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**First Lady's November Trip to Russia, Ukraine, Kazakhstan,
Kyrgyzstan and Uzbekistan**

UZBEKISTAN

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UZBEKISTAN: MAIN ISSUES IN BILATERAL RELATIONS

Interest in U.S. ties. Despite its slow pace of internal reform, Uzbekistan actively seeks closer U.S. ties. It has supported U.S. positions in the UN on controversial issues such as Iran and Cuba; it has cooperated actively in efforts against weapons proliferation and narcotics; and it has been an active participant in Western security initiatives under Partnership for Peace, OSCE and the Euro-Atlantic Partnership Council. Uzbekistan is also a member of the Central Asian Peacekeeping Battalion (Centrasbat) with Kazakhstan and Kyrgyzstan, which in September held joint military exercises that included U.S. participation.

Mutual benefits. Uzbekistan values closer relations with the U.S. to assure its independence, counter the regional ambitions of Russia and Iran, assert its own regional role, and attract western investment. The U.S. in turn recognizes Uzbekistan as a regional leader, representing relative stability in a turbulent region; a growing market for U.S. exports (\$350 million in 1996); a producer of natural resources such as gold, uranium, and natural gas; and as a likely regional hub for infrastructure such as pipelines, transportation, and communications, in which U.S. firms seek a leading role.

- **Joint commission.** The desire for closer relations on both sides has led to an agreement to form a Joint Commission, chaired by Ambassador-at-Large Sestanovich and Foreign Minister Kamilov, to be inaugurated in Washington, most likely in January 1998. Formation of the Joint Commission, an idea endorsed by President Clinton in his June 1996 meeting with Karimov, institutionalizes our effort to build closer relations. While both sides seek to deepen military and regional cooperation, the Commission will also serve to push political and economic reform.

Differences. Despite close cooperation in a number of areas, there are sources of friction in our bilateral relationship. These arise from Uzbekistan's slow pace of economic reform, poor human rights record and sometimes meddlesome regional activities.

a) Economic reform. Reform has stalled since Uzbekistan's October 1996 decision to restrict currency convertibility. This has reduced IFI programs and hampered foreign companies seeking to invest. Other concerns are slow movement on medium/large-enterprise privatization and bureaucratic obstacles to investment and trade. More positively, a new tax code was passed in April; we will monitor its implementation closely.

b) Human rights. President Karimov, a former Uzbek Communist Party First Secretary, has fallen far short of his declarations in favor of a democratic society and free press: the government refuses to register human rights NGOs or real opposition parties; there remains pervasive press censorship; and there have been numerous reports of beatings and torture by police. Karimov, a former Uzbek Communist Party First Secretary, defends his political record by claiming the need to defend the state against ethnic and fundamentalist unrest.

c) Regional aspirations. Despite its fear that the conflict, instability and Islamic fundamentalism in neighboring countries could spill across its porous borders and threaten its own secular state, Uzbekistan has taken some potentially destabilizing actions within the region. Uzbekistan has supported renegade ethnic Uzbek officers in neighboring Tajikistan, which threatens to disrupt that nation's fragile peace process. Moreover, in Afghanistan -- although it has at times played a moderating and constructive role -- the Uzbek government has supported ethnic Uzbek military activity, which helps perpetuate Afghanistan's civil conflict.

Future relations. The U.S. believes that Uzbekistan's stability and prosperity could better be assured by a firmer commitment to economic and political reform, an issue we will pursue in the Joint Commission. Lack of progress on both fronts will jeopardize continuation of some USG assistance and undermine the overall relationship. We also continue to encourage Uzbekistan to maintain a neutral role in the civil conflicts in neighboring Tajikistan and Afghanistan. In addition, we want to build on the success of September's Centrasbat exercise by making it an annual event, and to expand IMET and other forms of training for Uzbek military forces.

UZBEKISTAN: POLITICAL AND SOCIAL OVERVIEW

Uzbekistan is politically one of the least changed states in the former Soviet Union. Power is now concentrated in the hands of President Karimov instead of the Communist Party, but the legislature functions largely as it did in the Soviet era. There is no independent judiciary.

Consolidation of presidential power. During his first few years as President, Karimov focused on consolidating power. He outmaneuvered his rivals within the government and crushed the largest non-Communist political opposition movement in Central Asia, although he did so largely without resort to force. A former First Secretary of the Uzbek Communist Party, Karimov was elected President in a contested election in December 1991 in which the most popular prospective candidate, Abdurahim Pulat, leader of the main opposition movement, was not allowed to run.

Opposition. Following a student riot in early 1992 and mounting opposition criticism of the regime, police suppressed Birlik and Erk, the two main independent political movements that had emerged during the era of perestroika. The authorities also cracked down on Islamic activists in the Ferghana Valley. Opposition and religious leaders were harassed, beaten or arrested. Others, including Birlik Chairman Pulat, Erk Chairman Solikh and former Grand Mufti of Uzbekistan Sadiq were forced into exile.

Popular support. Despite his use of repression, Karimov appears to have popular support. A 1996 International Foundation for Election Systems (IFES) poll showed that over two-thirds of the respondents said that they were satisfied with "the situation in Uzbekistan today," and three-fourths said that the overall quality of their life today was either "very good" or "fairly good" -- indicating high levels of satisfaction, according to U.S. polling experts.

Status quo. Absent a rapid deterioration in the economic situation, Karimov is likely to succeed in his bid to stay in office past the year 2000. This reflects not only his successful repression of opposition and public acceptance of his approach to reform, but also the cohesive nature of the population (three-quarters ethnic Uzbek), an unbroken history of authoritarian rule, and the a growing sense of national identity that Karimov has helped build. Although the legacy of repression in Uzbekistan probably stifled the level of dissent expressed to the pollsters, the uniform results nevertheless suggest that many Uzbekistanis appreciate the stability that Karimov has brought to

the country and accept his claim that political reform must be implemented gradually to prevent chaos..

Attention to western concerns. As Karimov has attempted to attract foreign investment, he has sought to accommodate, at least superficially, Western concerns about human rights and democratization. Karimov allowed Radio Liberty to reopen an office in Tashkent and has allowed the establishment of local independent television stations. The government invited the OSCE to hold a seminar on human rights in Tashkent and permitted the brother of Birlik Chairman Pulat, Abdumannob Pulat, who was given political asylum in the U.S., to return to Uzbekistan and attend the meeting.

Superficial reforms. Nevertheless, democratic reforms have been largely cosmetic. In practice, the Uzbekistani Government continues to restrain, either directly or indirectly, fundamental freedoms. Karimov broke his promise to consider his current term in office -- extended by a March 1995 referendum -- as his last, by having parliament to declare in August 1995 that he is eligible to run again in the year 2000.

UZBEKISTAN: ECONOMIC AND COMMERCIAL OVERVIEW

Energy and agriculture. Uzbekistan's labor-intensive economy is centered on agriculture and mineral extraction. It has been less vulnerable to the disruptions experienced by other countries of the former Soviet Union, because rapid growth in the production of oil and gas -- which grew by 180 and 19 percent, respectively, between 1991 and 1996 -- allowed Uzbekistan to reduce its oil imports at a time when energy prices were increasing sharply. Uzbekistan -- a net gas exporter -- took advantage of these higher prices and increased gas exports. In addition, the government's policy of shifting crop acreage from cotton to grains and other crops increased domestic food supplies, heading off social tensions and the need for food imports.

Economic performance. Uzbekistan's GDP declined 17 percent, but industrial production held steady, between 1990 and 1996 -- easily the best performance of all the CIS countries. Nevertheless, rapid energy growth has masked steep drops in other industrial sectors, including metallurgy, chemicals, and construction materials, ranging from 33 to 59 percent between 1990 and 1995.

Trade. Foreign trade has performed better than in other CIS countries. Although total two-way trade in 1996 was an estimated 50 percent of the 1990 level, exports to hard currency non-CIS partners -- mostly of cotton -- more than doubled during that period, and Uzbekistan was the only CIS country to import more from non-CIS partners than it had in 1991.

Reform. While initially rejecting serious economic reforms, in mid-1994 Uzbekistan implemented a macro-economic stabilization policy and other reforms with IMF guidance to deal with high inflation and to attract greater foreign investment. State control over the economy, however, remains strong. The government's tight rein on credits and deficit spending has reduced average monthly inflation from more than 20 percent in 1994 to four percent in 1996 and an estimated three percent in 1997.

Privatization. Housing and small-scale enterprises, mostly in retail and services, have been almost fully privatized. Employment in the state sector dropped from 67 percent in 1991 to 43 percent in 1996, and 95 percent of retail sales last year went through enterprises not owned by the government. Large-scale privatization has barely begun, however, and the government's approach has favored current employers and managers over a process more open to the public. In 1996, the government further changed privatization procedures to encourage the participation

of foreign investors. The government has permitted private ownership of livestock and expanded privatized cotton production. While most consumer prices are close to world levels, Uzbekistan maintains artificially low prices on cotton and wheat. Moreover, the government retains state orders -- as high as 50 percent -- on the cotton and wheat crops, as well as complete control over cotton exports, and it strictly controls participation in hard currency exchanges.

Foreign investment. Economic reforms have improved the foreign investment climate in Uzbekistan, but potential investors continue to face problems from an inadequate legal infrastructure and a cumbersome, often corrupt, bureaucracy. In October 1996, the government restricted the number of banks authorized to conduct foreign exchange transactions. Several small-scale investors have shut down operations, and major foreign investors have noted difficulties in purchasing foreign exchange to meet external obligations and repatriate profits. Although more than 1,200 joint ventures have been registered in Uzbekistan, only about half were operating in 1996.

UZBEKISTAN: HUMAN RIGHTS

Slow progress. Uzbekistan is an authoritarian state with limited civil rights. The government has failed to make significant progress on human rights concerns and political reforms. Chosen President by a 1991 election that was neither free nor fair, Islam Karimov had his term extended to 2000 by a 1995 Soviet-style referendum. The government continues to deny registration to independent political parties and other groups critical of the government, while creating several parties to support itself. It also continues to hold political prisoners. Police and security services use torture, harassment and illegal searches against activists. Police often beat criminal suspects to obtain confessions.

Freedom of the press. Press censorship remains pervasive. Almost all newspapers are government-owned, and citizens have little access to foreign newspapers. Radio Liberty, the Voice of America, BBC radio and expensive local cable television channels are among the few sources of uncontrolled news, but even their reporters face harassment. Freedom of expression is constrained by an atmosphere of repression and concrete measures including a law against "offending the honor and dignity of the President."

Positive steps. Nevertheless, some potentially positive steps on human rights were taken in 1996 and 1997. It remains to be seen to whether these measures are truly reforms or merely superficial. In 1997, legislation was enacted to increase access to information and protect journalists; to reform the penal system and protect the rights of prisoners; and to establish an ombudsman's office to monitor and investigate human rights abuses. During the summer of 1996 authorities permitted Human Rights Watch/Helsinki and Radio Liberty to open bureaus in Tashkent. In addition, just prior to a meeting with President Clinton in June 1996, President Karimov released fifteen political prisoners and invited exiled human rights activists to return to Uzbekistan. Later that year he established a National Center for Human Rights devoted to training professionals in human rights issues.

UZBEKISTAN: ETHNIC AND RELIGIOUS ISSUES

Discrimination claims. Despite official Uzbekistani government policy favoring the development of a multi-ethnic society, a number of non-Uzbek ethnic groups claim official discrimination. For example, some groups claim that their communities are shortchanged in distribution of government resources. This discrimination appears to apply particularly to those groups who are most isolated, such as the Karakalpaks who occupy the ecologically-devastated northwestern corner of the country near the Aral Sea.

Language issues. The government is moving to replace Russian with Uzbek as the official language by the year 2000, a move that is seen as disadvantaging the quarter of the country's 24 million people for whom Uzbek is not the first language. In addition, legal proceedings are often conducted in Uzbek without Russian translation, even when they involve Russian speakers, and Russian suspects are routinely forced to sign confessions written in Uzbek.

Freedom of religion. Uzbekistan's constitution provides for freedom of religion and separation of religion and state. Many groups worship freely, including the majority of (Sunni) Moslems, Jews, Russian Orthodox and several other Christian denominations. However, the government suppresses some religious groups and activities. For example, to counter what it perceives as extremist Islamic views, the government limits the expression of political views by religious leaders in sermons and elsewhere, and effectively controls the Islamic religious hierarchy. Authorities continue to use the tactic of convicting Islamic religious leaders on trumped-up criminal charges (e.g., possessing drugs and ammunition) to suppress their suspected criticism of government policy. Moreover, at least one evangelical leader has been arrested and briefly jailed for operating an unregistered church. Other evangelical groups have had difficulty registering and, as a consequence, operate in legal limbo. Acting on orders from presidential staff, customs officials confiscated and held for most of 1997 a shipment of 29,460 Bibles belonging to the Uzbekistan Bible Society.

UZBEKISTAN: EDUCATION ISSUES

High literacy. The high educational level of the Uzbek population is a great asset to this Central Asian nation. Literacy is near universal at over 98 percent in both rural and urban areas. Educational methods and curricula, however, are often outmoded and inappropriate, and rural schools are less well-equipped than their urban counterparts.

Deteriorating conditions. As in other social sectors, the Uzbek educational system experienced significant material and financial constraints following the breakup of the former Soviet Union. As a result, serious problems relating to the maintenance of educational institutions and the provision of necessary equipment and supplies such as textbooks have emerged. For instance, many schools, especially in rural areas, have no telephone, no running water, and no sewage system. In addition, low teacher salaries have caused many of the most talented teachers to leave teaching.

Length of schooling. Despite this bleak financial situation, the total mean years of schooling for both men and women in Uzbekistan exceeded 11 years in 1994. Also, the percent of all persons aged 6 to 23 enrolled in school was approximately 50 percent in 1994. However, this figure is over 10 percent lower than the equivalent figure for 1992. Also disturbing is the fact that the percentage of 19-year-olds still enrolled in full-time education declined from 31 percent in 1992 to 26 percent in 1994.

Continued decline? The needs in the educational sector must be addressed fairly quickly to preserve the quality and availability of education for all children and young adults. Hence, during coming years, Uzbekistan must try to maintain its educational achievements by revising and restructuring curricula to meet the requirements of a modern, independent nation. Assistance is also urgently needed for maintenance of the basic educational infrastructure, especially in rural areas. Education has not been a sector of specific concentration for USAID work.

UZBEKISTAN: WOMEN'S ISSUES

Women's rights. Uzbekistan has acceded to a number of international human rights-related treaties, almost all of which prohibit discrimination based on gender. Both the Constitution and the 1992 law on citizenship prohibit discrimination on the basis of sex. However, enforcement mechanisms are inadequate, and women are unaware of their rights and too poorly organized to advocate for themselves effectively.

Traditional society. Uzbekistan is a traditional society in which Islamic culture is becoming more of a presence. Women assume that raising children and managing the home are exclusively the domain of women. Early, arranged marriages are common, and young brides are expected to have a child within the first year of marriage and to care for their mothers-in-law.

Education. The female literacy rate in 1990 was 96 percent, which compares very favorably with a 60 percent rate worldwide. Opportunities for women to obtain an education are declining, however. Because traditional attitudes toward women favor early marriage and child rearing, education for women receives a low priority. The government has abolished the compulsory attendance law, making it easier to keep girls out of school. Declining financial support for state schools has resulted in the best educational opportunities requiring entry payments amounting to bribes. Economically hard-pressed families are more likely to do this for sons, for whom a career is considered as required, while keeping daughters at home.

Economic Participation. Women's employment and labor force participation is high (71%), but women tend to be employed in low-skilled occupations or in low-paying occupations such as education and health. Women make up three-fourths of the country's doctors and nurses and 60% of teachers, but only a third of technicians and engineers. Women seeking to be entrepreneurs face a host of obstacles, including cultural attitudes, family and household responsibilities, and lack of access to family assets, which reduces access to scarce credit.

Political representation. The proportion of women represented in Parliament has dramatically decreased since independence. Before the 1989 elections, due largely to a quota system, women comprised 35% of the Supreme Soviet. Now, only 13 of the 250 deputies in Parliament, or five percent, are female. Few women hold influential positions in the executive branch and those that do tend to serve in ministries dealing with social issues such as health and education. A woman deputy prime minister was appointed to handle women's affairs. She is the only female in

the Cabinet and has no program funds or real power. Women serve as deputy governors for women's affairs at the province and district levels, but have no program funds and limited chances to put issues forward in a male-dominated environment.

NGOs. The Republican Women's Committee, a government-sponsored NGO headed by the Deputy Prime Minister, has supported a few useful projects. A number of women-oriented, grassroots NGOs deal with specific gender issues but, as with most NGOs in Uzbekistan, they are weak and lack depth in their leadership.

International activities. A national delegation was sent to the United Nations Fourth World Conference on Women in Beijing as well as to the 1996 meeting in Bucharest. Support from outside the country permitted key women leaders not affiliated with the government to attend the Beijing conference. Since Beijing, the government has prepared a paper entitled "The Government's Conception on Improving the Status of Women". In May 1997, a Gender in Development Unit under the Republican Women's Committee, financed by the UN, began developing a National Action Plan to be based on the Government's concept paper.

Social benefits. Under the Soviet Government, a comprehensive system of social benefits assisted women and gave them preferential treatment, including child allowances, maternity leave, and favorable retirement pensions allowing earlier retirement than men. Unfortunately, this system of social welfare is grossly underfunded. Benefits are too small and often paid late. Until it is reformed, women are likely to suffer disproportionately.

Demographics.

Female population - 11.5 million (50.5% of population) (1995)

Number of women 15-45 in 1995 = 5.6 million; in 2015 = 8.9 million

Life expectancy - 72 years (as opposed to 66 for men)

Total fertility rate - 3.8

UZBEKISTAN: POPULATION AND FAMILY PLANNING

Projected trends. With a total population of approximately 23.7 million, Uzbekistan is the third most populous country in the former Soviet Union. With the current population growth rate of 2.5 percent, the population will dramatically increase in the next fifteen years and is projected to reach 35.7 million by the year 2025. Forty percent of the population of Uzbekistan is less than 14 years of age. Fertility in Uzbekistan has declined in recent years by one child. Total Fertility Rate (TFR) for women is 3.3 children.

Contraception. Currently, reproductive health services are available at hospitals and polyclinics at the oblast, rayon, and city levels, and at primary health care institutions through the public sector. According to demographic and health data, knowledge of contraceptive methods is virtually universal among Uzbekistani women and 51 percent of currently married women are using a modern method of contraception, primarily in-uteri devices. Most of the women obtain their contraceptive method from the public sector.

International assistance. The United Nation Fund for Population (UNFPA) with the EU credit has supplied the contraceptive for the public sector. This may change in the future as the commercial sector becomes more active. USAID is helping the Ministry of Health to improve the accessibility and availability of contraceptives through the commercial sector. However, the recent adoption of regulations to control and limit foreign exchange for businesses have affected USAID's efforts.

Abortion. An abortion rate of 0.7 abortions per woman in Uzbekistan is lower than estimates for other areas in the former Soviet Union. These lower rates are largely due to greater availability and use of alternative contraceptive methods.

UZBEKISTAN: CHILDREN'S ISSUES

Decline in social services. Despite recently increased efforts on the part of the government of Uzbekistan to address the general downturn in the country's social indicators, preoccupation with macroeconomic issues as well as real budgetary constraints has meant that social services for the most vulnerable groups -- especially children -- are shrinking and in danger of not furnishing even minimum support. Some 41 percent of the population is under the age of 16; this places high demands on scarce social services.

Nutrition. A wide range of serious nutritional problems affect a large percentage of children, especially in rural areas. Among the major reasons are large families, low family incomes and sporadic supplies of major food products. The USAID-funded 1996 Uzbekistan Demographic and Health Survey (UDHS) found that close to 15 percent of the child population is stunted and another three percent wasted. This is in line with percentages generally found in Central Asia, but higher than those for other areas. Breast-feeding is almost universal in Uzbekistan; 96% of all children are breast-fed during their first four to six months of life. This satisfies the World Health Organization recommended minimum four months of breast feeding.

Infant health care. Almost all births in Uzbekistan (94%) take place in health facilities and under the care and supervision of trained medical personnel. Uzbekistan provides a full range of inoculations (polio, measles, BCG and DPT/DT) to 85 percent of the children aged 12 - 23 months. The highest coverages are for Polio 1 and Diphtheria 1, 99 percent. The lowest is for measles, 89 percent. USAID addressed vaccine security issues early on in Uzbekistan and Central Asia. It provided technical assistance to modernize antiquated and inefficient immunization protocols. USAID has also been in the forefront of helping combat other diseases by providing vaccines and associated assistance.

Aral Sea. In the Aral Sea zone, children have been especially susceptible to the air and waterborne diseases associated with the ecological disaster area. Although the infant mortality rate has fallen in recent years, it remains higher than in other areas of Uzbekistan. USAID mobilized resources quickly in 1994 to fulfill Vice President Gore's commitment to the area. Uzbekistan shared with Kazakhstan in USAID's \$22 million Aral Sea Initiative to bring potable water to people of the Aral Sea region. This initiative has now shifted from infrastructure projects to ones addressing water policy and sustainability.

Adoption law. While international adoptions of Uzbekistani orphans are legal, government officials are not in agreement on who has authority over such adoptions. Only three foreign adoptions took place in FY 1997. Uzbekistan is not a party to the Hague Convention on the Civil Aspects of International Child Abduction. Thus, cases of children abducted to or from Uzbekistan must be handled in the family courts of the country to which they have been taken. When such cases are brought to the attention of the Department of State, the natural parents are advised to retain legal counsel in the country to which the children have been taken. The Department of State is not aware of any pending cases in Uzbekistan.

UZBEKISTAN: HEALTH ISSUES

Major problems. Uzbekistan's major health problems include high maternal and infant mortality rates; poor women's health, including reproductive health; intestinal and parasitic infections; high rates of cardiovascular diseases; and increasing incidence of tuberculosis and vaccine-preventable diseases, including polio, diphtheria, and anemia, particularly in women and children.

Deteriorating conditions. Historically, the national health care system in Uzbekistan was comprehensive. Services available to a large percentage of the population were provided mainly free of charge. However, health sector resources have declined since the breakup of the former Soviet system, reducing health care quality, accessibility and efficiency.

Drinking Water. Lack of access to potable water continues to be a major problem for half a million people in the Aral Sea area. This is a main cause of higher incidences of diarrheal disease in the region. The government and USAID have already improved two large water treatment plants serving half a million people in the Aral Sea region through installation of chlorination and other water cleaning equipment. These efforts immediately improved drinking water quality, which in turn reduced health risk. A regional effort in water management and water pricing is underway.

Reform and USAID assistance. Recently the Government of Uzbekistan has indicated readiness to pursue health reforms more consistent with a market-oriented economy. USAID is focusing on issues of health care financing and improved primary health care. This complements USAID's existing assistance in improving access to contraceptives through the private sector; reducing vaccine-preventable infant deaths; strengthening epidemiological monitoring of infectious diseases; and developing hospital partnerships with U.S.-based hospitals to transfer modern clinical technologies. USAID has provided some \$3 million to the health sector in the past two years, in addition to roughly \$5 million to improve water supply systems. USAID works closely on health issues with the World Bank, the World Health organization, and other United Nation Agencies.

UZBEKISTAN: ASSISTANCE PROGRAM OVERVIEW

Total funding commitment. The United States has provided approximately \$137.5 million to fund humanitarian aid, technical assistance and investment promotion activities in Uzbekistan since 1992. These programs seek to lay a basic foundation for market economic and democratic reform in an effort to encourage the government of Uzbekistan to embrace such reforms in earnest. The U.S. has contributed an additional \$16.6 million to the UNHCR and International Organization of Migration's 1997 Joint Appeal for the CIS Migration Conference follow-up for programs in Uzbekistan, as well as Kyrgyzstan and Kazakhstan.

Funding for economic reform. U.S. funding since 1992 for private sector development and economic restructuring in Uzbekistan totals approximately \$18 million. This relatively low figure compared to aid to other NIS reflects the slow pace of economic reform in Uzbekistan to date. Despite declarations to the contrary, the Uzbek government has been reluctant to implement many of the reform ideas generated by U.S.-funded programs. In addition, Uzbekistan's restrictions on currency convertibility undercut its efforts to attract foreign investment.

Economic programs. Our programs are nevertheless helping to lay the groundwork for a market-oriented economy by working with selected, reform-minded GOU officials. USAID has fielded a team of resident advisors that has been working closely with Uzbekistan's government on tax, fiscal, and financial reform. These advisors played a key role in drafting Uzbekistan's new tax code, which parliament passed in April 1997. USAID advisors are also working to draft new laws on budget formulation, reform the pension system, train banking system supervisors and streamline Uzbekistan's legal framework for international trade and investment in preparation for possible WTO membership.

Central Asian-American Enterprise Fund. The USG has also pledged \$150 million to capitalize the Central Asian-American Enterprise Fund, which operates in Uzbekistan, Kazakhstan, Kyrgyzstan and Turkmenistan. We created this fund to support the development of small and medium-sized enterprises in Central Asia by making equity investments and providing micro-lending services. The fund has invested \$23.4 million in 10 Uzbek businesses in the manufacturing, food processing, construction, and service sectors. Unfortunately, currency convertibility problems have prevented even greater Fund activity in Uzbekistan thus far.

Democracy and human rights. The GOU has moved slowly on democratic reform, continues to repress its political opponents and resists the emergence of an independent media. Democracy-building aid activities have consequently been limited to working to strengthen civil society by supporting the development of a variety of NGO's in areas such as women's rights, advocacy for the handicapped and general human rights. People-to-people

programs such as USIA exchanges, farmer-to-farmer programs, and the Department of Commerce's SABIT Business Internship Program contribute to the development of Uzbekistan's civil society. Another project assists 16 local television stations.

Health care programs. Since 1992, the U.S. has allocated approximately \$7 million for improvements in Uzbekistan's health care system which have benefited women and children in particular. At the national level, the U.S. is helping Uzbekistan create a computerized national disease surveillance system. At the local level, USAID is beginning a major project that will develop pilot programs for financing rural hospitals.

Family planning programs. Underlying these programs is a focus on women's reproductive health and children's health. USAID supports two family planning programs that seek to reduce rates of maternal morbidity, infant mortality and abortions by creating model training clinics and conducting public education campaigns on the use of modern contraceptives. Recent data from project sites throughout Central Asia indicate a significant decline in abortions and increase in contraceptive use in recent years. USAID and the U.S. Center for Disease Control are also operating training programs aimed at battling infectious diseases such as polio, diphtheria, and Uzbekistan's two major causes of child mortality -- pneumonia and diarrhea. A medical partnership between Tashkent State Medical Institute and the University of Illinois at Chicago Teaching Hospital has been awarded over \$1.5 million in grants since April 1995 for work on treatment of high-risk pregnancies, training in neo-natal resuscitation, and establishment of a Women's Wellness Center.

Environmental programs. The USG has provided nearly \$9 million for environmental programs in Uzbekistan since 1992. A large portion of these funds have financed projects that address the environmental disaster zone surrounding the Aral Sea. USAID has provided \$7 million for capital improvements in water treatment facilities in communities near the Aral Sea. USAID has also sponsored intense efforts to promote regional cooperation on water management and sharing. Thanks to this initiative, the presidents and prime ministers of Uzbekistan, Kyrgyzstan and Kazakhstan are close to agreement on a common water management policy. USAID has also funded pollution control projects at a major oil refinery and cement plant.

Energy programs. The U.S. has recently initiated a new project that aims to develop a legal and regulatory structure for Uzbekistan's energy sector. The goal of this program is to create the necessary conditions to attract foreign investment.

Humanitarian Assistance. We have delivered \$58.7 million in medical equipment, medicines, and other commodities donated by the U.S. Department of Defense and private voluntary organizations since 1992.

UZBEKISTAN: ENVIRONMENTAL ISSUES

Serious problems. Caused largely by the former Soviet regime's mismanagement of natural resources in the region, Uzbekistan's environmental problems include depletion of water supply, deteriorating water quality, water contamination from both agricultural pesticides and fertilizers and industrial enterprises, increasing water salinity, public health crises, improper waste and wastewater disposal, and air pollution from the industrial sector, concentrated in Tashkent province. Uzbekistan's economy relies largely on agriculture and extraction of natural resources, both carried out in an unsustainable manner, particularly with respect to water use.

Aral Sea disaster. Uzbekistan includes the southern portion of the Aral Sea. Due to Soviet agricultural development policies, large amounts of water were diverted from this sea for irrigation, leading to its shrinkage to slightly more than half its previous volume. The massive diversion of water from the two main tributaries, the Amu Darya and the Syr Darya, in combination with unsustainable agricultural practices, has destroyed the Aral Sea as a viable ecosystem and ruined local economies in the process. The U.S., along with the World Bank, UNDP, the EU, and Canada, is now focused on trying to stabilize the situation; any hope of restoration is dim at best.

USAID assistance. Much of USAID's initial focus has been on the urgent public health needs arising from the sea's degradation. Several million people living in the sea's basin have been deprived of access to safe water and have experienced abnormally high rates of morbidity, non-specific diarrheas, and viral hepatitis. In response, USAID undertook a series of multi-million dollar potable water projects to provide increased clean water access to over a million Central Asians. Some \$7 million of capital improvements including new disinfection systems, coagulation units, and expanded testing capabilities were provided to potable water treatment facilities in the major towns of northwestern Uzbekistan. Uzbekistan has committed resources to insure the ongoing maintenance and operation of these renovated facilities. USAID has provided legal and regulatory review to help develop Uzbekistan's National Environmental Action Plan, and has emphasized use of economic instruments to promote environmental improvements and discourage liability hazards.

Water sharing and management. Donors including USAID, the World Bank, UNDP and the EU have sponsored intense efforts to promote cooperation among the five new Central Asian Republics in water management and sharing, thereby addressing the underlying causes of the Aral Sea disaster. From workshops and a demonstration

project to promote concepts of water pricing, protection of water resources for beneficial uses, and water demand management, donors have shifted to application of these principles at the Toktogul Reservoir, the largest multi-year storage facility in Central Asia, used primarily for irrigation and secondarily for power production. Acreage under irrigation provided by Toktogul water generates hundreds of millions of dollars from cotton and other crops in Uzbekistan and somewhat less from rice and other agricultural production in Kazakhstan.

Competing needs. Acute tension has arisen from competing needs for power generation for winter heating of homes in Kyrgyzstan and irrigation of crops in the summer for downstream countries. A series of year-long agreements between the countries on the dam's operation and the sharing of water have collapsed.

Water management agreement. Over the last year and a half, USAID has worked with the Interstate Council of the Republics of Kazakhstan, Kyrgyzstan, and Uzbekistan (ICKKU) to establish a multi-year agreement applying the principles of water pricing and demand management. The result is a draft agreement which ICKKU will submit for approval by the three governments by early 1998. USAID intends to assist in successful implementation of the agreement. Based upon the lessons learned through Toktogul, USAID also plans to assist with the development of other water basin management agreements along the Syr Darya. On a more local level, USAID is helping to form agricultural water user associations through training seminars and drafting of sample incorporating documents.

Waste minimization. Over half of Uzbekistan's industry is centered in Tashkent Oblast. Principal environmental problems are air emissions of particulates from power plants and cement plants, wastewater from chemical plants, and disposal of solid wastes from mineral extraction and processing. To tackle these, USAID funded demonstration projects in waste minimization in two industries. An oil refinery and a cement plant installed pollution reduction equipment, resulting in large energy and dollar savings and substantial reductions in carbon dioxide and particulate emissions.

Environmental NGO Development. Non-governmental organizations are a key means of overcoming the Soviet legacy of environmental mismanagement. USAID has funded ISAR, a non-profit organization that supports NGOs working on environmental issues in the Newly Independent States since 1993. ISAR has awarded \$500,000 in small grants (from \$300 to \$5,000) to local NGO's to conduct concrete actions in environmental education, awareness, monitoring, and law; alternative energy; sustainable development; sustainable agriculture; and related areas.

EMBASSY OVERVIEW: TASHKENT, UZBEKISTAN

Location and staff. Embassy Tashkent opened in March 1992 and moved to its present site in a former Soviet Youth Center about five miles from downtown Tashkent later the same year. Staffed initially by fewer than ten full-time Americans, the Embassy has grown substantially to reflect the increasing complexity of U.S.-Uzbek relations and U.S. interests in the region. The Embassy now has about 32 full-time direct hire American positions plus several local hire Americans.

Offices and programs. The State Department complement includes political/economic, political/military, administrative and consular sections. In addition, the newly-created regional environmental office is located here, covering the five Central Asian states most affected by the Aral Sea crisis. The following agencies also are present in Tashkent:

USIS. USIS is staffed by a Public Affairs Officer and a Regional English Language Specialist.

USAID. USAID for Central Asia is based in Almaty, but represented in Tashkent by one direct-hire American.

Foreign Commercial Service. The Foreign Commercial Service is represented by a Senior Commercial Officer, who also oversees the operations of the American Business Center here.

Defense Attaché. The Defense Attaché Office (DAO) is headed by an Army Lieutenant Colonel assisted by an Operations Coordinator. DAO oversees the Partnership for Peace Program and the bilateral military educational and training exchanges.

Peace Corps. The Peace Corps maintains two programs countrywide, one focusing on English teaching and the other on small business development and education, with about 50-60 total volunteers.

Other. Family services for resident Americans are developing gradually as funding increases and Uzbek officials become more comfortable dealing with an international business and diplomatic presence. There is a locally organized International School and an International Clinic. The U.S. government contributes significantly to both institutions.

UZBEKISTAN: TASHKENT SCENESETTER

History. Tashkent was the fourth largest city in the Soviet Union and the Russian/Soviet administrative center for central Asia. Until its conquest by the Czar's armies in 1863, Tashkent had been a minor town (its name means "stone village" in Uzbek). By the mid-nineteenth century, however, Tashkent had grown into a prosperous trading town.

City setting. Tashkent has the appearance of a modern city, owing mostly to its near-total destruction by an earthquake in 1966. It was rapidly rebuilt in a "Soviet modern" style. Post-independence, much new building is going on and the government has encouraged a more Asian architectural style. Many new buildings have white columns and turquoise domes. The combination of this new style with the broad, tree-lined boulevards built by the Soviets makes Tashkent a pleasant city to visit.

UZBEKISTAN: SAMARKAND SCENESETTER

History. Samarkand, which celebrated its 2,500th birthday last year, was already a major urban center when it was conquered by Alexander the Great. For almost a thousand years, beginning in the second century B.C., virtually every caravan on the Silk Route passed through Samarkand. It remained an important trade city until sea routes between Europe and the Orient were opened. The city's glory ended with its destruction at the hands of Genghis Khan in 1220. However, by early in the thirteenth century, Samarkand recovered when Tamerlane (known here as Amir Timur, the "Iron Emir") chose it as his capital.

City setting. Today Samarkand, with a population of about 500,000, is a center of commerce supporting agricultural activity in the surrounding countryside. There has been some light industrial development. Samarkand is set apart from other Central Asian cities by its spectacular historic sights.

UZBEKISTAN: BUKHARA SCENESETTER

History. Considered by many to be Uzbekistan's most beautiful city, Bukhara celebrated the purported 2500th anniversary of its founding on October 19, 1997. Successively ruled by Achaemenids, Greeks, Seleucids, Parathions, and Kushans before being captured by Arabs in the eighth century, it was a major trading, cultural, and educational center for much of its history. It was the capital of the Samanid empire -- the first independent central Asian state -- in the tenth century. Largely destroyed by Genghis Khan, the city's fortunes improved in the second half of the sixteenth century as it became the center of various Khanates or Emirates until 1920. The Emirate of Bukhara became a protectorate of Russia in 1873, although the Emir was allowed to continue to rule. Bukhara was a center of counter-revolution during the Russian civil war and was taken by the Red Army in September 1920. Any semblance of Bukharan independence (under a Bukharan People's Republic) was ended in September 1924 when the region officially joined the Soviet Union.

