Making Women's Wellness Sustainable

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EXECUTIVE SUMMARY

A. Background

The American International Health Alliance (AIHA) was established in 1992. It operates under cooperative agreement with the United States Agency for International Development (USAID) to establish, support and manage partnerships between health care institutions in Central and Eastern Europe (CEE) and the New Independent States (NIS) of the former Soviet Union and their counterparts in the United States (U.S.).

The Women's Wellness Center model was developed by the AIHA Women's Health Initiative Task Force, a joint NIS and U.S. task force comprised of women's health clinicians and educators associated with the partnership program. The Women's Wellness Centers represented a new model of health care delivery for women. It emphasized health and well-being and focused on prevention.

AIHA has established 15 Women's Wellness Centers in eight countries within NIS and CEE. The Women's Wellness Centers were built upon AIHA hospital partnerships, using existing programs and administrative structures that have already been developed by the partnerships. These partnerships are based on peer-to-peer relationships of health care providers, and focus on solutions to health care delivery problems that are both technologically and economically sustainable in the host countries. The partnerships also address several key interrelated elements of health care reform, one of which includes a re-orientation towards primary care. There are 42 partnerships operating in nine countries of CEE and 11 republics of the former Soviet Union. In addition to coordinating partnerships between health institutions in CEE and NIS and the U.S. counterparts, AIHA also manages 11 cross-partnership programs including the Women's Wellness Initiative.

During the past two years, AIHA staff has received significant anecdotal evidence promoting the success of the Women's Wellness Initiative. AIHA has also received requests from ministries, oblast officials, and international organizations to replicate the model in new territories. However, there has not been a comprehensive analysis of the Women's Wellness model. In order to advance this wellness model successfully and

provide improved health services in more areas of the region, the fundamental elements that make the Women's Wellness Centers sustainable must be identified and analyzed. In October 1999, AIHA recruited four graduate students from New York University's Robert F. Wagner Graduate School of Public Service to conduct an evaluation of AIHA's Women's Wellness Centers. The purpose of the study was to answer three questions about the Women's Wellness Centers:

- What makes the WWC model sustainable?
- What are the factors that contribute to success and patient satisfaction?
- What supports the long-term growth of existing centers?

B. Methodology

The evaluation was designed to be a qualitative evaluation of the essential components of sustainability at three Women's Wellness Centers. The study examined sustainability during a two-week site visit in January 2000, from the following perspectives: organizational stability, financial stability, and patient satisfaction. The sites in the evaluation included Women's Wellness Centers in Dubna, Russia; L'viv, Ukraine; and Tashkent, Uzbekistan.

In an effort to minimize bias, sustainability was examined from multiple perspectives. This approach, known as triangulation, provides validity to findings by avoiding distortion and stultification that single measures of performance may produce. Data was collected through interviews, observations, sampling patient records and a review of Center records. Interviews were conducted over two days at each Center with 32 staff members (including the Directors), two hospital officials, two local health officials and 59 patients. Observations, unaided by AIHA staff, were also conducted over the course of two days. Fifty patient records were randomly pulled and examined at each of the three Centers. Lastly, other documents on topics such as sexually transmitted information, contraception, inventory, and finances, when available, were also examined.

C. Findings

Organizational Stability

The Women's Wellness Centers evaluated appear to have achieved a high degree of organizational stability.

Mission

The study found that the mission of the Women's Wellness Centers was clearly understood by a majority of staff members. Staff interviewed consistently responded with a similar vision, one of "providing women with comprehensive health care services," or "promoting healthy lifestyles," and the "prevention of disease." The mission is viewed as a competitive advantage by Center staff, that distinguishes them from other health care services.

Clear physical manifestations of the mission exist as well. Each Center had a sign at or near the entrance that welcomed patients to the Women's Wellness Centers. These signs mark a departure from the traditional Women's Consultation Centers and welcome patients to an independent and unique approach towards women's health. Additionally the Centers were well lit, cheery and comfortable.

The focus on education programs also promotes and furthers the mission of the Centers. Each Center had a patient education space, complete with TV, VCR and educational materials. Workshops were also organized on a variety of topics and held at the Center, in local schools and in the workplace.

Training

The study found that training was a critical aspect of organizational stability. AIHA and the Women's Wellness Centers' U.S. partners have offered a number of training and medical exchange opportunities. The training sessions varied at each Center, ranging in topics from building organizational stability and management practices to utilizing new equipment and other technical medical skills. These training sessions were highly valued by staff, as they supported the mission and aided in building operational capacity at each Center.

Leadership

The study found that the Women's Wellness Centers Directors were innovative and mostly engaged in autonomous decision making. According to the Director interviews, the factors of successful leadership are autonomy and innovation. Under the leadership of the current directors, the Women's Wellness Centers in this evaluation can point to a number of innovative initiatives. They include:

- The use of the Internet to reach university-age women and provide them with a forum to discuss health issues
- The establishment of satellite Centers to expand the reach of the Center into under served communities or to initiate fee-for-service activities that will cross-subsidize the original Center
- Partnerships with pharmaceutical companies to publish educational materials in the local language
- Partnerships with NGOs and health care agencies to increase the inventory of educational maaterials at the Center
- Gaining recognition from the Ministry of Education to expand school-based educational programs
- Creating spreadsheet programs to track patient flows per doctor.

