

Program Evaluation Report:

AIHA Primary Healthcare Partnerships

in the Newly Independent States (1998-2006)

Health Results

- *Better health* achieved for 1.2-1.5m persons in 11 NIS countries. Mortality and long-term disability have declined in the partnership care sites, particularly from cervical and breast cancer, hypertension, neonatal and perinatal conditions, and occupational injuries. Work and school absenteeism reduced, particularly from asthma and hypertension. Incidence rates have declined for female hypertension, STIs, dental caries, nosocomial infections, and abortions, particularly teenage. Cessation of smoking and drug use reported across partnerships.
- *Demand has grown* for quality care and disease prevention knowledge and skills. Patients and communities seek PHC providers for primary health contact, 'maintenance visits' in chronic conditions, early pregnancy visits, psychiatric and behavioral counseling, and social support.
- *Access to care has been improved* in model and replication care sites by expanding PHC to new public and personal health areas; adjusting services to local environmental, social, and occupational risks.
- *Utilization of care is more efficient* as clinical volume has shifted from specialty and inpatient care towards primary care. The number of PHC encounters has grown in response to increased supply and quality of pregnancy care, health education activities, screening programs, chronic disease management services, and social counseling and support.
- *More competent self-care and active peer support* achieved by involving households and patient peer groups in health care decisions. The locus of control remains with professional caregivers, however there is a shift from a paternalistic health care model toward a model based on personal responsibility.



Provider Strengthening Results

- *PHC providers can now address health problems and concerns* of an estimated four of five of their patients who represent 70 percent of the burden of disease in their countries.
- *PHC providers have improved their skills* in diagnostics, treatment management, health promotion, and illness prevention. These improvements have resulted from the program's major investment in the transfer of information, education and training, equipment, and systems modernization.
- The highlight of improved *physician skills* is their increased ability to use current evidence as the basis for practice decisions – an important result of the program's successful effort to introduce evidence-based practice guidelines and ensure their sustainable application through modernized clinical training, Learning Resource Centers, and PHC practice access to better diagnostic equipment and health supplies.
- Progress has been made towards the achievement of the six *quality of care* aims and 11 contributing conditions of quality distinguished by the Institute of Medicine.

