviews

Dr. Oleksandr Serdiuk, Partnership Coordinator

Partnership: Kiev, Ukraine — Coney Island, New York

NIS/CEE Interviews

Dr. Mihail Natsuik, MD, Partnership Representative, Head Physician;

Dr. Guriev, Deputy Director; Emergency and Disaster Medicine Training Center

Dr. Yuri Klyatsky, Deputy Chief Physician, Medical Director, Kiev Ambulance Service;

Dr. Guyreve, Director of Disaster Management Program, EMS Training Center

U.S. Interviews

William Walsh, CEO, Coney Island Hospital

Partnership: Kiev, Ukraine — Philadelphia, Pennsylvania

NIS/CEE Interviews

Dr. Victor Dydichenko, MD, Partnership Representative, Center for Maternal and Child Health

Elena Sulima, Director, Neonatal Resuscitation Training Center, Kiev Maternity Hospital #7

Svetlana Purij, Chief Nurse, Children's Hospital #2

Lesia Yakovenko, Medical Director, Women's Wellness Clinic

U.S. Interviews

M. William Schwartz, MD, US Partnership Representative, Children's Hospital of Philadelphia

Patrick Storey, University of Pennsylvania School of Medicine

Susan Gennaro, University of Pennsylvania School of Nursing

Partnership: Kiev, Ukraine — Philadelphia, Pennsylvania

NIS/CEE Interviews

Dr. Zinaida Klimenko, Partnership Coordinator

U.S. Interviews

William E. Aaronson, PhD, US Partnership Coordinator, Temple University

Partnership: L'viv, Ukraine — Detroit, Michigan

NIS/CEE Interviews

Dmytro Dobriansky, MD, PhD, Associate Professor of Pediatrics, Department and Faculty and Hospital Pediatrics, Director, L'viv Regional NRP Training Center

Lubov M. Zatchek, Chief of the Centre, Regional Scientific and Training Centre of Emergency States of L'viv

Iryna W. Melnyk, Head of Casualty Ward, Therapeutist, Gomotoxicologist, Municipal Clinic the First Aid of L'viv

U.S. Interviews

Gail Warden, CEO, Henry Ford Health System

Partnership: L'viv, Ukraine — Cleveland, Ohio

NIS/CEE Interviews

Dr. Borys Lemishko, Partnership Coordinator

Yuriy Filts, MD, Chief, Department of Diagnostics, Information Coordinator, L'viv Clinic #5

Partnership: Odessa, Ukraine — Boulder, Colorado

NIS/CEE Interviews

Dr. Volodymyr Kolodenko, Partnership Coordinator, Pro Rector, Social Medicine and Healthcare Management Department, Odessa State Medical University

U.S. Interviews

Barbara Fisher, MSN, MHA, US Partnership Coordinator, Vice President, Boulder Community Hospital

Partnership: Odessa, Ukraine — Coney Island, New York

NIS/CEE Interviews

Dr. Vasili Gogulenko, MD, Partnership Representative, Director;

Dr. Grigory Tyapkin, Director, Learning Resource Center;

Dr. Kuidmilla Kapitonova, Director of Nursing; Odessa Oblast Hospital

Natalia N. Nizova, MD, PhD, Medical Department of Obstetrics and Gynecology, Dean of Postgraduate Education, Odessa State Medical University

Svetlana Posohova, Director;

Dr. Valentine Goloblunka, Executive Manager; Women's Wellness Center

U.S. Interviews

Terry Mancher, Chief Nurse Executive, Coney Island Hospital

Partnership: Uzhgorod, Ukraine — Corvallis, Oregon

U.S. Interviews

Mark E. Rampton, MD, Corvallis Family Medicine, P.C.