Financial Stability

The Centers experienced both internal and external challenges to financial stability. All three Centers were units of larger health care institutions and had very little control over internal challenges to their financial stability. Thus, the Center's financial relationship with the parent hospital is a double-edged sword. The advantages are clear: they do not have the burden of daily financial management as the central finance administration of the parent organization assumes responsibility for the payment of utilities, communications and salaries and other operational expenses. However, disadvantage of not having budgetary and financial decision-making power is also conspicuous in the slow development of financial management tools. The centralized nature of financial management at the hospitals had negative implications for the Centers. For instance, all

three Centers lacked a strategic plan that monitored cash flow, projected revenues and planned for future capital investments.

Innovation and a number of best practices characterized responses to external challenges of financial stability. In areas where the Centers were able to exert control, all three Women's Wellness Centers had done so successfully, particularly when addressing the challenge of maintaining or expanding services in the face of reduced funding.

Patient Satisfaction

The long-term growth of each Center is related in part to the ability of the Centers to continue to attract patients. Patient satisfaction, was the result of the doctor-patient relationship, the patient's perception of new and western equipment, the warm and inviting physical environment, short waiting times, the integrated approach to health care and the potential for educational opportunities. This study found that patients are currently satisfied with service at each of the three Centers.

B. Conclusion and Recommendations

This study used a model of sustainability is that is drawn from a combination of organizational stability, patient satisfaction and financial stability. The Women's Wellness Centers in Dubna, L'viv and Tashkent have achieved an impressive level of organizational stability and patient satisfaction. The financial stability of the Centers, however, is not as easily assessed but the study found that the Centers have as much financial stability as comparable institutions.

The answer to the question of sustainability, particularly financial stability, is, perhaps, linked with the factors of success. The factors of success include the considerable tangible and intangible inputs from AIHA, USAID, the U.S. and Russian partners. Unfortunately, this evaluation is unable to determine how long the Centers will be able to sustain these factors of success independent of AIHA or partner support.

The long-term growth of the clinic, however, was directly related to the ability of the Centers to continue to perform at current levels or higher. Sustaining patient satisfaction therefore is the tool with which to maintain and increase the Centers' current level of activity. Patient satisfaction requires multiple efforts, all of which require money.

In an effort to support the continued growth and expansion of Women's Wellness Centers, the study recommends three strategies:

- Creation of an NIS-based Women's Wellness Center NGO;
- Promotion of Creative Strategies toward the development of patient education programs;
- Promote the use of Information Technology.

INTRODUCTION

A. The Partnership Idea

The American International Health Alliance was formed in 1992 to establish and manage partnerships and cross-partnership programs. The partnerships are founded on volunteerism and community-based programs to improve the health care of individuals in the New Independent States (NIS) of the former Soviet Union and in Central and Eastern Europe (CEE). AIHA operates under a series of cooperative agreements with the U.S. Agency for International Development (USAID) and a grant from the U.S. Department of Energy.

Since 1992, AIHA has supported more than 80 partnerships with its successful partnership model that focuses on peer-to-peer relationships between health care providers in 21 nations. The focus of the partnerships is on solutions to health care delivery problems that are technically and economically sustainable in the host countries. Key elements of the health care reform include a re-orientation toward primary care and the development of resource management.

In addition to coordinating partnerships between the health institutions in the former Soviet Union and U.S. counterparts, AIHA manages 11 cross-partnership programs, one of which is the Women's Wellness Initiatives.

B. History of The Women's Wellness Vision

In the mid-1990's, the American International Health Alliance launched the Women's Health Initiative with the formation of an AIHA Women's Health Task Force. The Women's Health Initiative has one goal: to improve the health of women in the NIS by addressing their unmet health need. Out of this Initiative, the WWC model was created to serve as a highly visible comprehensive model for addressing and managing the health care needs of women through an effective programmatic mix of health promotion, education, early diagnosis, treatment and follow-up. In January 2000, there were fifteen

Women's Wellness Centers[1] in eight countries with two additional slated to open in Spring, 2000. The Centers are designed to introduce the concept of one-stop health shopping through collaborative integrated care and a client-centered approach to women's health care through services that address women's health needs throughout their life continuum.

The services of the Women's Wellness Centers provided in an ambulatory setting include family planning and reproductive health; perinatal care; STD/AIDS prevention, detection and management; cancer screening and education; mental health education; counseling and support groups related to depression, rape and domestic violence; substance abuse education and identification; chronic disease screening; education and referral management; health issues of older women; healthy lifestyle education and adolescent health programs. In addition to those services, the three Ukrainian WWCs have introduced a Breast Screening and early detection services that include mammography, education, screening, ultrasound, needle localization, counseling, referrals and follow-up.