City setting. Today, Bukhara is a quiet city of roughly 300,000 inhabitants. While there are some industrial enterprises in the new part of the city, the city was not as heavily industrialized as others in central Asia. Moreover, the old city, with its narrow, twisting streets, maintains a separate atmosphere from more modern sections of Bukhara, and kept its historic identity intact.

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UZBEKISTAN

Tashkent – Chicago, Illinois

TASHKENT, UZBEKISTAN – CHICAGO, ILLINOIS PARTNERSHIP

AIHA's Medical Partnership Program between the cities of Tashkent, Uzbekistan and Chicago, Illinois, funded under a cooperative agreement with the United States Agency for International Development (USAID), was formed in October 1992. The Uzbek partner, the Second Tashkent State Medical Institute (TashMI II), is one of the ten largest hospitals in the NIS. Further, TashMI II is the largest medical facility in Central Asia. The US partner, the University of Illinois at Chicago (UIC) Medical Center, is a major academic medical center, and it includes the UIC Hospital.

The general areas of focus for this partnership have been Neonatology and perinatal medicine, women's health, hospital and clinic administration, nursing and medical education, general surgery and neurosurgery, and various medical specialty areas (such as orthopedics and anesthesiology).

Program Outcomes

Neonatology and Perinatal Medicine: Partnership efforts have resulted in tangible advances in the services and quality of care provided at TashMI II. There has been a steady decline in the number of infant and maternal deaths within the Institute's facilities. A new neonatal intensive care unit (NICU) was equipped and staffed by physicians trained at UIC, and substantial improvement has occurred in resuscitation techniques and the care of premature infants. Teaching programs have been developed for nurses and physicians utilizing lecture materials and videos made available by UIC.

The Ministry of Health of Uzbekistan has played an active role in dissemination efforts and provided support by allocating five million Uzbek som (approximately US \$2000) to TashMI II in order to renovate facilities for a high-risk pregnancy center which would be developed as a center of excellence for perinatal care. In the spring of 1995, TashMI II established the Center for Extra-Genital Pathology, which identifies and treats women of child-bearing age who have pathologies that could impact their health and the health status of their children.

The Ministry, TashMI II and UIC faculty has cooperated in providing a number of conferences designed to improve the identification and treatment of high-risk women and neonatal outcomes. In the fall of 1994, a partnership-sponsored neonatology conference took place in Tashkent. The conference was attended by over 100 health care professionals from TashMI II and various oblasts across Uzbekistan as well as from AIHA partnership institutions in Kyrgyzstan, Russia, Turkmenistan and Ukraine. The conference continued an unprecedented dialogue on modern problems in perinatology/neonatology between the NIS and the US health care community.

During the past year, a focus of partnership activities has been to develop a Neonatal Resuscitation Training Center at TashMI II. The Center was officially opened in April 1997, with visiting UIC faculty participating in opening ceremonies as well as the initial training sessions provided at the Center. The Center trains physicians, nurses and midwives from both TashMI II and other health care institutions in the region through monthly courses in neonatal resuscitation. A medical institute in Urgench, another city in Uzbekistan, also has an interest in developing such a training center. Both UIC and TashMI II have provided assistance to facilitate this effort. During June and July of 1997, a neonatologist from Urgench was part of a visiting delegation from Uzbekistan. She was

TASHKENT, UZBEKISTAN – CHICAGO, ILLINOIS PARTNERSHIP

oriented to approaches for training physicians and nurses in neonatal resuscitation, and she spent time in observing the delivery of care in UIC's perinatal and neonatal high-risk units.

Women's Health: The involvement of TashMI II in improving care to high-risk women was a factor in the Institute's selection as one of several NIS sites for development of a Women's Wellness Center. The Center is scheduled to open in the fall of 1997; it will provide a model for delivery of a full range of preventive, primary care, diagnostic and treatment services to women. During June and July of 1997, the designated Medical Director (an obstetrician) and the Nurse Manager for the Center visited UIC, together with another obstetrician and nurse who will also work in the Center. The group visited various women's health programs associated with UIC, and they gathered ideas for marketing the Center, recruiting patients, and assuring the effective delivery of the care to be delivered at the Women's Wellness Center. The need to develop expertise in prevention and early diagnosis was emphasized during the visit. The group was also exposed to innovative approaches to family planning and reproductive health and the delivery of services to women experiencing problems related to menopause and aging.

Hospital Administration and Financial Reform: Exchanges in hospital management and financial administration have focused on the reorganization of the hospital's management structure and the development of improved relationships between the medical institute and the clinical departments. Several physicians in high-level positions at TashMI II have taken advantage of AIHA/AUPHA's management training seminars, and the administrative practices at UIC have been studied by TashMI II visitors. TashMI II has improved the financial standing of its hospital facilities by retiring nearly two-thirds of its beds, reducing average inpatient stays (from more than 18 days in 1992 to less than 10 days now), opening an outpatient unit (or day hospital), and shifting part of the patient base into outpatient care. As a result, costly inpatient services have been reduced, decreasing general overhead costs, while outpatient services have grown.

TashMI II previously ventured into fee-for-service care in both outpatient and inpatient settings, with patients demonstrating a willingness to pay for services in internal medicine and gynecology. An attempt was also made to relate the salaries of physicians to productivity. However, governmental policies have been implemented recently which discourage fee-for-service arrangements in public institutions such as TashMI II. Major Uzbek employers are likely to assume greater responsibility for ensuring access to quality health care for employees and their families, although future directions related to financing care are difficult to predict with precision at this time.

Nursing Reform: Nursing reform efforts have resulted in the establishment of performance and competency standards at TashMI II. Nurses are now required to pass clinical performance reviews in their specialty to ensure quality of patient care. Nurses are provided with remedial training to improve their clinical skills if performance is low. Within the Chronic Disease Hospital of TashMI II, the nurses have primary responsibility for patient care and management of a unit (in a manner comparable to what is usual in the US).

Nurses from TashMI II have been well represented at AIHA nursing conferences held in recent years. These conferences have been instrumental in providing direction to the development of standards for nursing practice, the enhancement of nursing roles, the assertion of nursing leadership through skill-building, the reform of the nursing curriculum, and the increase in the visibility of

TASHKENT, UZBEKISTAN – CHICAGO, ILLINOIS PARTNERSHIP

nursing as a profession. An association of nurses has been established with the involvement of TashMI II nursing leaders.

The Women's Wellness Center will provide an opportunity for demonstration of the expanding roles of nurses. Along with the Medical Director, a Nurse Manager will have responsibilities associated with administration of the Center. Nurses will also assume expanded roles in outreach and prevention, patient education and counseling.

Physician Training: Over the past five years, over 30 physicians have participated in intensive training programs in Chicago ranging from two weeks to six months. Training modules have been conducted in neonatology, orthopedics, neurosurgery, cardiac diagnostic and surgical procedures, obstetrics and gynecology, hospital administration, nursing management, and medical education. Physicians have received instruction in modern techniques and practices with the expectation that they would return to TashMI II and serve as trainers within their respective departments. Recently, TashMI II has participated in outreach to other parts of Uzbekistan (e.g., Urgench).

UIC has now been host to two physicians from Uzbekistan who have been awarded training fellowships for extended periods of time. One Uzbek neurosurgeon had a fellowship for a six-month course of study. An obstetrician/gynecologist arrived at UIC in June of 1997 for a three-month internship (with both a clinical and administrative focus in women's health) after spending the previous twelve months at the Humphrey Institute of Public Affairs at the University of Minnesota under a Fullbright scholarship program.

Future Plans for the Partnership

The partners plan to continue successful projects in the areas of neonatology and perinatal medicine, women's health, hospital and clinic administration, nursing administration and nursing education. Activities will focus on the implementation and development of the Women's Wellness Center and the Neonatal Resuscitation Training Center at TashMI II. A commitment has also been made to the development of a Neonatal Resuscitation Training Center in Urgench. As funding permits, attention will also be given to other outreach and "train the trainer" programs in Urgench. A Nursing Resource Center is also expected to open in Tashkent early next spring.

Although progress has been made in the upgrading of high-risk services for maternal and neonatal patients, there remains a need for the continued development of the Center for Extra-Genital Pathology (in the Maternity Hospital) as a referral center for high-risk care. Visitors from Uzbekistan will continue to be oriented to concepts related to delivery of care within a perinatal system.

The partners will work together to improve managerial skills in financial accounting, human resource management, and patient records and data management systems. They will continue to promote consolidation of departments and expansion of ambulatory care.

Advanced training for nurses will be provided in nursing management and in the clinical areas of neonatal/perinatal care and women's health. The partners will continue to facilitate the

TASHKENT, UZBEKISTAN - CHICAGO, ILLINOIS PARTNERSHIP

development of on-site training programs based upon the expectation that those benefiting from training will, in turn, serve as the trainers for others.

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UKRAINE

Donetsk – Orlando, Florida

Kiev – Coney Island, New York

Kiev – Philadelphia, Pennsylvania

L'viv – Buffalo, New York

L'viv – Detroit, Michigan

Odessa – Coney Island, New York

DONETSK, UKRAINE – ORLANDO, FLORIDA PARTNERSHIP

AIHA's Medical Partnership Program between the Orlando Regional Healthcare System in Orlando, Florida, and the Donetsk Oblast Trauma Hospital in Donetsk, Ukraine, funded under a cooperative agreement with the United States Agency for International Development (USAID), began in September 1995.

The general areas of partnership focus are orthopedics and joint replacement, infection control, biomedical engineering, computing communications, emergency medicine, and women's health.

Program Outcomes

Orthopedics/Joint Replacement: The US partners evaluated the capacity of the operating room for conducting orthopedic surgery, observed surgical procedures and inventoried equipment needs. The NIS partners have observed surgeries in joint replacement and have been trained in the use of various types of orthopedic equipment. As a result, new techniques in joint replacement for the hip and knee have been learned and seventy-two joint replacement operations have been performed.

Infection Control: The NIS partners observed infection control practices in both the operating room and on patient care units. They were also trained in sterilization techniques for instruments and supplies. According to a report submitted by the Donetsk Oblast Trauma Hospital, the average length of stay at the hospital decreased from 30.6 days in 1995 to 27.8 days during the first six months of 1996. During the same period the mortality rate decreased from 2.4 to 1.9, for 10,000 treated patients. As a result of a new regulation set forth by the Head Physician, two new positions for epidemiologists were established at the hospital. Data has been gathered to establish baseline status and procedures are in place to monitor these indicators on a continuous basis. The nursing staff at the hospital has been very involved in implementing an effective system of infection control.

Future Plans for the Partnership

The partnership will continue to assess and evaluate infection control practices, including data collection and analysis. The partners will establish and implement an employee training program to reduce the risk of infection to hospital staff as well as patients. A comprehensive immunization program will also be established for the region.

Clinical training will be conducted in the areas of surgery, rehabilitation/physical therapy, and radiology. The partners will evaluate the current use, effectiveness, and supply of prosthetics in the area of joint replacement, as well as physicians trained in this area. The role of the nurse in post-operative care and infection control will continue to be expanded upon.

Training will be provided to staff on the usage of equipment, recommendations for preventative maintenance, and procedures for repair. The partners will assess biomedical policies and procedures, and the documentation of preventative maintenance of equipment.

An EMS curriculum, including documentation and monitoring of outcomes, for training of EMS personnel will be introduced. Guidelines for communication between the hospital and EMS personnel will be established. Partners will identify and establish the role of the hospital within a

DONETSK, UKRAINE – ORLANDO, FLORIDA PARTNERSHIP

citywide EMS system. An EMS Training Center will be established in November 1997. Instructors for the Center were trained by their counterparts in Orlando.

Physicians and staff at the hospital have been trained on the use of the Internet for both medical reference and education. The Local Area Network will be fully developed within the coming year.

The Women's Health Initiative will be undertaken in 1998 based on the specific needs of the Donetsk region and patterned after other women's health programs in the NIS.

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KIEV, UKRAINE – CONEY ISLAND, NEW YORK PARTNERSHIP

AIHA's Kiev EMS Training Center was opened on December 15, 1995, on the campus of the city's Hospital of First Help (EMS Hospital). The Center is one of nine EMS Training Centers developed by AIHA and its partnerships in the NIS to provide local capacity to train emergency first responders. Emergency response was an area largely neglected in the former Soviet Union and one which enjoys an especially high priority for the new governments now in light of the increased risks for disasters which have resulted from the profound economic deterioration.

As in the case of all partnership activities, funding for the center comes from a variety of sources. Substantial funding and in-kind contributions were made by the Ministry of Health and the City of Kiev to refurbish and furnish the center classrooms and offices; USAID/AIHA funds were used to equip the center with instructional materials and technologies and to pay for travel of instructional staff and administrative costs; and thousands of expert training hours in the United States and in Kiev are being contributed by Coney Island Hospital and New York City Fire Department.

To date, eighteen pre-hospital training courses have been conducted for a total of nearly 900 health professionals trained by the Ukrainian faculty. The student population includes professors, physicians, interns, feldshers and nurses, as well as other emergency service personnel. In addition, members of the Antarctic Expedition have been trained by the Center's staff. In keeping with the train-the-trainers methodology of the program, US representatives helped to conduct the early courses, served as course monitors, and assisted with faculty development.

As a result of the efforts of the Training Center's leadership, in June of 1996 the Minister of Health issued an order requiring all ambulances throughout Ukraine to be supplied with specialized equipment. This equipment, which was introduced at the EMS Training Center, includes spinal immobilization devices and extrication cervical collars. The Center has also conducted training of the Presidential Security Staff and representatives of the Ministry of Internal Affairs. Plans for the next twelve months include the presentation of seventeen various pre-hospital EMS and instructor training courses for a total of 550 students. At the request of the Ministry of Internal Affairs, the Partnership has developed a "First Responder" program.

As the interest and growth of the AIHA EMS Special Initiative, the Partnership has assumed the role of a major training and educational facility for emergency and disaster medicine. In August of 1997, the US and Ukrainian partners presented a Train the Trainers course entitled: "Infection Control for the Pre-Hospital Care Provider" to the faculty members of AIHA's EMS Training Centers. In addition, the Partners will be conducting an Instructor Training Program for new Instructors. The faculty members of the Kiev in concert with their US colleagues, will assume the role of Instructor Trainers for the system of satellite EMS training centers throughout Ukraine. A new course is being developed to address the medical management of a Catastrophic Casualty Producing Incident, or Disaster. The curriculum will debut in mid-1998.

In June of 1997, the Partners met with senior representatives of the Ukraine Ministry of Health in order to discuss reform of the EMS System in Ukraine. All parties pledged their assistance in helping to create an efficient emergency medical service and national disaster medical system in this nation of 55 million people.

KIEV, UKRAINE – CONEY ISLAND, NEW YORK PARTNERSHIP

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KIEV, UKRAINE – PHILADELPHIA, PENNSYLVANIA PARTNERSHIP

AIHA's Medical Partnership Program between the University of Pennsylvania Schools of Medicine and Nursing, the Hospital of the University of Pennsylvania, and The Children's Hospital of Philadelphia, and the Left Bank Center for Maternal and Child Health Care in Kiev, Ukraine, funded under a cooperative agreement with the United States Agency for International Development (USAID), has existed since October 1992.

The general areas of partnership focus are maternal and child health, including management of pregnancy, prenatal evaluation, ultrasonography, and family planning; pediatric sonography, cardiology, and gastroenterology; nursing education and practice; women's health; and breast cancer screening and education.

Program Outcomes

Obstetrics/Gynecology: The Center for Maternal and Child Health Care (CMCHC) is recognized as a center of excellence for obstetrical care and consequently attracts clients from the surrounding districts of Kiev. Both the Ministry of Health and the City Health Administration have recognized the reforms implemented by increasing budget allocations to the hospital for purchase of modern equipment and consumables. The Center's reputation as a high-quality provider has attracted many women from other districts to deliver their babies there. Indeed, while the municipal birth rate decreased by six percent in 1994, CMCHC actually experienced a 1.6 percent increase in deliveries since 1993. In 1997 the birth rate has continued at a rate of 3000 per year.

According to a mid-year report submitted by the CMCHC in 1996, the average length of stay for all patients decreased from 7.9 days in 1995 to 7.2 days, in addition to strides made in specific departments. The average length of stay (ALOS) in the obstetrics department for post-operative treatment decreased from 7.1 days in 1995 to 5.2 days. In the gynecology department the ALOS for post-operative treatment decreased from 6.6 days in 1995 to 6.1 days. In 1995 the Center opened an outpatient unit for gynecological patients.

Quality of labor and delivery services has greatly improved as a result of training in neonatal resuscitation and the introduction of labor and delivery relaxation techniques. The creation of a School for Young Mothers, offering instruction in prenatal care, pain management techniques and fetal development, will continue to effect better fetal and maternal outcomes in the delivery room. In a drastic deviation from traditional clinical practice, husbands that attend the preparation for birth classes with their wives receive permission to attend delivery and act as a labor coach. The newly created Patient Education Center is staffed by two midwives and a psychologist who lectures to the group on the advantages of attending a delivery class as well as including fathers in delivery education and process. In 1996 sixty fathers participated in the program.

The success of the Philadelphia-Kiev Partnership attracted the attention of First Lady Hillary Rodham Clinton. She visited the CMCHC in May 1995, to tour and witness its demonstrated success in improving the health of mothers and babies in Kiev. During her visit, Mrs. Clinton observed a birthing education class at the recently organized School for Young Mothers and talked with obstetrician-instructors and expectant mothers.

KIEV, UKRAINE – PHILADELPHIA, PENNSYLVANIA PARTNERSHIP

Prenatal Evaluation and Ultrasonography: Partners established a Prenatal Evaluation Center in Hospital No. 3 which contains consultation rooms and equipment for fetal monitoring and fetal ultrasound. The formation of a ten-bed ambulatory day care unit for women with high-risk pregnancies has given a significant boost to overall efficiency and productivity. The unit allows patients to receive treatment for conditions such as anemia and hypertension on an outpatient basis. In conjunction with other clinical and administrative innovations, the Center has been able to achieve a decrease in the postpartum length of stay for normal deliveries from 7.4 to 4 days. Fetal monitoring in the hospital's new Prenatal Evaluation Center has added to the decline in mortality rates because of ultrasound diagnosis of fetal abnormalities.

Perinatal and Neonatal Care: As a direct result of improved techniques in ultrasonography, fetal testing, neonatal resuscitation and labor and delivery services, the Center has reported a 62 percent decrease in perinatal mortality since 1993. In 1997 the infant mortality rate was reported to be 9.6/1000. Intense training in neonatal resuscitation and consequent improved management of neonatal asphyxia has resulted in a decline in infant mortality rates.

CMCHC statistics in 1996 document that the early neonatal mortality was reduced from 4.9 per 1000 in 1995 to 4.8 per 1000. The rate of infectious disease among newborns was nearly halved from a rate of 2.5 per 1000 in 1995 to 1.4 per 1000 in the first half of 1996. The Center opened a new Level II Neonatal Intensive Care Unit in 1995 and began performing artificial pulmonary ventilation in a lasting ventilation regime, special infant management techniques using intubation and artificial pulmonary ventilation, and phototherapy techniques for newborns with hemolytic disease.

Family Planning: A polyclinic at the Center for Maternal and Child Health Care initiated a family planning program offering a range of women's health services, health education and contraceptives donated by the University of Pennsylvania. Together with contraceptive counseling, distribution of contraceptive pills, donated by the University of Pennsylvania and Project Hope, to over 600 women contributed to a 30 percent decrease in abortions performed at the hospital in 1994. The ratio of abortions to live births in 1997 is 1:1, continuing the downward trend from greater than 2 abortion:1 live birth at the inception of the program.

Pediatric Sonography, Cardiology, and Gastroenterology: Diagnostic skills in the ultrasound department continue to improve and be developed. The Center now has a fully equipped facility for neurologic, cardiac, and abdominal studies. Work in this area with the US Partners led to the diagnosis of a case of sub-acute bacterial endocarditis, which was successfully treated with antibiotics. The endoscopy suite is also fully equipped and techniques continue to be improved upon. The implementation of GI guidelines from the partners has led to a decrease in the number of studies that are done on young children.

Nursing: Building on the experience of the Nursing Leadership Conference in Moscow, the partners are working together to enhance the nursing profession and the role of nurse leaders. An initial step in this process was made in May, 1995 when the Center hosted an organizational meeting to facilitate the creation of the nursing associations within Ukraine. The associations' goals will include expanding the scope and methods of nursing education; improving the level and quality of nursing administration; creating collaborative relationships between nurses and other health care

KIEV, UKRAINE – PHILADELPHIA, PENNSYLVANIA PARTNERSHIP

providers; and defining the scope of nursing practice. The Nursing Association of Kiev was formed in June 1995. A Nursing Learning Resource Center was opened in April 1997, which serves as a resource for nurses at the Center as well as students in the areas of both education and training.

Future Plans for the Partnership

Additional training will be given to delivery room staff for immediate care of the newborn. A continuous quality improvement program will be implemented in the delivery room in an attempt to establish internal monitoring which may help to sustain those changes made in techniques and functions of the delivery room.

The scope of the Perinatal Evaluation Center will be expanded upon to include the use of protocols for the management of normal pregnancies and routine complications, such as pre-eclampsia and premature labor.

New treatment methodologies for patients with asthma and cystic fibrosis will be addressed in order to decrease hospitalization rates and length of stay and move toward outpatient treatment of these diseases. The partners will also work in pulmonary physiotherapy and outpatient management of cystic fibrosis. Protocols will also be developed to address appropriate treatment modalities and improve pulmonary health for patients with these diseases.

The parent education center will be expanded allow for dissemination both within the Center, as well as at other hospitals in the region. A curriculum will be developed, including study guides and audio-visual materials, and additional staff will be trained.

The partnership will implement the Women's Health Initiative, which will focus on three areas: family planning, diagnosis and treatment of sexually transmitted diseases, and adolescent health. The adolescent health aspect will attempt to focus upon teen health issues including sexuality, family planning, and sexually transmitted diseases.

The breast cancer program will focus on educating and screening women for breast cancer. The major features of the program include community based screening, educational outreach for breast self examination and mammography, patient support groups, and patient centered care. A liaison between the Center and the local oncology center has been established which will help manage the treatment of patients diagnosed with breast cancer.

KIEV, UKRAINE – PHILADELPHIA, PENNSYLVANIA PARTNERSHIP

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L'viv, Ukraine – Buffalo, New York Partnership

AIHA's Medical Partnership Program between Millard Fillmore Health Systems and the SUNY Buffalo School of Medicine and Biomedical Sciences in Buffalo, New York, and L'viv Clinical Railway Hospital and L'viv Perinatal Center in L'viv, Ukraine, funded under a cooperative agreement with the United States Agency for International Development (USAID), has existed since April 1993.

The partnership emphasizes obstetrics and gynecology, infection control, ophthalmology, resource center development, hospital administration, and laparoscopic surgery.

Program Outcomes

Obstetrics and Gynecology/Surgery: Implementation of prenatal screening and diagnostic ultrasound has enabled the partners to better identify high-risk pregnancies and, ultimately, improve fetal outcomes at the L'viv Perinatal Center. They have also introduced the utilization of the vaginal probe with ultrasound for prenatal diagnosis. Training in the primary care of women has also been conducted, combined with specific efforts in the reduction of low birth weight infants and their care. Between 1992 and 1995 the number of complications due to infections decreased in both the maternity and the gynecology units. In the maternity unit it has decreased by 2.8 times and in the gynecology unit it has been reduced by a factor of 3.8.

The mid-year report in 1996 revealed a number of statistics regarding strides that have been made in the Perinatal Center. The average length of stay in the maternity unit decreased from 13.6 days in 1995 to 11.2 days in 1996. The average length of stay in the gynecology unit was reduced from 5.8 days in 1995 to 5.4 days in 1996. In addition, the length of stay for a woman after a normal delivery was reduced to 3 days. Perinatal mortality rates were decreased from 27 percent in 1995 to 26 percent in 1996. Intra-natal mortality rates were reduced from 15.5 percent in 1995 to 14 percent in 1996. The mortality rate of full-term infants was also lowered in 1996 to 2 percent from a rate of 3 percent in 1995.

The L'viv Perinatal Center has begun performing the following new diagnostic procedures: hysteroscopy, amniocentesis, and ultrasound examination with the use of a transvaginal meter. The following treatments and procedures have also been introduced at the Center: laparoscopy, cystectomy, laparoscopy tubectomy, LAVH, laparoscopic surgical sterilization, minilaparotomy, and prolongation of pregnancy despite premature release of amniotic fluid.

The Perinatal Center has begun providing laboratory examinations on an out-patient basis prior to surgery, and treating women with gynecological diseases. A short procedure unit was opened at the Center, in addition to a neonatal intensive care unit and a prenatal diagnostics unit.

Infection Control: Both NIS partner hospitals have implemented infection control programs including Universal Precautions, improved cleaning, disinfection and sterilization techniques, and prophylactic vaccination of health care providers against Hepatitis B and diphtheria. As a result, the incidence of nosocomial infections at L'viv Perinatal Center has been reduced by 15 percent. The position of Infection Control Officer has been added at Railway Hospital. This individual has responsibility for hospital-wide infection control and the quality improvement program. Nurses continue to be trained in Body Substance Isolation and Universal Precautions. Statistics at Railway

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Hospital show that both hospital personnel contact with patients' blood and hospital infections between patients have been significantly reduced. The overall length of stay at Railway Hospital has been decreased by 2 days.

Ophthalmology: At Railway Hospital, extensive hands-on training in early detection of myopia and cataracts has led to a 40 percent increase in early detection and an estimated 20 percent decrease in vision related disabilities. Treatment was changed from intra-capsular to extra-capsular techniques, and over 125 patients received extracapsular implants with correctly fitted lenses to restore full vision. Training has continued in the areas of extra- and intra-capsular lens implementation surgery as well as phaco-emulsification. To date over fifty phaco-emulsification procedures have been performed. New diagnostic tools have helped to identify over 2600 patients with cataracts and over 800 patients with glaucoma. Surgery has been indicated and performed for ninety-two of the glaucoma patients.

Resource Center Development: Librarians from the L'viv Scientific Library have received training in Buffalo to increase their knowledge of computers and the use of bibliographic materials. They have studied the hospital library system and its support of patient care and have been trained in special search techniques on new equipment that they now have in L'viv. They plan to implement a computerized bibliographic system stored in two databases at the Resource Center. The partners have successfully translated "Prologue in Obstetrics" and disseminated educational materials to a vast audience. Reference materials and textbooks have been transferred to the L'viv partners for establishment of a medical reference library.

Hospital Administration: Billing and collection procedures and cost containment strategies have been implemented at both L'viv hospital sites. The role and responsibilities of the Infection Control Officer were developed to include the management of infection control data and statistics.

In February 1996, a cost accounting department was opened at the Railway Hospital. The hospital now provides services for which they receive payment. Revenues from these services total over \$5,000 per month. The hospital anticipates that within five years they will transition to a completely fee-for-service institution.

Laparoscopic Surgery: Laparoscopic training has been conducted in three stages: research and study of the techniques, observation of the techniques, and, lastly, using a laparoscopic trainer under the supervision of a US trainer. Physicians have observed and studied the following surgeries: laparoscopic cholecystectomy, appendectomy, herniorrhaphy, colon resection, and Nissen fundoplication. A new laparoscopic surgery department was opened at Railway Hospital in February, 1996; the department is staffed by physicians and nurses who were trained in Buffalo. A new laparoscopic technique, double combined extirpation of uterine tissue, was introduced at the Perinatal Center in 1996. Statistics that were received in June 1997 from Railway Hospital indicate that 1603 laparoscopic GI procedures have been performed using the equipment and techniques learned from US Partners. Eight GI endoscopists have also been trained and have begun performing laparoscopic gynecologic surgeries at Railway Hospital.

Future Plans for the Partnership

A comprehensive approach to women's health and breast cancer screening will be fully implemented, enabling the L'viv partners to provide screening programs for breast, cervical, and uterine carcinomas, as well as to offer appropriate treatment interventions. Mammography procedures will be standardized and an educational outreach program will be developed, including instruction in Breast Self Exam. Pap smear testing and staining will be standardized using the Bethesda Classification method. Basic birth control services will be provided in an outpatient clinic. Outpatient treatment of cervical dysplasia, including colposcopy and cryotherapy will be provided on an outpatient basis.

An NICU will be developed at the Perinatal Center and personnel will be trained in the treatment of premature newborns with respiratory illness. A birthing room and "Birthing Center" will be created at the Perinatal Center.

The partners will develop a preventative maintenance program. Equipment will be evaluated for potential maintenance. The partners will work together to assure the proper functioning of laparoscopic, ophthalmologic and laboratory equipment.

The partnership will work in the area of nursing continuing education program by enhancing collaboration on nursing school curriculum. They will also assist with the development of the Nursing Learning Resource Center.

Training will be conducted in advanced laparoscopic techniques and gynecological laparoscopy at both hospitals. Gastrointestinal and ENT laparoscopy will also be developed at Railway Hospital.

The computer network will be expanded and the potential for dial-in access from both hospitals will be evaluated. Additional training in the use of biomedical databases will be provided.

L'viv, UKRAINE – BUFFALO, NEW YORK PARTNERSHIP

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L'viv, Ukraine – Detroit, Michigan Partnership

AIHA's Medical Partnership Program between Henry Ford Health System in Detroit, Michigan, and L'viv Oblast Clinical Hospital (LOCH) and the L'viv Medical Institute in L'viv, Ukraine, funded through a cooperative agreement with the United States Agency for International Development (USAID), has existed since April 1993.

The general areas of partnership focus are neonatology, urology, rheumatic fever, and emergency care. Other areas of attention have included laparoscopic surgery, ophthalmology, otolaryngology, operating room organization and operation, nursing education and function, and hospital administration.

Program Outcomes

Neonatology: The partners have focused their efforts on establishing a Level III Neonatal Intensive Care Unit to meet the needs of critically ill and pre-term infants being transported to LOCH from throughout the city and oblast. This was accomplished by redesigning the 48-bed unit and establishing eight intensive care beds complete with cardio-respiratory monitoring, capability for providing mechanical ventilation, controlled intravenous therapy, central blood pressure monitoring and supportive treatment. Development of a Neonatal Lecture Series by the US partners was the foundation for education of the LOCH staff. A collaborative practice model for physicians and nurses for care at the bedside was developed as well as one for Unit management. A Nurse Educator position was developed, in addition to the Head Nurse role, to support the education and role development of the bedside nurse. A Collaborative Practice Committee, which utilizes quality management tools introduced by the US partners, meets monthly to solve Unit problems and address practice related issues.

The partners, with the help of the members of the Ukrainian Village Corporation in Warren, Michigan, who provided an infant transport isolette, have established a transport system for sick infants in the oblast. The development of the transport system was significantly supported by the L'viv Oblast Health Department which created new regulations regarding the transport of infants, thereby ensuring that sick infants will be transported to LOCH early in life. Outreach education for district hospital personnel has been established as physicians from LOCH are consulted on neonatal care during transports. Physicians and nurses from district hospitals also come to LOCH for two weeks of bedside training with the staff of the premature baby unit. The planning for a neonatal follow up clinic is underway.

A database was created by physicians at LOCH to measure mortality and morbidity statistics as well as Unit related activities, such as mechanical ventilation, admissions, and transports. A bedside documentation system for physicians and nurses, modeled after the one at Henry Ford Hospital, is currently in use at LOCH. In their yearly reports the hospital has noted a number of strides that have been made in the area of neonatal care. The number of neonates admitted during their first three days of life has increased from zero in 1992 to 74 in 1995. In-hospital mortality rates for pre-term infants were reduced from 6.3 in 1992 to 3.0 per 100 cases for 1995. In April 1996, the unit began providing 24-hour coverage to the NICU.

The partners hosted annual Neonatology Conferences in L'viv in 1996 and 1997. The first addressed Primary Resuscitation of the Newborn and resulted in the Ministry of Health supporting

L'viv, Ukraine – Detroit, Michigan Partnership

the implementation of the Neonatal Resuscitation Program nationally, by way of a national resolution. The resolution stated that the neonatal resuscitation training model developed by the L'viv-Detroit partnership at LOCH would be used for replication nationwide. The 1997 Conference addressed Current Critical Issues in Neonatal Care. Both conferences were attended by over 175 health professionals from all over Ukraine.

The partners began training physicians and nurses from LOCH in Neonatal Resuscitation techniques, and subsequently have trained over 200 health care givers in L'viv and the L'viv Oblast. The first Neonatal Resuscitation Training Center (NRTC) for Ukraine was opened at LOCH in January 1997, and this model will be replicated in four other locations within Ukraine. The Deputy Minister of Health of Ukraine has agreed that these NRTCs will be officially recognized by the MOH. The US partners have trained 25 National Faculty for this national replication effort.

Rheumatic Fever: A L'viv Oblast-wide initiative to identify and develop protocols for the diagnosis and treatment of rheumatic fever and its major sequelae, rheumatic heart disease, continues. During the past year, the collection of demographic-based data concerning the location and incidences of rheumatic fever outbreaks was analyzed and became the focus of plans for the program. Several staff exchanges of physicians to L'viv and Detroit were conducted to develop a coordinated program to address rheumatic fever in the L'viv Oblast. Staff involved included personnel in the departments of infectious diseases, pathology, rheumatology, internal medicine, cardiology, cardiac surgery and pediatrics.

A significant result of the data collection and analysis was the development of a Rheumatic Fever Conference held in L'viv in November 1996. Attended by approximately 200 physicians from throughout Ukraine, the conference included faculty from both Henry Ford Health System and LOCH as well as Ukrainian health officials. A major thrust of the conference was the encouragement of an increased use of prophylactic antibiotics, and a number of conference attendees reported in informal sessions that they would be more aggressive in the use of primary and secondary prophylaxis. A follow-up conference will be conducted in November 1997.

Urology: US partners have conducted training in transurethral resection (TURP) of the prostate and bladder and in related infection control and nursing practices. Dissemination of this information has resulted in the completion of over 200 transurethral surgeries at LOCH. Further, training and donated equipment have allowed L'viv surgeons to successfully develop a urodynamics laboratory at LOCH and perform laparoscopic cholecystectomies. These improvements have contributed to a reduction in average length of stay from 20 days to 5 days while reducing associated patient pain and trauma as well as hospital costs.

Surgeons are now performing endoscopic operations on prostatic adenoma and cystic cancers. The average length of stay for patients with prostatic adenoma was reduced from 21 to 8 days; the average length of stay for patients with cystic cancer was reduced from 27 to 6 days. In addition, a transurethral operating room was opened. Surgeons have also begun endoscopic operations on gallbladder and biliary duct diseases. The average length of stay for these patients was reduced 65 percent, from 16.3 to 5.7 days.

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Emergency Care: During the past year, exchanges to L'viv and Detroit focused on evaluating the function of receiving acutely ill patients at LOCH and planning to implement change to improve the process. Training was provided in critical care resuscitation, patient tracking and management, physical layouts of an emergency receiving department, record keeping, and quality assurance. In addition, the L'viv staff observed physician-nurse collaboration and the role of the nurse in a busy emergency department and was exposed to a system of continuing medical and nursing education preliminary to evaluating the current curriculum at LOCH.

Because acute toxicologic emergencies play a major role in emergency services at LOCH, as well as in the US, a concentrated effort was made to provide training in that area both at Henry Ford Hospital and at the Detroit Poison Control Center. A copy of a computerized data base system (Poisindex) was provided to the LOCH staff, as well as five computer monitors to help in developing a regional toxicology center at LOCH.