Figure 1. PHC Partnership Program at a Glance

Primary Health Care	Women's Care	Knowledge Resources	Nursing	Goals	Objectives	Inputs	Processes	Outputs	Outcomes	
<p>Improve PHC quality and health outcomes, and promote healthy lifestyles, contributing to the reorientation towards primary care in targeted countries.</p> <p>↑ capacity to deliver quality primary care services in targeted communities.</p> <ul style="list-style-type: none"> ↑ patient satisfaction with PHC services. ↑ acceptance and availability of PHC evidence-based practices and clinical practice guidelines. ↑ community participation in improving the health of the community 	<p>Provide a client-centered approach to women's health care through services that address women's health needs throughout their life continuum.</p> <p>↑ capacity to deliver comprehensive, outpatient services to women of all ages.</p> <ul style="list-style-type: none"> ↑ utilization of health promotion/prevention services within Women's Wellness Centers (WWCs) Maintenance of a high level of patient satisfaction with WWC services. ↑ implementation of practice guidelines for women's care. ↑ use of contraceptive methods to avoid unwanted pregnancy. ↑ sustainability of WWCs. 	<p>Promote improved health care practices through increased access to, use of, and understanding of available knowledge resources.</p> <p>↑ access to up-to-date health care knowledge resources.</p> <ul style="list-style-type: none"> ↑ promotion of evidence-based practice. Demonstrated ability to sustain access to knowledge resources independent of AHA funding. ↑ development and use of information and communication technology tools and applications. 	<p>Improve patient care through effective, quality nursing practice and strengthening the profession's contribution to systemic health care reform.</p> <p>↑ capacity for professional nursing education that meets international standards.</p> <ul style="list-style-type: none"> ↑ status of nursing as a profession. Improve nursing practice by introducing new models of nursing care and nursing roles. ↑ access of nurses to information resources and networking through sustainable Nursing Resource Centers (NRCs). 			<p>Funding and in-kind contributions: \$75.9m. Of that number: - Cash spending: \$29.4m, - In-kind: \$46.5m. • U.S. Organizational and community engagement: - 38 cities/communities in 22 states and D.C. - Over 200 institutions, incl. 85 health systems and 61 universities.</p> <ul style="list-style-type: none"> NIS engagement: - 11 countries with the total population 255.3m (2004) - Over 140 provider facilities and networks, medical education institutions, and health administrative agencies. 	<p>Professional travel: 15,398 US to NIS days + 13,520 NIS to US days = 28,918 total days. • Provider training: 300 training courses per year (in 2003, when the program implementation was in full swing). • Community education: 2,900 education and outreach activities have involved 74,000 participants in 2003. • Knowledge strengthening: Two clinical or educational evidence-based practices reviewed every year.</p>	<p>28 model PHC clinics established according to the integrated model of PHC, an estimated 270 clinics replicated w/o partnership funding.</p> <ul style="list-style-type: none"> Two million patient visits/year in partnership-sponsored PHC clinics. 29 community health councils and 37 patient clubs (involving 4,600 members) are functioning Over 1,300 NIS health professionals benefited from exchange > 30,000 PHC residents and practitioners trained 	<p>24 Nursing Resource Centers (NRCs) were established</p> <ul style="list-style-type: none"> By 2003, almost all partnerships reported institutionalization of new roles and responsibilities for nurses, incl. institutionalized written nursing standards 	<p>Technical quality: All model PHC clinics meet >= 8 of 10 quality criteria related to counseling, use of clinical evidence, screening services, involvement of nurses, availability of patient education materials, group health education classes, CQI activities, implementation of occupational health and infection control, and community outreach activities.</p> <ul style="list-style-type: none"> Patient satisfaction: Patient surveys conducted in 2002-03 in 20 model PHC facilities have shown on-target level of customer satisfaction (>=5.8 on a 7-point scale for 22 variables of provider performance) in 6 facilities, and just below the target in 6 more. PHC-to-specialist referral rate has declined from 2/3 to an estimated 20 percent across model PHC clinic.

Systems Management Results

- *Management of quality in education:* Significant progress achieved in modernizing teaching technologies, curricula, and instructional materials.
- *Management of quality of care:* The main contributions relate to the introduction of clinical guidelines and standards, particularly through provider training and Learning Resource Centers.
- *Resource management:* Equipment management skills strengthened to match the much-improved access of the PHC practice to technology. Carelift International and AIHA have provided partners with equipment and related training.



Effects on Professionals, Organizations, Society

- Empowered by new knowledge, better access to information, and broadened responsibility and autonomy, PHC *providers* have gained in their professional and social status; developed civic activism and upward mobility towards important jobs in the government, academe, and legislative bodies.
- The health care *organization* has made modest progress towards a participatory management style and in several partnerships has flexibly adjusted its resources to the new strategy of PHC.
- The *community* now participates in PHC priority setting. While care providers are not necessarily accountable to the community, they are better informed about community needs and customer feedback.

Sustainability and Replication

- *Sustainability:* All 17 factors of sustainability, assessed during the study, work to support partnership-sponsored PHC strategies, systems and practices. Partners have strengthened some of these factors, while environmental supports reinforced the others. As a result, major program achievements are sustained to date and stand a good chance to remain in use in the future.
- *Replication scope:* The case of six Ukraine-based partnerships illustrates the extent of replication observed in the program. The estimated population served under the comprehensive model of PHC has grown from 245,200 in the model clinics to 373,200 after the innovation was extended to several satellite clinics; to 1.96 million at the level of rural districts, towns, and cities, to 5.12 million at the regional replication stage (the capital city and oblasts), and to 14.5 million nationwide in 2005.
- *Replication mechanisms* include continuous dissemination of partner best practices for inclusion in NIS government policy and technical. Partnerships have created supply-driven pressure from general practitioners, previously unknown in the NIS health policy milieu dominated by specialty physicians. The advocacy potential of the NIS partners has significantly increased and so has their personal/professional vesting in the new model of care.



- Partnership program management has adopted a politically winning approach to the promotion of partnership strategies and achievement. The local demand-driven, participatory nature of the partnerships empowers the NIS professionals, builds their self-esteem, and allows innovations to take root and spread.