C. Objectives

In the past two years, AIHA staff has received significant anecdotal evidence that the WWC initiative is successful. Center directors have reported a high level of patient satisfaction and Health Ministry support. They have received requests from ministry, oblast officials and international organizations to replicate the model in new territories. However, to date there has been no comprehensive analysis of the WWC model. In order to advance this model successfully and provide improved health services in more areas of the region, several fundamental questions need answers.

Among these are the following:

- What makes the WWC model sustainable?
- What are the factors that contribute to success and patient satisfaction?
- What supports the long-term growth of existing centers?

[1] "Staff and Partner Directory: WWC's." American International Health Alliance Online. <http://www.aiha.com/english/aiha/aihadir/wwc.htm>.

D. Scope

Women's Wellness Centers face enormous challenges to sustainability. They operate in economic and social environments that make stability and planning tenuous. The great need for women's health care services in their communities makes it difficult to prioritize services and manage their limited resources. Finally, the transitional nature of the economies of the former Soviet Union makes financial management or revenue diversification a near impossible task.

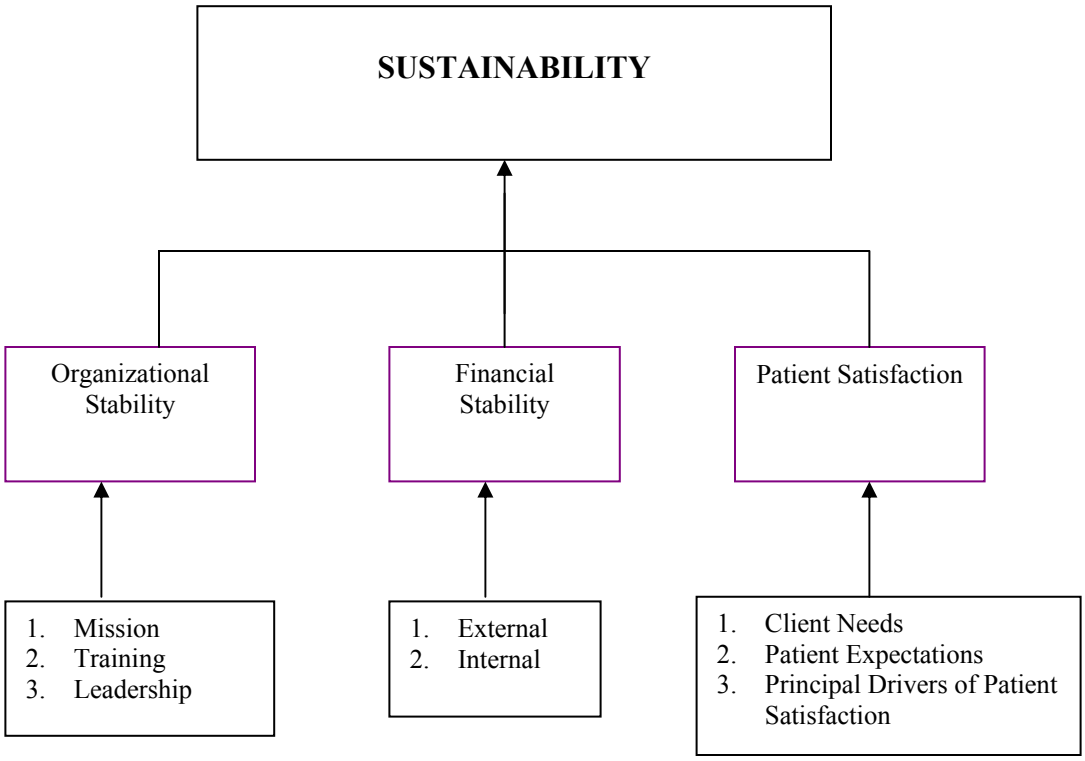
Sustainability is a complex notion. The Family Planning Handbook[2] defines sustainability as "the ability of a program to provide quality services to its clients, expand its scope of services and client base, increase or maintain demand for services, and generate income from the program through local funding mechanisms, while decreasing its dependence on funds derived from external donors." In other words, sustainability is the product of organizational stability and planning, patient satisfaction and a diverse financial foundation.

For this study, an adaptation of The Management Science Health Model as developed in The Family Planning Handbook[3] was used. This model depicts causal relationships from specific practices such as a strong mission and internal financial controls to intermediate individual strategic objective results, such as organizational stability or financial stability. The model also portrays the causal relationship between the strategic objective and the achievement of a broad program goal—in this case, sustainability.

[2] *The Family Planning Manager's Handbook*. "Making Your Program Sustainable" <http://erc.msh.org/fpmh_english/chp10/p1.html>

[3] *Ibid.*

Figure 1. The Management Sciences Health Model



i. Organizational Stability

Organizational stability is comprised of three components as Figure 1 describes. The first is the importance of mission statements.[4] In any organization, a mission statement is important as it serves external and internal functions. Externally, the mission characterizes the organization, defines its purpose, and establishes short-and long-term goals. Internally, the mission is then able to attract the right staff, motivate them, and provide a common platform to evaluate the success of the organization. Despite the intangible qualities of a mission statement, it is a vital component of organizational stability.