Future Plans for the Partnership

In neonatology, the partnership will create a Developmental Assessment Clinic to follow the progress of infants cared for in the Unit and will conduct a third Neonatology Conference in the Spring of 1998. Partnership staff from both Detroit and L'viv will participate in the training of faculty for the Neonatal Resuscitation Centers to be established throughout Ukraine. A new ambulance, which will be purchased with donated funds, will be delivered to LOCH in Fall or early Spring.

Urology exchanges will continue training in transurethral procedures for both surgical and nursing staffs. Training will be provided in the vaportrode approach to TURP and the services provided by the donated urodynamics laboratory will be monitored.

Progress in diagnosing and treating rheumatic fever will continue to be monitored through analysis of the developing database, and preparations will be completed for the 1997 rheumatic fever conference in L'viv.

A plan for the creation of a system of emergency care at LOCH, including the development of a toxicology center, will be developed and monitored.

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ODESSA, UKRAINE – CONEY ISLAND, NEW YORK PARTNERSHIP

AIHA's Medical Partnership Program between Coney Island Hospital in New York, and Odessa Oblast Hospital in Odessa, Ukraine, funded under a cooperative agreement with the United States Agency for International Development (USAID), has existed since October 1992.

The partnership emphasizes surgery, infection control, neonatology, nursing, dentistry, hospital administration, women's health, and breast cancer.

Program Outcomes

Surgery: Hands-on training at Coney Island Hospital in thoracic, vascular, ophthalmologic and orthopedic surgery have provided Ukrainian physicians with the opportunity to employ new methods in every day practice and disseminate them to their colleagues in the Odessa Oblast. In the five years of the partnership's collaboration approximately 2,000 laparoscopic procedures were completed by the surgeons at Odessa Oblast Hospital(OOH). Six surgeons from OOH have become experts in laparoscopy and laparoscopic cholecystectomy is now performed as a standard procedure in 73 percent of patients with cholecystitis. As a result of all the improved surgical techniques, there has been a reduction in average length of stay for cholecystectomies from 11 days to 3.8 days. Through the partnership training three thoracic surgeons have gained expertise in the performance of thoracic operations. The OOH was the first hospital in Ukraine to perform laparoscopic vagotomy. This experience and knowledge is being disseminated to a number of regional hospitals.

The partnership has sponsored three Annual All-Ukrainian Surgical Conferences in Odessa. These conferences have become an important source for the dissemination of knowledge and advanced experience on a nation-wide level. Every year these conferences attract from 120 to 160 leading surgeons from all over Ukraine. The latest conference in May 1997 was dedicated to the economic benefits of laparoscopic surgery.

A new professional society, the Ukrainian Association of Laparoscopic Specialists, was formed in Spring 1997. The Association will serve to provide education in laparoscopic procedures to all regional hospitals. There are currently 102 members, representing 16 regions of Ukraine. The chairman of the Association is a physician at the Odessa Oblast Hospital who has received extensive training in laparoscopic surgery at Coney Island Hospital.

Infection Control: New infection control procedures, including changes in hand-washing protocol, pre-operative showers, surgical skin preparation and other universal precautions, have decreased the rate of post-surgical infection by half. The overall length of stay in the hospital has been reduced by two days. The nursing staff continues to take a leading role in the implementation of the infection control program. The department of surgery at the hospital now has an infection control committee, which meets monthly to discuss infection-related issues. The position of hospital epidemiologist was created in May 1996. Odessa Oblast Hospital (OOH) has also initiated a comprehensive program to protect hospital personnel from blood borne infections.

The achievements of the partnerships in the area of infection control influenced the Ministry of Health of Ukraine and US Infection Control Experts to chose OOH as a site for conducting an infection control survey. The survey is part of a program to develop a model hospital protocol in

ODESSA, UKRAINE – CONEY ISLAND, NEW YORK PARTNERSHIP

the are of infection control. In July 1997 five epidemiologists, representing the Ministry of Health, were trained in infection control protocols for two weeks at Coney Island Hospital.

WHONET: Odessa Oblast Hospital is one of the AIHA partner hospitals that are pilot sites for the new WHONET program. This program is part of AIHA's Infection Control Initiative. Its goal is to introduce current methods of quality control for microbiological tests; to introduce current methods of antimicrobial resistance testing; and to establish a system of antimicrobial susceptibility monitoring, using the WHONET program, developed by the World Health Organization.

Microbiology lab staff from Odessa Oblast Hospital have received equipment and supplies that allow quality testing of antimicrobial resistance and monitoring of the results. They have received training in current methods of antimicrobial resistance testing and in using WHONET.

Over the next year, WHONET participants will develop and implement mechanisms to control the use of broad spectrum antimicrobial agents. Based on WHONET data, and with assistance from their American partner and from the Society of Healthcare Epidemiology of America, each participating NIS hospital will design protocols for empirical and targeted antimicrobial therapy for major infections.

Neonatology: Initiation of training in neonatal resuscitation and neonatal intensive care has resulted in improved fetal outcomes, specifically in reduced infant mortality, at Odessa Oblast Hospital. Many advances have been made in medical practices, including newer treatments of various diseases and most importantly, complete education in the area of neonatal resuscitation. Four physicians have already been trained as certified instructors in neonatal resuscitation. The data collection mechanisms which were developed to collect information on nosocomial infections have assisted in the reduction of infection rates in the nursery and neonatal intensive care unit..

Nursing: The Partnership Nursing Conference, *Leadership in Nursing*, which was sponsored by AIHA and the Odessa Oblast Trade Union of Medical Workers, was held in Odessa in June 1996. In attendance were over one hundred and fifty nurses from twenty-six regions of Ukraine. The conference focused upon revising the role of nurses in infection control, treatment, and management. In September 1996 a Nursing Learning Resource center was opening at Odessa Oblast Hospital. The Center has served to encourage independent learning, to enhance traditional teaching methods, and to disseminate the advance experience gained through the partnership collaboration. The Center continues to help promote the development of nurses in the areas of practice, curriculum, and professional skills.

Dentistry: The concept of preventive care, including diagnostic x-rays, routine periodontal screenings, and periodic examinations, which was introduced by the US Partners, are now being utilized at Odessa Oblast Hospital and disseminated to nearby clinics. Through lectures and clinical training, the Ukrainian partners are able to assist in clinical procedures at the dental clinic, review radiological exposure, and develop new diagnostic techniques. Universal precaution, as it applies in dentistry, and a dental management system have also been implemented.

Hospital Administration: The head accountant, head economist and assistant head doctor for organizational systems for the Odessa Oblast Hospital spent short-term residencies in New York

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working with the administration of Coney Island Hospital to improve inventory, staffing, accounting procedures, and quality control in the Odessa region. The director of primary care has implemented a number of administrative and market-reform changes since visiting Coney Island Hospital. Odessa now markets in the local media a private, evening, fee-for-service clinic. In addition, nurse rotation has begun, allowing for broader cross-training and better use of human resources.

Future Plans for the Partnership

The partners will continue to disseminate expertise in techniques and methods in surgery, including urology, orthopedics, nursing, anesthesiology, and infection control. The knowledge base of the operating room staff will be enhanced with regard to all aspects of pre-operative, peri-operative, and post-operative patient care. The partners will hold another hands-on surgical conference for the region. The level of care provided in the Surgical Intensive Care Unit will continue to improve.

The Women's Health Center in Odessa is scheduled to open early in 1998 at the Odessa Oblast Hospital (OOH). The Center will provide clinical and educational services and to address the health needs of women throughout their lives. The OOH maintains ongoing communication with twenty-six hospitals and two prenatal clinics in the region.. The Center will provide a centralized approach to women's needs through a multi-disciplinary team consisting of obstetrician/gynecologists, family practitioners, nurses, midwives, health educators, and a psychologist. The role of the Ob/Gyns will be to be the primary care giver for patients at the Center. Special emphasis will be placed upon the preventative aspect of women's health, starting from adolescence to post-menopause.

The partnership is rapidly developing plans for the Breast Cancer Center to be opened early in 1998. The partners have already collaborated in conferences, study tours, and hands-on training in the area of breast cancer education, screening, and early diagnosis.

Reduction of infant and neonatal mortality will continue through continuous improvement of techniques in neonatal resuscitation and medical management of infants requiring intensive care. This will be supplemented by the opening of a Neonatal Resuscitation Training Center at the Odessa Oblast Hospital early in 1998.

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Stavropol – Iowa
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DUBNA, RUSSIA – LA CROSSE, WISCONSIN PARTNERSHIP

AIHA's Medical Partnership Program between the cities of La Crosse, Wisconsin, and Dubna, Russia, funded under a cooperative agreement with the United States Agency for International Development (USAID), has existed since December 1992. Hospital No. 9, Central City Hospital, and the Bolshaya Volga Hospital, which houses the Diabetes School and the Children's Rehabilitation Center, are the Russian partners. Lutheran Health System, Franciscan Health System, Gundersen Clinic, Skemp Clinic and the La Crosse Visiting Nurses Association represent the American side of the program.

The general areas of partnership focus are home care and hospice programs, cardiac rehabilitation, diabetes education, alcohol rehabilitation and education, orthotics, renal dialysis and women's health.

Program Outcomes

Home Care and Hospice Programs: More than 300 elderly are currently part of the home health program whose focus is to reduce health sector costs and improve quality of care. This has been accomplished by reducing inpatient lengths of stay, reorienting non-acute care to home settings and increasing the number and the educational level of home care workers. As a result, budget savings of 150 million rubles have been realized over each of the past two years. The Moscow Oblast cities of Klim, Elektrostal, and Taldom have become involved in preliminary steps for replication of this model. In addition, a hospice program, which was established in August 1994 continues to grow each year. A regional hospice seminar was held in 1996 to disseminate information about steps to develop a comprehensive hospice care service for the Moscow Region.

Cardiac Rehabilitation: Partnership collaboration on cardiac rehabilitation has resulted in dramatic reduction in length of stay for uncomplicated myocardial infarctions. The average length of stay has been reduced from 30 days to approximately 14-16 days. In addition to this advance, nurses are now using American Heart Association brochures and materials to conduct inpatient teaching. These materials have been translated and distributed throughout Dubna. Training through community health fairs has continued in the areas of risk factor modification, community education, and curriculum development in cardiac risk factor management.

Diabetes Education: The partnership's Diabetes School has educated more than 600 patients in diabetes self-management since September 1993. As a result, average insulin dose levels have declined 30 percent for Type I and 24.4 percent for Type II patients, and the average length of stay for hospitalized diabetics has fallen from 33 days in 1992 to 20 days in 1995. These clinical outcomes have led to cost savings of approximately 188 million rubles.

The Diabetes School model includes a multi-disciplinary approach. Educational sessions offered within the Diabetes School include six three-hour sessions for patients and their families on a number of topics: diet and diabetes, the accurate use of glucometers, physical exercise, treatment of diabetics with insulin, hypoglycemia and hyperglycemic and podiatric and ophthalmologic problems of the diabetic.

These activities have led to a collaborative agreement between the La Crosse, Wisconsin - Dubna, Russia Partnership, AIHA, the Russian Ministry of Health, and Eli Lilly to utilize the existing Diabetes School as a central training center. To date, five replication sites in the Moscow Oblast, and within Moscow city limits have been selected and trained at the Dubna School. The sites in Moscow Oblast

include: Balasicha, Krasnogorsk and Dmitrov. The Moscow City sites are Medical Diagnostic Center No. 2 and Polyclinic No. 139. Teams of patient educators led by the Chief Endocrinologist from each site have received training from Dubna and La Crosse diabetes professionals. This initiative is expected to serve as a model for similar programs throughout Russia in coming years.

Alcohol Rehabilitation and Education: Due to the partnership's efforts, Alcoholics Anonymous (AA) and Al-Anon groups have been in existence in Dubna for over two years, and this model has been successfully replicated in Dmitrov, Zaprudnia, Sergiev Posad, Taldom and Klin, with the support of a grant from World Learning. More than 1600 individuals meet each month in AA and Al-Anon groups throughout the replication sites. Television call-in programs, newspaper advertising and community forums on alcoholism have maintained AA attendance at about 30 participants per meeting. Alcohol counselors and community specialists in each of those cities have established treatment centers and developed resource centers for literature dissemination. Two centers have developed detoxification centers. Each center is engaged in prevention strategies in schools and in the community at large.

Orthotics: The partners have collaborated to facilitate the establishment of an Orthotics Center in Dubna, including the development of a fabrication process. Professionals from Dubna have been trained in the identification of patient needs, in the fabrication and fitting of orthotics, as well as the management of an Orthotics Lab. Therapists have been trained to work with both adults and children in the fitting of orthotics. They have also learned how best to identify appropriate follow up care for orthotics patients. The center has been designated a regional prosthetic center by the Moscow Oblast Health Administration.

Women's Health: A comprehensive Women's Wellness Center is expected to open in Dubna by December 1997, as part of AIHA's Women's Health Initiative. The center will offer comprehensive services to women of all ages in the areas of childbirth education, reproductive health, disease prevention and health promotion, nutrition, breast feeding, education, newborn infant care, sick infant care and follow up care.

With the help of contraceptive counseling, educational materials, and an accessible supply of oral contraceptives, family planning clinics in Dubna have had a dramatic affect on abortion rates in the Dubna area. The number of abortions at Central Clinical Hospital was reduced from 431 in 1994 to 351 in 1995; the ratio of births to abortions was reduced from 1:2 to 1:1.6 over the same period. At Hospital #9 abortions were reduced from 575 in 1994 to 323 in 1995; the ratio of births to abortions was reduced from 1:2.2 to 1:1.1. Overall the abortion rate is declining, the number of women using contraception is increasing, and the birth rate is increasing.

Renal Dialysis: Through the efforts of the partnership program and the Dubna City Health Administration, a firm infrastructure has been established to support the expansion of this program. The result is a two-station Renal Dialysis Center in Central City Hospital. The unit has been in operation since November 1996.

Future Plans for the Partnership

Future plans for the partnership include:

- To increase the number of CPR instructors in Dubna and surrounding communities by 10%.
- To increase the number of personnel trained in CPR in the Dubna area by 15%.
- To distribute at least 130 copies of the Russian CPR Manual for training assistance.
- To identify a process to integrate home care services of hospitals, polyclinics, charity services and the hospice.
- Through additional training of health care providers, to enhance care provided to the elderly of Dubna.
- To enhance the clinical use of orthoses in the physical rehabilitation area.
- To identify goals and objectives and design a community-based alcoholism prevention program for at-risk youth in Dubna.
- To establish a ten-week comprehensive, school-based alcoholism prevention program for grades 4-6.
- To continue the self-management education of diabetics in Dubna and in each replication site.

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MOSCOW, RUSSIA – AUSTIN, TEXAS PARTNERSHIP

AIHA's Moscow EMS Training Center was opened October 23, 1995, at the Institute of Continuing Education of the Federal Directorate for Biomedical Problems and Disaster Medicine. The Training Center is partnered with the City of Austin Emergency Medical Services Department and is supported by the Ministry of Health and Medical Industries of the Russian Federation.

Program Outcomes

Since its inception, the center has conducted training courses for more than 445 health professionals, including physicians, nurses, feldshers, and other emergency service personnel. The initial training courses were presented jointly by US and Russian partners. Presently, US representatives serve as course monitors and assist with further faculty development.

The partners worked together to develop a modified 48-hour first responder course with special emphasis on radioactive emergencies. This course will be presented in locations throughout Russia during the Fall of 1997.

The partners also created a public service video, to be aired on national television, aimed at educating citizens to properly respond to medical situations they might encounter.

Future Plans for the Partnership

Future plans include the presentation of 15 courses annually for approximately 525 health professionals. Personnel trained will include representatives from the medical facilities of the Federal Directorate for Biomedical Problems and Disaster Medicine; the City of Moscow Department of Health Care; and related chemical, nuclear, and space industries

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MOSCOW, RUSSIA – BOSTON, MASSACHUSETTS PARTNERSHIP

AIHA's Medical Partnership Program between Brigham and Women's Hospital of Boston, Massachusetts, and Pirogov First Municipal Hospital of Moscow, Russia, funded under a cooperative agreement with the United States Agency for International Development (USAID), has existed since October of 1992.

The general areas of partnership focus are infection control, nursing education, quality management, hospital administration and finance and general surgery.

Program Outcomes

Infection Control: Pirogov Hospital has been selected by the Ministry of Health as a model site for the development of hospital infection control techniques. The partners have organized a ten-member Infection Prevention/Quality Assurance Committee which monitors post-operative infections, establishes universal precautions and regulates operating room equipment. The committee enacted major facility enhancements in the operating room, including ultraviolet lights, new floors and secure doors.

The Head Specialist in the Division of Infectious Diseases Prevention for the Ministry of Health (MOH) of the Russian Federation met with the Infection Control Committee at Brigham and observed US infection control practices in order to prepare for the MOH/AIHA Infection Control Workshop in Moscow in June 1994. The workshop enabled the Ministry of Health to review implementation plans for Regulatory Order #220.

The partnership's First International Nursing Conference, in October 1994, was entitled "Nosocomial Infections: Prevention and Control." It introduced the audience to principles of aseptic technique, assessment of infection, nutritional health and infection prevention, infection surveillance and other issues. The conference syllabus was distributed to attendees for dissemination and to use as a learning tool.

From July 23-29, 1995, AIHA's Infection Control Task Force conducted an intensive infection control survey of Pirogov Hospital. This survey consisted of three components: interviews with personnel; observation of facilities, equipment, supplies and practices; and a prevalence survey of active nosocomial infections, utilization of invasive devices and procedures and antimicrobial prescription. A detailed written assessment of the survey was submitted to the hospital to use as a measurement guide in improving its infection control practices. In addition, the US partners devised a surgical wound classification guide for use by the Pirogov Infection Prevention-Quality Assurance Committee.

The partnership developed an infection control assessment document, which includes over 70 recommendations for NIS hospitals to decrease infection rates. This document has been reproduced in Russian and English.

During partnership exchanges focusing on infection control, members of the BWH Infection Control Committee have conducted a series of lectures and seminars on Tuberculosis, Hepatitis A, B, Non

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AB and HIV. These presentations addressed the current status of these diseases in Russia and worldwide, and they also discussed their potential impact in the future. All of the lectures have been translated into Russian for dissemination.

Continuing Nursing Education: In October 1994, the partnership held their first International Nursing Conference in Russia for over 250 nurses from Moscow and ten republics of the former Soviet Union. The event increased awareness of the integral role of nurses in patient care delivery, specifically in the prevention and control of nosocomial infections.

On November 30 and December 1, 1995, the partnership hosted nurses and hospital administrators from each AIHA hospital partnership at their second international nursing conference, entitled "Professional Issues in Nursing." This conference emphasized the need to increase the clinical and management role of the nurses in NIS medical institutions. On December 5 and 6, 1996, the partnership hosted their third such conference, which focused on "Interventions in Trauma."

In May 1997, the partnership held a teleconference between Boston and Moscow, entitled "Nursing Management." The conference was well attended in Moscow, by Chief Nurses from Pirogov and by faculty and students from the Graduate Nursing Program at the Moscow Medical Academy. The teleconference addressed: methods of nursing care delivery, evaluation as a tool for nurse managers, coaching, teamwork, and other topics related to nursing management.

Nurses from Pirogov have participated in multiple exchanges with Brigham and Women's Hospital. During the course of these exchanges, they have focused on methods of nursing care delivery in the United States, and they have been able to participate in conferences organized for BWH nurses.

Hospital Administration and Finance: Administrators from Pirogov have focused on issues of quality management, management planning and financial management.

In the field of financial management, the partners have focused on insurance policies and cost-accounting. In response to their decreased share of the state healthcare budget, Pirogov is expanding its revenue base to non-Muscovite fee-for-service clientele through a variety of mechanisms which could eventually include managed care.

Administrators from Pirogov have become familiar with capitation-based systems of payment, and with the system at BWH in particular. They have also focused on contracts and on funds-allocation for employee wages.

Surgery: Pirogov physicians and nurses have renovated and reorganized the Emergency Room to include a special dispatching area staffed by feldshers, who are responsible for managing patient flow. These dispatchers register patients based on diagnosis, to enable emergency physicians to separate acute and non-acute trauma patients and, thus to provide more effective treatment.

The partnership sponsored a conference entitled "Contemporary Problems in Surgery" in Moscow in June 1993 for over 600 NIS clinicians. Presentations included the following topics: laparoscopy,

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infection control, the role of nurses in surgery and cost-effectiveness in evaluating surgical procedures.

Future Plans for the Partnership

The partners plan to continue successful projects in infection control, nursing education and hospital administration. Pirogov hospital will continue as a model site for the development of hospital infection control techniques for the Ministry of Health. Furthermore, the partners will continue to implement concepts of quality assurance and utilization review.

The Infection Control team at BWH and Pirogov is planning to create an Infection Control Website, in order to better disseminate the most current information in this area.

The partnership conducted an interactive teleconference on September 12, 1997, discussing two case studies of acute myocardial infarction.

On December 4 and 5, 1997, the partnership will host it's Fifth International Conference, entitled "Emergency Care of Ill and Injured Patients."

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MOSCOW, RUSSIA – CHICAGO, ILLINOIS PARTNERSHIP

The Chicago - Moscow partnership, linking the Medical Center of the General Management Department of the President of the Russian Federation in Moscow with Premier, Inc., in Chicago, officially graduated from AIHA's partnership program in April 1996. The graduation date coincided with the Grand Opening of the newly renovated International Patient Department at Moscow's 1400-bed Central Clinical Hospital.

During the past three years, the partners have addressed such issues as maternal health, diagnostic and interventional cardiology, nursing education and practice, medical education, ambulatory care, outpatient surgery, medical insurance, quality indicators, food and nutrition services, healthcare administration, human resource management, blood banking, intravenous therapy practices, cardiovascular surgery, endoprosthetics, clinical case management and customer service. Using the resources of Premier affiliates such as Mount Sinai Hospital and Beth Israel Medical Center (New York), Strong Memorial Hospital/University of Rochester (Rochester), The Cleveland Clinic Foundation (Cleveland), Millard Fillmore Health System (Buffalo), and Mount Sinai Hospital Medical Center (Chicago), the partners have had frequent exchanges to and from Moscow. Three major, multidisciplinary conferences were conducted onsite in Moscow; these programs were open to participants from other partnership programs.

As an affiliate of Premier, Central Clinical Hospital is enrolled in the Maryland Hospital Association Quality Indicators Program. Recipient of an Abt Grant, the QI team presented a poster at the International Quality Indicators Meeting in Jerusalem in May 1996. Representatives of Central Clinical Hospital will participate in the International Congress on Performance Measurement and Improvement in health Care in Chicago during November 1997.

Post-graduation, the NIS partners have continued to impact and participate in AIHA-sponsored regional activities, including local conferences and educational symposia. Two abstracts were presented at the 1997 Nursing Conference in Kiev, Ukraine; two speakers will contribute to the 1997 Annual Partnership Conference in Atlanta. The partners have enjoyed an outstanding working relationship; they credit AIHA with facilitating this relationship and supporting program initiatives.

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MOSCOW, RUSSIA – NORFOLK, VIRGINIA PARTNERSHIP

Building on the initiatives of the neonatal resuscitation initiative, in 1995 AIHA joined with the USAID funded partnership between the Children's Hospital of the King's Daughters in Norfolk, Virginia and the Ministry of Health (MOH) and the Institute of Pediatrics and Children's Surgery in Moscow, Russia to establish a core group of Russian physicians and nurses skilled in neonatal resuscitation and the basics of immediate newborn care. This will be accomplished by conducting week-long training courses with the Russian MOH under the auspices of the Neonatal Resuscitation Training Center, which was opened in May 1997.

Program Outcomes

Thus far, the US partners have conducted seven courses in neonatal resuscitation and the basics of neonatal care for medical professionals in Moscow Oblast, two courses in Samara, and one course in Tver. Approximately 370 Russian health care providers have been certified in the American Heart Association/American Academy of Pediatrics Neonatal Resuscitation Program. A revised clinical protocol on delivery room assessment and newborn care has been distributed to all regions of Russia by the MOH.

A neurodevelopmental clinic has been established at Hospital No. 13, in Moscow for follow-up of high risk premature infants. Approximately 300 patients have been followed serially by the clinic. The CAT/CLAMS neurodevelopmental assessment tool of visual, language, and cognitive development has been translated into Russian. Training videos for neurodevelopmental evaluation of premature infants have also been created. A manuscript is in preparation entitled: Neurodevelopmental Pediatrics in Russia: The Follow-Up of High Risk Premature Infants in Moscow, Russia.

An AIHA sponsored Learning Resource Center has been established at the Institute of Pediatrics and Children's Surgery. The computer center allows connection with Internet and the transmission of e-mail, thereby expanding upon the availability of current medical information and enhancing communications and consultation opportunities.

Future Plans for the Partnership

The long term goals of this partnership include improving neonatal health care in Russia by assisting the MOH in creating a cadre of physicians, nurses, and midwives skilled in neonatal resuscitation and in the basics of immediate newborn care and who are capable of sustaining an effective neonatal outreach education program throughout Russia. The partnership will facilitate neonatal care policy reform by assisting the MOH in revising existing policies and regulations and in developing new clinical protocols for newborn care. The partners also aim to decrease infant morbidity by establishing a coordinated and comprehensive neurodevelopmental follow-up program for infants.

Other related objectives include the promotion of the model Regional Neonatal Resuscitation Training Center that is charged with training instructors for other training cites and hospitals throughout Russia. The partners plan to revise existing protocols and develop policies and procedures for normal newborn care and for the clinical management of common neonatal diseases. The Learning Resource Center will continue to be developed in order to expand access to the current medical literature and to allow for world-wide consultations with other health care providers.

MOSCOW, RUSSIA – NORFOLK, VIRGINIA PARTNERSHIP

Lastly, the partnership will establish a coordinated and comprehensive neurodevelopmental follow-up program for infants in Moscow Hospital #13 and a Neurodevelopmental Pediatrics Department at the Moscow Institute of Pediatrics and Children's Surgery.

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MOSCOW, RUSSIA – PITTSBURGH, PENNSYLVANIA PARTNERSHIP

AIHA's Medical Partnership Program between Magee-Women's Hospital, Pittsburgh, Pennsylvania, and Savior's Hospital for Peace and Charity and the Main Medical Administration of Moscow, Russia funded under a cooperative agreement with the United States Agency for International Development (USAID), has existed since December 1992.

The general areas of partnership focus are maternal and child health, family planning, consumer and community education, and hospital administration.

Program Outcomes

Maternal and Child Health: In July 1993, the partners created a Woman and Family Education Center, which offers classes in prenatal care, family planning, labor and birth preparation for parents and siblings. The center also provides general women's health classes designed for adolescents. Six Russian childbirth educators, trained and registered with the International Childbirth Educators Association (ICEA), staff the Center. The Center serves an average of 400 Russian women per week from Moscow and two outlying rural areas.

The Moscow Main Medical Administration donated the ruble equivalent of \$500,000 in support of a renovated birth house with Western medical standards and a model of obstetric care. US partners shipped two 40-foot containers, filled with equipment and supplies, to Savior's Hospital to assist in the renovation. The shipment, valued at \$94,800, is a result of in-kind donations by Magee-Women's Hospital and private companies in the Pittsburgh area. In addition, Johnson & Johnson will supply the Birth House with discounted medical supplies for delivery and obstetrical services. With the renovated Birth and improved obstetric care, the partnership's goal is to deliver 3,000 infants and train 350 Russian obstetricians annually.

First Ladies Hillary Rodham Clinton and Naina Yeltsin visited Savior's Hospital in January 1994. The First Ladies toured the pediatric ward and attended a childbirth education class at the Savior's Hospital. They also participated in a round-table discussion with the partnership's leaders and representatives from AIHA and USAID.

In conjunction with the University of Pittsburgh School of Medicine, the Moscow Main Medical Administration and the Russian National Academy of Obstetrics and Gynecology, the partnership sponsored the First Annual 1994 Moscow Update in Obstetrics and Gynecology. American and Russian experts presented on medical advances in pre-term labor, sexually transmitted diseases (STDs), pre-eclampsia, menopause, pelvic inflammatory disease and antenatal assessment.

Additional seminars have been offered by the partners in collaboration with the Main Medical Administration of Moscow. Approximately 250 physicians and midwives from nine AIHA partnerships attended the dissemination conference entitled "Partners in Birth: The Role of Labor Support in the Medical Management of Labor" on February 2-3, 1994.

Magee Womancare International received a grant award in 1994 for \$540,000 from World Learning to establish twenty Woman and Family Education Centers in Russia. Over the course of 24 months, the partners built a network of independent women's health education centers throughout Russia. They trained over 70 health professional trainers from 24 regions of Russia in consumer education,

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train-the-trainers methods, education center design and management, fundraising and community organization. As a result of this grant, the first professional Russian association of childbirth educators was established with members in 27 regions of the Russian Federation.

In collaboration with First Lady Naina Yeltsin, the Russian Ministry of Health and Medical Industry, the Woman and Family Education Center, and Magee Womancare International, ASPO/LAMAZE held its first annual certification conference for Russian childbirth educators in September 1995. Over 300 Russian health care professionals were trained in the Lamaze method of prepared childbirth and in the health curriculum of the Woman and Family Education Centers throughout Russia.

Savior's Chief of Surgery, in collaboration with Magee cardiologists, designed treatment protocols for women with cardiological disorders during prenatal and post-natal periods. In addition, he worked with Magee ambulatory care administrators on plans for the future Savior's Ambulatory Care Center for Women.

Family Planning: In May 1994, the partners opened the Woman and Family Planning Clinic which offers low-cost, high-quality family planning services. It is the first comprehensive family planning program in the eastern region of Moscow and one of the first clinics in Russia to include pap smears, sexually-transmitted disease testing and preventive health counseling in a standardized model of women's health care. In its first four months of operation, more than 2,000 women used the services offered. Due to increased demand, the Center is now expanding and anticipates seeing approximately 700 clients per month. USAID granted the Magee-Savior's partnership \$400,000 to replicate the Magee-Savior's Family Planning Clinic in 18 regions of the Russian Federation.

The Soros Foundation granted the partnership over \$160,000 to establish eighteen women's health clinics in eighteen regions of Russia. Building upon the successful model implemented in Moscow, these clinics were established by July 1997. This network of women's clinics will provide Russia with a community health services model of family planning. In addition, health education training for adolescents was offered through the established Education Centers and in collaboration with the Soros Foundation's Regional Health Education Program.

The partnership has completed an epidemiological study to record baseline data and statistics from the Woman and Family Education Center, the Woman and Family Planning Clinic and four Moscow birth houses.

Consumer and Community Education: The partnership has printed and distributed over 10,000 pregnancy-guide calendars, family planning materials, contraception and women's health brochures and breast self-exam cards. Video productions in Russian include "You and Your New Baby," "Puberty," "Partnership in Birth," "A Time to Grow," and "Its Up to You: Adolescent Sexuality."

From February 27-March 3, 1995, CNN International aired a series on women in Russia that featured the partnership's Woman and Family Planning Clinic and Woman and Family Education Center.

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On April 14, 1995, the Magee-Savior's partners hosted Moscow adolescents and their parents for "Teen Day," an event launching the partnership's new adolescent clinic program. Adolescents are encouraged to visit the Woman and Family Planning Clinic on a regular basis during special hours to consult with the clinic's adolescent instructor.

Created by the partnership, the Woman and Family Foundation at Savior's is the first non-government fundraising arm affiliated with a Russian hospital. In cooperation with this foundation, the Woman and Family Education Center has launched a local fundraising campaign which has raised over \$50,000 through special events, grants and hospital services.

Over the past three years, the Magee-Savior's partnership has worked with various Russian and international organizations to sponsor an annual community event. The Womancare Wellness Festival (formerly the Celebration of Women). Most recently in March 1997 the Wellness Festival brought in nearly 2,000 women from Moscow and the surrounding regions to participate in wellness information sessions, a healthy lifestyles exhibit fair. With sponsorship from Avon Beauty Products, Johnson & Johnson and Upjohn Pharmaceuticals, the festival gave women an opportunity to obtain new information, receive free health screenings and grow both personally and professionally.

Hospital Administration: Selected as a training site by Management Sciences for Health, Magee has hosted over 400 Russian health care executives for training in hospital financial management. To date more than 300 Russian professionals have been trained in basic infection control techniques, policies and procedures for hospital workplace safety and management, including the orientation and training of non-medical hospital staff, the writing of job descriptions, employee contracts and performance appraisals, and budgeting for cost centers.

Future Plans for the Partnership

The Magee-Savior's partnership will sponsor the Third World Conference on Childbirth Education in October 1997 in Budapest, Hungary. This year's conference will bring health professionals from throughout the US, NIS and Central and Eastern Europe for the future global development of women's health education.

As part of AIHA's Women's Health Initiative, Magee-Savior's will enhance the services offered at the Savior's Family Planning clinic to include comprehensive menopause and older women's health programs. The program will include an informational resource center on breast health as well as screening for hormonal replacement therapy. In addition, the partnership plans on producing a video and additional educational materials in this area of women's health.

Magee-Saviors will initiate a new program with the Avon Beauty Products company to produce infomercials on women's health issues. With a \$100,000 grant from the Avon Foundation, Magee, Savior's and Avon will produce ten infomercials on issues such as family planning, adolescent health, pregnancy, breast cancer and menopause. The infomercials will be aired in various cities throughout Russia.

MOSCOW, RUSSIA – PITTSBURGH, PENNSYLVANIA PARTNERSHIP

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MURMANSK, RUSSIA – JACKSONVILLE, FLORIDA PARTNERSHIP

AIHA's Medical Partnership Program between the cities of Jacksonville, Florida, and Murmansk, Russia, funded under a cooperative agreement with the United States Agency for International Development (USAID), has existed since October 1992. Murmansk Regional Hospital and Murmansk City Ambulance Hospital are the Russian partners. From 1992 through June 1996, St. Vincent's Medical Center and Memorial Hospital of Jacksonville represented the American side of the program. Effective July 1, 1996, coordinating responsibility for this partnership, on the American side, has been transferred to the Jacksonville Sister Cities Association. Sister Cities will draw on the expertise of health care professionals from the greater Jacksonville area. On the basis of this change, the partnership has been extended for one year.

The general areas of partnership focus are laparoscopic surgery, quality indicators, hospital administration, infection control (STDs and HIV/AIDS), emergency medical services and women's health.

Program Outcomes

Emergency Medical Services: From March 23 - 28, 1995, the Jacksonville-Murmansk partners sponsored two workshops on pre-hospital emergency care. The first workshop, a modified American Heart Association Pediatric Advanced Life Support Course, provided strategies for early recognition of infants/children at risk for respiratory failure and/or cardiopulmonary arrest. At this workshop the participants practiced airway management, vascular access and basic life support techniques. The second workshop, "Trauma, Resuscitation and Stabilization," presented the fundamentals of pre-hospital trauma management of acute care patients. Approximately 100 professionals were trained at each of these workshops.

In September 1995, a six-person delegation traveled to Jacksonville to receive additional training in emergency preparedness.

The partners installed an intercom system at Murmansk Regional Hospital to assist in intra-institutional communication and to improve situation response time.

Women's Health: In September 1994, the partnership initiated a prenatal vitamin study including 100 patients in Maternity Homes No. 2 and No. 3. This project was designed to improve the nutrition of mothers and reduce maternal and neonatal morbidity and mortality rates. OB/GYN physicians and nurses from St. Vincent's Medical Center and the former Memorial Hospital of Jacksonville have worked with their counterparts in Murmansk to improve the treatment of women with high-risk pregnancies.

A training program was also developed to educate women in Murmansk about diagnosis and treatment of breast cancer. The program included instruction in breast self-examination.