Other Results

- Learning Resource Centers (LRCs)* have been sustained in the following functions: (i) libraries with electronic access to information; (ii) tele/multimedia-conferencing facilities enhanced with a satellite communication system; (iii) the centerpiece of an evidence-based clinical training and skills-testing center; (iv) support for the health education; (v) on-line access, e-mail, and data management.
- Program management and cross-partnership initiatives and activities* are instrumental in advancing partnership objectives. They have formed the program identity, provided comprehensive support at

the pre-partnership and start-up stages, brought partnerships into organizational contact and technical exchange, played an important policy mediation role between partnerships, USAID, and NIS health agencies; served as a clearinghouse and exchange for the partnership best practices; and provided administrative backstop.

Best Practices, lessons learned and Recommendations

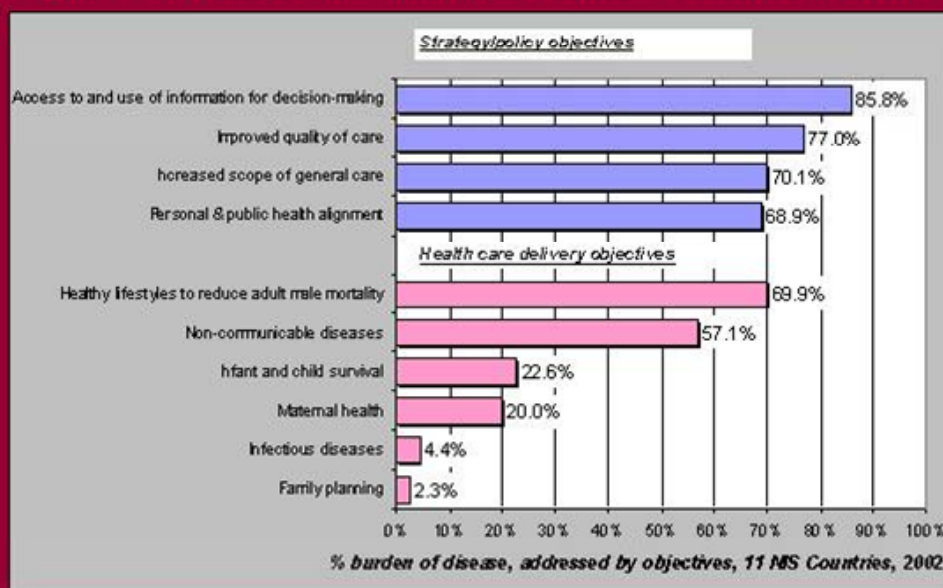
- Implementing new care strategies and models within existing health delivery networks reduces the need for immediate structural change and mitigates political and professional tension while innovations are demonstrated, accepted and expanded.
- Piloting a new model of care through several types of PHC organization allows leveraging of risks associated with any specific type of organization and increases buy-in from both providers and administrators, thus making change more inclusive and sustainable.
- Rural primary care reform is a universal challenge. Partnership achievements in embedding the integrated care model in rural practice and in strengthening provider/community ties are remarkable.
- Most partnerships nurture change at the local level and are successful at that. However, it takes more than proven local success to replicate the model. The partnership program management interfaced between partnership organizations and governments; brokered strategic solutions developed at the partnership level, and developed decision-maker vesting. These activities greatly facilitated replication.
- Crucial to sustainability and replication is the insightful monitoring of the 'big picture' of national policies in the host countries, projection of emerging areas of national interest, and identification of synergies that such developments create for replication. For example, the program management took advantage of the European integration trends to spur further interest towards partnership-sponsored innovation in NIS countries working toward EU accession.
- Many donors may have resources to support successful partnership innovations. Effective donor support requires conceptual alignment and coordinated decision making among programs. This may be challenging since organizational identity and procedural requirements of donor agencies and implementing teams do not always align with the model, standards, and quality requirements developed through partnership-supported innovation.