[4] Oster, S. M. "The Mission of the Nonprofit Organization". *Strategic Management for Nonprofit Organizations: Theory and Cases.* New York: Oxford University Press (1995): 17-28.

Training is the second component of organizational stability. Staff training aims to provide a strong system of management that imparts new skills and develops an organizational ethos. The vision of Women's Wellness Centers- new technical skills, clinic practice guidelines, proper use of equipment, and a team approach- are all taught. It is important for these skills to be modeled and integrated into daily practice, for the concepts to become second nature. These concepts and skills are believed to build capacity at each Center[5]. Building capacity in an organization translates into leadership skills in managers, strengthens effective planning, helps to maintain effective recruitment procedures, and develops processes that promote institutional, programmatic and financial sustainability. Developing and improving these skills enables NGOs, CBOs and public sector health programs to make rational management decisions and provide sustainable high-quality health services to their patients.

The third component of organizational stability is leadership. Strong, committed, innovative and visionary leadership is critical to an organization and its stability. A leader is someone who can anticipate what may be possible, and can envision new services, new markets, new sources of revenue, or new ways of cutting costs. A leader is one who can plan for future constraints and opportunities and adjust to changing circumstances in order to ensure the organization's survival.[6] Skills that are critical to strong leadership are included in Appendix D.

ii. Financial Stability

The second determinant of sustainability is financial stability. Both internal financial management and external demands influence the financial stability of an organization. Internal financial management is based upon the classic elements of the financial management cycle. They are:

- budget preparation
- projecting revenues and monitoring cash flow
- controlling and managing funds

[5] *The Family Planning Manager's Handboo.* "Developing Organizational Stability." <http://erc.msh.org/fpmh_english/chp10/p2.html>.

[6] *Ibid.*

- financial monitoring
- determining and comparing the cost of services
- meeting both donor and institutional reporting requirements
- understanding and using financial reports for decision making.

The internal challenges to stability may be the inability to perform those functions, i.e. any threat to the cycle of providing services, receiving cash, paying for expenses, and reporting to donors and other outside sources on the use of funds that have been provided. (See Appendix E)

The external challenges are many. They include maintaining or expanding services in the face of reduced funding from donors or governments, creating alternative financing sources, comparing the effectiveness of different service approaches or sites, and meeting the different reporting and procedural requirements of multiple funding sources.[7] The best defenses against external challenges involve minimization of risk and a diversification of revenues. This protects capital investments and ensures stability in daily operations. Taken together, this will ultimately promote the sustainability of operations.

iii. Patient Satisfaction

Patient satisfaction is the third component in maintaining the sustainability of the Women's Wellness Centers. Satisfied patients generate client demand. A satisfied patient means a return patient and perhaps a referral source[8]. A dissatisfied patient may serve as a detriment to the practice. Patient satisfaction is comprised of:

- The principal drivers of patient satisfaction
- Client needs
- Patient expectations.

[7] *Ibid.*

[8] *The Family Planning Manager's Handbook*. "Creating Client Demand and Expanding The Client Base". <http://erc.msh.org/fpmh-english/chp/chp10/p3.html>.

E. Methodology

The study was completed by graduate students at The Robert F. Wagner School of Public Service at New York University for American International Health Alliance (AIHA) during a two-week site visit in January 2000. The focus of the study were the Women's Wellness Clinics in L'viv, Ukraine; Dubna, Russia and Tashkent, Uzbekistan.

This evaluation is a qualitative study of the essential components for sustainability of three Women's Wellness Centers. The three essential components identified in this study include organizational stability, patient satisfaction and financial stability.

The research design of this project aimed to bring more than one research method to bear on the topic of sustainability. In developing a variety of data collection techniques, this study sought to avoid single measures of performance. This approach, called triangulation, looks at the issue from multiple perspectives and provides validity to the findings by avoiding distortion and stultification that single measures of performance can produce.

The data collection process focused on four methods: interviews, observations, sampling patient records, and review of Center records.

Interviews The evaluation interviews took place over two working days at each site. Interviews were conducted with patients, Center staff, Center directors, hospital administrators and local health officials. As can be seen in the table below, 59 patients, and 32 staff (including directors) were interviewed.

INTERVIEWS At Women's Wellness Centers	DUBNA	L'VIV	TASHKENT
DIRECTOR	1	1	1
HOSPITAL ADMINISTRATOR	1	1	0
LOCAL HEALTH OFFICIAL	1	0	1
PATIENTS	15	24	20
STAFF	9	12	12

The range of age of patients was 19-53 in L'viv, 18-51 in Dubna and 14-45 in Tashkent. Out of 59 women interviewed in three sites, 42 were regular and 17 were first-time patients.

Additionally, evaluators had the opportunity to conduct informal conversations with hospital administrators and local health officials. The interviews were carried out in a private room and each staff member or patient was informed at the outset that their responses would remain confidential. The interviewers were assisted with a translator for the full duration of the interview.

Observations A Quality Management Checklist was developed to facilitate observation[9]. The QMC indicators focused on the physical appearance, availability of educational materials and infection control. The checklist was completed over the course of the two-day visit independent of other data collection efforts.