Partnership: Tashkent, Uzbekistan — Chicago, Illinois

NIS/CEE Interviews

Dr. Khamid Karimov, MD, Partnership Representative, Rector;

Dr. Kamil Akramov, Chief Doctor, 1-st Clinic;

Dr. Vlacheslav Avakov, Director,

Dr. Sergey Abdusalamov, Deputy Director, EMS Training Center;
Dr. Ravshan Azimov, Partnership Coordinator;

Dr. Allonur Saidov, Information Coordinator;

Dr. Ravshan Umarov, Director, Neonatal Resuscitation Training Center;

Dr. Dilmurod Yusupov, Director, Women's Wellness Center;

Dr. Svetlana Akhmedzhanova, Director, NLRC; Second State Medical Institute

U.S. Interviews

Fran Jaeger, MSW, DrPH, US Partnership Coordinator, Administrator, Perinatal Center, University of Illinois Hospital

Partnership: Tashkent and Fergana, Uzbekistan — Atlanta, Georgia

NIS/CEE Interviews

Faizulla Yuldashev, Partnership Coordinator, Director, Fergana Affiliate of the Republican Center of Urgent Care

U.S. Interviews

Brian Williams, Morehouse University School of Medicine

AIHA

Washington, DC

James Smith, Executive Director
Marty Saggese, Deputy Executive Director and Chief Financial Officer
Donald Harbick, Associate Executive Director for Partnership Programs
Bernice Bennett, Senior Program Officer
Eun-Joo Chang, Program Officer
Laura Kayser, Program Officer
Laura Faulconer, Program Officer
Kate Schecter, Program Officer
Mark Storey, Program Officer, Information and Communication Technology
David Sturgill, Information Associate
Irina Carnevale, Information Analyst / Webmaster
Suzanne Grinnan, Publications Manager
Evangeline Coleman-Crawford, Editorial Assistant

AIHA Board Members

Dennis Andrulis
Roger Bulger
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Alan Weinstein

CEE/NIS Regions — Regional Directors and Coordinators

Arsen Kubataev, MD, Regional Director, Caucasus
Nata Avaliani, MD, MPH, Program Coordinator, Caucasus
Zaza Varsimashvili, MD, Program Coordinator, Caucasus
Zhamilya Nugmanova, MD, PhD, Regional Director, Central Asia
Bauyrzhan Amirov, MD, Program Coordinator, Central Asia
Sanda Apostolescu, Country Coordinator, Romania
Victor Boguslavsky, MD, Regional Director, Russia
Alyona Gerasimova, Regional Director, West NIS
Anne M. Nowrocky, Senior Program Coordinator, West NIS
Ihor Nykolyn, Coordinator, Educational Projects and Logistical Support, West NIS

USAID

Washington, DC

Donald Pressley, Assistant Administrator, Bureau for Europe and Eurasia
George Ingram, Deputy Assistant Administrator, Bureau for Europe and Eurasia
Gene George, Director, Bureau for Europe and Eurasia
Mary Ann Micka, Bureau for Europe and Eurasia
Ray Kirkland, Associate Assistant Administrator
Forest Duncan, Health Development Advisor
Janet Kerley, Monitoring and Evaluation Specialist, Europe and Eurasia
Halla Assam, AAAS Fellow

Missions

Armenia

J.K. Cheema, PhD, Deputy Mission Director, Yerevan, Armenia
Kim Delaney, Director, Office of Democracy and Social Reform, Yerevan, Armenia
Anna Grigoryan, Project Management Specialist, Office of Democracy and Social Reform, Yerevan, Armenia

Caucasus

William McKinney, Country Coordinator, Baku, Azerbaijan
Khalid Hasan Khan, Humanitarian Assistance Specialist, Baku, Azerbaijan
Kerry Pelzaman, MPH, Chief, Health Division, Baku, Azerbaijan
Kent Larson, Chief, Office of Humanitarian Response/Social Transition, Caucasus
Catherine Fischer, Regional Health Specialist, Caucasus
Gegi Mataradze, P roject Management Specialist in Health, Caucasus, Tbilisi, Georgia
Central Asian Republics
Jennifer M. Adams, Director, Office of Social Transition, Regional Mission for Central Asia, Almaty, Kazakstan
Sholpan Makhmudova, Office of Social Transition, Mission for Central Asia, Almaty, Kazakstan
Tatiana Dementieva, Mission Representative, Central Asia, Bishkek, Kyrgyzstan
Cheri Vincent, MSPH, Health Advisor, Regional Mission for Central Asia, Tashkent, Uzbekistan
Alisher Ishanov, MD, PhD, Health Assistant, Regional Mission for Central Asia
Mary Skarle, RN, MSN, FNP, MPH, Public Health Management Specialist, Regional Mission for Central Asia

Romania

Susan C. Monaghan, DrPH, Senior Heath A dvisor, Bucharest, Romania

Russia

Kerry Pelzman, Mission Representative, Russia
Natalia Voziianova, Mission Representative, Russia

West NIS

Eliot J. Pearlman, MD, Senior Health Adviser, Office of Democracy and Social Transition, Mission Representative, West NIS, Kiev, Ukraine, Boris Uspensky, Reproductive Health Advisor, Kiev, Ukraine

Others

U.S.