Through the partnership, an advanced training program for diagnosis and treatment of sexually transmitted diseases (STDs) was developed to train Murmansk health care professionals. In September 1995, supplementary lectures on STDs and infertility were presented to Murmansk physicians and nurses.

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Infection Control: In December 1996, the director of the Murmansk HIV/AIDS Clinic and Laboratory traveled to Jacksonville to receive advanced training in education, prevention, diagnosis, treatment and outreach programs for HIV/AIDS. Planned Parenthood of N.E. Florida has become actively involved in providing additional training in education and prevention of STDs and HIV/AIDS. The executive director traveled to Murmansk in March of 1997, delivering lectures to over 150 nursing students, high school students, school psychologists, midwives and other healthcare professionals.

Quality Indicators, Hospital Administration and Finance: Through a partnership exchange, four senior health care administrators from Murmansk Regional Hospital and Murmansk City Ambulance Hospital were trained in key aspects of quality assurance and utilization management at St. Vincent's Medical Center and the former Memorial Hospital of Jacksonville. These senior health care administrators returned to Murmansk and implemented these administrative practices. As a result, the partners have seen improvement in the areas of financial management, documentation, medical records administration and general hospital administration.

In September 1995, a four-person delegation from Jacksonville visited five Murmansk medical institutions to review quality assurance and quality improvement projects. The delegation found that the institutions have begun to implement quality improvement systems despite financial constraints. The US team worked with the administrators to develop incentives to motivate physicians to incorporate quality improvement systems in their practices.

The partners are continuing efforts in this area. In December 1996 a senior administrator from Murmansk Regional Hospital and the director of the Murmansk Insurance Fund received advanced training in medical insurance reimbursement issues from Jacksonville area healthcare providers, HMOs and insurance companies.

Due to partnership efforts, the average length of patient stay following surgery at City Ambulance Hospital has decreased from 14-15 days to 9-10 days. This change reflects the maximum utilization of hospital resources and a subsequent reduction in hospital costs.

Laparoscopy: The partnership sponsored an international medical conference in Murmansk with more than 300 health care professionals in attendance. A group of fifteen physicians, nurses and administrators provided concurrent lectures and practica in laparoscopy, ACLS, neurology, nursing and hospital administration.

In April 1996, two surgeons and a gastroenterologist from Columbia/Memorial Hospital of Jacksonville conducted a one-week, interactive, train-the-trainer course in laparoscopic and endoscopic diagnosis and treatment for their colleagues in Murmansk.

In November 1996, two surgeons and an anesthesiologist from Columbia/Memorial assisted their Russian colleagues in a one-week, interactive course, focusing on special anesthesia procedures for laparoscopic surgery and new techniques for herniorrhaphies and cholecystectomies. Surgeons, nurses and an anesthesiologist from Murmansk have traveled to Jacksonville for continued, advanced, hands-on training.

MURMANSK, RUSSIA – JACKSONVILLE, FLORIDA PARTNERSHIP

In early 1997, Murmansk surgeons assisted their US partners in surgery, marking the first time AIHA partners have performed surgery in the US.

Since 1993, surgeons at Murmansk City Ambulance Hospital have performed approximately 300 laparoscopic cholecystectomies with minimal complications.

Future Plans for the Partnership

The partners have developed a comprehensive workplan for this program year. Building on past work, they will focus on the areas of Orthopedic Laparoscopic, Pediatric and Cardiovascular Surgery, Infection Control (STDs and HIV/AIDS) and Women's Health.

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ST. PETERSBURG, RUSSIA – ATLANTA, GEORGIA PARTNERSHIP

AIHA's Medical Partnership Program between Georgia Baptist Healthcare System, Atlanta, Georgia and St. Petersburg Medical University in the name of Pavlov, funded by the United States Agency for International Development (USAID), has existed since April 1993.

The general areas of partnership focus are obstetrics and gynecology, radiology, ophthalmology, medical education, nursing education and hospital administration and finance.

Program Outcomes

Obstetrics and Gynecology: The Second International Symposium on Obstetrics and Gynecology was hosted at Pavlov in June 1994. Demonstrations and lectures addressed the management of complex obstetrical patients, endoscopic procedures and reconstructive techniques following oncological surgery. 400 nurses and physicians attended from the NIS, the United States, Germany and Austria.

In April 1997, the partners sponsored another Symposium on Obstetrics and Gynecology, in St. Petersburg, focusing on the use of fetal monitors, donated by the Atlanta partners, and on the surgical techniques of hysterectomy and laparoscopy. Another symposium is planned for October 18-25, 1997.

Radiology: The partnership has sponsored a number of exchanges in the field of medical imaging. In winter 1995, a radiologist from Pavlov visited Georgia Baptist to begin preliminary training on the operation of a CT scanner and interpretation of imagery. In spring 1995, a radiologist from Georgia Baptist provided further training in St. Petersburg. During his visit, he installed the Winrad teleradiology system which enables radiologists in Atlanta and St. Petersburg to study imagery together to facilitate collaborative diagnosis and training. The radiologists in St. Petersburg also hope to use this teleradiology system to study and compare imagery with other hospitals in Russia.

Medical Education: The partnership has sponsored a number of international symposia in St. Petersburg on ophthalmology, laparoscopy and endoscopy. At each symposium, new procedures and technology are demonstrated to NIS physicians and nurses. In spring 1995, a physician from Atlanta traveled to St. Petersburg to deliver a microscope donated by Georgia Baptist for vitreous-retinal surgery. While in St. Petersburg, he assembled the microscope, provided direction regarding its use and maintenance and observed a successful operation by Russian doctors using the microscope. Over 1000 laparoscopic procedures, including 60 gynecological procedures, have been performed at Pavlov.

During winter 1996, the partners focused their efforts on the areas of urology and ophthalmology. Two partnership representatives and two members of the Atlanta business community traveled to St. Petersburg Medical University to explore options for further development of the hospital's ophthalmology department. A two-week educational and training program was held in Atlanta, exposing surgeons from St. Petersburg Medical University to radical prostatectomy surgery and treatment procedures for male infertility at both Georgia Baptist and Southeast Fertility Institute. As part of the education exchange, one urologist from St. Petersburg was invited to present a paper on Bilharzia of the urinary tract at Grand Rounds at Emory University.

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Training in the areas of ophthalmology and urology has actively continued, with partnership exchanges in both areas in early 1997.

Nursing Education: The partners developed a new curriculum for the College of Nursing at Pavlov to enhance the clinical knowledge base and practicum. The new curriculum emphasizes clinical, psychological and pathophysiological skills, as well as English language training. Following successful completion of the courses, graduates will serve as head nurses and participate in post-graduate education programs for nurse managers in St. Petersburg.

To supplement efforts to further nursing education, Georgia Baptist obtained funding from Emory University and the local education community to support educational exchanges for nursing students. Already three groups of US students have traveled to the NIS and three student delegations from St. Petersburg have traveled to the US.

In May 1996, a delegate from Atlanta traveled to St. Petersburg to review progress in nursing reform and continuing education. The Dean of the School of Nursing expressed the need to incorporate additional courses focusing on patient education and interpersonal skills into the nursing curricula to ensure better patient care. The partnership will work to determine whether the courses should be included in the regular or post-graduate nursing program to best address the needs of the hospital before developing and implementing the new course curriculum. A focus on psychosocial aspects of nursing will continue to be a major component of the partnership agenda.

In February 1997, a group of St. Petersburg nurse-educators visited Atlanta, followed by an April visit by Atlanta nurses to St. Petersburg. The focuses of these visits were evaluating and revising the nursing education curriculum in St. Petersburg and exploring the possibility of developing a joint course.

Hospital Administration and Finance: In September 1995, administrators from Georgia Baptist held a seminar on hospital administration and finance at Pavlov. The seminar focused on developing a strategic business plan and budget for a hospital and introduced participants to product line management, pricing and costs of service. Through this and other partnership exchanges, administrators from Pavlov have become familiar with the overall financial and business operations of Georgia Baptist and developed a strategic business plan and budget for their hospital.

In April 1997, a delegation from Atlanta traveled to St. Petersburg in order to explore possibilities for the partnership in fund-raising and foundation development.

Future Plans for the Partnership

The partners plan to continue current projects that have proven to be successful in obstetrics and gynecology, radiology, medical education, ophthalmology, nursing education and hospital administration and finance.

A nursing learning resource center (NLRC) will open at the College of Nursing in November 1997. A delegation of nurse leaders from Atlanta will provide on-site training in the use of the center and participate in the grand opening activities.

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On-site nursing education in Atlanta will focus on developing an understanding of fetal reactivity, fetal decelerations, early fetal decelerations and variable fetal decelerations.

Laparoscopic surgery, including an emphasis on intra-abdominal suturing will continue.

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ST. PETERSBURG, RUSSIA – LOUISVILLE, KENTUCKY PARTNERSHIP

AIHA's Medical Partnership Program between Jewish Hospital Health Care Services (JHHS) of Louisville, Kentucky and Medical Center of St. Petersburg in the name of Sokolov (formerly Hospital No. 122), funded under a cooperative agreement with the United States Agency for International Development (USAID), has existed since April 1993.

The general areas of partnership focus are hospital administration and finance, medical education, nursing education and emergency medicine.

Program Outcomes

Hospital Administration and Finance: Sokolov has taken a number of steps towards privatization. With the assistance of the finance specialists at Jewish Hospital and Clark Memorial Hospital, the St. Petersburg partner developed a corporate reorganization plan with subsidiaries and defined relationships to a holding company. Administrators at Sokolov also completed an expanded marketing program and opened a hospital gift shop to increase revenue. Another example of this progress was the partnership's efforts to establish a micro-hospital unit, which offers Western style health care delivery on a fee-for-service basis. The profits made by the micro-hospital unit support other programs throughout the hospital.

Administrators from Sokolov have reviewed and studied cost accounting systems in place at Jewish Hospital and Clark Memorial Hospital in order to reformulate and expand Sokolov's account system to capture real costs of surgical procedures and evaluate cost effectiveness of current services. A performance evaluation system has been developed, complete with evaluation ratings, salary incentives, and a re-organization program to increase cost effectiveness and outcomes.

In addition, a special curriculum in Economics and Business management has been developed jointly by Jewish Hospital, the University of Louisville and Sokolov. Eight representatives from Sokolov participated in Part One of this curriculum, in Louisville, in November 1996, and part two was conducted in St. Petersburg in February 1997.

Jewish Hospital hosted two US Department of Commerce Special American Business Training Program (SABIT) interns. Rimma Grigorieva, MD, Vice President of Sokolov participated in a six-month administrative fellowship in the areas of finance, outpatient services, quality assurance and patient care services. Irina Bakhtina, MD, Dean of the Post-Graduate School of Nursing in St. Petersburg, recently completed a SABIT internship focusing on administration of nursing education programs.

The hospital recently became a foreign affiliate of Premier Inc.

Nursing Education: One of the partnership's major objectives has been to improve the post-graduate education of nurses at Sokolov. Through the partnership, a six-month post-graduate nursing course in clinical practice and management was established. This program has been successful in increasing the responsibilities of nurses at Sokolov in patient care and management.

Over the past four years, there have been numerous exchanges of nurses from Sokolov and from Jewish Hospital and Clark Memorial Hospital. During the course of these exchanges Sokolov

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nurses have received extensive hands-on training in the Western model of nursing care. They have been exposed to the fields of marketing, management and quality assurance.

The US and NIS partners co-chair AIHA's Nursing Task Force. Dr. Bakhtina, director of the Post-Graduate Nursing School at Sokolov, was appointed chairperson of the Society of Educators of Nurses, a multidisciplinary group of professionals who share an interest in nursing education. She was invited to speak at the May 1997 All-Russian Conference of Nurses, and to develop a questionnaire for conference participants, in order to formulate a general strategic plan for the development of nursing in the Russian Federation.

Sokolov's nurses are actively participating in AIHA's series of Nursing Videoconferences.

Women's Health Initiative: As part of AIHA's Women's Health Initiative the partners have begun work to create a Women's Wellness Center as an affiliate to one of their partnership institutions. In addition to addressing unmet health needs of women, the Center will serve as a highly visible model for comprehensively addressing and managing the health care needs of women through an effective programmatic mix of health promotion, education, early diagnosis, treatment and follow up. Clinic and resource management, the utilization of nurses as educators and administrators, patient-centered education and service, and the development of sustainable financing for the Center will be program priorities.

The center's scope of services will include family planning, diagnosis and treatment of sexually transmitted diseases, menopause and breast health. The center will open in fall 1997.

Medical Education: In 1994, the US partners conducted an intensive practicum on-site in St. Petersburg on general and reconstructive surgery and anesthesiology. Through the partnership's educational programs, Sokolov has expanded its service base by adding cardiovascular surgery, orthopedics and endoscopy.

1994 Goodwill Games: Sokolov was chosen as the medical support base for all visiting journalists and dignitaries during the 1994 Goodwill Games. The partners developed the clinical and administrative basis for an international polyclinic for the participants of the games and the general St. Petersburg community. At the Goodwill Games, US participants assisted their NIS partners in the management of the outpatient clinic and, during this two-week period, cared for patients from the United States, Bulgaria, Afghanistan, Finland, Canada and Russia. Stomatology emerged as a primary clinical care area following the Goodwill Games and is an on-going clinical agenda for the partnership.

Infection Control: In January 1997, Sokolov was the third AIHA partner hospital to undergo an infection control hospital survey. The survey was conducted by a team of US physicians and infection control practitioners, including a representative from Centers for Disease Control. Future staff of an Infection Control Training Center in Moscow, as well as Sokolov infection control staff observed the survey. The team used a model survey protocol developed for the NIS by AIHA's infection control task force, based on the International Hospital Infection Prevention and Quality Assessment Program (INQUAL).

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The survey team is prepared a report, giving specific recommendations that address all aspects of a hospital based infection control program including organizational issues, surveillance activities, policies and procedures, facilities, patient care practices, environmental cleaning and waste. In addition, this and other survey results have been used to develop case studies for the Basic Infection Control Manual; to introduce the model survey to NIS ministries of health for adaptation and replication; and to assist the ministries in modifying national infection control regulations.

WHONET: Sokolov is one of the AIHA partner hospitals, which are participating in the new WHONET program. This program is part of AIHA's Infection Control Initiative. Its goal is to introduce current methods of quality control for microbiological tests; to introduce current methods of antimicrobial resistance testing; and to establish a system of antimicrobial susceptibility monitoring, using the WHONET program, developed by WHO.

Microbiology lab staff from Sokolov have received equipment and supplies that allow quality testing of antimicrobial resistance and monitoring of the results. They have received training in current methods of antimicrobial resistance testing and in using WHONET.

Over the next year, WHONET participants will develop and implement mechanisms to control the use of broad-spectrum antimicrobial agents. Based on WHONET data, and with assistance from their American partner and from the Society of Healthcare Epidemiology of America, each participating NIS hospital will design protocols for empirical and targeted antimicrobial therapy for major infections.

Future Plans for the Partnership

The partners plan to continue current projects that have proven to be successful in hospital administration and finance, nursing education, medical education and stomatology services. In addition, women's health has become a major partnership focus, culminating in the upcoming opening of a women's health center at Sokolov.

Administrators from JHHS will work with administrators from Sokolov to expand the cost accounting system; analyze current services for cost effectiveness and consider their continuation, expansion, reduction or elimination; determine new programs or business lines; and develop a continuous quality improvement program.

Nurse educators from Louisville and St. Petersburg will continue clinical evaluation and practice for nurses completing Sokolov's six-month post-graduate nursing course. The newly revamped nursing curriculum will be initiated and evaluated.

Nursing administrators at Sokolov are currently developing a curriculum for a masters of Science in Nursing program. They are in the process of discussing these plans with the Ministry of Health of the Russian Federation, in order to get approval.

Dental professionals from Louisville will assist their Russian partners to improve outcomes.

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Sokolov will be the site of a Nursing Learning Resource Center. The area for the center has been selected and a renovation plan has been developed. The opening has been scheduled for early November 1997.

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STAVROPOL, RUSSIA – IOWA PARTNERSHIP

AIHA's Medical Partnership Program between the State of Iowa and Stavropol Krai, Russia, funded under a cooperative agreement with the United States Agency for International Development (USAID), has existed since May 1993. The Regional Ministry of Health, Stavropol Regional Hospital (SRH), and Stavropol City Hospital No. 2, the Oncology Center and the Women's Health Center in Essentuki are the leading Russian partners. The Iowa Hospital Education and Research Foundation (IHERF), the foundation of the Association of Iowa Hospitals and Health Systems, represents the American side of the program. Participating hospitals include: Iowa Methodist Medical Center and Iowa Lutheran Hospital in Des Moines; Mercy Medical Center in Cedar Rapids, University of Iowa Hospitals and Clinics in Iowa City, Mercy Medical Center in Des Moines, People's Memorial Hospital of Buchanan County in Independence, Marshalltown Medical and Surgical Center of Marshalltown, Grinnell Regional Medical Center of Grinnell and Muscatine General Hospital of Muscatine.

The general areas of partnership focus are hospital administration, infection control, surgery, emergency medical services, pediatric hematology, orthopedics, nursing education, women's health and biomedical engineering.

Program Outcomes

Infection Control: Infection control has been a major programmatic focus of the partnership since its inception. Over 30 physicians and nurses from have participated in seminars and training sessions on infection control during partnership exchanges to Iowa. They have also participated in grand rounds, infection control committee meetings and surgery. Over 300 physicians and nurses have participated in educational programs and seminars in Stavropol Krai, conducted by specialists from both the US and Russian sides of the partnership. Two surgical teams from Stavropol were trained in infection control techniques in the operating room and post-operative recovery area. Extensive discussions occurred outlining the administrative structure of hospitals in the Stavropol Krai. Based upon this understanding, a position description for an infection control nurse was drafted and positions were created at Hospital No. 2 and the Stavropol Regional Hospital. Observations during 1996 and 1997 indicate that improvements in technique have been adopted in the OR and recovery areas. This resulted in a decreased length of stay for surgical patients. Exchanges of specialists will continue and will focus on more advanced techniques and on educational programs for the medical and nursing staffs, in order to disseminate these techniques more widely.

Surgery: The partners have created a Model Surgical Unit based on Western standards, at the Stavropol Regional Hospital, which will serve as a center for replication throughout the Krai. The unit has implemented a strict operating room dress code as well as protocols for hand-washing, environmental cleansing, instrument sterilization and prevention of cross-contamination, thereby effectively linking the infection control and surgery initiatives.

Several exchange visits were devoted to assessing the status of the cardiac surgery program at the regional hospital in Pyatigorsk, and training and orientation have been conducted for surgeons, anesthesiologists and nurses at the University of Iowa Hospitals and Clinics. A plan was developed to create an open-heart surgery program at Pyatigorsk. Because crucial resources and infrastructure

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upgrades were not available, the establishment of that program has been delayed until such resources can be identified.

Emergency Medical Services: Thirty Russian physicians and nurses have participated in train-the-trainer seminars in Iowa in basic and advanced life support techniques. Iowa physicians and nurses have conducted seminars in resuscitation and emergency medicine in Stavropol and Essentuki. Paramedics provided instruction on extrication and transportation techniques to clinicians and to police and fire department personnel. These training programs represent a significant advancement in first provider emergency care in Stavropol Krai.

Orthopedics: After three exchange visits by orthopedic surgeons and the sharing of surgical and infection control techniques, the Russian partner asked that specialists from Iowa visit Stavropol to evaluate the current program of production of artificial limbs and assess the feasibility of producing more advanced prostheses. In April 1996, an orthopedic surgeon and a prosthetist went to Stavropol, visited the orthopedic surgical departments of the hospitals, met with senior administrative officials in the Health and Social Protection ministries, and visited the facility at which artificial limbs are produced. The US representatives developed two alternative plans in response to this request from the Russian partner. The first proposal would require some minor equipment upgrades at the factory, the retraining of some key staff, and periodic exchange visits to maintain quality. The result would be a lower cost, higher quality artificial limb. The second proposal would create an entirely new facility with new equipment and newly trained staff. It would also produce the new, lower cost, higher quality artificial limb. Both partners are studying the financial feasibility of these proposals.

Pediatric Hematology: Three teams of physicians and nurses from the Stavropol Children's Hospital visited the University of Iowa Hospitals and Clinics, and were trained in new treatment techniques for leukemia and other children's cancers. Physicians from Iowa visited Stavropol, presented lectures and seminars, and worked directly with their colleagues in developing enhancements to the current treatment protocols.

Women's Health: In September 1995, the partners began a maternal and child health program that focused on three activities: developing a perinatal care program; reduction of complications through enhanced infection control procedures during delivery; conducting training for physicians and nurses in neonatal resuscitation. Three exchanges were conducted to establish these programs. In 1996, the scope of this program was broadened to include comprehensive women's health services. A site in Essentuki was selected, an on-site assessment conducted and three exchange visits conducted to develop this set of program activities.

Nursing Reform: From the outset of the project, the reform of nursing was a key activity that was to be accomplished through education. Nursing was involved in all project components and nurses participated in virtually all exchanges. In 1995, the partners agreed that a more general approach to nursing education would be preferable to targeted action within program areas, such as women's health or infection control. Exchanges were conducted with the faculty of the Department of Continuous Nursing Education for Stavropol Krai, which is located at the Oncology Center. Faculty from Stavropol visited nursing schools in Iowa, observed continuing nursing education programs in hospitals, and shadowed nursing staff on the hospital floor. Iowa delegations to Stavropol

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conducted seminars and lectures for the medical and surgical nurses receiving continuing education at the Oncology Center. A partnership team designed enhancements to the curriculum, including patient and physician psychology, that were taught jointly by the US and Russian partners and then were incorporated into the standard curriculum. Agreement was reached to add a nurse educator to the faculty of the department, and a job description was developed.

Future Plans for the Partnership

During the period May 1, 1997 through September 30, 1998, the Partnership will focus on three areas of activity: nursing education, infection control and women's health.

Nursing Education: The partners will establish nursing associations in the cities of Stavropol and Essentuki. A Nursing Learning Resource Center (NLRC) will be established, staff identified and training of the staff completed to enable use of the NLRC by nursing staff throughout the city and the Krai. Increased access and use of the Internet by nursing staff will also be accomplished by occasional visits paid by the participants.

Infection Control: The partners will identify a hospital epidemiologist and infection control nurse at Hospital No. 2 in Stavropol. Both of these individuals will receive supplemental education and training in infection control and teaching techniques. These two individuals and other clinicians from the partnership will develop a model hospital-wide infection control plan, which would be pilot tested at Hospital No. 2 in Stavropol. The Stavropol Medical Academy will include these new infection control practices and the model plan into the nursing curriculum. Declines in nosocomial infection rates will be documented. Plans will be developed to maintain communication and information-sharing electronically.

Women's Health: In Essentuki, the number of abortions will be reduced and the usage of contraceptives increased. Educational programs designed to provide information regarding healthier lifestyles, prenatal education, childbirth, teenage sexuality, nutrition, breast feeding and breast self-examination will be developed and taught to the public. As a result of interactions between physicians in the partnership, the number of transfusions given post-operatively in childbirth will be reduced. A business plan will be jointly developed that establishes a financially viable women's health center. Marketing of the center will begin with a special public relations event, a Health and Wellness Fair. Plans will be developed for ongoing communication through electronic means.

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VLADIVOSTOK, RUSSIA – RICHMOND, VIRGINIA PARTNERSHIP

AIHA's Medical Partnership Program between the cities of Vladivostok, Russia, and Richmond, Virginia, funded under a cooperative agreement with the United States Agency for International Development (USAID), was formed in March 1993. The Russian partners are City Clinical Hospital No. 2, a teaching and referral hospital, and Vladivostok State Medical Institute. The US partner is the Medical College of Virginia (MCV), the fourth largest university-affiliated hospital in the US.

The general areas of partnership focus have been emergency medical services, nursing education reform and hospital administration and finance. Recently intensive work has also been done in implementation of new surgical procedures and establishing Infection Control Training Center.

Program Outcomes

Emergency Medical Services: Vladivostok has been selected as one of seven Emergency Medical Services Training Center sites in the NIS. Over seventy 100-hour courses have been conducted since the Center opened in October 1994, with over 700 emergency medical professionals (physicians, fieldshers, nurses, and other rescue personnel) trained thus far in didactic and practical skills. The first-responder training course covers a wide range of topics, including airway, breathing and circulation management; spinal immobilization; and trauma management. Since the ninth training course, the Russian partners have conducted 100 percent of the instruction.

In addition to these training courses for health professionals, the partners have expanded training in basic EMS to policemen and fire fighters. They have also begun an outreach program to teach first aid and CPR to secondary school students. A videotape has been created of the students as they participate in a mock earthquake/disaster drill. The partners have provided this training video as a model educational tool for other EMS Training Centers and use it to attract medical students.

Instructors from the Vladivostok EMS Training Center participated in an EMS Train-the-Trainers course in Richmond, Virginia from July 31-August 11, 1995. The course focused on continuing education in emergency medicine and first-responder protocols, including a review of principles of adult learning, case-based learning, the use of videos as audio visual aids, sessions on disaster planning and equipment maintenance and repair. In addition, the center directors received training in administration and data management.

Hospital equipment and supplies from a decommissioned Department of Defense trauma hospital in Japan, valued at \$5 million, were donated to Municipal Clinical Hospital No. 2 in late summer 1995.

In October 1996, the Vladivostok EMS Training Center hosted an international EMS conference for health professionals from the US, Russia, Ukraine, Moldova, Kazakstan, Turkmenistan, Georgia, and Armenia. This conference focused on the topic of disaster management, including issues in program planning, education and training, and communications. In 1997 the Vladivostok EMS Training Center continued consultations helping new Training Centers in Moscow and in Ashgabat.

In 1997 a new model of Emergency Services was established in rural areas of Primorskiy Krai, in the town of Partizansk. A special team of paramedics from the town were trained in Vladivostok,

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special computer programming for dispatcher's services and database on the Emergency Services' activity was provided and equipment was donated by the Richmond Ambulance Authority.

At the same time Emergency Department of the Hospital #2 has also provided a lot of educational training for the physicians of the Region: 142 physicians attended different seminars and conferences in 1997 and 245 third-year medical students attended 15-hours course "Intensive Care Patients and their subsequent Rehabilitation".

Nursing Reform: Nurses at Vladivostok Municipal Clinical Hospital No. 2 have created a committee to coordinate educational seminars for nursing staff. These presentations are modeled on skills development seminars which were conducted by the US partners for nurses in Municipal Clinical Hospital No. 2, the nursing school and nearby hospitals. Topics have included the management of patient emergencies, the concept of accountability and the development of "unit educators" or "procedure nurses" to train colleagues in infection control procedures and the standardization of clinical practice.

In April 1997 Vladivostok City Hospital #2 opened its Nursing Learning Resource Center. The purpose of the Center is to provide continuing education to currently practicing nurses, to train newly employed nurses, and to provide assistance to medical students of the local university. A number of questionnaires and test of nurses' current level of experience have been developed. The results of these questionnaires have helped in the development of the Center's curriculum. The center's educational seminars and trainings are being taught by experienced nurses in close collaboration with physicians and members of Infection Control Committee.

Hospital Administration and Finance: Building on partnership efforts begun in 1994, Abt Associates; ZdravReform project in June 1995 awarded a grant to the partners to develop a cost accounting and financial planning system at Municipal Clinical Hospital No. 2. The partners have developed methods to capture the costs of care in order to develop payment rates that reflect the true cost of efficiently delivered services. This information system will facilitate transactions with the Territorial Mandatory Health Insurance Fund and can be replicated in other health care facilities throughout the Primorskiy Krai.

Hospital administration met and provided seminars for all department heads and head nurses with the purpose of improving their managerial skills and enhancing the quality of overall management of the hospital. Hospital administration actively participated in re-certification process for county medical administrators and presented at the meeting of county physician-experts. Hospital CEO shared his experience in financial management with the county administrators.

Infection Control program: Inpatient facilities of the hospital have organized an Infection Control Committee to implement new infection control policies. A number of training programs for hospital staff have been prepared, including "Prevention of Urinary Tract Infections", "Prevention of Post-Operative Infections", "Proper Technique of Performing Blood Transfusions and Prevention of Blood Infections".

264 members of the hospital staff attended continuous education sessions dedicated to infection control procedures in inpatient wards. Hospital epidemiologists have provided a course of lectures

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on infection prevention in surgical units. The following five programs were prepared to be used in training: "Clean Hands", "Prevention of Spread of Infections among Hospital Staff", "Prevention of HIV Infection and Parental Transmission of Hepatitis", "Methods of Sterilization and Disinfecting of Endoscopic Tools", "Modern Disinfection".

A database containing information on infection outbreaks within the hospital has been installed and prepared for connection with a computer program *Epilnfo*. Development of a program explaining proper use of antibiotics for preventative and curative purposes is also in progress. Hospital physician-microbiologists are also involved in the Infection Control Program and plan to develop a unit of bacteriological control within the Program.

In January 1997, Hospital No. 2 was the fourth AIHA partner hospital to undergo an infection control hospital survey. The survey was conducted by a team of US physicians and infection control practitioners, using a model survey protocol developed for the NIS by AIHA's infection control task force, based on the International Hospital Infection Prevention and Quality Assessment Program (INQUAL).

The survey team has written a complete report, giving specific recommendations that address all aspects of a hospital based infection control program including organizational issues, surveillance activities, policies and procedures, facilities, patient care practices, environmental cleaning and waste. In addition, this and other survey results have been used to develop case studies for the Basic Infection Control Manual; to introduce the model survey to NIS ministries of health for adaptation and replication; and to assist the ministries in modifying national infection control regulations.

WHONET: Hospital No. 2 is one of the AIHA partner hospitals that are pilot sites for the new WHONET program. This program is part of AIHA's Infection Control Initiative. Its goal is to introduce current methods of quality control for microbiological tests; to introduce current methods of antimicrobial resistance testing; and to establish a system of antimicrobial susceptibility monitoring, using the WHONET program, developed by the World Health Organization.

Microbiology lab staff from Hospital No. 2 have received equipment and supplies that allow quality testing of antimicrobial resistance and monitoring of the results. They have received training in current methods of antimicrobial resistance testing and in using WHONET.

Over the next year, WHONET participants will develop and implement mechanisms to control the use of broad spectrum antimicrobial agents. Based on WHONET data, and with assistance from their American partner and from the Society of Healthcare Epidemiology of America, each participating NIS hospital will design protocols for empirical and targeted antimicrobial therapy for major infections.

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Future Plans for the Partnership

The EMS Training Center will continue to reach out to regional rescue personnel to provide training in first aid and CPR. The partners also plan to introduce a special advanced training course for paramedics, which will be operational by May 1997. In addition, a curriculum for dispatch and communications personnel will be developed in cooperation with Medical Priority Consultants.

The Partnership will be working on the development and implementation of a drug utilization system. They are in the process of developing a pharmaceutical reference manual and a drug master list. The partners plan to implement a standards of quality care, develop and implement a program of monitoring side-effects and develop a continuously running program of drug use evaluation.

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KYRGYZSTAN

Bishkek – Kansas City, Kansas

BISHKEK, KYRGYZSTAN – KANSAS CITY, KANSAS PARTNERSHIP

AIHA's Medical Partnership Program between the Kyrgyzstan and the University of Kansas Medical Center (KUMC), funded under a cooperative agreement with the United States Agency for International Development (USAID) was formed in October 1992. In addition to the Kyrgyzstan Ministry of Health, the Kyrgyz partners are the Institute of Oncology and Radiology, the Institute of Obstetrics and Pediatrics and, since 1996, the Institute of Cardiology and Internal Medicine. Since the inception of the partnership, over 100 Kyrgyz physicians and nurses have visited KUMC, while over 70 US physicians, nurses and health administrators have traveled to Kyrgyzstan.

The general areas of focus for the partnership have been nurse education, introduction of family medicine, management training, pediatric oncology, laparoscopic surgery, prosthetics and orthotics, neonatology, respiratory disease, emergency and burn care, and continuing education.

Program Outcomes

Health Care Reform: In collaboration with the Ministry of Health, the partnership has focused on three main components of health care reform in Kyrgyzstan. These include nursing education, introduction of family practitioners/family medicine, and management training for nurses and health care administrators.

In order to reduce overhead costs and generate revenue, the Institute of Oncology and Radiology has decreased its number of beds by closing a hospital wing, renovating the facility and re-opening it as a hotel for relatives of patients. A private rehabilitation hospital in Bishkek was founded after studying the American health care system during a partnership visit.

Nursing Reform: The priority given to nurse education and the development of management skills represents a pioneering attempt by the partners and the Kyrgyzstan Ministry of Health to upgrade health care delivery in the country by elevating the skills of nursing professionals. Senior nurses from throughout Kyrgyzstan have participated in intensive one- and two-month training programs at KUMC focusing on skills development and hospital administration. The partners developed the "Kyrgyzstan Nursing Administration Course," emphasizing management skills for nurse administrators. The nurses receive a general overview of the structure and function of the US health care system, especially the role of the nurse, nursing education, nurses' clinical skills, and the administrative structure of nursing in the hospital. The visiting nurses accompany nurse managers on the floors, visit nursing skills labs, and are introduced to the work of the Home Health Nurse, who provides health care in a home setting. In addition, they attend lectures on standards of patient care, infection control, and prevention.

New nurse administrator/manager positions have been created by the Ministry of Health and filled by these nurses in their respective institutions. Nurses have been hired in each oblast of the Republic to the newly-created position of senior nurse-administrator with a salary comparable to that of chief physicians. In addition, nurses have been invited to KUMC to participate in a train-the-trainers courses designed to prepare them to teach other nurses at the Bishkek School of Nursing. KUMC has donated equipment for five nursing laboratories at the School for this purpose.

In May 1995, the partners hosted a conference in Bishkek for chief nurses from each of the Central Asian Republics (CAR). Over 120 nurses participated in the CAR Leadership in Nursing" seminar, which specifically addressed management and administrative issues pertaining to the region. A

BISHKEK, KYRGYZSTAN – KANSAS CITY, KANSAS PARTNERSHIP

second nursing conference took place in Bishkek during September 1997. This conference was preceded by a "train-the-trainers" seminar for nurse educators at the Bishkek School of Nursing, using a new nursing textbook developed by the partners.

Neonatology: The partnership program has also focused on neonatal resuscitation of full-term normal weight infants. A series of seminars were conducted by KUMC specialists on thermal regulation, intubation, and general diagnostics. The program started in partnership hospitals in Bishkek; however, responding to requests from the Ministry of Health, the program has been expanded to include neonatologists from all over Bishkek. The US teams also traveled to Osh and repeated the training seminars in that city. Over 110 physicians from ten of the twelve birthing units in the Kyrgyz Republic were trained in a series of "train-the-trainers" courses to become instructors in neonatal resuscitation. Translated textbooks on neonatology were distributed to the participants to increase their knowledge base. The training in neonatal resuscitation conducted at multiple sites around Kyrgyzstan is having a significant impact on reducing morbidity and mortality. KUMC staff project infant deaths have been reduced by thirty percent as a result of the training across the republic.

Respiratory Diseases: The Partnership program has also focussed upon Respiratory Diseases. Three teams of Kyrgyz physicians traveled to KUMC to observe the American treatment of asthma and bronchial infections. Three pulmonologists traveled to Bishkek to conduct seminars and give lectures. Of interest to the American physicians were salt chambers and native herbs used in treatment of bronchial diseases in Kyrgyzstan.

Management Training: Partnership efforts, augmented by AIHA/AUPHA management training workshops, have given health care managers from Bishkek the opportunity to participate in a series of training seminars in diverse areas, such as grantsmanship, informed decision-making and financial management.