Patient Records Fifty patient records from each Clinic were examined, and information was extracted and documented.[10] The researcher worked with an interpreter. The patient records provided an overview of patient demographics and characteristics.

Center Records Information on contraceptive inventory, patient visits and STD treatment information were requested from the Director at each Clinic. Follow-up questions, as necessary, were posed to the Directors for purposes of clarification.

F. Limitations

Time was a factor in this study. Ideally, a longer period of time at each Clinic would have been possible. This would have provided a greater amount of time for data gathering and reflection.

[9] See Appendix G for a sample Quality Management Checklist.
[10] A copy of the Patient Record Checklist is attached in the Appendix H.

The visit to the WWC in L'viv, Ukraine, fell during the Orthodox holidays. As a result, patient traffic was slower than on an average day, which limited the evaluators' ability to speak with patients and get a full picture of the Center during normal operations.

Site selection may have also been a factor. The selection of WWC's visited was conducted by AIHA. The decision was made based on Center size, location, the financial organization of each site and ease of coordinating travel.

Language was also a barrier. Despite working with mostly excellent interpreters, the lack of language skills may have influenced data collection and interpretation. Additionally, at two of the three[11] sites, one interpreter was absent on the first day. This limited the number of staff and patient interviews conducted.

Further, Women's Wellness Center staff may have been perceived the NYU evaluators as AIHA staff instead of independent investigators. As a result, some staff may have felt apprehensive about the evaluation inquiries and cautious when answering survey questions. AIHA staff was occasionally present during interviews. This may have added to any uneasiness experienced by interviewees.

The evaluation process may have disrupted the daily work of the WWC due to space limitations. The interviewers used working offices and accommodated interruptions during the interview. In one Center, the Director sat in on several interviews and was presented with a copy of all questions asked of the center's staff. While this was impossible to avoid, the presence of other staff undermined the notion of confidentiality and could have influenced the respondents' answers.

Finally, financial data was difficult to procure. Financial records are kept by a central source and financial decision-making is generally in the domain of an external hospital officer. The WWC Directors were all forthcoming and helpful but in many cases did not have access to adequate amounts of information that could provide full financial detail of the WWC.

[11] The evaluation staff was short interpreters in Dubna and Tashkent.

FINDINGS

A. ORGANIZATIONAL STABILITY

The Women's Wellness Centers in this evaluation appear to have achieved a high degree of organizational stability. The table (1) below represents a snapshot of the centers.

At a glance…	DUBNA (N=50)	L'VIV(N=50)	TASHKENT (N=50)
Patient Visits			
Total, 1999[18]	13036	14017	16107
% New Patients	36%	74%	40%
% Repeat Visits	64%	26%	60%
Geographic Spread			
% From Local Area	98%	64%	86%
% From Outside City	2%	26%	14%
Age Spread			
18 and Under	0%	0%	2%
19 – 35	46%	40%	58%
36 – 55	38%	54%	40%
56 and older	16%	6%	2%

Note: Patient volume data is taken from WWC records.

Table 1. Current Snapshot

i. Mission

The staff of the Women's Wellness Centers demonstrated thorough knowledge and understanding of the Centers' missions in the interview portion of the evaluation. When asked, "What is the mission of the Women's Wellness Center?," staff consistently responded with a similar vision. Interviewees spoke of "providing women with comprehensive health care services," or "promoting healthy lifestyles," and the "prevention of disease."

The staff sees their mission as a competitive advantage. In the evaluation interviews, staff was asked "What makes your Center unique?" The majority of responses included a reference to the mission of the Center. Staff felt that their Centers differentiated most from other health care institutions based upon their overall approach to women's health.

There are clear physical manifestations of the mission. The Women's Wellness Centers had a well-lit and comfortable waiting area. There were adequate seats for patients to use while they wait. The rooms were painted in bright and cheery colors and were decorated with plants, artwork and educational posters. There were signs either at or near the entrance to the Centers clearly announcing the Women's Wellness Centers. Patient education rooms were available in the Centers.

What makes your Center unique?

"The staff, the training and the educational opportunities in Chicago. We try to be similar to them and try to look like them."

- Nurse in Tashkent

Finally, patient education programs represent the programmatic extensions of the mission. The Women's Wellness Centers have a scope of activity beyond patient treatment. The Centers have invested resources, financial and human, into the development of patient education programs. Each Center had a patient education Center, complete with TV, VCR and educational materials. The Centers also organize workshops on a variety of topics, including partnership and delivery[12], breast self-exams, osteoporosis, menopause education and family planning and sexual health. The workshops are held at the Center, in local schools and in the workplace.

The table (2) details contraceptive and family planning methods available at each clinic.