Dennis Muscato, World e-inclusion, Hewlett-Packard Company, Corvalllis, Oregon

CEE/NIS

Lia Marmaladze, President, Georgia Nursing Association, Chief Advisor to the Minister of Health on Nursing Matters, Tbilisi, Georgia
Avtandil Jorbenadze, MD, Minister, Ministry of Labour, Health and Social Affairs of Georgia
Grace Hafner, RPh, MPH, Zdrav Refor m, Regional Office for Central Asia and Kazakhstan
Aukenova Tamara, MJD, Pavlodar Region Administration, Kazakhstan
Naken Kasiev, State Secretary of the Kyrgyz Republic and former Minister of Health, Bishkek, Kyrgyzstan
Dr. Guljigit Aaliev, Deputy Minister of Health, Bishkek, Kyrgyzstan
Mrs. Tamara Saktanova, Chief Nurse, Ministry of Health, Bishkek, Kyrgyzstan
Dr. Pamir Muratov, Head, Department of Education, Human Resources, Ministry of Health, Bishkek, Kyrgyzstan
Ministry of Health, Bishkek, Kyrgyzstan
Svatopluk Hlavacka, MD, Director, Health Care Organization and Management, Ministry of Health, Petrzalka, Slovakia
Dr. Babylova, Deputy Health Minister, Kiev, Ukraine
Dr. Zhanna Tsenilova, Head of the International Affairs Department, Health Ministry,

Kiev, Ukraine

Dr. Shipiro, Head, Infection Center and Chief Researcher, Institute for Infectious Diseases, Health Ministry, Kiev, Ukraine
Dr. Pischykov, former Head, Department of Prevention and Infectious Diseases, Health Ministry, Kiev, Ukraine
Jaroslav I. Dutkewych, PhD, Director, Peace Corps of the United States, Ukraine
Galina Frolova, Project Coordinator, Agribusiness Volunteer Program, The Citizens Network for Foreign Affairs Inc., Kiev, Ukraine
Dasmin Asadov, First Deputy of Minister, Ministry of Health Protection, Uzbekistan
Rikhsiniso Salikhodzhayeva, Chief Nurse, Ministry of Health, Tashkent, Uzbekistan

Appendix 5

USAID and the AIHA Partnership Program

Since it was established after World War I, USAID has operated in environments where countries were poor, people lacked education, and basic infrastructure for change was non-existent. When the Soviet system collapsed, the United States was presented with unique challenges and opportunities. The population was well educated, and the countries were industrialized. But the Soviet era had created stagnant and inefficient economic systems that, in many areas, had not been able to support basic social services.

Congress responded by passing the 1989 Support for East European Democracy Act (SEED) and the 1991 Freedom Support Act (FSA) that govern how aid is coordinated for Eastern Europe and the former Soviet Union, respectively. Shortly thereafter, some 20 Secretaries of State from most of the large industrialized countries of the world met in Washington, D.C. to coordinate humanitarian assistance to the NIS. That meeting was organized around six working groups in various traditional areas of humanitarian assistance including health, food, housing, and energy.

The United States and Japan chaired the working group that was examining medical assistance. The situation necessitated new USAID approaches. Based on a successful USAID strategy in the CEE, the United States proposed to establish hospital partnerships as a way to work cooperatively with skilled NIS health professionals and bring emergency assistance to a rapidly crumbling and bankrupt health care system. The hospital partnership initiative was one of those announced at the end of the meeting of the Secretaries of State.

Partnerships were viewed as a strategy that would effect change in a mutually cooperative manner. The Bureau for Europe, within USAID, had managed the partnership initiative established in the CEE. When the Soviet Union opened up, USAID created a bureau to address the needs of the NIS. Given the expanse of space and difficulty of communication, it was decided to create regional missions and country offices throughout the NIS.