In an effort to establish model blood banks in Bishkek, partners have worked toward improving the administrative skills of blood bank directors. Their training will lead to greater efficacy and management of blood banking, including infection control. Specialists from US community blood banks traveled to Bishkek and Jalal Abad in December 1995 to assess the work of blood banks in Kyrgyzstan. The specialists made recommendations on donor recruitment, materials management, and standard operating procedures. They also donated and installed a computer with word processing, database and accounting software to Regional Blood Bank in Bishkek.

Pediatric Cancer Registry: Through several exchange visits, the KUMC and Kyrgyz partners have established an academic exchange program and a national pediatric cancer registry in Bishkek, which has allowed the partners to collect accurate cancer morbidity and mortality rates in Kyrgyzstan. In addition, the partners have begun to conduct a comprehensive cancer screening and treatment project in the township of Malli-Say, which in 1993 was struck by an earthquake which reopened an abandoned mine and uncovered uranium waste. At the request of partners at the Institute of Oncology and Radiology, KUMC diagnostic teams examined residents for radiation-related illness, collected data, and treated patients. Together, the partners are analyzing the data to assist in the long-term treatment of victims of this disaster.

BISHKEK, KYRGYZSTAN – KANSAS CITY, KANSAS PARTNERSHIP

Laparoscopic Surgery: Surgeons from Kansas City demonstrated laparoscopic techniques at a conference of surgeons in Central Asia. They performed six operations at the Institute of Oncology and Radiology, using equipment donated by KUMC. In addition they presented two lectures: one for operating room nurses on the maintenance of laparoscopic equipment, the other for anesthesiologists on the use of resuscitation equipment.

Prosthetics/Orthotics: At the request of the Ministry of Health, the partnership took steps towards the establishment of a center for clinical training and production in prosthetics and orthopedics. One prosthetist and one orthotist traveled to Bishkek in the Fall of 1995 to review local prosthetic and orthopedic services and to study current medical practices related to prosthetic care. In addition, they visited the Bishkek prosthetic plant to evaluate the equipment and technology available. The specialists made recommendations to enhance education and improve the prosthetic rehabilitation of patients.

Catastrophic Emergency Care and Burn Care: Following a very successful two week program on emergency and burn care, the ministry asked the partners to repeat the seminar and expand the program to include the city of Osh and the firefighters and first responders in both cities. A team of physician, nurse, two therapists and an emergency technician traveled to Bishkek and Osh to teach two seminars and set up a comprehensive burn department at Hospital No. 4 in Bishkek and the Oblast Hospital in Osh. All supplies to set up these departments were donated by 20 hospitals in Kansas, cleaned and packaged by the firefighters and shipped by container from the State Department to Kyrgyzstan. The departments will be set up in such a way that they can function independently in the future.

Future Plans for the Partnership

Nursing reform through practical skills development will continue to be a major area of partnership focus. Plans are underway to upgrade the existing nursing skills laboratories, introduced to hospitals with partnership assistance. Discussions have also begun regarding the establishment of a masters degree program for nurses at the Medical Academy. They will also be conducting a seminar to train nurses to teach nurses.

The Partnership also plans to continue in it's efforts of supporting Catastrophic Emergency Care and Burn Care. They will continue to work on the two comprehensive burn care centers in Osh and Bishkek together with educating first responders. This program represents a nationwide effort in Kyrgyzstan and a statewide effort in Kansas.

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KAZAKSTAN

Almaty – Tucson, Arizona
Semipalatinsk – Houston, Texas

ALMATY, KAZAKSTAN – TUCSON, ARIZONA PARTNERSHIP

The primary partners in Almaty are the Institute for Pediatrics and Children's Surgery, the primary pediatric referral center in the Republic, and the Almaty City Emergency Hospital, an adult acute care hospital. Other institutions include the Almaty City Perinatal Center, the Emergency Medicine Training Center, the Almaty Medical College, and the Almaty Women's Wellness Center. The US partners include eight hospitals in Tucson, with Tucson Medical Center serving as the organizing partner of a coalition which includes University Medical Center and the Arizona Health Sciences Center, Columbia Northwest and El Dorado Hospitals, Carondelet Health Care of America (St. Mary's and St. Joseph's Hospitals), the Veterans' Affairs Medical Center, and Tucson General Hospital. Pima County Health Department and the Kino Community Hospital also participate in training activities. This partnership builds upon an existing Sister City relationship between Almaty and Tucson.

The general areas of partnership focus have been physician training in specialty areas, establishment of programs in toxicology, perinatology, leukemia and respiratory disease, infection control, nursing education, emergency medical services, and health care administration and management reform. Learning resource centers have been established by AIHA at the Institute for Pediatrics and Children's Surgery, the City Emergency Hospital, and the Almaty Medical College.

Program Outcomes

Infection Control: The Almaty City Health Administration has taken an active role in the reform of in-service training for nurses in infection control. Responding to an Almaty City Health Administration request, the U.S. partners conducted a train-the-trainers course in July 1994 for the faculty of the Republican School for Continuing Education and Allied Health on basic infection control techniques, including hand washing, proper handling of linens, and sterilization of surgical instruments. As a result, a number of similar training programs on infection control have been launched throughout the Republic, and approximately 300 nurses throughout Kazakhstan have been trained. The City Health Administration has also created the new position of Head Nurse for Infection Control at all 11 Almaty hospitals.

Recently, the partners implemented surveillance-modeled infection control demonstration projects in the Institute for Pediatrics and Children's Surgery, the Emergency Hospital and the Perinatal Center. Using the Memorandum of Understanding as a source of authorization, the Minister of Health issued special rules for infection control practices for the participating hospitals. Based on the results of preliminary data, the Deputy Minister of Health has asked the Tucson partners to assist with the implementation of an oblast wide pilot study. The demonstration project will utilize a CDC based surveillance reporting system. When this project is complete, the partners will work on a republic-wide revision of infection control laws and regulations.

Nursing Reform: Working in collaboration with the partners, the Almaty Medical College has developed and implemented a revised and expanded nursing curriculum that provides for basic nurse education as well as expanded clinical practice and administrative/managerial training. The curriculum was approved by the Ministries of Health and Education. In addition, the Ministry of Labor has approved new job classifications for graduates of the program. At the end of each year of nursing training, students can enter a certified nursing position in a public hospital. Fourth-year graduates will now enter the work force at a higher pay level, equal to that of a graduate of the six-

ALMATY, KAZAKSTAN – TUCSON, ARIZONA PARTNERSHIP

year physician education program. Two classes of baccalaureate nurses have graduated from the program.

The Almaty Medical College also has established a night school for senior nurses who wish to enhance their clinical training or expand their role in administration and management. Meeting four nights a week, these senior nurses can complete years three and four of the new nursing curriculum in two and one-half years. The partner hospitals in Almaty are supporting the program by providing sites for practical and clinical training. Over forty senior nurses graduated from the program in July 1997. These nurses will become the major force behind nursing reform. The Soros Foundation has provided a grant to the college to purchase computers and teaching aids.

The role of nurses has changed significantly within the partnership hospitals as physicians are finding that the new roles for nurses complement physician practice. The Institute of Pediatrics and Children's Surgery recently created a new nurse educator position for nurse orientation and training, and have established a training and orientation program for their new nursing employees. The partner hospitals are establishing demonstration units with nurse managers. The City Perinatal Center initiated the first demonstration unit, with a nurse managed post-partum recovery unit in which nurses from each level are working.

EMS Center: Almaty has been designated as one of seven AIHA-sponsored EMS Training Center sites in the NIS. Over thirty-five 80-hour courses have been conducted since the Almaty center opened on October 1, 1994, with over 1000 ambulance team members trained thus far (including physicians, nurses and feldshers), as well as 225 medical students and 30 rescue team personnel. EMS Training Center faculty also traveled to partnership hospitals in Semipalatinsk, where they conducted a basic training course for 90 EMS specialists. The training course teaches didactic and practical skills on topics such as airway, breathing and circulation management; spinal immobilization; and trauma management. The impact of the training has been confirmed by field reports of life-saving methods being used in extrication and airway management by ambulance personnel, including drivers.

NIS faculty members were trained as instructors in "train-the-trainer" programs, and are responsible for ongoing instruction with minimal technical assistance by U.S. faculty. In addition to sessions on center administration and data management, the faculty training course provided continuing education for the director and instructors on emergency medicine and first responder protocols, disaster planning, and training equipment maintenance and repair. Participants also were instructed on principles of adult learning, case-based learning, and utilization of videos in developing audio-visual aids. Foreign companies have paid tuition to the center to train their employees, and the center is accumulating funds to help support its transition to independence from AIHA funding.

Faculty members at the Almaty EMS Training Center have developed and presented two practical skills lessons on Kazak national television. In addition, the Director of the EMS Training Center has appeared several times on national television to discuss the activities, goals and objectives of the center.

A curriculum for hospital physicians in receiving departments has been developed to improve the coordination of care between ambulance teams and in-hospital personnel. The first course was

ALMATY, KAZAKSTAN – TUCSON, ARIZONA PARTNERSHIP

taught to physicians from the Emergency Surgery Department at the Emergency Hospital in Fall 1995. In collaboration with the Almaty Medical University, senior medical students were provided training in EMS and faculty members are also being trained.

Model Perinatal Center: The Ministry of Health and the City Health Administration have supported the partners in their initiative to establish a Model Perinatal Center to demonstrate clinical and educational services to improve pregnancy outcomes. The Tucson partners have provided training, consultation, medications, supplies and equipment. The Center performs an average of 22 deliveries per day in a family-centered delivery unit on a fee-for-service basis. Revenues generated by the private units are used to augment programs throughout the clinic. In addition, medical staff have introduced family planning services within the past year that have been welcomed by patients.

The center staff has successfully implemented "rooming in" for babies with their mothers, reduced lengths of stay for both vaginal and cesarean deliveries, and has supported a breast-feeding program in which over 90 percent of the mothers are participating.

Neonatology: The US partners conducted a training-of-trainers course in neonatal resuscitation in Fall 1994. The Department of Neonatology of the Almaty Institute for Continuing Education of Physicians (located in the Perinatal Center) then assumed responsibility for teaching the course. Over 100 neonatologists and obstetricians from across Kazakstan have participated in the training sessions.

Toxicology Information Center: In collaboration with the City Health Administration, the U.S. partners have helped to establish a Toxicology Information Center at the Emergency Hospital. Physicians from across Kazakstan can contact the center in case of emergency 24-hours a day to receive qualified consultation on first aid for poisoning and drug overdose. In addition, the center is integrated into the city emergency system, with established communications between the center and ambulance teams and receiving departments. The physician director of the Center underwent three months of training at the Arizona Poison and Drug Information Center. The U.S. partners continue to provide 24-hour clinical consultation via e-mail in complex cases. The Center has been equipped by the U.S. partners with a computer donated by Intel and the PoisIndex database donated by Micromedex and updated quarterly. The City Health Administration refurbished facilities for the Center and will staff and operate it as a national referral center for poison and drug overdose information. The Soros Foundation has provided a grant to the center to support community education and encourage citizens to call the center when they have questions or problems about the toxic exposures, poisonings or drug overdoses.

The Toxicology Information Center and the Emergency Medicine Training Center co-sponsored a national conference on the management of emergency toxicology cases in the spring of 1997. Two specialists from Tucson participated as faculty. The two centers have also cooperated in a program to introduce the treatment of drug overdoses with Naloxen. The drug was distributed to ambulance teams, who have successfully administered it on site and saved lives and reduced hospital admissions.

ALMATY, KAZAKSTAN – TUCSON, ARIZONA PARTNERSHIP

Physician Training: Since the partnership program began, six physicians have completed three-month training programs in Tucson in the areas of cardiology, hematology-oncology, pulmonology, pediatric intensive care, toxicology and emergency medicine. The physicians had the opportunity to develop new skills and techniques and familiarize themselves with procedures and equipment in their areas of specialty. In addition, they developed peer relationships with their U.S. colleagues to facilitate the continued exchange of information and improve access to the latest developments through electronic mail and facsimile. Other physicians have participated in training programs of 10 to 30 days in a variety of specialty areas.

Extensive collaborative efforts in the treatment of leukemia, gastroenterology, bleeding disorders and respiratory diseases have evolved between the Children's Research Center at the Arizona Health Sciences Center and the Institute of Pediatrics and Children's Surgery resulting in improved pediatric care and reduced hospital stays.

Center for Endoscopic Surgery at the Almaty City Emergency Hospital: Through donations from Johnson and Johnson and Olympus, equipment and supplies were provided to the Almaty City Emergency Hospital, whose surgeons were trained in laparoscopic surgery techniques. Over 500 laparoscopic surgeries were performed in the first year of the Endoscopic Surgery Center. Improved patient outcomes and reduced lengths of stay have resulted in increased demand for this surgical technique. The center has trained surgeons from other partner hospitals and one of the surgeons is setting up a new program in another hospital in the city.

Future Plans for the Partnership

Institute for Pediatrics and Children's Surgery: The Director of the University of Arizona Children's Research Center will seek funding from the National Institutes of Health to support an applied clinical research program in pediatric gastroenterology. The institute will be the site for the implementation of a telemedicine program to support continued collaboration in the areas of respiratory disease, leukemia and bleeding disorders, and gastroenterology. Once this program has been successfully implemented, the telemedicine program will be expanded to include other partner hospitals.

Almaty City Emergency Hospital: The Toxicology Center will be supported in its efforts to increase calls from the public as well as physicians and to provide a community education program. The implementation of case review and standardization of responses to calls will also be a focus of partner collaboration.

The surgeons in the laparoscopic program will be trained to perform surgeries on patients with complex gastroenterological problems.

Almaty City Perinatal Center: Support will be given to the center to assist it in becoming designated a "WHO Baby Friendly Hospital." A learning resource center is to be established at there. The Tucson partners have donated equipment and supplies to upgrade the laboratory and the surgical department, and the center expects to double the size of the privatization unit this year.

ALMATY, KAZAKSTAN – TUCSON, ARIZONA PARTNERSHIP

Almaty Women's Wellness Center: The Center will have a Grand Opening Ceremony in November 1997. The center staff will continue to receive clinical training as well as the technical assistance required to enable it to become a self-sustaining clinic. Educational programs will be developed to include community outreach and educational programs for women of all ages, including teens and menopausal women.

Infection Control: The partners expect to collaborate on the implementation of a republic wide surveillance infection control program based on revised legislation and supported by a training program for all SES and hospital staff.

The focus of the program activities in the future will be on bringing projects to closure and seeking funding from sources outside USAID and AIHA to fund continued collaborative efforts in clinical training and applied clinical research.

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SEMIPALATINSK, KAZAKSTAN – HOUSTON, TEXAS PARTNERSHIP

The Medical Partnership Program between the cities of Houston, Texas, and Semipalatinsk, Kazakstan, funded under a cooperative agreement with the United States Agency for International Development (USAID), was established in February 1995. The Semipalatinsk Regional Administration and six local hospitals in Semipalatinsk participate in the partnership. The Regional Oncology Dispensary, the Regional Clinical Hospital, the Regional Children's Hospital, The Emergency First Aid Hospital, the Regional Diagnostic treatment Center in Kurchatov, the Semipalatinsk Gynecological Hospital, and the Semipalatinsk Medical Academy provide care for the population of Semipalatinsk and Kurchatov.

The partnership is led on the US side by The Methodist Hospital (TMH) and Baylor College of Medicine. TMC is an internationally renowned facility, which provides primary, secondary and tertiary care services to the Houston metropolitan area and the state of Texas, and is the primary teaching facility for Baylor College of Medicine. Other participating institutions on the US side include Texan Children's Hospital, Veterans Affairs Medical Center, and Harris County Hospital District. In addition, Baylor scientists are deeply involved in several collaborative research projects and scientific exchange programs in Russia, Ukraine and Belarus focusing on health effects of exposure to radiation resulting from the Chernobyl power plant accident.

The general areas of focus for these partners are cancer screening and tumor registry, infection control, nursing education, health care reform, maternal/child health, women's health, disaster management, clinical pathology, and public health education of the population.

Program Outcomes

Cancer Registry: A major focus of the partnership is assisting with the elimination of the effects of nuclear radiation on the people of Semipalatinsk. Until 1989, the Semipalatinsk region was home to the Soviet Union's Nuclear Test Site. Increased incidences of cancer, infant mortality, birth defects, and early aging syndrome have been attributed to the nuclear testing program. The programmatic focus of the partnership is responding to the critical needs of the population through a broad-based set of initiatives in cancer screening and registry.

A cancer registry center for Semipalatinsk and the region is being established through the training of oncologists and a cancer registrar at TMH's Cancer Registry Center, and exposing trainees to computerized office automation and data management in a hospital environment. Further more, the partners plan to develop a cancer prevention program for physicians and public health educators by introducing them to cancer screening programs as part of the patient's regular examination and with programs related to cancer education and prevention.

The partners also plan to identify reagents needed for screening and will train physicians in treatment and follow-up of early stage cancer diagnosed by the screening methods. In July of 1997, for Houston specialists traveled to Semipalatinsk to lead a Cancer Registration Conference, with the goals of improving histology/morphology coding, quality control, and data analysis. The partnership is also in the process of developing and implementing cancer registry software, which will assist in the coding and screening process.

SEMIPALATINSK, KAZAKSTAN – HOUSTON, TEXAS PARTNERSHIP

Health Care Reform: In collaboration with city and oblast level health care officials, the partners plan to develop a model for health care reform in the Semipalatinsk region with specific attention to the possible impact of privatization. To date, twelve health care leaders from the oblast have participated in workshops on financial management/cost accounting, decision-making and effective grant proposal writing through partnership efforts augmented by AIHA/AUPHA management training. The Head Physician and the Head Economist of the Semipalatinsk Ophthalmology Center participated in the sessions and are currently using their training to manage the Center's newly established fee-for-service department.

Infection Control: The partners plan to establish infection control programs in each of the partnership hospitals by providing training in current infection control methods for physicians and nurse educators from Semipalatinsk. As a result of recent partnership exchanges, a representative from Semipalatinsk had the opportunity to train extensively with TMH's Infection Control Committee, focusing on prevention of nosocomial infections, the importance of intra-hospital epidemiological studies and support services.

Maternal and Child Health: In collaboration with key Semipalatinsk health care officials, the partners have developed a plan to reduce infant mortality by improving prenatal, neonatal and infant care in Semipalatinsk and remote areas by training partners in neonatal resuscitation, principles of immunization, nutrition counseling, and other aspects of maternal and child health care as part of prenatal and postnatal health.

In October 1996, the director of the Semipalatinsk Gynecological Hospital participated in a four week long training program in Houston, concentrating specifically on surgery and quality/infection control.

In February 1997, a group of four pediatricians, including the Director of the Semipalatinsk Regional Children's Hospital, participated in extensive training sessions at Texas Children's Hospital specializing in leukemia treatment.

Nursing Reform: A primary objective of the partners is to develop nursing leadership and improve nursing functions in the partnership hospitals. As a part of the continuing effort to reform the role of nurses in Kazakstan, six nurses from various regional hospitals in Semipalatinsk traveled to the US for a four-week visit beginning in July 1996. The nurses participated in training sessions with TMH inpatient nursing staff, attended patient education activities, and met appropriate faculty.

In October 1996, nurses from Houston and Semipalatinsk attended a biannual conference for Continuing Nursing Education in Semipalatinsk. The conference emphasized the need to increase the role of nurses in patient care and health care administration in the NIS. A second annual conference is expected in September 1997.

Semipalatinsk nurses have succeeded in establishing a Semipalatinsk Nursing Association, with 2,000 members to date. They interact and correspond with other international associations, including the Association of Operating Room Nurses in the United States.

SEMIPALATINSK, KAZAKSTAN – HOUSTON, TEXAS PARTNERSHIP

Emergency Medicine/Disaster Planning: An additional component of the partnership's efforts will focus on the establishment of a disaster management and emergency medical care program with an outreach component to surrounding areas. In order to initiate the process, the directors from the Emergency First Aid Hospital and the Kurchatov Regional Diagnostic Center traveled to TMH to study ER and disaster management procedures, safety education and evacuation procedures. They met with Houston area officials responsible for emergency services and civil defense. In May of 1997, the Director from City Emergency Medical Services of Semipalatinsk, as well as the Faculty Head of the Disaster Medicine Department of the Semipalatinsk Medical Academy traveled to Houston for a four-week long training program in their specialties.

Other Activities

In November 1996 scientists from the United States and Kazakstan convened in Kurchatov, Kazakstan for a Workshop on Health Effects of Environmental Radiation Exposure in Kazakstan. Representatives from the US side included the Armed Forces Radiobiology Research Institute, Department of Energy, National Cancer Institute, Centers for Disease Control and Prevention, and NASA. Kazak Participants included the Minister of Science and Technology, representatives from the Ministry of Ecology and the Environment and the Ministry of Health. The president of the National Nuclear Center in Kurchatov organized and co-convened the workshop. The objectives of the workshop were to standardize data collection and analysis, prioritize a research agenda, evaluate preliminary research findings, explore the feasibility of conducting cross-cultural collaborative research within the current infrastructure, and identify potential collaborators and institutions. A follow-up workshop is tentatively scheduled for November of 1997.

The Houston-Semipalatinsk Partnership has also been successful in leveraging funding and support from additional sources, including General Board of Global Ministries, Santa Fe Pacific Gold, Department of Defense, AmeriCares, Counterpart, NIEHS, and Kodak.

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First Ladies Speak Out on Women's Health

COMMONHEALTH asked First Ladies in the NIS and CEE to talk about women's health in their nations and their work in health promotion for families. The First Ladies of Kazakhstan and Latvia submitted written answers to a set of questions. Future issues of COMMONHEALTH will include interviews with other First Ladies.



Sara Nazarbaeva, First Lady of Kazakhstan.

SARA NAZARBAEVA, FIRST LADY OF KAZAKSTAN

What are the most important health issues facing women in your nation?

Kazakhstan is moving toward a market economy. It is well known that everything that is new suffers "growing pains." In such times, life is especially difficult for women. They are working in factories on equal footing with men. They also must take care of their families and children. There is no time to think about one's health, although there are many problems, such as the extremely high level of abortions, and an increase in breast

and reproductive system cancers. Unfortunately, there is a growth of sexually transmitted disease as well. In several rural regions there are practically no healthy women; many of them suffer from anemia. This is because of unfavorable ecological conditions left as an inheritance from the past. (See articles on Semipalatinsk, p. 25-29 of this issue.)

How are you using your role as First Lady to advocate women's health issues?

We have established the charity foundation Bobek (Baby) for the children of Kazakhstan, and I serve as its president. Its work is directed toward the children, and hence toward the families and the moms of these families. It is very important for women to know how to support their own and their children's health and how to provide good nutrition for their families.

Our foundation is closely collaborating with the Republican Center of Mothers' and Children's Health Care, whose primary mission is the care of pregnant women and those with gynecological dis-

eases. We have several joint projects, which, when fulfilled, will improve the situation.

If you could alleviate one health challenge confronting women in your country, what would you choose?

Currently, our foundation pays a great deal of attention to the education and upbringing of children and teenagers. They are our future, our hope. The future of the country depends much upon how we manage to teach our children to preserve their health while they are young.

I would like to start more consistent and systematic work with teenagers, with young girls and younger children. It is very important to make them enthusiastic about good health, which is so important for a life full of value. I want to show them the dangers of smoking, alcoholism and drug addiction. It is necessary to explain to the young people in an attractive way the rules of private hygiene and safe sex (if it is not possible to avoid it before marriage).

I hope for the collaboration in this field with AIHA, which has experience in publicizing of healthy lifestyles among the population.

Kazakhstan has an enormous amount of territory and a low density of population. That is why the inhabitants of distant rural regions do not have any modern information about healthy lifestyles and about their responsibility to preserve their own health and that of their children. In these conditions, it is very important to organize with the help of mass media a wide-scale public education program.

AINA ULMANE, FIRST LADY OF LATVIA

What are the most important health issues facing women in your nation?

Women's health and health problems



"I have always emphasized that the family is responsible for the health of the next generation.

Children's health, and thus the health of the next generation, depends largely on the mother's health."

reflect the current situation in our health care system and the impact of the environment and economic conditions on health. Hospitals are short of funds, and a large number of vulnerable people cannot afford the high cost of health care. People are also lost in the ever-changing labyrinths of the health care system — they are not sure where and to whom to turn. As a result, people seldom visit doctors; according to an opinion poll, no respondents had visited a health care institution within the last two weeks to seek preventive care, only to treat an actual health problem. Taking responsibility and understanding their own health is not valued. This, unfortunately, refers in large part to women.

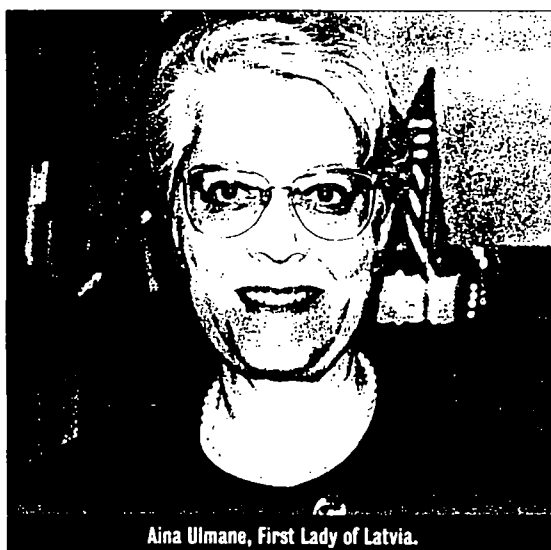
It is painful to note that would-be mothers are becoming less responsible. Women enter pregnancy unprepared and in ill health, and diagnosis is often delayed. We have a large number of would-be mothers who have high-risk pregnancies, and there are many complicated births that result in maternal deaths.

We have an inexcusably high number of pregnancies that are artificially interrupted; according to statistics, there are 114 abortions for every 100 live births. This, in combination with sexually transmitted diseases, results in serious complications and even in barrenness in women.

The main problem lies in a careless lifestyle, facilitated by the social and economic situation, inferior nutrition, gaps in education, as well as an insufficient national framework for preventive measures.

How are you using your role as First Lady to advocate women's health issues?

I think that issues of women's health, like general health issues, must be solved with combined efforts — the state, physicians and women themselves must contribute to seeking solutions. However, as the first lady tends to be the focus of public attention, her opinion and presence add a certain weight to this



Aina Ulmane, First Lady of Latvia.

issue. Although she is not able to directly influence solutions to a particular problem, her opinion is taken into account.

During visits and meetings of high-level statesmen and officials, their spouses have special itineraries, often focused on children and health care issues. As a most successful example of this I would like to mention the cooperative program between the Latvian and St. Louis, Missouri hospitals. The program was initiated in July 1994 when US President Bill Clinton and Mrs. Clinton visited Latvia. Within the framework of this visit, Mrs. Clinton was presented with a review of the health care

situation in Latvia, and, following her recommendations, ALHA considered cooperative opportunities with Latvia. In June 1995, a partnership agreement between three Latvian and three St. Louis hospitals was signed in the White House, with Mrs. Clinton's and my participation.

This program pays particular attention to the health care issues of women, children and the elderly. I believe that women's health is closely linked with children's health issues. A mother's health has an impact on her child's health, both physically and spiritually, and a mother has a responsibility to educate her child about healthy behaviors.

I am doing my utmost to attract the media's attention regarding the joint efforts of these medical personnel, so that they do not remain neglected by society at large.

If you could alleviate one health challenge confronting women in your country, what would you choose?

It would be really difficult for me to select a particular health problem as each of them are important, and I believe that a solution to one particular problem will not bring adequate results.

I have always emphasized that the family is responsible for the health of the next generation. Children's health, and thus the health of the next generation, depends largely on the mother's health. Thus, parents in each family, thinking about the future of our nation, must acknowledge the value of their children's health and teach them responsibility for their own health. ■



L'viv's Smallest Success Story

BY SUDHAKAR EZHUTHACHAN, MD, DCH, AND CHRISTINE NEWMAN, MS, RNC

The infants are tiny enough to fit in the palm a nurse's hand, with hearts barely the size of a walnut and underdeveloped lungs struggling for oxygen. But with the help of the American partners at the Henry Ford Health System (HFHS) in Detroit, Michigan, these babies at the L'viv Oblast Clinical Hospital (LOCH) in L'viv, Ukraine now have a fighting chance.

"Little things really do count," said LOCH neonatologist Zoriana Salabay, referring to the improvements made in neonatal techniques that have helped save the lives of hundreds of premature infants.

From increased training of doctors and nurses to the use of mechanical ventilators, the L'viv-Detroit partnership has improved the level of infant care, not only at the Premature Baby and Neonatal Intensive Care Units (NICU) within LOCH, but to infants throughout the oblast. The partnership created a successful framework for care by adapting the principles of regionalization — a system of care based on the level of risk for the baby — used in the United States since the 1950s but new to Ukraine. Very ill babies from throughout the region now come to LOCH for treatment.

In 1993, infant mortality in Ukraine was 13.5 per 1,000 live births, compared with 8.2 per 1,000 live births in the United States, and 4.4 per 1,000 live births in Japan — the lowest in the world. However, unlike in the United States and Japan, the data from Ukraine do not include infants weighing less than 1,000 grams — meaning that the mortality rate is higher than the statistics indicate.

"We are fighting for every child's life," explained Head of the L'viv Oblast Health Administration Mykhola Khobzei.

The high infant mortality rate, coupled with declining birth rates, have made improved care for premature babies a priority for the Ukraine Ministry of Health, said Elena Sulima, MD, chief neona-



A nurse holds the tiny hand of a premature infant at LOCH.

tologist with the Ministry of Health. Good management of low birth weight babies at partnership hospitals in L'viv produced some early positive results, added Sulima.

For example, last year 70 percent of the 80 newborns in critical condition brought to the NICU at LOCH within their first three days of life survived. In 1995, the NICU had a 45 percent survival rate for transported infants weighing under one kilogram, compared to a 25 percent survival rate at regional birth

houses. The use of modern approaches to improve newborn care at LOCH has decreased length of stay from 32.1 days in 1993 to 29.8 days in 1995.

Prior to 1993, L'viv Oblast did not have a neonatal intensive care unit. Partners selected neonatology as the most critical area of focus for the partnership to respond to the high infant mortality level in Ukraine. The partnership's four-part model addresses all the responsibilities of a Level III (the most intensive) regional neonatal center as outlined in the "Guidelines of Perinatal Care," published by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, including clinical service, education, quality assurance and unit management.

An important initial step in the creation of the unit was the development of the Collaborative Practice Committee, comprised of unit nurses and physicians to oversee issues as they relate to patient and staff concerns and analyze outcomes. Members of the



committee were educated on principles of quality management and encouraged to use them to run their monthly meetings, identify priority issues and analyze results.

Technical Advances in Care

In 1995, an eight-bed intensive care area was established at the Premature Baby Unit, and was equipped with equipment donated from the health care community in southeastern Michigan, local equipment vendors and colleagues within the Henry Ford Health System.

Advances in technology introduced in the neonatal unit at LOCH included mechanical ventilation, regulated oxygen delivery, continuous positive airway pressure through the nose, cardio-respiratory and oxygen saturation monitoring, controlled infusion therapy, phototherapy (including use of a biliblanket to keep the baby warm), and appropriate dosing and administration of antibiotics. Guidelines for clinical practice were developed and translated into Ukrainian, and are available as a pocket-sized reference for unit staff.

Introduction of mechanical ventilation was not without problems, however; use of mechanical ventilators drained existing meager oxygen supply, and voltage differences made transformers essential. With increasing experience on the use of this technology, the average duration of ventilation has increased over time, and ventilated infants have been surviving in greater numbers.

One of the main issues identified by the partnership is the inability to ensure that sick infants reach the regional center in a timely fashion. Typically, only those critically ill infants who lived longer than

seven days were transported to LOCH. In most instances, however, they arrived very sick and cold (with a body temperature less than 35 degrees Celsius), and in some instances, efforts to keep the infants warm with hot water bottles resulted in exten-



A mural in Kiev's Obstetrical and Gynecological Hospital No. 3 promotes happy, healthy babies.

sive burns. Hypothermia is still a frequent problem since most infants are transported by car.

A regional infant transport program, is key to effectively transporting sick infants to LOCH. A donation from Detroit's Ukrainian community last winter helped with the purchase of an infant transporter, which now can carry critically ill newborns to the LOCH referral center from distant birth houses and hospitals (see *COMMON-HEALTH*, Winter 1996). Reliable ambulance support is needed, however, to ensure that this effort continues uninterrupted.

Education: The Key to Success

The most important component of L'viv's model and the key to establishing a high-quality Level III neonatal unit is education. Educational efforts included the development of a neonatal curriculum and clinical bedside training for physicians and nurses. Consisting of 40 lectures and instruction outlines, slides and audio-visual equipment donated by HFHS, the curriculum provided a template for continuing education efforts within the region. Practical bedside training in intubation, chest tube insertion, umbilical catheter insertion and suturing was an essential part of the curriculum. A library of western medical and nursing literature — books and journals donated by HFHS employees, Toronto Children's Hospital and several others — also was established at LOCH. Similarly, teaching videos, a television and a video cassette recorder were donated by US partners to assist with meeting the staff's educational needs. Over 160 health care providers from LOCH have been trained in neonatal resuscitation techniques. Supplemental, Ukrainian-language course material was also produced for staff with the

aid of Malteiser Humanitarian Aid Organization.

"L'viv neonatologists are the first who have applied the new approaches to the care of the newborn," explained Nina Goida, MD, head of the Department of Maternal and Child Health Care at the Ukrainian Ministry of Health.

Speaking at the May 1996 regional conference on neonatal resuscitation and regionalization, Goida encouraged neonatologists to develop programs modeled after the LOCH program, which has introduced "a practical level of skills" to neonatologists



Regionalization of Care

Level I	Uncomplicated care
Level II	Care of moderately ill
Level III	High-risk care
Level III Referral Centers	Level III care + neonatal transport and regional outreach education

and "affected declines in early neonatal mortality" at the LOCH Premature Baby Unit. These early positive outcomes prompted the Ministry to work with AIHA to introduce the LOCH Neonatal Resuscitation Program throughout Ukraine, Goida concluded.

LOCH physicians and nurses realized that in order for clinical care to improve, the existing role of the bedside nurse would have to be altered. A nurse educator position was created within the unit to help ensure sustainable improvements in care and provide ongoing education to nurses. The unit's first nurse educator, Olha Vlad, participated in an intensive, one-month training program at HHHS and continues to provide ongoing education and support to nurses in the NICU in Lviv.

And the outcomes of these courses are significant, noted Salabay. "We accomplish more in our unit thanks to the expanded role of our nurses."

Nurses in the unit now provide bedside care to small, sick infants on ventilators, and are responsible for routine monitoring of vital signs, interpretation of monitor and bedside laboratory data, listening to breathing through a stethoscope, endotracheal suctioning to clean the trachea, initiating IV therapy, and monitoring central blood pressure. Nurses in NICU also perform basic bedside laboratory testing, including microsedimentation rates to determine if a baby has an infection, hematocrit to determine hemoglobin count, urine specific grav-

ity to measure urine concentration, and blood gas analysis — changes which necessitated major alterations in patient care documentation.

Dmytro Dobriansky, MD, a neonatologist at LOCH, and Andrew Tooziak, MD, a post-graduate student at the Lviv Medical Institute and LOCH, designed a bedside flowsheet to

document patient data in the NICU, modeling it after the one used at Henry Ford Hospital. The information documented by the nurses is readily available to the physicians, who also use the flowsheet to write daily orders. This has greatly improved both communication and collaboration between physicians and nurses, contributing significantly to better patient care.

Education of support service staff in radiology, pharmacy and microbiology also addressed specific needs of sick infants, because if these staff do not function at peak efficiency, the critical care provided to these infants could be jeopardized.