Contraceptive Method	Women's Wellness Center		
	Dubna	**L'viv**	**Tashkent**
Oral Contraceptive	√	√	√
IUD	√	√	√
Injectables	√	√	√
Condoms	√	√	√
Diaphragm	Not available	√	Not available
Natural Family Planning	√	√	√
Female Sterilization	√	√	√
Emergency Contraception	√	Not available	Not available

Table 2: Contraception Available at Each Women Wellness Center

[12] Partnership and delivery programs are for both fathers and mothers and seek to promote prenatal health.

ii. Training

AIHA and the U.S. partners provided ongoing technical assistance and consultation to each Center through the establishment and maintenance of professional information exchange and continuing education programs. The topics of the educational programs included:

- Practice guidelines: clinical protocols and operational
- Policies
- Client-centered model of women's health care
- Family planning and health education
- Non-communicable disease prevention
- Breast health training
- Prepared childbirth
- Management training
- Center design and management
- Business planning development
- Infection control and safety
- Domestic violence

In addition, AIHA sponsored workshops to develop and implement a WWC database and a clinical practice guidelines reference manual for use at each WWC. The Breast Health Initiative partners and Task Force have sponsored a study tour, specific breast health training exchanges and two workshops addressing clinical practice guidelines, referral protocols, skill development and quality assurance. In addition, AIHA collaborated with PATH (Program for Appropriate Technology in Health) to develop and disseminate breast health educational materials.

The comprehensive Women's Wellness Center training program has, in the opinion of the staff, improved professional skills. A majority of the staff who participated in the evaluation interviews indicated that they had participated in an AIHA-sponsored training program. Staff felt that the training programs "taught them new skills," and "helped them to understand the possibility of women's wellness." Additionally, staff commented that

the training programs promoted "teamwork" at the Center and helped them to become "experts in the field of women's health."

The training programs have also influenced the image that patients have of the Centers. Staff believe that patients are drawn to their Centers because they offer the “best-trained staff,” know how to use the most “modern” equipment and treat the patients with respect, each of which was cited as a direct result of the medical exchange with the U.S. partners.

What factors do you think contribute to the success of the Clinic?

“Excellent managers, nurse manager and the director. A small team-oriented staff that works well together. And people who connect to their work.”

-Nurse in Dubna

Women's Wellness Center staff, in the evaluation interviews, identified future training as critical to the success of the Centers. Staff turnover means that some staff has not had the opportunity to participate in a training program and other initiatives would benefit from follow-up. This is the case for the clinical practice guidelines. Clinical practice guideline manuals have been developed in a series of trainings and meetings with the WWC directors, partners and AIHA staff. WWC Staff interviewees indicated unanimously in all three Centers that they had not participated in any training devoted specifically to the guidelines. Consequently, many staff members are only aware that such guidelines exist in theory, but have not been trained or use the guidelines.

iii. Leadership

According to the Center Directors, the factors of successful leadership are autonomy and innovation.

Autonomy in decision-making provided two of the Directors the ability to select their own staff and put together the right team. In the evaluation interviews, all of the Directors repeatedly underscored the importance of the "team approach" to the success of the Centers. The team approach promotes, according to the Directors, efficient coordination

of services, the maintenance of a pleasant and friendly atmosphere, short waiting times and the resources to solve problems.

Innovation helps to promote the long-term success of the Centers. Under the leadership of the current directors, the Women's Wellness Centers in this evaluation can point to a number of innovative initiatives. They include:

- The use of the Internet to reach university-age women and provide them with a forum to discuss health issues
- The establishment of satellite Centers to expand the reach of the Center into under served communities or to initiate fee-for-service activities that will cross-subsidize the original Center
- Partnerships with pharmaceutical companies to publish educational materials in the local language
- Partnerships with NGOs and health care agencies to increase the inventory of educational aids at the Center
- Gaining recognition from the Ministry of Education to expand school-based educational programs
- Creating spreadsheet programs to track patient flows per doctor.

B. Financial Stability

All three Women's Wellness Centers in this study have very little control over internal challenges to their financial stability. The Centers are units of larger health care organizations. As such, they enjoy the advantage of not having the burden of daily financial management. The central finance administration of the parent organization assumes responsibility for the payment of utilities, communications, salaries and other operational expenses.

The Center's financial relationship with the parent hospital is a double-edged sword. The disadvantages of not having budgetary and financial decision-making power are evident in the lack of, or slow development of, financial management tools. No Center in this study had a strategic plan. No director could give precise information on cost of services.

Financial reports were used in a limited fashion.[13] Directors lacked the basic knowledge, information and tools to project actual revenues, monitor cash flow or plan for future capital improvements.

Beyond skills, there are also institutional barriers to localized financial management. One Director mentioned, for example, that it would be "almost impossible" to create independent revenue-raising services because the hospital is allowed only one registered bank account. In addition, high taxes (60%) are an additional burden.

On the other hand, the responses of the WWCs to the external challenges of financial stability demonstrate innovation and a number of "best practices." In those areas where the Centers have been able to exert control, they have done so successfully. This is especially evident in the ways that the WWCs have addressed the challenge of maintaining or expanding services in the face of reduced funding from donors or governments.

One Center opened a satellite Center to provide services in partnership with another hospital. The patients at the satellite Center are treated under an insurance system. When the patients there utilize the satellite Center, the insurance credits flow back to the Center's parent hospital. While they do not directly enhance the budget of the WWC, they do improve its position within the hospital and can be leveraged by the director in budget negotiations.