Meanwhile in Eastern Europe, USAID had all ready begun establishing country missions. USAID merged CEE and NIS operations under the Europe and Eurasia Bureau (E&E). The E&E Assistant Administrator works closely with the Office of the Special Adviser for the NIS within the State Department on policies and budgets for the regions. The director of E&E conducts strategic planning and budgeting in collaboration with the State Department's Office of the Special Adviser for the NIS. E&E manages matters of personnel and operations. USAID missions must routinely demonstrate quick, measurable results to E&E in order to justify budgets and successfully obtain new funding. The performance measurement system that documents these results is the "R-4" process. In this environment, programs that emphasize structural change and a longer cycle of activity (such as the Partnership Program) are under fiscal pressure.

Although USAID managed the original CEE health partnerships through individual contracts, the NIS partnership program that began in 1992 was structured differently. The old system of individual contract management required considerable USAID management involvement. When establishing the new partnership program, the agency chose to establish a consolidated program under the direction of one organization that was knowledgeable in hospital management and health care delivery. USAID convened a meeting of groups representing nearly all the hospitals in the United States and asked them if they were interested in taking on the challenge. After some thought, these groups formed AIHA, with Jim Smith as Executive Director. A non-competitive, three-year cooperative agreement was signed, and less than two months after the meeting of the Secretaries of State, representatives from AIHA traveled to the NIS and to set up partnerships. (A list of the founding AIHA groups and its current Board of Directors appears in Appendix 2.)

Nearly all of the initial AIHA trips and early work in the NIS occurred where there were no USAID country missions (except for Moscow) and few State Department representatives. AIHA established relationships with NIS ministries of health, and U.S. partners initiated work as the USAID missions were being staffed. The early program was primarily designed to bring technical assistance and some supplies to the NIS and to provide a single organization to funnel and coordinate assistance. This program generated tremendous enthusiasm as one of the early successes of USAID's efforts in the former Soviet Union.

Over the three years of the original cooperative agreement, the United States established diplomatic missions in all the new countries. USAID moved rapidly to establish its own structure. Four regional offices—in Moscow, Kiev, Almaty, and Tbilisi—coordinate and oversee U.S. assistance. USAID—which has traditionally vested a good deal of authority in overseas missions—chose to have regional missions oversee the strategy for each region, with countries in the region reporting through these regional missions. As they gained their footing, the missions sought ways to improve assistance to the evolving countries, and they engaged in discussion with AIHA on how their efforts applied to the Partnership Program. Meanwhile, the Partnership Program also matured from providing emergency assistance to seeking ways to meet the needs of the diverse communities served. During this period, AIHA was awarded a second cooperative agreement to manage partnerships in Central and Eastern Europe. In May 1995, most NIS program activities were consolidated under this second cooperative agreement.

In 1998, USAID decided to extend the health care Partnership Program, but regional and country missions felt that a new program needed to address more directly the strategic needs of each country and region and focus more on community health. The resulting request for assistance (RFA) called for four sub-regional cooperative agreements and a region-wide agreement under the framework of an unfunded, overarching NIS cooperative agreement (the basic agreement). After considering the responses to this integrated RFA, USAID awarded all six of the new cooperative agreements to AIHA and required that they be managed through five separate financial accounts.

During the same period, AIHA broadened its organizational structure and established regional offices where USAID had located its missions. In all cases, host country nationals head these offices, but a U.S. comptroller serves on the staff. USAID funds continue to support U.S. institutional partnership volunteer activities. Most funds have been expended for travel, training, and equipment to enable the partnerships to succeed.

The 1998 cooperative agreements were structured to achieve broad regional and community impact. Programs in such areas as healthy communities, women's health, and infection control were emphasized. These programs were to respond directly to needs identified by USAID missions. AIHA was aware that the regional USAID missions had not fully bought into the original Partnership Program and that the missions sought greater control over AIHA—much as they might have over a contractor. In an attempt to address these concerns, AIHA and USAID regional offices, at the beginning of the three-year cooperative agreement, arrived at mutually agreed upon program goals.