Outreach efforts to neonatologists and nurses in the Lviv region culminated in the creation of two- to four-week training programs in patient management and bedside care. Physicians and nurses from district hospitals in western Ukraine visit LOCH for training. In addition, their realization that small babies had a chance to survive at LOCH has resulted in earlier transport of small and sick infants.

Parent education is an essential component of the neonatal education program. This includes conducting ongoing classes for parents and providing informational brochures on important issues related to their infant's care.

Evaluation of Program Outcomes

Collection of accurate data is the only way to evaluate any program or change.

Morbidity and mortality data collection in Ukraine is currently not consistent with that of western nations.

Recently, a policy change in the Lviv Oblast required that all infants who die, including those less than 1,000 grams, be evaluated by a pathologist. This modification will allow data comparisons with western nations.

Computers donated to the partnership have aided the staff in developing a program that provides them an extensive database on many aspects of patient care. Staff physicians enter data into the computer on all patients at the time of discharge. Using this data, trends can be identified in the newly instituted practice of mechanical ventilation and care modified if needed. The computer support has facilitated regular communication through e-mail with colleagues in Lviv. This allows us to have an ongoing dialogue about issues and aid in problem solving in a very expeditious and cost-effective manner.

Though partner efforts have resulted in improvements in care, critical problems remain that threaten the ability to sustain the changes and successes achieved. The need for a steady stream of supplies, more equipment and — last but not least — the attitude of continuously challenging old, ineffective practices cannot be underestimated. We continue to be amazed at the dedication and commitment of our colleagues despite an unending series of obstacles. We have learned that collaboration, not only between the partners, but with other departments, organizations and the community, is vital to ensure that quality care can be provided even to the tiniest, most fragile patients at LOCH. ■

Sudhakar Ezhuthachan, MD, DCH, and Christine Newman, MS, RNC, are US partners from the Henry Ford Health System, Department of Pediatrics, Division of Neonatology and the Department of Nursing (Detroit, Michigan). Dmytro Dobriansky, MD, assistant professor at Lviv Medical Institute and a neonatologist at LOCH, provided numerical data.



Innovations in Care at the Tashkent Women's Health Center

BY JOANNE NEUBER

Children will soon comprise more than 50 percent of the Uzbek population, according to Uzbek Ministry of Health statistics. This high birth rate, coupled with the fact that Uzbekistan has one of the highest maternal mortality rates in the former Soviet Union —

estimated at 46 per 100,000 live births — is placing increasing demands on the country's already strained health care system.

The changing demographic patterns in Uzbekistan prompted the Second Tashkent Medical Institute (TASHMI II) to create one of the country's first women's health centers, in collaboration with the AIHA Tashkent-Chicago partnership program in April 1996.

"We see the importance of promoting a health care system based on primary care," Hamid Karimov, MD, rector of TASHMI II said. "And women's health is a necessary component of that system."

This innovative women's health center provides comprehensive "cradle to grave" care for women in the region. It includes a maternity center, a neonatal care unit, and an ambulatory women's health clinic for women with medical, gynecological or obstetrical problems.

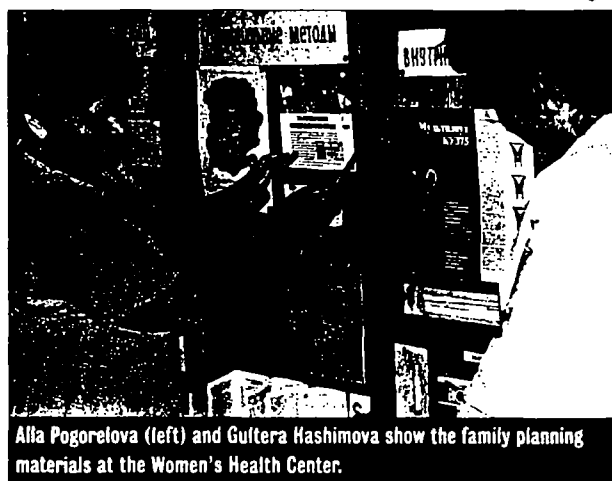
In a departure from traditional practice, the center consolidates women's health services in one building — services that tradi-

tionaly-centered prenatal education, screening, and counseling services to expectant mothers. Midwives at the center have been trained to conduct Lamaze classes about childbirth techniques for expectant mothers and their birthing partners, who because of religious and cultural reasons are often a female relative or friend rather than the father. Promotion of family-centered childbirth at TASHMI II is a significant accomplishment, where traditional beliefs formerly discouraged birth partners from being present during childbirth, said the center's director and obstetrician Alla Pogorelova, who has trained with University of Illinois at Chicago (UIC) partners in obstetrics, high-risk maternal care and gynecology.

One area where partners have had a great impact is educational training in neonatal and perinatal care. Tashkent partners collaborate with colleagues from Chicago to learn effective, low-tech ways to manage and care for high-risk mothers and infants. Vidyasagar said that partnership training programs at TASHMI II that target low-tech neonatal resuscitation techniques, have contributed to the decline in infant mortality at TASHMI II, from 27 per 1,000 live births (1,000 to 1,499 grams) in 1992 to 15 per 1,000 live births in 1995.

"The positive results in maternal and child health at TASHMI II are a result of the partnerships' collaborative program in neonatal and perinatal care," Vidyasagar said. "This program has been very effective in improving the care of mothers and their newborns."

The ambulatory women's health clinic is a "more effective system than the referral system of the past," Pogorelova said. Women who opt to come to the clinic for a medical consultation are not required to have a special referral from their polyclinic, and may



Alla Pogorelova (left) and Gultera Hashimova show the family planning materials at the Women's Health Center.

tionally were either non-existent, or were situated in buildings far from each other. For example, women deliver in their own private rooms. After delivery, women are transferred to a four-bed unit in the center with their babies to promote greater mother-child bonding. This new "rooming in" technique is also improving the level of breast-feeding in Uzbekistan, which is only 10 to 15 percent, according to US partner Dharmapuri Vidyasagar, MD, director of the Division of Neonatology at the University of Illinois at Chicago.

The maternity center also provides fam-



visit the clinic throughout the day or evening, she said.

Patient visits at the clinic have doubled since it was opened last year due to a change in pre-natal services practices to include greater patient education, according to Pogorelova. "There is more open discussion between physicians and women of family planning alternatives," she said.

The clinic also provides ongoing, free family planning services to women. A fam-

ily planning education classroom at the clinic was created with the help of many international health organizations to promote increased awareness of contraceptive alternatives, including IUDs, condoms and oral contraceptives. Women are also encouraged to consult with their physicians on possible social and economic issues that may affect the number of children they have, explains Pogorelova. Partner clinical training of doctor/nurse teams at TASHMI II complements

these programs, noted Pogorelova.

The most important outcome of the center may not be measured in hard data, but rather as the "change in the way we view women's health," Pogorelova said. Earlier, certain women's health issues like birth control alternatives and family planning were "simply not discussed" in traditional Muslim society she said. "Now we can openly discuss important and necessary women's health issues." ■

Mother and Child Health Information Center Opens in Albania

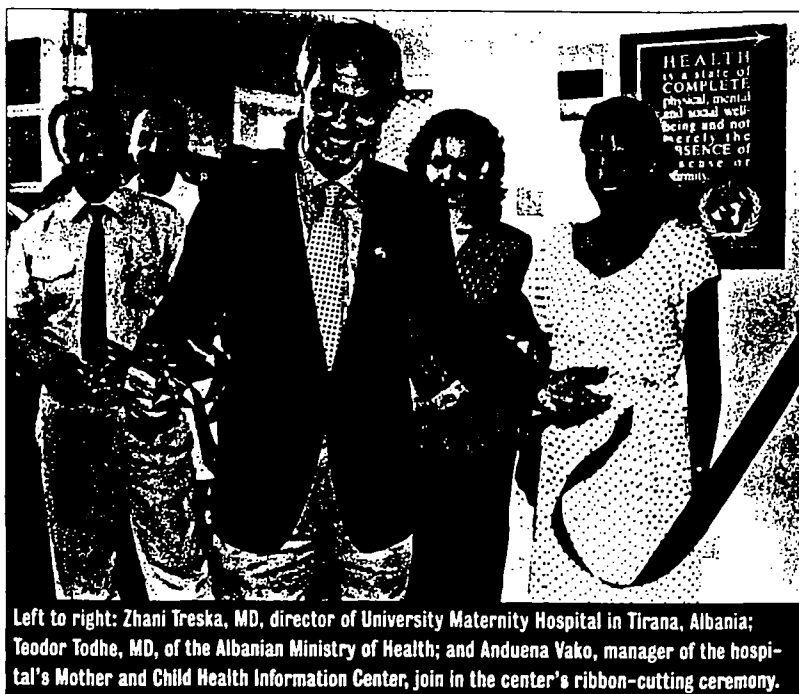
New parents and health professionals now have their own resource center at the Maternity Hospital in Tirana, Albania, thanks to the support of AIHA and Albania's Health for All Foundation. A reception and ribbon-cutting were held July 5 to mark the formal opening of the hospital's Mother and Child Health Information Center, with a ministry of health representative, USAID officials, hospital staff and AIHA staff members in attendance.

The center houses a library with medical books and professional journals for physicians and nurses (largely in-kind donations from AIHA partner Jacobi Medical Center in Bronx, New York), and a computer with CD-

ROM capability and a planned Internet connection. For new parents, the center offers educational materials on topics such as breast feeding and care of the newborn. Two full-time staffers, provided by the Health for All Foundation (with support from the Soros Foundation), will coordinate educational seminars for new parents, to be held in the center's large meeting room. This room will also be available for workshops and seminars organized by the hospital's physicians and nurses.

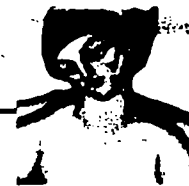
Various officials attended the opening, including: Teodor Todhe, MD, general director for hospitals at the Albanian Ministry of

Health; Deedee Blane, USAID Representative to Albania; Cam Pippitt and Silva Mitro of USAID; Zhani Treska, MD, director of the Maternity Hospital; Tatjana Daci, director of the Health for All Foundation; Bill Walsh, chief operating officer of Jacobi Medical Center; and Charles Brecher, professor of public administration at New York University, representing AIHA's health management education partnership between Albania and New York.



Left to right: Zhani Treska, MD, director of University Maternity Hospital in Tirana, Albania; Teodor Todhe, MD, of the Albanian Ministry of Health; and Anduena Vako, manager of the hospital's Mother and Child Health Information Center, join in the center's ribbon-cutting ceremony.

The center will also serve as an office for AIHA's new in-country coordinator for Albania, Judy Biletnikoff.



Health Status of Women in CEE and the NIS

The rapid political, economic and social changes occurring in the countries of central and eastern Europe (CEE) and the new independent states (NIS) of the former USSR have created conditions that fundamentally affect

the population. These changes have led to social and economic hardship and, in some cases, to war. The result is a widening gap in health between the eastern and western halves of Europe, a serious inequity. A closer look at CEE and the NIS reveals that while women bear more of the burdens imposed by change, they also comprise an invaluable, largely untapped resource for improving their communities and their health.

It must be emphasized that the information available on women's health is quite limited. In the past, the collection of gender-specific data was uncommon globally. Only in recent times have the fundamental differences in the health of men and women been formally recognized. Further, a great deal of the available data is uncertain. Not only do the systems of data collection vary greatly in quality and comprehensiveness, the types of data collected and the methods of analysis are often quite limited.

Most of the diseases that are major threats to the health of populations in CEE and the NIS develop over long periods of time. Causal factors interact with other influences in complex ways. Many health problems are related

to the life situation, to conditions of work and to patterns of behavior, all of which tend to vary in gender-specific ways.

Life Expectancy

Data comparing life expectancy at birth provide an overview of differences in survival for the female population of CEE and the NIS in relation to European Union (EU) averages. In 1993, the average life expectancy for women in the NIS was six years less than the average for women in the EU. The difference for women in CEE was five years. Within CEE and the NIS, there is a seven-year average difference between the countries with the lowest and highest figures, from 69.3 years in Turkmenistan to 76.5 years in the Republic of Georgia.

In the 1980s, life expectancy in CEE and the NIS showed a very gradual increase. But for most of the countries, life expectancy fell from 1990 to 1993. Life expectancy at birth in the Russian Federation decreased from 74.4 years to 72. Latvia fell from 74.5 to 73.3 years.

Cardiovascular Disease and Cancer

Diverging trends between CEE and the NIS and the rest of the region in the two



Nurila Narina of Bishkek, Kyrgyzstan, gave birth to twins at the Institute of Obstetrics and Pediatrics last February. The Institute has improved neonatal mortality, from 8.1 percent in 1994 to 7.5 percent in 1995.

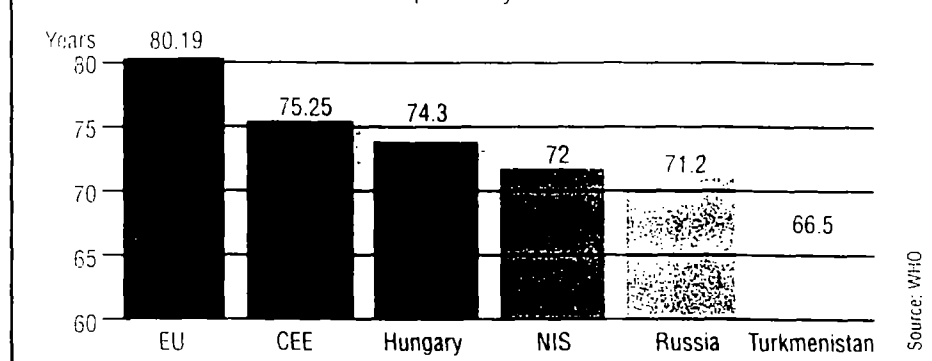
main causes of overall mortality for males and females (cardiovascular disease and cancer under the age of 65) give rise to concern. Particularly worrisome are the death rates for cardiovascular disease for females. The lowest female rate in CEE and the NIS — Lithuania at 72.95 per 100,000 — is more than one and a half times the European average of 47 per 100,000 and more than twice the EU average. Subregional variations in cardiovascular mortality are particularly large — Turkmenistan has 165 deaths per 100,000 women, while Estonia has 81. While mortality from cardiovascular disease (mainly ischemic heart disease and cerebrovascular disease) in females has been decreasing since 1980 in western Europe, no progress was made in CEE and the NIS.

The gap in cancer mortality rates for females is less dramatic than that for cardiovascular diseases, but growing larger.

Excerpted from "Investing in Women's Health: Central and Eastern Europe," World Health Organization, 1995 and WHO's "1995 Highlights on Women's Health in Europe."



Female Life Expectancy at Birth, 1993-94



CEE and the NIS have not enjoyed the consistent decline in mortality from cancer in females under 65 that has been found in other countries of the region since 1995.

The standardized death rate for female lung cancer in CEE is similar to the EU average of 6.48 deaths per 100,000 women under 65. As in the western countries of the region, the rate in CEE rose in the 80s. Female lung cancer rates in the NIS, however, were low and stable, with 3 deaths per 100,000 in Tajikistan and 5 per 100,000 in Russia in 1991, possibly because of a lower smoking rate among women.

Mortality from cancer of the breast, in contrast to most other major causes of death among women, is lower in CEE and the NIS than the rest of the region. The EU average is 20 deaths per 100,000 women under 65, but the CEE average is 16 and the NIS average is 14.5. It appears, however, that breast cancer may more often reach an advanced stage before being detected. Estonia has reported that 30 to 40 percent of all new cases of breast cancer are advanced.

The rates for cervical cancer are among the highest in Europe: 7 per 100,000, compared with the EU average of 2.3. The NIS average is slightly lower than that of CEE.

Cervical cancer is decreasing in the rest of Europe, mainly as a result of effective early detection and treatment.

Maternal Mortality

Maternal mortality rates in the NIS are about twice those in CEE and about four times the average for the region. Maternal mortality in Romania and Albania fell dramatically after the legalization of abortion in 1989. Nevertheless, abortion remains a major cause of maternal mortality in both countries.

In 1990, the maternal mortality rate in Tajikistan was 42 per 100,000 live births; two years later it leapt to 83. In Georgia, the rate rose from 20.5 in 1990 to 50 in 1992. A portion of the increases is probably due to better reporting systems, but real increases in maternal mortality arise from deteriorating socioeconomic conditions, limited access to safe and effective health services and other factors. Still, it is important to note that at the same time, several nations report decreases in maternal mortality, such as Kyrgyzstan, whose rate went from 73 in 1990 to 43 in 1994.

Only in Georgia, Kyrgyzstan and Kazakhstan, where most birth-related deaths are due to hemorrhage, is abortion not the primary cause of female deaths associated with pregnancy and birth.

Family Planning

Because of the reliance on abortion, awareness of family planning alternatives remains quite limited. Although most countries report a growing interest in contra-

ceptives, limited availability and cost remove them as viable options for many people. In a 1993 survey of St. Petersburg women, almost 34 percent said they use no contraception. A 1994 Centers for Disease Control study in Romania found that the most prevalent method of contraception is withdrawal (34 percent) followed by the calendar method (8 percent). Only 14.5 percent of the women studied used "modern contraception" such as birth control pills or intrauterine devices (IUDs).

Abortion remains the most frequently used means of family planning. In many CEE and NIS nations, the rate is as high as one abortion for each live birth. Data from 1992 show three abortions for each live birth in Romania. In St. Petersburg, the ratio rose from 2:1 in 1990 to 2.48:1 in 1992. Estonia's rate rose from 1.13:1 in 1990 to 1.5:1 in 1994. But in several Central Asian nations, the ratio of abortions to live births is dipping slightly: In Kyrgyzstan, the ratio dropped from .606:1 in 1990 to .588 in 1994. In Kazakhstan, the ratio was .975:1 in 1990 and .88:1 in 1994.

Lifestyles

Where information is available, the evidence shows that the prevalence of smoking is still far lower for women than for men. The relatively greater rates of death attributed to smoking among men as compared to women reflect the usually lower smoking prevalence among women. In Albania for example, 7 percent of women smoke, whereas 50 percent of men smoke. In Belarus, 37 percent of deaths of males ages 35 to 69 are attributed to smoking; only 1 percent of women in that age group died of causes related to smoking. However, it is feared that the targeting of young people, particularly young women, in tobacco advertising will lead to higher smoking rates among women.

While little is known about the rate of
See Health Status, page 24

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15 Between tradition and modernity: the dilemma facing contemporary Central Asian women

SHIRIN AKINER

Introduction

By the end of the nineteenth century a huge part of Asia had been brought under Russian rule – in terms of surface area, a territory far larger than that encompassed by modern India. The indigenous population was almost entirely Muslim, of the Sunni sect. In the north (approximately equivalent to the territory of present-day Kazakhstan and Kyrgyzstan) and the south-west (present-day Turkmenistan), the local peoples followed a nomadic or semi-nomadic way of life. Religion here tended to be syncretic, only superficially Islamicised. In the oasis-river belt of Transoxiana (present-day Uzbekistan and western Tadzhikistan), there was an ancient urban culture. The cities in this region had long been famous as centres of Muslim scholarship. There were hundreds of *madrassah* (religious colleges) and thousands of (male) students of Islamic law. The focal point of the social as well as the religious life of the community was the mosque, at least one of which was to be found in every hamlet or town ward. Folk traditions and customs were inextricably intermingled with Islamic practices. At the popular level these were reinforced by the authority and prestige of representatives of the mystic orders – Sufi adepts, wandering dervishes (*kalendar*) and local holy men (*ishan*) – who were frequently credited with possessing supernatural powers of healing and soothsaying.

Under Soviet rule, Central Asia underwent an intensive process of modernisation. In effect, the region was wrenched out of Asia and thrust into Europe. Traditional culture was either destroyed or rendered invisible, confined to the most intimate and private spheres. In the public arena, new national identities were created, underpinned

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Shirin Akiner

by newly fashioned languages and Western-style literatures and histories. Universal compulsory education was introduced, at first at primary level, later extended to secondary level; medical and social welfare networks were established, as a result of which health standards were greatly improved and average life expectancy raised by several years. Society was secularised: Islamic legal and educational institutions were abolished and Islamic beliefs and practices almost obliterated. Western-style cultural amenities such as museums, art galleries, opera and ballet companies and theatres took the place of traditional forms of artistic expression, thereby altering the social, cultural and intellectual environment. These and the many other changes that were set in motion at this time were ideologically driven and underwritten by major allocations of human and financial resources from the central government. This degree of official support (accompanied, from time to time, by ruthless coercion) enabled substantial progress to be achieved within a remarkably short period.

It was against this background of dynamic transformation that the campaign for female emancipation – or more precisely, for gender equality before the law, in the home, in education and at work – was launched. Thus, the struggle to redefine women's rights did not take place in a vacuum, but as part of a larger process, and was strengthened and amplified by other reforms that were implemented concurrently. The basic aims were underpinned by a variety of practical measures that gave substance to these new rights and opportunities for women. These might appear to have been optimum conditions in which to bring about a radical change in the position of Central Asian women. Yet this was only partially achieved: despite the very real improvement in facilities and range of choices, and the greater visibility of Central Asian women in public life, in the private sphere older patterns of behaviour continued to dominate gender relations. Soviet-style modernity was accepted by the indigenous population, but subtly transformed (or subverted) so as to accommodate traditional concepts of social order and propriety.

Today, since the collapse of the Soviet Union and consequent disintegration of the political and economic framework within which the modernisation of Central Asia was accomplished, many aspects of the Soviet legacy are being re-examined. In each of the newly independent states a new phase of nation building has been initiated and a redefinition of the national identity is under way. Traditional cultural and social values are now being emphasised and Islam is again beginning to play a prominent role in public life. At the same

time, this region, which until very recently had almost no direct access to non-Soviet sources of information, is suddenly experiencing a flood of exogenous influences: foreign films and publications, businessmen from all parts of the world, tourists, international civil servants, aid workers and missionaries (representing every shade of Islam and Christianity, as well as other faiths or sects such as the Baha'i and Hare Krishna) are introducing new ideas and helping to shape new aspirations. Attempts at economic and political reform are also creating an impetus for change.

The emancipation movement was one of the defining elements of the ideological construction of Soviet Central Asian identities. It is not surprising, therefore, that as part of the current, post-independence process of refashioning national identities, the validity of the Soviet view of gender relations is being called into question. However, the situation is in flux. It is by no means clear whether the newly independent Central Asian states, individually or as an integrated group, will choose to remain within the European socio-cultural orbit that they have inhabited for the past half century, or whether they will seek to associate themselves more closely with their earlier, Islamic/Asian heritage. Central Asian women themselves are caught between conflicting impulses: some feel the need to return to their 'authentic' roots, with a renewed emphasis on traditional domestic obligations; others, to continue along the road to greater personal independence and freedom of choice. The great majority, however, would like to retain the balance between tradition and modernity that was reached, slowly and sometimes painfully, during the Soviet period. The dilemma that now confronts Central Asian women, poised between two value systems, subscribing in part to both, but not wholly to either, can only be understood in the context of the rapid, enforced, and not fully internalised, transition from a pre-modern to a modern society. It is therefore necessary to take a broader chronological perspective when dealing with this region than with other parts of the former Soviet Union, where the discontinuities have not been so profound. Hence, this paper begins by briefly reviewing the position of Central Asian women in the pre-Soviet period; it then looks at the relevant aspects of the Soviet emancipation movement; and, finally, at the challenges that are confronting Central Asian women in the post-Soviet states.

The term 'Central Asian women' is here used to refer collectively to the women of the titular peoples of these states, namely, the Kazakhs, Kyrgyz, Tadzhiks, Turkmen and Uzbeks. Ideally, were space to permit, each of these national groups should form the subject of a

separate study. However, they do still share a sufficient number of common features – in large part the legacy of a shared Soviet experience – for it to be possible to make some valid generalisation about their present situation. This may not continue to be the case in the future, but as yet the divergences are quite slight. The issues that affect the position of women in the settler communities are rather different and it is beyond the scope of this paper to consider these groups. Likewise, indigenous peoples such as the Bukharan Jews, who have a different cultural background from the majority of the population, are not covered here.

Central Asian women in pre-Soviet society

Central Asia was incorporated into the tsarist empire over a period of some 150 years, beginning with the creeping annexation of the Kazakh steppes in the early eighteenth century and ending with the subjugation of the Turkmen tribes in the deserts of the south in the late nineteenth century. Russian policies towards their new subjects varied over time and from one area to another, but, in general, they were less interventionist than those of other European colonial powers. The tsarist government was mainly concerned with the creation of an effective administrative apparatus and the development and exploitation of the economic potential of the region. The local rulers were generally deposed (in most cases to be coopted into the service of the new regime), but the emir of Bukhara and the khan of Khiva were allowed to retain semi-independent status. Even in the areas that came under direct Russian rule, there was very little interference with traditional institutions. In the legal sphere, the most serious crimes were transferred to the jurisdiction of the Russian courts, but in all other cases *sharia* (Islamic canon law) and *adat* (customary law) continued to regulate the lives of the indigenous population. Although some Russian and Russo-native schools were opened, education, too, remained predominantly Islamic.

Information on pre-Soviet Central Asian society (or more accurately, *societies*, since there were many different groupings, all of which had their own traditions and customs) is very sparse. Moreover, it is almost entirely confined to the 'outsider's' view, as recorded in the accounts of tsarist officials and ethnographers, West European and American travellers, and Soviet field researchers of the 1920s.¹ The evidence they present is valuable, but it is incomplete, and informed by very particular cultural biases. Inevitably, this has given rise to misunder-

standings and distortions. Indeed, such material generally reveals more about the prejudices and ideals of the writers than about Central Asian perceptions of their own society. However, despite the inadequacies of these sources, it is nevertheless important to review the picture they provide of Central Asian life at this period, since this construct has formed the basis for two, mutually contradictory, mythologising projects: that of the Soviet activists, who used it to promote a negative image of traditional society; and that of anti- and post-Soviet nationalists, who created from it an idealised image of a 'golden age', uncorrupted by Europeanising/Russifying influences, and hence an inspiration, if not a model, for the future development of the region.

In this period (that is, the nineteenth century), large extended families were the norm amongst nomads as well as sedentary peoples.² Several married groups, spanning at least two generations, would form a single entity, living, working and, in the case of the nomads, migrating, together. Marriages were arranged by close relatives in accordance with the rules of Islamic and customary law; neither the bride nor, generally, the bridegroom had any say in the choice of their future partner. There was frequently a considerable difference in age between husband and wife, since the financial obligations incurred by the male were very heavy, especially the payment of the 'bride price' (*kalym*); only young men from the wealthiest families could afford this. The minimum age set by Islamic law at which a girl could be given in marriage was nine years. Islamic law permitted a man to be wedded to up to four wives at any one time (on condition that all were treated equally), but local practice in some places allowed many more.³ Concubinage was also not uncommon. In theory, both husband and wife had the right to initiate a divorce, but in practice it was invariably the husband who took such action.

Female members of the family made an important contribution to the family economy, producing foodstuffs, clothing and furnishings. However, child-bearing was probably their most important function. Large numbers of sons were considered to be vital for the security and prosperity of the household, but proverbs suggest that daughters were regarded as a burden.⁴ Female mortality was very high;⁵ this was probably owing to frequent pregnancies starting from a very young age, but it is possible that girls were given less care and nourishment than boys. Medical help was minimal, for the most part restricted to the services of local holy men who were credited with supernatural healing powers, occasionally enhanced by some knowledge of traditional remedies.

In urban communities, girls and women led a segregated existence, contact with males being restricted to close relatives. Within the family home they had their own quarters; when they went out, they wore a cloak-like over-garment (*parandzha*) and a waist-length horse-hair veil (*chachvan*) which concealed their faces. In nomad and semi-nomad communities, and possibly in remoter settled areas, women were not veiled, although they did wear some form of headgear which also covered part of their upper body. They did not have segregated dwellings, but there was a strict division of labour which served to mark out the boundaries of male and female space. Given the paucity of source material, it is impossible to gain a coherent picture of regional, social and economic variations. It is generally supposed that women in nomad communities enjoyed a greater degree of freedom. This may not have been the case at the lower end of the social scale, but amongst the ruling elites, women appear to have been able to act with a substantial degree of autonomy.⁶ In settled communities, women were probably subjected to greater formal controls, although those who were skilled artisans could possibly acquire some independence through membership of craft guilds.⁷ By the early twentieth century, there were some facilities for the education of girls. For the most part, these took the form of elementary religious schools run by the wives of the local *mullah* (religious functionary). In middling and upper-class circles women received a fuller education; a few became accomplished literary figures in their own right.⁸

Almost nothing is known about intra-family relationships and the way in which they affected the position of women. By analogy with societies that have similar traditions (for example, in Afghanistan and Pakistan) and also with modern, post-Soviet family structures, it seems reasonable to assume that although there was strong patriarchal control, and overall gender asymmetry in terms of authority and prestige, within their own domain women had parallel hierarchies that were as rigidly ranked and almost as powerful as those of the male world. Moreover, as wives, and the mothers of sons, women would have been able to exert very considerable influence not only within the family unit, but also in external affairs.

Soviet gender politics

In the aftermath of the Russian revolution, Central Asia, as other parts of the tsarist empire, was swept by civil war. The main contenders were various Slav military and political factions, but in some areas

contingents of foreign (mainly British) interventionists played an active role; there were also nationalist movements that sought to establish autonomous states in Kazakhstan and Kokand, and amorous bands of rebels, known as *basmachi*, under the leadership of local warlords. By 1920, Soviet power had been firmly established in most areas, though the *basmachi* continued to offer a guerrilla-type resistance for almost a decade longer. They claimed to be fighting a 'holy war' in defence of Islam and traditional values. Although they only represented a serious military threat, their influence amongst the indigenous population was so strong, especially in the 1920s, that the Soviet authorities were forced to temper their reformist zeal with a degree of caution, and to delay for some years the full implementation of programmes such as the emancipation of women and the campaign against religion.

Nevertheless, a number of measures were introduced at this time which laid the foundations for later developments. The most important of these was the National Delimitation of 1924–5, whereby administrative-territorial units were created on the basis of the ethnolinguistic affiliations of the main indigenous peoples. Two of these units, Uzbekistan and Turkmenistan, immediately acquired the status of full Union republics, while Tadzhikistan, Kazakhstan and Kyrgyzstan were elevated to this status some years later. These formations were entirely new, with no basis either in the tsarist provincial divisions or in the pre-colonial khanates. The reasons for this exercise of territorial division are debatable, but certainly it was more successful in consolidating the main ethnic groups within a single unit than were similar boundary-drawing projects enacted by other colonial powers in Asia and Africa. Without any movement of peoples, an average of some 90 per cent of the Uzbeks, Turkmen, Kazakhs and Kyrgyz were included within the borders of their respective titular republics.⁹ The Tadzhiks fared less well: they were so closely intermingled with the Uzbeks that it was impossible to make an equitable territorial division of the land they both occupied; the new borders deprived them of the historic centres of Bukhara and Samarkand, and, as a result, over a third of the ethnic Tadzhiks were brought under Uzbek jurisdiction.¹⁰ In addition to the indigenous Central Asian peoples, there was already a sizeable Slav (mainly Russian) presence in the region;¹¹ the percentage share of the titular people in the total population of each of these republics decreased during the first decades of the Soviet period owing to the constant influx of migrants from other parts of the Soviet Union, especially from the European

republics.¹² This helped to dilute further the traditional culture and to accelerate the process of social and economic change.

Creating the legal and operational infrastructure

Ideologically, the campaign for the emancipation of Central Asian women grew out of Russian Marxist feminism, drawing inspiration and moral support from leading activists such as Nadezhda Krupskaya, Klara Zetkin, Inessa Armand and Aleksandra Kollontai (who is sometimes credited with being the instigator of the movement in Central Asia).¹³ The project was organised and monitored by the central organs of the Communist Party in Moscow. From the earliest days of Soviet rule it was regarded as a strategic priority. There were three main reasons for this. Firstly, there was genuine horror and disgust at the social injustice: to Russian eyes, the treatment of Central Asian women in traditional society seemed tantamount to slavery. Secondly, there was a political imperative to create a 'surrogate proletariat' to engage in the class war and also the related war against religion.¹⁴ Thirdly, there was an economic necessity to draw women into socialised production.

During the first years of the emancipation campaign (c. 1918–26), the main emphasis was on the creation of an organisational infrastructure. One aspect of this was to establish a legal framework that codified women's rights, as well as the measures that could be used to enforce them. Islamic courts, using the *sharia* and *adat* legal systems, functioned alongside Soviet courts until 1928, but their powers were circumscribed and in some areas of family law they ceased to have any jurisdiction in the early 1920s. Laws and decrees passed by the state took precedence over the provisions of all other codes. In 1918, the official registration of marriages, births and deaths was made compulsory. Also, the option of having recourse to Soviet divorce law instead of the *sharia* code was introduced, in an effort to give women greater protection. Between 1921 and 1923, laws were passed banning such practices as polygamy, the payment of *kalym* and marriage without the consent of the bride; the minimum age for marriage for girls was set at sixteen years, for boys at eighteen years. Any violation of these laws was treated as a criminal act and subject to severe penalties. The land and water reforms of 1925–9 gave women an independent entitlement to a share of these resources, thereby emphasising their autonomous status in law and in society. Great efforts were made to publicise these new legal provisions: the laws were translated into the

local languages and the texts disseminated widely. Public meetings and rallies were held to explain women's civil and constitutional rights. Moreover, Central Asian women were urged to take an active part in the legal process. Several were given basic training in Soviet law and attached to the courts as People's Assessors. Later, longer courses were provided and towards the end of the 1930s they began to enter the judiciary.¹⁵

Another aspect of the work of these years was the training of local cadres. The first activists were almost all young Russian communists;¹⁶ few of them had any knowledge of the local languages or customs. Gradually, however, from about 1925 onwards, they were joined by Central Asian supporters. These were mostly young girls from poor backgrounds who, for one reason or another, had become isolated from their families; they joined the Communist Party and became actively involved in the emancipation movement.¹⁷ By 1920, a number of women's sections (*zhenotdely*) of the Communist Party had been organised in Central Asia. At first they made little impact on the lives of the indigenous population, but they were later to play an important role in strengthening and consolidating the emancipation movement. Much of the practical support and training for Central Asian women in this period of transition was channelled through these bodies; they also acted as watchdog committees, monitoring working conditions and ensuring that local officials and employees fulfilled their statutory obligations towards women. They were likewise responsible for ideological education and were much involved in consciousness-raising activities among the local women.

One of the most important areas of the work of the women's sections was the organisation of social clubs exclusively for women. Here they were able to provide a secluded, protected environment in which Central Asian women could feel at ease outside their own homes. The first such club was established in the old quarter of Tashkent in 1924; others soon appeared throughout the region, even in remote, rural areas.¹⁸ The clubs offered a range of medical, legal and educational services; other activities included sewing and reading circles; amateur dramatics, devoted mainly to the performance of playlets on contemporary themes; consultations on nutrition, hygiene and child care; and also lectures, film shows and concerts.¹⁹ Given the very controlled and segregated conditions of female existence in Central Asia at the time, the clubs were a remarkable innovation. They represented the first tentative step towards women's full participation in public life.

Casting off the veil

The decision to intensify the emancipation campaign by initiating the mass unveiling of Central Asian women was taken in Moscow in the autumn of 1926.²⁰ The organisation and preparatory propaganda work was delegated to specially constituted regional party committees, but the overall strategy continued to be formulated and directed by the central authorities. By this time some 25,000 Central Asians had joined the party and almost 55,000 were members of the Young Communist League; thus there was a body of 'shock troops' in place to carry out the operation.²¹ In Uzbek it was known as the *khudzhum* (the attack), and indeed it was conceived in terms of a military exercise. The key target areas were the densely populated cities of Uzbekistan, where the practice of wearing the veil was most deeply entrenched.