Another Center is able to raise revenues through patients with pre-paid insurance. These revenues go directly to the general hospital budget. The insurance, however, resembles a fee-for-service program because patients buy "insurance" for an individual procedure, not for a period of time.

[13] One Director created a simple chart showing number of patients per doctor. With the tool, the Director broke down the patients into categories to see how much insurance revenue each doctor was bringing into the Clinic (or hospital). With the chart, the Director was able to determine that one doctor was not providing a standard service because his average revenues were lower than the rest.

All three Centers have created educational programs in partnership with local schools, employers or television. All three directors commented that a lack of internal resources has limited their ability to develop an educational program to the extent that they desired. Instead, they have found willing partners outside of the Center. The partners have provided space, material or airtime (television); the Centers provided the trained staff.

All Centers in the evaluation also had local sponsors to assist with the purchase of equipment or procure in-kind services. For example, one Center has established a relationship with a local television network and has the opportunity to produce a health education television program. Directors in all three Centers felt that this type of support would expand as the economic conditions of the region stabilized.

Finally, only one Director had sought support through a donor agency. The grant request, however, was declined. The Director explained the rejection on the grounds that the Center is a publicly funded institution. Donor agencies that support small-scale projects, according to the director, are concentrating their resources on non-governmental organizations.

C. Patient Satisfaction

According to patients, the doctor is the most important determinant of their satisfaction. The majority of patients indicated that they sought services at the Center because of the positive relationship they had with their physician. Overall, patients felt that their doctor "listened and was patient" and "created a comfortable environment." Other patients expressed that they "felt free to discuss their health" at the Center and they "valued the relationship with the doctor."

The primary role of the doctor in developing patient satisfaction was further underscored at one Center in the evaluation. At this Center, fewer patients expressed a high level of overall satisfaction than at the other centers. At the same time, a majority of respondents detailed their

"I just absolutely love this Center. It is really clean. Above all, I love the warmth and the caring attitudes of the doctors and staff. I feel very much at home here... I know my doctors care about my health and I trust my doctor 100%. With such a great team of people, I feel confident that I will feel better"

-Voice of a Tashkent Woman

dissatisfaction with one physician. While this evaluation cannot make a precise correlation between the two, it is at the least an important coincidence worth noting and highly suggestive that nothing is more important to satisfaction than the physician-patient relationship.

The patient interviews revealed that patients are also attracted to the Centers because of the medical equipment. A majority of patients at each center indicated that the perceived quality of the equipment led them to choose the Women's Wellness Centers over other health care institutions. According to patients, they associated new, western-style equipment with better quality care. Patients perceive the quality of care the Centers to be higher than at comparable institutions. The majority of interviewees indicated that they had other health care choices in the communities but came to the Center because of "better services" and "better trained" physicians. Indeed, many patients indicated that they felt the staff at the Centers established a connection between higher quality care and staff training programs in the United States.

Patients value the short waiting times. In the three centers, the patients judged their average wait to be between 20 and 30 minutes. When asked if they felt the waiting time was reasonable or too long, most patients indicated that it was reasonable. Interestingly, many patients voluntarily indicated that they didn't mind waiting because of the quality of the services. Some of them even thought that waiting time was necessary in order for doctors to thoroughly examine patients.

A surprising outcome of the interviews related to perception of an integrated approach to health care at the Centers. Less than half of the patients interviewed at the Centers indicated that the "one-stop shopping" approach attracted them to the centers. However, those that did come for this reason found the incorporation of treatment and diagnostic services a convenience and improvement in health care delivery over traditional practices in their communities.

Lastly, the majority of interviewees indicated that they would participate in education workshops or seminars or take educational brochures if they were offered and accessible.

At all three Centers, most patients responded that they had not received any educational material from their doctors, and very few took materials that are placed in the waiting area. For the patients, the main barrier to the current brochures is language. The majority of brochures displayed in the waiting area are in English, with a few in the Russian language. In Tashkent, there are currently no educational materials in Uzbek.

The results of the patient interviews showed few respondents had previously participated in education programs. This result, however, is likely to be misleading in regards to the educational efforts of the Centers. The majority of the Centers' education programs are held in schools and in the workplace. The evaluation methodology did not include observations of any workshops nor were any participants in the health education programs interviewed for this study. The results of the interviews only demonstrate that internal educational opportunities are still in the growth stage and should not be considered representative of the educational programs at the Centers.

CONCLUSIONS AND RECOMMENDATIONS

The study set out to answer three questions. The first asked about the factors that contributed to sustainability; the second concerned the factors of success and patient satisfaction; and the third examined the long-term growth of the existing Centers. Through interviews with directors, staff and patients at three Women's Wellness Centers, observations and research, qualitative data was gathered to answer these questions. While the results are most applicable to the three Centers in this study, there are general themes that could apply to all current and future Centers.