- USAID may want to consider developing a sustainability-monitoring tool and using it for a periodic inquiry into the sustainability status of major partnership achievements. Based on the monitoring results, target grants could be provided for programs with major impacts.
- The integration of model practice sites with basic and continuing provider education is among the most productive ways to sustain the innovation.
- To be successful in serving the demand for best practice information LRCs will have to integrate with external resources of connectivity and research. LRCs may evolve into a different type of entity, for example, become part of multi-organizational medical informatics / library / research centers or networks.
- Each viable partnership should be supported by good evaluation. Having sound baseline data is mission-critical for increasing the replication value of a successful partnership. This requires careful evaluation planning, robust methodology, and adequate budget.

Appropriateness of Partnership Objectives

Figure 2. Importance of Partnership Objectives for NIS Health Needs



- PHC partnerships used a demand-driven process to set their objectives, involving multiple sources of information, broad stakeholder participation, and sufficient time preceding and following the signing of Memorandum of Understanding.
- The resulting objectives are strategically aligned with the E&E and Missions' regional and country programs. Some of the most important partnership objectives have played a forward-looking role, as

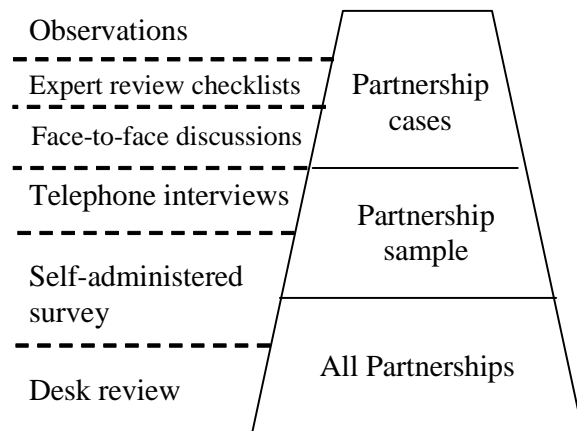
they provided an experiential ground for the E&E Bureau and Missions in updating their regional and country strategies.

- The partnership objectives and planned interventions were chosen to address all major burden of disease (BoD) factors in the region. The partnership agenda fully reflected the need for increasing PHC scope and capacity to prevent and manage non-communicable diseases and injuries – the categories of conditions that account for 89 percent of the BoD in the 11 host countries (Figure 2).
- At the same time, partnerships sufficiently emphasized the need for strengthening the core PHC functions of combating infectious diseases and improving maternal and children's health, reflecting the worrisome TB and HIV/AIDS trends in the European NIS, as well as traditional infectious, respiratory, mother-child and nutritional conditions in the Central Asian countries.

Evaluation Design

- The design of this evaluative study is based on the logical model, postulating that *inputs* are engaged in *processes* to produce *outputs* that, if *sustained*, result in *outcomes* with a system *impact* proportionate to the level of their *replication*.
- The 18 evaluation questions from USAID were organized into seven evaluation clusters and twelve content areas. The resulting evaluation program proved to be non-overlapping, guided by the original USAID questions, and relevant to stakeholder agendas.
- The three-tier ‘population—sample—case’ methodology (Figure 3) included: (1) at the ‘all-partnerships level’: desk review of program and partnership documentation; (2) at the sample level: self-administered questionnaire-based survey, conducted with the partnership response rate of 71 percent (20 out of 28 partnerships); (3) at the case level: interviews and expert review checklists applied in five visited partnership sites.
- The methodology’s strengths, weaknesses, and difference from the previous program evaluations are presented in the evaluation report.

Figure 3. Three Tiers of the Evaluation



Conclusion

The positive results of the partnership program are becoming more topical since the E&E Bureau is now particularly interested in the post-presence sustainability of past programs’ achievements and has been “exploring appropriate post-presence initiatives as a way to consolidate assistance gains and carry support for democracy and markets into the future, even after a local USAID mission is closed. Post-presence initiatives consist of American or East-East regional partnerships established with USAID assistance...” (USAID/E&E Bureau, 2004). This strategic approach implies a direct call for revisiting the

positive legacy of the PHC partnership program with a view to its post-presence potential. Another important assistance strategy, also leading to the appreciation of the program legacy, is to ‘harness private flows’ – “generate public-private partnerships to mobilize non-official resources and know-how” (USAID and U.S. Department of State, 2003). Most conclusions and recommendations that have emerged from the evaluation may prove helpful in strengthening USAID post-presence initiatives and public-private partnerships in the NIS region.