The first large-scale public displays of unveiling took place in 1927, on International Women's Day (8 March). Preliminary estimates claimed that on that one day 8,500 had cast off their *parandzha* and *chachvan* and ceremonially incinerated them on giant bonfires.²² In reality, the figure of those who unveiled was far lower; moreover, of those who did make this gesture, many, including several Young Communist League members, redonned the veil the following day. However, this did not deter the party-state authorities. The wearing of the veil was not banned by law (although some activists were in favour of this), but a variety of so-called 'administrative' measures were used to further the campaign. Special privileges were given to women who discarded the veil; the husbands of those who did not were liable to be penalised.²³ In some enterprises it was a condition of employment that women should be unveiled. On occasion, more ruthless methods were used; women were intimidated into unveiling, or unveiled by force.²⁴ Meanwhile, there was ceaseless ideological indoctrination through newspaper articles, films, posters, lectures and even house-to-house visits.²⁵ The results of these efforts was that by the mid-1930s it was increasingly rare to see a fully veiled woman. However, in country areas or in the old quarters of the cities, women continued to cover their heads and shoulders with large headscarves.

The *khudzhum* was a definitive episode in the social transformation of the region. To the Russians, the *parandzha* symbolised everything that they were fighting to eradicate: oppression, ignorance, injustice and human degradation.²⁶ However, from the little contemporary and circumstantial evidence that is available, it would seem that, for

Central Asians, the veil had a very different range of associations. It was a protection against unwanted contact with strangers and also against the physical grime of the environment. It could be, too, a status symbol, indicating social standing.²⁷ Most importantly of all, it was a statement about the fundamental ordering of society: the nature of gender relations, the division between public and private space, the conventions of civility. For the Russians, the success of the *khudzhum* was an ideological victory. For the Central Asians, it was a defeat and a brutal rape: the honour and dignity of the community was suddenly and monstrously violated. No other measure of Soviet policy – not the closure of the mosques, the sedentarisation of the nomads, collectivisation or the purges – provoked such violent and outspoken resistance. Even senior party officials at first refused to allow their wives to unveil.²⁸ Women who did throw off the *parandzha* were often rejected by their families. More than a thousand unveiled women were murdered, either by their relatives or by the *basmachi*, in these years.²⁹ It was not, however, only men who were opposed to the *khudzhum*. Published Soviet sources generally present the reaction of Central Asian women to the campaign to cast off the veil in very enthusiastic terms. Occasionally, though, there are hints that there were some who were prepared to speak out openly against it.³⁰ However, the terror that was unleashed in the 1930s effectively put an end to any further opposition. The trauma of the *khudzhum* was suppressed, buried in the sub-conscious, as were so many of the other tragedies of this period. A new generation of women grew up in a world in which Soviet values had already become the accepted norm: for them, the discarding of the veil took on the significance of a rite of passage that marked the entry into a new era of progress and enlightenment. Concomitantly, the former way of life was made to seem very remote, alien and primitive, an attitude which facilitated the inculcation of a negative evaluation of traditional society as a whole.

Political and economic mobilisation

The Soviet authorities regarded education as an essential component of political and economic mobilisation. In Central Asia, in the early 1920s, the level of literacy amongst the indigenous peoples (as estimated in Soviet sources) ranged from an average 7 per cent amongst the Kazakhs, to just over 2 per cent amongst the Turkmen and Tadzhiks; in rural areas it was lower, and amongst women, scarcely above 1 per cent. One of the first priorities of the new state

was to remedy this situation. Special ABC (*likbez*) courses were set up in railway coaches, tents, factories and every other conceivable venue. Great efforts were made to reach the female population. The women's sections were especially active in this field, but the trade unions (*profsoiuzy*), Young Communist League and other socio-political organisations also contributed to the campaign. At the same time, the network of schools and teacher-training colleges was expanded, while the Islamic educational institutions were gradually phased out; by 1927, the entire educational system had been Sovietised.³¹ In the larger towns and cities most of the schools were co-educational, but in rural areas many families refused to allow their daughters to attend mixed establishments. Fully integrated education was not achieved until the 1930s.

Primary schooling was made compulsory for boys and girls alike by about 1930. This was later expanded to an eight-year (incomplete secondary) course;³² eventually an optional two to three years (higher secondary) were added. Central Asian girls began to embark upon tertiary education in significant numbers in the late 1930s and thereafter to enter the professions, particularly law, medicine, teaching and scientific research. Nevertheless, in the 1970s the proportion of Central Asian women with higher education was still considerably lower than the average for the Soviet Union as a whole.³³ The chief obstacle to raising the level of attainment was the tendency of Central Asian girls to leave school early in order to marry. Some later returned to full- or part-time education, but the majority did not progress beyond the minimum school-leaving qualifications.

School was not only the place where a general educational programme was provided; it was also the channel through which the values and goals of communism could be inculcated in the younger generation. The educational process was also used to challenge inherited conventions regarding the role of women in society. As one former Soviet citizen put it, 'they constantly told us that women must be fully equal with men, that women can be flyers and naval engineers and anything that men can be'.³⁴ Central Asian girls were encouraged not only to study, but also to take part in physical training and team sports; in performing arts such as ballet, acting (on stage and in films) and singing; and in occupations requiring technical skills such as tractor driving. Perhaps nothing so vividly illustrates the changes that were taking place at this time as the appearance, in the 1930s, of the first female parachutists in a society in which only ten years previously women had been heavily veiled.³⁵

During the same period, energetic efforts were made to involve Central Asian women in the political-administrative process. Female delegates were elected to represent their communities in public meetings at local and republican level. Activists were sent for training to the Communist University, the Turkic School of Soviet and Party Work and other such institutions.³⁶ In the early 1920s, Central Asian women began to join the party, some no doubt impelled by idealism and belief in the reform programme, but others by a realisation of the practical benefits that would accrue from such a move. In percentage terms their participation remained low, but actual numbers were quite high, given their lack of previous political experience; in Uzbekistan, for example, by the beginning of 1929 there were over 1,000 Uzbek women party members.

In response to Lenin's injunction that more women should be elected to the soviets, Central Asian women gradually came forward to stand as candidates. However, progress was slow; not only were the women reluctant to take part in elections, but there was much covert opposition from the male members of the community. Nevertheless, the authorities continued to press for an improvement in the situation. There was a constant monitoring of the proportion of women in senior managerial posts, and shortcomings as well as successes in this field were widely publicised.³⁷ Positive discrimination was used to accelerate promotion and a quota system was introduced whereby women were allocated approximately a third of the posts in government and in party-administrative organs. This, along with the effusive public acclaim that was accorded to women's achievements in other fields such as the arts, sports and science, provided a high degree of female visibility in society. It created a range of positive, 'progressive' role models with whom Central Asian girls could identify.

Another important aspect of the political mobilisation of Central Asian women in these years was their role in the anti-Islamic campaign. Since women were regarded as the chief victims of religious oppression, it was they who were selected to take a leading part in the campaign to eradicate Islam. The *mullahs* were equated with the wealthy peasants and represented as both class enemies and the enemies of progress. Branches of the Godless League (later renamed the 'Militant Godless League') were set up in all the Central Asian republics. They grew rapidly in the frenzied, fear-dominated atmosphere of the day. In Uzbekistan, for example, in 1928, 3,500 Uzbek women were members of the League; by 1931, the number had

reached 27,000. Anti-religious circles were set up in most enterprises and about 80 per cent of the members were local women.³⁸

The result of this onslaught was that knowledge of the religion was reduced to a minimum. Almost all that survived were some of the rituals connected with the major life-cycle ceremonies (male circumcision and burial rites, for example), and some semi-folk, semi-Islamic practices such as visits to the graves of revered individuals, where prayers and sacrifices were offered up in the hope of securing benediction. Women remained active in keeping such informal aspects of Islam alive. So far as more orthodox beliefs and practices were concerned, some of the older generation of women continued to perform as best they could some of the prescribed ritual prayers and to observe at least a part of the fast of Ramadan. However, few of the generation that grew up after the Second World War maintained this tradition. Islamic prohibitions on the consumption of pork products and alcohol were increasingly disregarded by Central Asian men, many of whom spent most of their working lives in multi-ethnic environments, where they were under constant pressure to conform to the norms of Soviet society; women, however, protected by the privacy of their homes, were able to observe these dietary laws more strictly.³⁹

The first steps to draw women into socialised labour were made through women's cooperatives. These were organised in the early 1920s, and represented a half-way stage, enabling women to continue practising their traditional tasks, such as weaving, sewing and dairying, but outside the family home, in a group environment and for financial reward. Special shops and consumer cooperatives were set up through which women could sell their products directly, without the intervention of middlemen.⁴⁰ Towards the end of the decade there was a proliferation of light industrial enterprises, and increasing numbers of local women found work in factories concerned with food-processing, silk-spinning and the production of garments and hosiery. Heavy industry was developed somewhat later, but relatively few female workers were employed in this sector since conditions were considered to be unsuitable for women for physical as well as psychological reasons.

By contrast, the agricultural sector was regarded as eminently suitable for female labour and a concerted effort was made to draw Central Asian women into the work-force. In the north, this was mainly devoted to various forms of animal husbandry, while in the south, the chief areas were cotton cultivation and silk-worm breeding.

Women's involvement in the development of the cotton-growing industry was the most problematic area, and subsequently attracted much adverse criticism. By 1934, women were involved in almost all aspects of the production of the cotton crop; however, the majority were employed on a seasonal basis for the back-breaking job of harvesting the cotton by hand.⁴¹ Their achievements in helping to secure 'cotton independence' for the Soviet Union were praised in the mass media and those who exceeded their set norms were rewarded with medals and special privileges. The other side of the coin was that work conditions in the plantations were very arduous and that the women were, in effect, used as human tools.

Central Asian girls were taught that it was their right, and also their duty, to seek useful and gainful employment in the public sector. As adults, most of them were to have some experience of work outside the home, but the period of employment was often quite limited, owing to the almost continuous cycle of child-bearing and child-rearing. Moreover, the goal of gender equality at work was never fully attained. Here, as in other parts of the Soviet Union (and in many other countries, too), employers were reluctant to take on female workers on the grounds that they were less productive than their male counterparts; there were also complaints about the length of the statutory maternity leave. Women were frequently (and illegally) paid less for the same work as men; they were also not given as many opportunities for in-service training to raise their qualifications.⁴² As a result, many remained trapped in low-paid, unskilled or semi-skilled jobs. This made them vulnerable to redundancy when more efficient technology was introduced.⁴³

The main motivation for the economic mobilisation of Central Asian women was undoubtedly the need to boost the labour force at a time of major industrial and agricultural expansion. However, it was seen, too, as a means of reinforcing the emancipation movement, since it gave women the possibility of achieving financial independence through waged work. It also provided them with an opportunity to experience new conditions, and to come into direct contact with people from different social and ethnic backgrounds. In most parts of the world, the move to paid employment outside the home has had an important impact on the way women regard themselves, as well as on their position in the family and in the broader community. In Central Asia, however, this did not happen to any significant degree. There was scarcely any redefinition of gender roles, scarcely any extension of the traditional kin-based networks of friendship, solidarity and support.

This is less surprising than it might at first appear: Central Asian women (and men), confronted with the headlong pace of change in the public sphere, reacted by holding on yet more firmly to the order they knew in the domestic sphere, where they had a greater degree of control. Thus, Central Asian women did not in fact assume the role of a revolutionary force to destroy traditional society. Rather, they colluded in its preservation: by accommodating external pressures through the adoption of additional identities, appropriate to the public sphere, they deflected intrusions into the private domain, thereby protecting the integrity of the older disposition of family roles. This is not to imply that the public identities were a sham; on the contrary, all the indications are that they were the product of genuinely held perceptions and aspirations. However, they were confined to one area and were not permitted to penetrate beyond that space, and thus could not bring about the radical change of society that had been anticipated.

Family and community

Family and community relations were (and remain) the most conservative areas of Central Asian society. Even in cities, amongst the most educated and travelled groups, there was relatively little structural change during the Soviet period; in rural areas, social conventions were even more strongly preserved. Hence, there were perceptible continuities with the pre-Soviet period. The extended family networks remained powerful. The actual size of cohabiting units fell sharply, owing to such pressures as the nature and availability of accommodation, changes in employment patterns (including, of course, collectivisation) and the general regimentation and homogenisation of life under Soviet rule. Nevertheless, close contact was retained amongst the members of the larger family even when they were physically dispersed through frequent (wherever possible, daily) visits and telephone calls.⁴⁴ Adult sons would often continue to live at home even after they had married. In such cases, it remained customary for them to hand over their wages, as well as any earnings of their wives, to the head of the family to use as he pleased. The absolute authority of the father was mirrored by the less formal, though perhaps psychologically yet more compelling, authority of the mother. In accordance with the Islamic precept, 'Happiness lies at the feet of the mother', sons treated their mothers with huge respect, regarding her every word as a sacrosanct command. This honoured

status gave her as great a degree of control over their lives, and over the lives of their dependents, as she herself wished to exercise.

Within the family unit there was a high degree of order. This expressed itself through a strong, almost ritualised, code of civility which regulated every aspect of behaviour. Children were socialised in this environment to accept their place in the hierarchical structure, with the attendant obligations, responsibilities and privileges. Constructions of masculinity and femininity were internalised at this stage and gender roles assigned. A strong sense of sibling solidarity was fostered, as well as respect and affection for the older members of the family. Habits of obedience, conformity and submission were fostered in girls and boys alike; the latter may have had greater freedom of action outside the home, but within the family both genders were equally bound by strict conventions. Discipline was maintained through positive encouragement in the form of praise and little gifts. Corporal punishment was very rare: patriarchal authority was clearly enough understood, even by very young children, for a warning tone of voice and a stern demeanour to serve as a sufficient reprimand. There was still a residual preference for sons, though in terms of care, affection and opportunities, daughters no longer appeared to be less privileged than sons.

On marriage, brides moved to the patrilocal residence. From the outset, they were expected to conform to the conventions of their husband's home. Attitudes towards the newcomer were often harsher and more demanding than towards the children of the family. For the young bride, the mother-in-law's word was final. If there was a dispute, the husband would almost always side with his mother, even if he sympathised with his wife's position, and this could cause the young bride to feel very isolated. Her defencelessness was underlined by the fact that her husband would normally take control of any money she might earn, giving back to her only what he considered to be an adequate allowance (thereby defeating the Soviet aim to give women economic independence through waged work). A girl would often not be able to visit her family without her husband's permission. In case of a complete marital breakdown, however, she would normally return to her parental home. There was no social stigma attached to divorce or to remarriage. A wife's status in the family improved with time, with the birth of children, also with the arrival of other daughters-in-law, the wives of younger sons. Initially, the experience of learning to live in the new household could be difficult. However, there was usually a great deal of encouragement and

support from other female members (including, sometimes, the mother-in-law herself) and normally the bride was assimilated into the new environment quite quickly.

Community relations usually involved extended kin-networks as well as neighbours. There was a high level of group solidarity, reinforced through numerous joint activities. The practical preparations for such events as a wedding or a wake were undertaken by the community as a whole, thus relieving the strain on the individual family. These were often huge affairs, requiring vast quantities of food (80 kg each of meat and rice were not uncommon provisions), chairs, tables, crockery, and pots and pans. The utensils and furniture were all provided from the communal stock. Women, whatever their status and professional qualifications, would take their place at the stove and the chopping board. These occasions provided an important opportunity for gossip to be exchanged, a family's reputation and standing in the community to be monitored, problems to be aired, and advice to be given and received. Thus, the community helped to offset the possible isolation of family life. In cases of major family disputes, the senior female of the community would act as counsellor and arbitrator, guiding the different sides towards a compromise. The community also provided additional opportunities for socialising children in traditional values, supervising them when they were out of the home and reinforcing habits of civility, consideration and courtesy. The positive aspect of community life was that it provided a highly effective, informal and very sensitive social security network. The negative aspect was that it was very difficult to escape from its all-embracing control.

Marriage and fertility

It has become an accepted axiom, confirmed by evidence from all over the world, that rises in female literacy rates are accompanied by a decrease in birth rates. Central Asian women, however, have to date proved to be an exception to this rule. Under Soviet rule the crude birth rate remained very high. Consequently, the age structure of the titular peoples of the Central Asian republics continued to conform to the model of the broad-based demographic pyramids of countries such as India, Kenya and Nigeria, with well over half the population under twenty years of age. There are a number of reasons why this pattern was maintained, but principally it was the result of a convergence between pro-natalist attitudes in traditional and Soviet society.

Custom, mediated through family and peer pressure, ensured that

marriage, preferably at an early age, remained the natural goal for Central Asian girls.⁴⁵ As in the past, children were regarded as a blessing, the foundation of the family's happiness and prosperity. Moreover, within the family unit, the young wife's status was to a large extent still determined by the number of children, especially boys, that she produced. At the same time, with improved medical care, female life expectancy rose and hence the period of fertility was extended. Since infant mortality was likewise reduced, the result was a high level of natural increase. The financial strain of a large family was relieved by the state provision of child and maternity allowances. The lump sum allocation at birth, as well as the monthly welfare benefit, increased in accordance with the number of children. Thus, a mother who had only one child received a considerably smaller sum for that one child than she did for her fourth or fifth child; for the eleventh child and above, the benefits were quite large.⁴⁶ In the European republics, where wages were generally higher and families smaller, these allowances were not of great importance. In Central Asia, however, they could constitute a substantial contribution to the family budget.

There were also other forms of state support for motherhood. There was a statutory obligation for employers to provide sixteen weeks' paid maternity leave, as well as entitlements to further unpaid maternity leave without loss of job or seniority. The status of motherhood was reified by the ceremonial award of honours, medals and privileges. The highest rank, that of 'Heroine Mother', was bestowed on those who had borne and reared ten or more children. In Uzbekistan alone, by 1987 over 100,000 women had been given this title; over a million had been awarded the order 'Mother's Glory' (seven to nine children) and over 2 million that of 'Medal of Maternity' (five or six children).⁴⁷ The holders of these honours were treated with great respect, their maternal achievements noted in the press and praised in party reports, alongside accounts of industrial and agricultural successes. Thus, motherhood, or rather, the child-bearing aspect of motherhood, was set on a par with other important contributions to society. By contrast, the domestic routine of child-rearing was regarded as an obstacle to full emancipation, hence to be eradicated as soon as possible through the provision of a full range of socialised welfare services. In fact, this goal was not realised and Central Asian women continued to be childrearers as well as child-bearers for a large portion of their lives.

In addition to these pro-natalist measures, there were other factors

which also helped to perpetuate the tradition of large families. Close-knit kinship networks ensured that there were generally other females available to help with child care and other domestic chores.⁴⁸ Women who wished to pursue professional careers, therefore, did not have to make a choice between having a family or continuing to work. At the same time, the close proximity of senior relatives meant that they were able to exert continued psychological pressure on the younger wives to produce children.⁴⁹ This, coupled with a high level of ignorance about sexual matters, very little medical counselling on family planning and a very inadequate supply of contraceptives, meant that even those who wished to limit their pregnancies were unable to do so.

Ill-health, domestic violence and self-immolation

For most of the Soviet period the campaign for the emancipation of Central Asian women was described in very positive terms, with great emphasis on the achievements, and a glossing-over of mistakes and unfulfilled goals. In the mid-1980s, however, during the period of perestroika and glasnost, a more critical attitude began to emerge.⁵⁰ One of the issues that attracted wide coverage, both in Moscow and in the Central Asian republics, was the use of harmful substances to sustain the cotton monoculture, and the effect that this was having on the health of the workforce, the great majority of whom were women and schoolchildren (who every autumn spent several weeks assisting with the cotton harvest). It was revealed that a highly toxic chemical, similar to Agent Orange, was being used to defoliate the cotton. Immediately after the spraying had been completed, women and children were sent into the fields to pick the cotton with their bare hands, without any protective clothing. Another malpractice was the use of huge quantities of chemical fertilisers, pesticides and herbicides to boost the yield; these then leached into the soil and water and in turn contaminated the food chain.⁵¹ Concerns were voiced at this time as to the possible long-term effects of measures such as these on the health of the population. Some feared that irreparable damage had already been inflicted on their immune systems; the term 'ecological AIDS' was coined to describe this condition.

Some of these reports undoubtedly owed more than a little to journalistic licence. There was also an element of political manipulation, with this and other examples of environmental mismanagement being used by the liberal-reformist lobby as a stick with which to beat the Soviet system as a whole. Until further, unbiased, medical research

has been carried out it will be impossible to assess the full gravity of the situation. It is, nevertheless, beyond dispute that there was gross exploitation of women and children and that this was causing major health problems.

More attention also began to be paid to shortcomings in the domestic sphere. As elsewhere in the Soviet Union, there was criticism of the heavy 'double shift' of work that women had to endure. In Central Asia, the burden was the more onerous owing to the prevalence of large families, relatively low provision of communal amenities such as crèches, canteens and laundries, and, outside the main cities, the chronic scarcity of labour-saving devices such as washing machines and electric vacuum cleaners.⁵² Concerns were voiced, too, about the dangers of frequent, closely spaced pregnancies and the debilitating effect this was having on the physical and mental well-being of Central Asian women, as well as on the health of the nation as a whole. The question of family planning began to be raised in public in the second half of the 1980s, though was soon dropped on account of strong local opposition.⁵³

At this time, there was also some discussion of the psychological pressures that were inflicted on women within the confines of the family. There was little specific mention of physical violence, but anecdotal evidence suggested that it was quite widespread, indicating that it was an accepted, or at least acknowledged, feature of marital behaviour. The one aspect of domestic violence that did come to light was the horrifying and baffling incidence of suicide by self-immolation. According to official sources, in Uzbekistan, in one year alone (1986-7), 270 girls and young women killed themselves in this way.⁵⁴ It was generally agreed that the actual figure was probably far higher and that many such deaths were being passed off as accidents. The phenomenon appeared to be limited to Uzbekistan and Tadzhikistan.

Some commentators believed that it was the relentless drudgery of women's lives, compounded by oppressive patriarchal attitudes in the family, that were to blame; others sought an explanation in a possible nutritional deficiency (a lack of protein, for example), which might cause depression and disorientation. It was also suggested that the practice might have its origins in some form of religious belief. However, Islam is categorically opposed to suicide. The more ancient faith of Zoroastrianism, which in pre-Islamic times had many adherents in Central Asia, did involve the practice of fire-worship, but the flame was regarded as holy and pure, not to be defiled by any form of live sacrifice. Animistic cults regarded fire as a cleansing force, but

there is no evidence that they sanctioned human immolation. Interviews with the local population revealed a wide variety of reasons, or at least triggers, ranging from persistent bed-wetting among young teenagers to quarrels with best friends; from aspersions cast on the virginity of a young bride to arguments over the payment of the bride price. The method of death, by the girl dousing herself with oil, then setting it alight, was excruciatingly painful; the very few who survived were dreadfully disfigured. Yet this did not seem to act as a deterrent, but rather as a goad to others to take more care with the preparations. Visitors to areas where there had been recent instances of self-immolation described an atmosphere of contagious, almost physically palpable hysteria.⁵⁵ Whether this phenomenon was in any way provoked or stimulated by conditions that were specific to the Soviet regime must be a matter of speculation. What it does indicate, however, is that even after more than sixty years of Soviet rule, there were areas of Central Asian life that were still unknown and unfathomable to outsiders.

Post-Soviet readjustments

The Central Asians acquired political independence not as a result of a struggle for national independence, but as a consequence of the disintegration of the imperial power. In January 1992, the governments of the new states inherited, almost literally overnight, direct responsibility for a formidable array of problems. Other former Soviet republics encountered similar difficulties, but in Central Asia the situation was rendered more acute by a number of factors that were specific to the region. One of these was the high level of specialisation in the production of primary commodities and the relatively low level of industrialisation; these republics were thus more dependent on inter-republican exchanges than were other regions. They were also poorer and therefore more reliant on budgetary transfers from the central government to help support their welfare services. The geographic location of these states, surrounded by steppes, deserts and mountains, and over a thousand kilometres in any direction from an open sea, was an added disadvantage. Moreover, the transport and communication links that had been developed during the Soviet period tied the region to Russia; there were virtually no direct connections of any sort with the world beyond the borders of the Union.

The difficulties of transition from Soviet republics to independent

states are today being compounded by social problems. The rapid rate of demographic increase is placing ever greater pressure on the resources of the new states. There is a high ratio of dependents to wage-earners, thus the rise in unemployment has affected the living standards of a wider section of the population than in the European regions of the CIS, where families are far smaller. The economic deterioration has likewise contributed to a heightening of inter-ethnic tensions. The settler communities feel threatened and many thousands have chosen to emigrate. In some ways this has helped to defuse the situation, but the sudden loss of large numbers of senior managers and technical personnel has inflicted substantial damage on the nascent post-Soviet national economies of the region.

The most potentially dangerous effect of the collapse of the Soviet Union was that it created an ideological vacuum. It was not only that the economic and administrative framework within which the modern Central Asian states had been developed abruptly ceased to exist, but that the theoretical justification for their formation was discredited. Consequently, the physical boundaries of the new states, and even the validity of the national identities that had been crafted during the Soviet period, were suddenly open to question. The result could have been the instant Balkanisation of the region. However, with the exception of Tadzhikistan (arguably the most flawed of the Soviet nation-building projects), this has not happened. The instinctive response to the threat of chaos has been a reassertion of the most conservative features of society. There has been no transfer of power to new leaders: on the contrary, it is because of their links with the previous regime that incumbent ruling elites are regarded as guarantors of stability. Equally, the majority of the population are prepared to accept a high degree of authoritarian control in order to guard against the perceived danger of social and regional fragmentation.

In all the Central Asian states, some appearance of political pluralism is currently permitted, but in reality, only those parties that support government policies are granted official registration. Genuine opposition movements have been suppressed, either, as in Uzbekistan, Tadzhikistan and Turkmenistan, by formal bans, or, as in Kazakhstan and Kyrgyzstan, by indirect, but scarcely less effective, controls (for instance, by restricting access to the media or creating obstacles to registration). Yet even without these curbs, it is unlikely that dissident groups would attract much support. In the late 1980s, their efforts to draw attention to political and social abuses were welcomed, but today they are regarded as perilously divisive. The emphasis now is on

conformity and solidarity. A form of self-censorship has re-emerged, stifling the discussion of potentially controversial questions. Thus, for example, it is acceptable to discuss mother and child welfare, since these are matters that relate to the health of the nation as a whole; moreover, problems in these areas can be blamed (with some justification) on the shortcomings of the Soviet system. Domestic violence or the phenomenon of female self-immolation, however, are issues which do not fit easily into the idealised image of traditional family life; also, they cannot easily be resolved without the public examination of questions that are still regarded as essentially private, falling within the domain of the patriarchal family. They are therefore treated, as in the pre-perestroika period, as taboo subjects.

New parameters for gender relations

Nation-building projects in the newly independent Central Asian states are drawing on three main elements: the reinstatement of Islamic values as the guiding ethic for society; the rearticulation of the national culture by such means as the rewriting of the historical narrative to establish linkages between the pre-colonial past and the post-Soviet present, and the reviving of 'authentic' traditional institutions, symbols and concepts of propriety; and the reassertion of patriarchal authority through the symbolic identification of the head of state as the 'Father of the Nation'. All three elements are contributing to a redefinition of the parameters of gender relations.

The Islamic resurgence in Central Asia began in the 1970s with the emergence of a small-scale revivalist movement in the Ferghana Valley (eastern Uzbekistan, southern Kyrgyzstan, northern Tadzhikistan). A second and stronger impetus was provided by a sudden shift in government policy towards Islam. Previously, Islam had been condemned as a pernicious force, inimical to progress. At the end of the 1980s, however, there was evidence of a more conciliatory attitude. This was partly the result of a greater tolerance to religion throughout the Soviet Union, but was also an attempt to combat the perceived threat of Iranian influence by fostering a sense of pride in an indigenous Islamic tradition. More mosques were opened in 1989 than in the whole of the previous decade, the public celebration of Islamic feast days was given official support, and copies of the Qur'an and records and cassettes of Qur'anic recitations suddenly began to appear in state-run kiosks. The number of Soviet Muslims allowed to perform the *hajj* (prescribed annual pilgrimage to Mecca) rose from

thirty in 1989 to 1,500 in 1990, and, in general, links with Muslims in other countries increased. These measures did not result in a mass return to religion, but they did reintroduce Islam into the public arena. Islamic symbols and references became an accepted part of life: Muslim clerics were accorded a new respect and invited to contribute to the process of *perestroika*.⁵⁶

After independence, the re-Islamicisation of the social environment was used as a substitute for the liberation struggle that had not taken place. There was a triumphalist fervour in the rash of mosque building that took place in the immediate aftermath of the collapse of the Soviet Union. In Turkmenistan, for example, there were only four mosques open for worship in the 1980s; by 1994, there were 181, with 100 or more at the planning stage; in Uzbekistan there were 300 in 1989, but over 5,000 by 1993.⁵⁷ There was a similar proliferation of mosques in the other republics. Schools and voluntary bodies began to teach the Arabic script (abolished in Central Asia in 1930) and to give instruction in reading the Qur'an. *Madrassah* and Islamic cultural centres were opened throughout the region. The finance for these undertakings was provided jointly by local Muslim communities, district authorities and charitable donations from Muslims abroad.

Today, although most Central Asians welcome the reintroduction of Islam into the public space, the majority do not want it to assume a regulative function: they still feel strongly that religion and the state should be separate. Nevertheless, a core of active and committed believers has begun to emerge. Quite a large proportion are from villages and provincial towns, or the poorer quarters of the capital cities, but there is also a substantial number of university students and young professionals. The proportion of women who actively espouse an Islamic way of life is as yet very small in relation to the total population of each of the five states. However, the fact that they have so categorically rejected the Soviet model of female emancipation (and likewise the more recently proffered Western versions) has a significance that goes far beyond mere numbers. Some interpret it as a portent of an imminent mass return to Islam. It is too early to predict whether or not this will happen, but certainly there has been an upsurge in the demand for a Muslim education for girls. In response to this, several women's *madrassah* have been opened and courses at some of the men's *madrassah* now accept women.⁵⁸ Women are also beginning to go abroad for further training to Islamic universities in Turkey, Egypt and other Middle Eastern countries.

Muslim women's organisations in Central Asia have not so far been very successful. Fledgling 'Leagues of Muslim Women' were founded in Uzbekistan, Kyrgyzstan and Kazakhstan soon after independence. However, the Kazakh organisation collapsed within months, owing to financial improprieties in the handling of its accounts; the other two groups are now also moribund. Schoolgirls and young university students have begun to wear the *hejab* (Muslim headscarf) and ankle- and wrist-length clothes, but this practice is still rare, especially in the cities; in the Ferghana Valley, a few of the older women have resumed the full *parandzha*.⁵⁹ As yet, however, the veil is still regarded as a symbol of a personal commitment to Islam. It has not become politicised as has been the case elsewhere.

While some women are certainly adopting an Islamic way of life of their own volition, in some areas there is a growing tendency for men to impose Islamic norms on women. This is most noticeable in the Ferghana Valley and in Tadzhikistan. Here it is men who set the standards for female modesty in behaviour and dress. It is also the men who decide whether or not women should be allowed to attend the mosque or to play an active role in religious undertakings outside the home.⁶⁰ The women here are more vulnerable because not only is the protection offered by the state now much weaker, but usually these women do not know their rights in Islamic law and are therefore unable to argue their case on those grounds.

The second element in the post-Soviet nation-building process – that of a rearticulation of the national culture – has not brought about a qualitative change in gender relations, but it has given renewed respectability to attitudes and practices that, during the Soviet period, were regarded as socially and politically unacceptable. This is most marked in matters concerning the family. The traditional power balance – patriarchal control allied to maternal authority – is now acknowledged with a sense of pride rather than decried as a vestige of primitive practices of the past. This new mood was vividly illustrated by the comment of a young Uzbek, who, when asked recently what were the qualities that had most attracted him to his bride-to-be, answered without hesitation, 'That she should be as a floor-cloth to my mother, then to my elder brothers' wives, then to me.'⁶¹ The phrasing is, of course, crude, and more urbane Central Asian males would certainly not formulate their view of their relationship with their wife in such terms. However, the very fact that anyone should voice such sentiments in public is in itself a sign of the changing times: a decade ago, this would have been inconceivable.

Other indications of the shift in attitude include a greater readiness to admit to the continued existence of a practice such as polygamy: this is still illegal, but the fragmentary evidence that is now emerging suggests that it is quite widespread and, moreover, not regarded with the disapproval that characterised Soviet writings on the subject.⁶² The positive aspects of traditions such as the payment of the bride price – now usually presented in the form of gifts of clothes, jewellery and household items – are also stressed. Likewise, participation in large-scale family and community functions, formerly frowned upon by the authorities, is now regarded as a positive feature of social life. In Uzbekistan, the role of the local neighbourhood (*mahalle*) in poverty alleviation and other social welfare projects has been institutionalised through the allocation of government funds and the formal recognition of the authority of community elders. Finally, the centrality of motherhood is being reaffirmed, but with a telling shift of emphasis: during the Soviet period, the maternal role was divorced from domesticity. Now, the domestic context has been reinstated and child-rearing is being accorded the same importance as child-bearing. Concomitantly, the role of women as the moral educators of the new generation is being highlighted.

The third element, that of the cult of the father-leader, is yet another reversal of a fundamental tenet of Soviet ideology. The image of the head of state as the loving but stern, wise but generous, head of the family-nation firmly reinstates the patriarchal discourse. This was implied in the personality cults that evolved around Soviet leaders, but in Central Asia today, especially in Uzbekistan and Turkmenistan, the notion has been elaborated far more comprehensively. The concept of male guardianship has now been re-established as a parameter of private as well as of public life. Society has finally freed itself from the emasculation imposed by the *khudzhum*. From a traditionalist perspective, it might be said that order and propriety are being restored. The result has been that gender asymmetry in power and status has re-emerged in unashamedly vigorous form, giving rise to a rapid masculinisation of the positions of authority. Today, women in Central Asia are not excluded from public affairs, but their participation is dependent on male sufferance.⁶³ Nevertheless, as in other male-dominated societies, individual women, especially those who are closely related to the ruling elites, may be accepted as honorary males in the highest echelons of the power structures with relatively little difficulty. It is those lower down the social scale who are beginning to experience the brunt of gender discrimination.

Economic pressures

The dislocation of supplies, services and trade which followed the collapse of the Soviet Union has had a devastating effect on the newly emergent national economies of the Central Asian states. Prices for industrial and domestic commodities continue to soar; transport networks have been decimated owing to fuel shortages. Many industrial plants have been forced to close down, or to introduce sweeping redundancies, because of lack of supplies, loss of markets and huge debts. Unemployment has spiralled. Welfare benefits, including child and maternity allowances, have been increased at regular intervals, but have been unable to stave off severe material hardship for large sectors of the population. Education and medical care have also been severely affected; standards have fallen dramatically, while the introduction of 'hidden charges' to services that were formerly free has further reduced the scope of welfare provision. Poverty and malnutrition are now becoming serious problems.

Women have been the chief victims of the shrinking labour market. It is not only the unskilled or semi-skilled workers who have been savagely hit by redundancies, but also the trained professionals. The quota system and positive discrimination that operated in support of female employment during the Soviet period have been abandoned. Now, whenever there is a choice between employing a male or a female, the former is automatically given precedence, on the grounds that he is the main breadwinner in the family. At the same time, features in the mass media and the pronouncements of public figures are helping to alter social opinion, creating a climate in which the home, rather than the shop floor or the office, is regarded as the 'right place' for a woman. Even in Kyrgyzstan, where official attitudes towards working women are still generally favourable, it was estimated that by mid-1993 almost 70 per cent of the unemployed were women; the economic crisis has deepened considerably since then and it is very likely that the present position is a great deal worse. However, it is difficult to gain an accurate picture of the situation in any of these states since, firstly, definitions of joblessness are abstruse, designed to conceal rather than reveal the true state of affairs (a phenomenon that is by no means unique to Central Asia); secondly, women are often retained on the staff of an enterprise or institution, but rarely given any work and paid, if at all, a nugatory salary.