The question of sustainability was evaluated with an adaptation of the Management Sciences for Health Sustainability Model found in the *Family Planning Manger's Handbook.* The model posits that sustainability is achieved through a combination of organizational stability, patient satisfaction and financial stability. The Women's Wellness Centers in Dubna, L'viv and Tashkent, as the results of this study demonstrate, have achieved an impressive level of organizational stability and patient satisfaction.

The factors that have led to organizational stability and patient satisfaction include the extensive planning undertaken by AIHA, the strong leadership demonstrated by the directors and the commitment to training and development on the part of AIHA and the U.S. and NIS partners. The product of these inputs is a strong sense of mission among the staff, a physical environment in the Centers that supports the mission and a commitment to programs that promote a new model of women's health in the region.

The financial stability of the Centers, however, is not easily assessable. The Centers in this study were all associated with publicly financed hospitals. There are advantages and disadvantages to this relationship. The advantages include fewer burdens in the area of financial management and a relatively larger resource base from which to draw support than if the Centers were independent. The disadvantages of the relationship are that the Centers have less ability to generate independent revenue flows and, ultimately, must have Center priorities in alignment with the budgetary priorities of the hospitals. This is

most evident in the area of patient education. The priority of the hospitals with limited resources is patient care. Education, perhaps, is seen as a luxury. While the Directors have been innovative in their approaches to developing educational programs, they still lack staff, space and material to execute a program to their desired standards.

The ultimate question of sustainability, however, cannot be answered in this evaluation. It appears that the Centers in this study have strong organizations, committed leadership, as much financial stability as comparable institutions and are well received by patients. The answer to the question of sustainability is, perhaps, more easily located in the second evaluation question: what are the factors of success.

The factors of success have already been stated. They include the considerable inputs from AIHA, USAID, the U.S. and NIS partners. The inputs include tangible items like equipment, Center renovation and supplies. They also include the intangibles such as training, support and the wellness model. Unfortunately, this evaluation is unable to determine how long the Centers will be able to sustain these factors of success independent of AIHA or partner support.

The long-term growth of the clinic, however, is directly related to the ability of the Centers to continue to perform at current levels or higher. Sustaining patient satisfaction will continue to be a result of physicians, equipment and the physical environment of the Center. Maintaining or expanding the level of satisfaction will require continual staff training, the acquisition of replacement equipment, supplies and general upkeep of the Center. All of these efforts require money.

In the absence of a donor agency or a restructuring of the health care finance system in the Centers' countries, the Centers will become more reliant upon the central hospital administration for support. While the relationship is overall, a positive one, the Centers could benefit from independent and diverse revenue bases. Education programs in particular would benefit.

Education programs at the Centers, in the opinion of the Directors, are largely underdeveloped due to a lack of financing. State hospitals must allocate their limited funds to priority areas such as primary care. Patient education is simply not a budgetary priority for the Centers' partner hospitals.

This study recommends **the creation of a NIS-based Women's Wellness Center NGO**. The mission of the WWC NGO would be to support the development of educational programs at all Women's Wellness Centers in the partnership program through fundraising, information exchange, training and partnerships with similar organizations. A WWC Director advanced the idea for this project. The Director suggested that an NGO of this type could provide the "guiding hand" in the absence of AIHA in the future.

The idea has merit and should be actively considered. The WWCs have encountered several barriers to diversification of revenue sources. In most cases, the WWCs have little ability to overcome those barriers. The centralized nature of hospital finance, government health care finance policy and the economic environments of their countries cannot realistically be affected by the WWCs, AIHA or the partnerships in the short term. However, the creation of a WWC NGO could open up new funding sources and attract support from local and international entities for specific activities.

A second recommendation is to **promote creative strategies towards the development of patient education programs.** At the three Centers in this study, the approaches to patient education varied. Patient education programs were developed for schools, workplaces, television, print and the Internet. There were formal in-center programs and informal, patient education during consultations. While some of these approaches were a function of the community, the broader network of Women's Wellness Centers could benefit from a handbook of best practices.

A handbook of educational ideas would support the goals of the Centers directly and at little cost. Staff and directors at the Centers identified the expansion of education programs as a priority because education programs provide an opportunity to market the Centers to various age groups and in new geographic areas. A handbook could provide

not only strategic ideas, but could also include lesson plans, tips for non-formal education and pedagogical guidelines.

The final recommendation is to **promote the use of information technology** in the Women's Wellness Centers. Currently, each Center has been provided with a computer, Internet access and a database designed to help track patients. These tools, however, are being utilized to varying degrees of success. Within the AIHA partnership network, local information coordinators exist. Information coordinators could become key advisors to the Centers, leading training programs designed to harness the available information technology and working with the Centers to assess their individual needs. Such training would enhance data-driven decision making, and make record keeping, data collection and analysis easier. The information coordinators may be an invaluable resource. They are in a position to evaluate local technology needs and help direct the development of a locally grown information technology system. Developing an information technology system locally with the end users (the Centers) involved in each phase of development ensures that the system will address the needs of each Center. Further local development encourages Centers to actively think about their needs, to commit to the products used and to guarantee that the product will be able to be run in the Center's environment.