Economic pressures are also beginning to have an adverse effect on female education. Schooling used to be free, compulsory and of a

reasonably high standard. Today, the quality of tuition in the state schools is so poor that those who can afford it send their children to private schools. These are very expensive. The state schools, too, though still nominally free, require so many extra contributions from parents that even this form of education is becoming a financial burden for poor families with large numbers of children. In these cases, it is the daughters' education that is sacrificed. The girls become semi-permanent truants, and are often set to work selling assorted oddments on street pavements in order to supplement the family income.

There are rumours that in return for a substantial down payment to the parents, some young girls are being sent to the Gulf states to work as household servants;⁶⁴ this may be utterly untrue, but the level of material deprivation is reaching such a point that even if this is not so, it is already taking shape as a fantasy solution. Female (and, to a lesser extent, male) prostitution is on the rise in Kazakhstan and Kyrgyzstan; for students, it is sometimes the only way of financing their studies.⁶⁵ In Kyrgyzstan, questions have been raised in parliament as to the desirability of licensing brothels, in order to limit the risk of spreading sexually transmitted diseases. The majority of those who are involved in prostitution are Slavs and members of other immigrant groups, but there are also quite a few Kazakhs and Kyrgyz. In the other Central Asian states it is uncommon for women of the titular groups to work as prostitutes. However, in the capital cities of the region (and perhaps in other large urban settlements), sexual conventions are no longer as strict as they once were and it is not unknown for local girls to enter into extra-marital relationships in return for financial benefit.⁶⁶

Another consequence of the economic crisis has been to bring about changes in attitudes to family planning. In urban areas, at least among the professional classes, young couples are beginning to worry about the cost of rearing a large family. Before, this was not a consideration, since all the major expenses were covered by the state. Now, it is not only that the price of essentials such as health care and education are rising, but that many more choices are available in terms of optional extra-curricular activities, fashionable clothes, toys and electronic gadgetry. Parents in these circles are coming to feel that they will only be able to provide the type of upbringing that they would wish for their offspring if they limit the size of their families to two or, at the most, three children.

In rural areas, especially in Uzbekistan and Tadzhikistan, birth rates are still amongst the highest in the world (over forty per thousand per

year). Since in all five countries the great majority of the titular people live in the countryside, it is not surprising that in most areas there has been a relatively small fall in the average rate of natural increase over the last three decades.⁶⁷ The governments in the newly independent Central Asian states are beginning to realise the economic implications of this high level of expansion. To date, however, it is only in Uzbekistan that an official family planning policy has been launched. This has involved intensive preliminary research into social attitudes, followed by education and information campaigns. The scheme is still too new for it to be possible to evaluate the likely impact. It is also difficult to know how the related scheme of (semi-) compulsory pre-marital medical counselling for young couples will develop. It is intended to raise awareness of health, sex and family welfare issues, but as it is formulated at present, with the emphasis on producing a population that is sound in mind and body, there is a hint of an underlying eugenic agenda.

External influences

In the immediate aftermath of independence, there was an influx of missionaries and various cultural delegations from Islamic countries. Such events were a novelty and aroused great interest. Now, however, the visits of delegations have become more of a routine activity and are greeted with less pomp, while the missionaries are, in most areas, subject to close state supervision. In all, the impact of Islamic countries on the Central Asian states has been considerably weaker than had originally been anticipated. The chief sources of external influence, particularly so far as women are concerned, are Western. There are two very different areas in which the effects of this pressure are felt: concepts of glamour and concepts of human development.

Little is known of traditional Central Asian concepts of female beauty other than the stereotyped descriptions of classical literature and the elegant, stylised figures in miniature paintings. These, however, are almost entirely images conceived by men; female perceptions of style and fashion, and attitudes to luxury, beauty care and physical perfection, are largely uncharted territory.⁶⁸ During the Soviet period, new stereotypes were introduced, projecting robust workers and indefatigable mothers as the ideal models, but how, why and for whom these women beautified themselves – or even if they did – was regarded as a matter too inconsequential to merit attention. Over the past two to three years, this has changed: the region has been

inundated with Western soap operas, video cassettes of the latest feature films, fashion magazines, advertisements for hair and skin treatments (sometimes even the actual products), and, most recently, beauty parlours and aerobics classes. Initially, Central Asian women were very cautious in their response to these blandishments, but, as with the women's clubs of the early Soviet era, they are gradually being overcome by curiosity and in the larger cities are starting to try these new recipes for health, beauty and a shining future. If the appearance of female parachutists and tractor drivers symbolised one turning-point in the modern history of Central Asia, then perhaps the appearance of the first be-swimsuited beauty contests may be said to have marked another.⁶⁹

A very different form of potential Western influence is diffused through aid and technical assistance programmes. These are administered through international organisations, the agencies of national governments, and also through non-governmental organisations (NGOs). Most have a brief to integrate women into development programmes. In principle, this may be a helpful approach; in practice, however, it often misfires. Central Asians, both men and women, deeply resent what they regard as the patronising attitude of some of the administrators of these programmes. The schemes the latter propose often have little relevance to local conditions; in particular, they frequently fail to take account of the existing high levels of literacy, indigenous professional experience and relatively wide range of modern amenities (albeit that these are now under threat owing to the economic crisis).

Another cause of irritation is the implicit, or even explicit, bias that some Western (or Western-trained) staff display against Islam and traditional society.⁷⁰ The message, in effect, is that the Central Asians must adopt Western institutions and norms since their own culture is characterised as 'underdeveloped'. However, many Central Asians now travel abroad and have access to the Western media, and thus are able to form their own opinion of Western societies. They find much to admire but, equally, are appalled by the social problems, especially those caused by the breakdown of the family. Thus, it is galling for them to have to endure the disparagement of their own values by those who, in their opinion, have been even less successful in creating an acceptable social environment. By contrast, respect for the achievements of the Soviet period are growing. As one Uzbek writer, formerly known for his outspoken criticism of the Soviet regime, commented recently, 'These Western activists are just like the Soviets, but at least

the Soviets gave us schools and hospitals along with their ideology, these give us only the ideology.'⁷¹ Similar sentiments are to be heard with increasing frequency throughout the region.

A third cause of complaint is the 'packaging' of Central Asian issues for the international community. Inevitably (and again as with Soviet activists in the 1920s), foreign aid and development programmes seek to enlist the support of local women. However, since project organisers are often more interested in pursuing their own agendas than in gaining an understanding of local conditions, still less of local culture, what they seek is confirmation of their views. Those who would work with them, sometimes out of conviction but sometimes, inevitably, as a means of securing the per diem allowances and other fringe benefits, reflect back what their sponsors want to hear. These are the women who then become the 'independent representatives' of the community and are invited to international conferences and seminars in order to articulate the required position.⁷² Translators and interpreters compound the problem, encasing their words in a straitjacket of jargon that effectively extinguishes any spontaneity or genuine insight into the situation. It is little wonder that such women tend to be regarded as opportunists by their compatriots. The fact that they receive such attention is viewed as additional proof of the insincerity (or at the very least, naivety) of Western agencies. This severely undermines the credibility, and hence the efficacy, of programmes that might otherwise have much to offer.

Passivity: a coping strategy?

There has been strikingly little attempt on the part of Central Asian women to articulate their views on what their rights should be. In the Soviet period, this passivity could be explained by the fact that they had no option but to support official policies. Now, however, they have a greater awareness of possible choices, and it might have been expected that they would take the initiative in gaining more control over their lives and in extending their political, economic and social demands. Yet to date there has been little sign of this. In 1991-2, a few women's movements made a fleeting appearance, most notably, the Uzbek-based Tumaris (the female wing of the opposition party Birlik). The Muslim Women's Leagues referred to above fared little better, also proving to be unsustainable.

Since independence, throughout the region semi-official Women's Committees have been formed, closely modelled on the women's

councils (*zhensoveti*) of the Soviet period. These are chiefly concerned with the dissemination and implementation of official social welfare policies relating to women. There are also bodies that are specifically devoted to mother and child health care. These organisations are mostly staffed by women and, indeed, provide one of the main outlets for female participation in public affairs. However, although they may have some input into policy formulation, their sphere of action is circumscribed by the fact that, as members of these committees, they have an official function. Consequently, they do not have the same degree of independence as representatives of NGOs in Western countries.

On an individual level, some women are exercising choice in the lifestyles or careers that they follow. Some have entered the private sector and are becoming successful entrepreneurs. Regional Businesswomen's Associations are beginning to appear; these, however, are professional bodies that, for the most part, focus on issues relating to the general business environment and not specifically to conditions for women. A number of women are engaged in careers that take them to foreign countries for study or training; a few have taken the opportunity to remain abroad for relatively long periods. In the larger cities, more typically in Kazakhstan and Kyrgyzstan, some younger women (generally those who have spent a considerable time in study or work away from home) have distanced themselves somewhat from their families and kin-group networks in order to lead a more independent existence; such a choice often entails the corollary of rejecting, or postponing, marriage. In a very different way, those who have opted to follow an orthodox Islamic way of life have also taken control of their lives.

The above examples of Central Asian women's attempts to establish their own space may seem insignificant when compared with developments elsewhere in the former Soviet Union, but even these are exceptional in the context of the region. The great majority of women have not shown any inclination to exceed the limits sanctioned by society. This apparent apathy is often regarded by outsiders as a sign of 'backwardness', from which Central Asian women need to be liberated. Yet they themselves view their situation in a very different way. They are conscious of being part of an organic whole, no one particle of which can be altered without the whole being affected. It is not that Central Asian women see their situation as perfect – indeed, they have as many complaints as women elsewhere – but that they perceive that it has compensations as well as shortcomings, that it offers good-neighbourly support as well as social constraints.

Central Asians are today under greater strain than at almost any other period in recent history. Under Soviet rule, despite all the external changes, these societies remained, in Durkheimian terms, largely 'mechanical', with a high degree of homogeneity, conformity and group solidarity. Now, faced with massive economic, social and environmental pressures, they are in danger of sliding towards anomie – the loss of shared values and the consequent breakdown of social controls. The civil war in Tadjikistan has provided a dramatic example of how easily and quickly this could happen. There is an acute awareness that the same process could be repeated elsewhere. This has provoked an almost maniacal insistence on the need to preserve stability; all other freedoms are seen as of secondary importance. This is not mere political rhetoric: it is a consistently recurring theme in private as well as public discussion.

Against this background, the 'passivity' of Central Asian women may be seen as a positive rather than a negative stance, a choice rather than a failure to choose. Today, as during the Soviet period, women are instrumental in moderating the pace of change, helping to mediate the effect of external influences. The perceived passivity could be interpreted as a sophisticated coping strategy for protecting the central values of society in a time of flux and stress, thus a crucial contribution to community life, and of fundamental importance in maintaining continuity and identity. It may of course be argued that even if this is so, the women are nevertheless involuntary victims of the system, trapped in a vicious circle of dependency and self-sacrifice. This does not seem to be borne out in practice. There are undoubtedly cases of abuse and oppression here, as in any other part of the world but, in general, Central Asian women, whether in urban or in rural areas, appear to be able to negotiate a position that is, to them, acceptable. If they do not take a public stand to articulate their demands this does not necessarily mean that they are too weak or too ignorant to do this: it could equally well indicate that they believe they are able to operate more effectively by working in an indirect way, using the social levers that are available to them within their families and their communities. This could change in the future: if there were to be a breakdown of society, then they might be forced to take a more independent position, to fight for their rights. Under such conditions, politicised feminist movements, either of a Western or an Islamic orientation, might emerge. It is, however, noteworthy that this does not, as yet, appear to have happened to any significant degree even in Tadjikistan. The upheavals of the war and the experience of the refugee

settlements have not acted as a mobilising impetus. Rather, there has been a consolidation of existing networks and of established patterns of behaviour.

Conclusions: Eurasia revisited

Central Asia lies at the heart of the Eurasian landmass. Once, it was the nodal point on the 'Silk Roads' of antiquity, the global trade network of the day. Today, after years of partial isolation on the periphery of Europe, the region is regaining its centrality: the old, long-suspended ties with neighbours to the east and to the south are being restored through modern transport and communications links. This does not mean that the Central Asian states will sever relations with Russia or reject the Soviet heritage. The complex network of personal and professional, political, economic, cultural and educational linkages that has been established over the past seventy years will certainly not be erased in the near future, though in time it may become a less dominant feature of contemporary Central Asian life. Similarly, many of the aspirations that were nurtured during the Soviet period, such as, for example, that of gender equality, will continue to shape people's hopes and expectations, even if they are not actively promoted. It is also very unlikely that contacts with the West will diminish. On the contrary, the Central Asian states have signalled their desire to remain a part of this world through numerous trade and diplomatic missions, as well as through membership of organisations such as the Organization for Security and Co-operation in Europe (OSCE) and NATO's Partnership for Peace programme. Western-sponsored aid and development projects, whatever their shortcomings, will no doubt continue to be implemented. Informal channels of Western influence, such as the media, will likewise continue to be a major source of influence.

However, these new states are also looking in other directions and finding points of reference and mutual understanding in, for example, China, Korea, Japan, Indonesia, Malaysia, India and Pakistan. These countries present models that differ very greatly one from the other, as well as from those of Western countries. Yet they also have some common characteristics, loosely described as 'Asian values', which include an emphasis on the importance of the family, on the interests of the community rather than those of the individual, and on consensus rather than confrontation. Central Asians recognise here a sense of social priorities similar to their own. Over the past few years

it is this discovery of sympathetic cultural echoes in the east and south which has perhaps had the greatest effect on the morale of the Central Asian states, giving them new confidence in the validity of their traditional values. This might well foster the emergence of more conservative trends in the future.

There are still too many uncertainties for it to be possible at this stage, scarcely five years after the traumatic transition to independence, to predict how these new states will develop. However, in view of their past history, it seems likely that there will be a very cautious and gradual recalibrating of the balance between public and private spheres, leading to a greater emphasis on traditional structures, eventually, possibly, of a revivalist hue. It is unlikely that there will be a qualitative change in the position of women in the near future. Further ahead, however, it is possible that in some of the states there may be a move towards a more Islamic way of life, with a reintroduction of the constraints, but also of the freedoms and rights, that Islam gives women. In the north-eastern parts of Kazakhstan and northern Kyrgyzstan, where there has long been influence from the settler communities, it is possible that there will be a more pronounced Westernisation of society, at least in the public sphere. However, much will depend on the resolution of present economic problems. If the recession continues to deepen, there could be a very rapid unravelling of society, with consequences that are impossible to predict, except for the very obvious point that in such conditions it is invariably the women and children who are the most vulnerable and are therefore likely to suffer a major deterioration in their situation. In these circumstances, perhaps the present preoccupation with stability is no bad thing.

Notes

Conventional systems of transliteration have been used for foreign words. It should be noted, however, that in a term such as *khudzhum*, which is here transcribed from the Cyrillic script (as used, for example, for Uzbek), since it refers to a specifically Central Asian phenomenon, the sound *j* (as in 'John') is rendered by *dzh*; however, in Arabic words which refer to general Islamic practices and are already, therefore, in use in English (e.g. *haji*), the same sound is rendered by *j*, since this is a more familiar spelling.

- 1 Good surveys of tsarist/Soviet source material relating to this period are given by Ol'ga A. Sukhareva, *Bukhara: XIX - nachalo XX v* (Moscow: Nauka, 1966), pp. 3-22; Tahira Kh. Tashbaeva and Mane D. Savurov, *Novoe i traditsionnoe v bytu sel'skoi sem'i uzbekov* (Tashkent: Fan, 1989),

...most informative Western source for this period is probably Shirin Akiner, *Turkistan: a garden of Asia and its people* (London: Duckworth, 1993).

...appears to have been an exception in this regard in that the evidence suggests that average family sizes were small, consisting of 4-6 individuals (Sukhareva, *Bukhara*, pp. 106-11). However, the definition of terms is not always clear, hence it is difficult to draw firm conclusions.

3 Bibi Pal'vanova, *Emansipatsiia musul'manki* (Moscow: Nauka, 1982), pp. 7-8.

4 E.g. 'Qiz bola tuqqandan kora tosh tuqqan iakhshiroq, negaki, tosh hech bolmasa devor qurishga iaraiddi-ku' ('It is better to give birth to a stone than a girl-child, because at least you can build a wall with a stone'). Quoted by Z. R. Rahimboboieva, in her speech to the 'First Uzbekistan Women's Conference', March 1958, published in *Ozbekiston khotin-qizlarining birinchi s'iezdi: stenografik hisobot* (Tashkent: Uzbek SSR Davlat Nashrioti, 1960), p. 16. Meakin (*Russian Turkestan*, p. 97) confirms that disappointment was the usual reaction to the birth of a daughter.

5 Sukhareva (*Bukhara*, p. 105) gives some statistical information on female life expectancy in Bukhara. In 1920, the percentage ratio of females to males in the Turkestan region was 47.7 to 52.3 (Pal'vanova, *Emansipatsiia*, p. 49). Cf. Russia in 1926, where the percentage ratio was 52.8 to 47.2, thus with a preponderance of females, unlike the situation in Central Asia, where there was a preponderance of males. (Source: Soviet Census of 1926, cited in Shirin Akiner, *Islamic peoples of the Soviet Union* (2nd edn, London: Kegan Paul International, 1987), under the relevant ethnic entries. Note: the information in this book is drawn from Soviet statistical material; for ease of reference, the ultimate sources of data are not cited in this article unless they are of particular interest.)

6 For example, Khansha Pupai, the wife of Abulkhair, mid-eighteenth century khan of the Kazakh Little Horde, seems to have played an active role in steppe politics; see Begezhan Suleimenov (ed.), *Kazakhstan v XV-XVIII vekakh* (Alma-Ata: Nauka, 1969), p. 141.

7 Very little information is available on this subject. Meakin (*Russian Turkestan*, pp. 100-2) indicates that several of the educated women in urban areas were engaged in trade, generally of objects that they had produced themselves. Zbigniew Jasiewicz, 'Professional beliefs and rituals among craftsmen in Central Asia: genetic and functional interpretation' in Shirin Akiner (ed.), *Cultural change and continuity in Central Asia* (London: Kegan Paul International, 1991), p. 173, speaking of a somewhat later period, mentions the existence of 'a certain form of organisation' amongst craftswomen of the region, notably women potters in the mountains of Tadzhikistan.

8 In the early nineteenth century, there were a number of talented poets at the court of the khan of Kokand, including Nadira (b. 1790), wife of the ruler, Umar Khan; they were presumably not merely literate but highly educated. On girls' schools in the early twentieth century, for example, Meakin, *Russian Turkestan*, p. 87. However, literacy rates varied greatly from one place to another. According to Sukhareva (*Bukhara*, p. 104), in 1926, 13.4 per cent of the female population of Bukhara were literate, compared with 46 per cent of the male population. The overall average literacy rate for the Uzbek SSR as a whole, though, was only 3.8 per cent (Akiner, *Islamic peoples*, p. 280).

9 According to the 1926 Soviet census, 84.5 per cent of Uzbeks were included within the territory of the Uzbek SSR, 94.2 per cent of Turkmen in the Turkmen SSR, 93.6 per cent of Kazakhs in the Kazakh ASSR, and 86.7 per cent of the Kyrgyz in the Kyrgyz ASSR. For a summary of the regional distribution of these peoples, see Akiner, *Islamic peoples*, under the relevant ethnic entries. (Reference is made here to Kazakh ASSR and Kyrgyz ASSR because at the time of the census they were Autonomous Soviet Socialist Republics, not yet full Soviet Socialist Republics.)

10 In 1926, 63.1 per cent of the Tadzhiks were included within the territory of the Tadzhik ASSR, which at that time formed a subordinate administrative unit within the Uzbek SSR; there were a further 35.8 per cent located elsewhere in the Uzbek SSR (see further Akiner, *Islamic peoples*, p. 306). These figures are based on the official ethnic designations as recorded in the 1926 census; some would claim that they do not accurately reflect the population's self-perception of their historical ethnic origins. The negotiation of territorial rights was by no means a smooth and amicable affair: there were many bitter arguments over border regions, especially those with mixed populations. A detailed account of this process is given by Rakhim Masov, *Istoriia topornogo razdeleniia* (Dushanbe: Irfon, 1991).

11 In 1926, Russians numbered 1,279,979 (19.7 per cent of the total population) in the Kazakh ASSR; 116,436 (11.8 per cent) in the Kyrgyz ASSR; 5,638 (0.7 per cent) in the Tadzhik ASSR; 75,357 (7.7 per cent) in the Turkmen SSR; 246,521 (4.7 per cent) in the Uzbek SSR. By 1959, these figures had increased to 3,972,042 (42.7 per cent of the total population) in the Kazakh SSR; 623,562 (30.2 per cent) in the Kyrgyz SSR; 262,611 (13.3 per cent) in the Tadzhik SSR; 262,702 (17.3 per cent) in the Turkmen SSR; 1,092,468 (13.5 per cent) in the Uzbek SSR. (See further Akiner, *Islamic peoples*, under the relevant ethnic entries.)

12 By 1959, the percentage share of the titular group in the total population of their eponymous republic was as follows: Uzbeks 62.1; Turkmen 60.9; Tadzhiks 53.1; Kyrgyz 40.5; Kazakhs 30.0 (Akiner, *Islamic peoples*, under the relevant ethnic entries).

13 Richard Stites, *The women's liberation movement in Russia: feminism*,

- nihilism, and Bolshevism 1860-1930 (Princeton: Princeton University Press, 1978), p. 332. For an account of the broader Soviet context of female emancipation see Mary Buckley, 'Soviet interpretations of the women question' in Barbara Holland (ed.), *Soviet sisterhood* (London: Fourth Estate, 1985), pp. 24-53.
- 14 The term was coined by Gregory Massell, *The surrogate proletariat* (Princeton: Princeton University Press, 1975); this is the first, and to date only major study by a Western scholar on the politics of female emancipation in Central Asia.
 - 15 For accounts of the creation of the legal infrastructure, see Dilorom A. Alimova, *Reshenie zhenskogo voprosa v Uzbekistane 1917-41 gg.* (Tashkent: Fan, 1987), pp. 11-12; Shodmon M. Masharipova, *Raskrepostshchenie zhenshchin Khorezma i vovlechenie ikh v sotsialisticheskoe stroitel'stvo* (Tashkent: Fan, 1990), pp. 12-13; Aleksandr M. Lobachev, *Protiv t'my* (Tashkent: Uzbekistan, 1990), pp. 32-6; Pal'vanova, *Emansipatsiia*, pp. 26-36; Rakhima Aminova, *The October Revolution and women's liberation in Uzbekistan* (Moscow: Nauka, 1977), pp. 37-8, 59-60.
 - 16 Leading Russian activists included: Ida Finkel'shtein, widow of the Tashkent commissar; Lidia Dvorkina; Berta Bendetskaia (b. 1898); Lukiia Shumilova (1873-1939); Lidiiia Otmar-Shtein (b. 1899); Eustaliia Ross (b. 1896). Serafima Liubimova (b. 1898), who was sent from Moscow to Tashkent in June 1923 to head the women's section of the Central Committee of the Turkestan Communist Party, was responsible for creating an infrastructure of social organisations to support the emancipation movement. See further Pal'vanova, *Emansipatsiia*, pp. 49-57; Alimova, *Reshenie*, pp. 14-15; Aminova, *October Revolution*, pp. 12-15; R. Ia. Radzhapova, et al. *Khhdzhum - znachit nastuplenie* (Tashkent: Uzbekistan, 1987), pp. 117-87.
 - 17 These included Risoliat-khon Alieva (b. 1898); Shamsikamar Gaibdzhanova (b. 1897); Tadzhikhon Shadieva (b. 1905). See further Pal'vanova, *Emansipatsiia*, pp. 62-7; Lobachev, *Protiv t'my*, p. 136; Masharipova, *Raskrepostshchenie*, pp. 14-17.
 - 18 Pal'vanova, *Emansipatsiia*, p. 106.
 - 19 Masharipova, *Raskrepostshchenie*, p. 37; Pal'vanova, *Emansipatsiia*, pp. 108-10.
 - 20 Pal'vanova, *Emansipatsiia*, p. 165.
 - 21 *Ibid.*, pp. 97, 147-8; Masharipova, *Raskrepostshchenie*, pp. 61-2; Aminova, *October Revolution*, pp. 63-4; Alimova, *Reshenie*, p. 61. Dilorom A. Alimova, *Zhenskii vopros v Srednei Azii* (Tashkent: Fan, 1991), p. 25.
 - 22 Aminova, *October Revolution*, p. 95.
 - 23 Alimova, *Zhenskii vopros*, p. 23; Alimova, *Reshenie*, pp. 30-2; Aminova, *October Revolution*, p. 121.

- 24 Pal'vanova, *Emansipatsiia*, p. 168, also personal communications made to the present author by Professor Pal'vanova in London, in 1992.
- 25 Lobachev, *Protiv t'my*, p. 40.
- 26 This was not only a Russian view; see, for example, the comments of Joshua Kunitz, *Dawn over Samarkand* (London and New York: Lawrence and Wishart, 1936), p. 274, where he describes the garment as 'monstrous and degrading', resembling 'a gray or dark-blue coffin standing stiffly on end, covered with a black, bulging, heavy lid'.
- 27 Meakin (*Russian Turkestan*, pp. 128-9) noted that "the man in the street" can generally tell at a glance the social standing of a woman by the quality and condition of her *parandzha*; those worn by the rich were often made of silk, but the majority were of cotton. The usual colour was a dull grey, but Tatar women would sometimes wear bright colours, such as canary yellow or bright red. Only women from the lowest strata of society (e.g. beggars) would venture out of the house without a veil.
- 28 Alimova, *Zhenskii vopros*, pp. 25-8; Aminova, *October Revolution*, pp. 92-103.
- 29 Alimova, *Zhenskii vopros*, p. 76; Masharipova, *Raskrepostshchenie*, pp. 23, 32, 51-6; Aminova, *October Revolution*, pp. 49-57.
- 30 Aminova, *October Revolution*, p. 92.
- 31 Alimova, *Reshenie*, p. 55; Aminova, *October Revolution*, pp. 179-92.
- 32 The move to an eight-year course was completed by 1962/63; see K. F. Fazylkhodzhaev (ed.), *Deiatel'nost' kompartii Uzbekistana i usileniiu sotsialnoi aktivnosti zhenshchin: Sbornik dokumentov i materialov (1959-1975 gg.)* (Tashkent: Uzbekistan, 1986), p. 26.
- 33 The numbers of women of the titular groups of the Central Asian republics who possessed higher (tertiary) educational qualifications in 1970 were as follows (per 1,000): Uzbeks 13; Kazakhs 20; Tadzhiks 7; Turkmen 10; Kyrgyz 15; cf. Soviet average of 37 (Akiner, *Islamic peoples*, under the relevant ethnic headings).
- 34 H. Kent Geiger, *The family in Soviet Russia* (Cambridge, Mass.: Harvard University Press, 1970), p. 130.
- 35 Aminova, *October Revolution*, pp. 211-12.
- 36 *Ibid.*, pp. 17-18.
- 37 Pal'vanova, *Emansipatsiia*, p. 270.
- 38 Alimova, *Reshenie*, p. 55.
- 39 Probably the best study to date on Soviet Islam is Tolib Saidbaev, *Islam i obshchestvo* (Moscow: Nauka, 1984); see also A. Ahadov, *Islom zamonga moslashganda* (Tashkent: Uzbekistan, 1989). For more recent developments, see Shirin Akiner, 'Islam, the state and ethnicity in Central Asia in historical perspective' in *Religion, state and society: the Keston Journal* 24 (2-3), December 1996 (forthcoming).
- 40 Alimova, *Zhenskii vopros*, pp. 35-8.

- 41 Alimova, *Zhenskii vopros*, pp. 47-9; Lobachev, *Protiv t'my*, p. 55; Pal'vanova, *Emansipatsiia*, p. 244.
- 42 Pal'vanova, *Emansipatsiia*, p. 205; Darikha Saburova, *Zhenshchiny Karakalpakstana* (Nukus: Karakalpakstan, 1989), pp. 37-46; Alimova, *Zhenskii vopros*, p. 46. The problems over equal pay, conditions and opportunities for women were not of course restricted to Central Asia; for the broader Soviet context see Alastair McAuley, *Women's work and wages in the Soviet Union* (London: George Allen and Unwin, 1981), especially pp. 11-31.
- 43 Alimova, *Zhenskii vopros*, p. 112.
- 44 This section is based mainly on material contained in Tashbaeva and Savurov, *Novoe i traditsionnoe*; also on personal interviews conducted by the present author 1985-95. Although the section is written in the past tense, since in the context of this article it refers to the Soviet period, the conditions described here are very much the same today, in post-Soviet Central Asia.
- 45 This is also part of the Islamic heritage; see, for example, Lois Beck *et al.* (eds.), *Women in the Muslim world* (Cambridge, Mass.: Harvard University Press, 1978), pp. 87-8; Parveen Shaukat Ali, *Status of women in the Muslim world* (Lahore: Aziz, 1975), p. 21. In 1959, the percentage of married girls of the titular group in the age group 16-19 years was as follows: Uzbeks 31.8; Kazakhs 28.7; Tadzhiks 36.6; Turkmen 32.0; Kyrgyz 44.2; cf. Russians 9.3. By 1970, the percentage of married girls in this age group had fallen to the following levels: Uzbeks 21.7; Kazakhs 12.3; Tadzhiks 24.9; Turkmen 19.1; Kyrgyz 20.1; cf. Russians 9.1 (Akiner, *Islamic peoples*, under relevant ethnic groups).
- 46 For the pre-1981 provisions see Bernice Madison, *Social welfare in the Soviet Union* (Stanford, Ca.: Stanford University Press, 1968), pp. 61-70; for post-1981, see Jo Peers, 'Workers by hand and womb: Soviet women and the demographic crisis' in Holland (ed.), *Soviet sisterhood*, pp. 116-44, especially p. 136. In 1981 the lump sum payment for the first child was set at 50 roubles, for the eleventh and subsequent children at 250 roubles each.
- 47 Tashbaeva and Savurov, *Novoe i traditsionnoe*, p. 38.
- 48 Geographic mobility was low, hence kin-groups generally continued to live within the same village, neighbourhood or collective farm. The level of urbanisation among the titular groups within their eponymous republics also remained low; in 1970, it was less than 30 per cent for four of the groups (only 14.5 per cent for the Kyrgyz), and only just over 30 per cent for the Turkmen (Akiner, *Islamic peoples*, under relevant ethnic groups). Mixed marriages between different ethnic groups were also comparatively uncommon, especially in rural areas.
- 49 Such is the preoccupation with fertility that even visiting strangers will be interrogated in great detail about the number of children they have, or

- intend to have. According to an Uzbek informant, mothers-in-law in rural areas would often accompany their sons' wives on visits to the bride's parents to ensure that they did not seek contraceptive advice (communication with the author, Tashkent, 1996). For a comparative international perspective see Helen Ware, 'The effects of fertility, family organization, sex structure on the labour market, and technology on the position of women' in Federici *et al.* (eds.), *Women's position and demographic change* (Oxford: Clarendon, 1993), pp. 257-84.
- 50 See, for example, Saburova, *Zhenshchiny Karakalpakstana*, p. 49.
- 51 A great deal has been written on this subject in recent years. A comprehensive account is given by Boris Rumer, *Soviet Central Asia: a tragic experiment* (Boston: Unwin Hyman, 1989), pp. 62-75. See also Aleksandr Minkin, 'Zaraza ubiistvennaia', *Ogonek* 13, 1988, pp. 26-27; Aleksandr Minkin, 'Posledstviia zarazy', *Ogonek* 33, 1988, p. 25; Shirin Akiner, 'Environmental degradation in Central Asia' in Reiner Weichhardt (ed.), *Economic developments in cooperation partner countries from a sectoral perspective* (Brussels: NATO, 1994), pp. 255-63.
- 52 See, for example, Saburova, *Zhenshchiny Karakalpakstana*, pp. 71-80; Tashbaeva and Savurov, *Novoe i traditsionnoe*, p. 67.
- 53 Alimova, *Zhenskii vopros*, p. 118.
- 54 *Ibid.*, pp. 118-19; E. Gafurov, 'The flames of feudalism', *International Pravda* 2(7), 1986, p. 24; Pal'vanova (*Emansipatsiia*, p. 8) indicates that the practice was not unknown in pre-Soviet times.
- 55 Personal communications to the author in Tashkent in 1990 by an Uzbek film-maker, Shukhrat Makhmudov, and his Kazakh wife.
- 56 Shirin Akiner, 'Islam in post-Soviet Central Asia', *Harvard International Review* 15(3), 1993, pp. 18-21. The article was written on the basis of information gathered by the author from informants in the Central Asian republics 1989-92.
- 57 *Aziia*, 11 June 1994, p. 24; *Nezavisimaia gazeta*, 6 January 1994, p. 3.
- 58 Anara Tabyshalieva, *Vera v Turkestane* (Bishkek: AZ-MAK, 1993), p. 123; *Slovo Kyrgyzstana*, 30 November 1993, p. 3.
- 59 These are subjective assessments, based on the author's personal observation made in the course of several visits in 1994-6 to Tashkent, the Ferghana Valley, Bishkek and Almaty. Some other observers feel that this is an underestimation and that both the *hejab* and the *parandzha* are becoming far more common. This perception may be influenced by the fact that such observers (local and foreign) regard the resurgence of Islam as a threat. It should be noted that the wearing of the *hejab* is a new phenomenon, imported from other Muslim countries; the traditional Central Asian covering is the *parandzha*. To some extent, these different interpretations of the Muslim dress code reflect divergent trends in Islam in Central Asia today. Wearers of the *hejab* tend to favour a more reformist, modernist approach to the religion, while wearers of the *parandzha* are

generally more conservative. However, regional and social factors also play a role here, hence no firm conclusions can be drawn about a woman's religious orientation solely on the basis of her outer garments.

- 60 Gillian Tett, in an unpublished paper on 'Women and Islam in Tadzhikistan', presented at the conference on 'Social change, demographic trends, family structure and gender relations in Muslim societies - with special reference to Central Asia', held at the School of Oriental and African Studies (SOAS), University of London, July 1992, made the point that while it was women who 'de facto carried the greatest religious burden during the Soviet years, it is now men who dominate Islam in the public sphere' and that it is men who are setting the agenda for what Islam should 'mean' for women.
- 61 Comment made to the author by a young Uzbek of about twenty-four years of age, with secondary schooling and further educational training, in the Ferghana Valley in 1994.
- 62 Tatiana Savelieva, in an unpublished paper presented at the conference on 'Social change, demographic trends, family structure and gender relations in Muslim societies - with special reference to Central Asia', at SOAS, July 1992, gave an account of recent fieldwork carried out in Uzbekistan; in one village, she reported, almost 20 per cent of the unmarried women were integrated into polygamous families.
- 63 In June 1995, the senior government posts held by women included the following: in Uzbekistan, deputy prime minister, chairman of parliament (*Oliy Madжлиs*), deputy chairman of parliamentary committee on labour and social security, deputy minister of labour, first deputy minister of social welfare; in Kazakhstan, deputy minister of trade and industry; in Tadzhikistan, deputy prime minister, deputy minister of health; in Kyrgyzstan, minister of foreign affairs. No information was available on the situation in Turkmenistan.
- 64 Personal communications to the author in Bishkek, 1996.
- 65 In one evening, a student can earn at least 30 US dollars, the equivalent of some six times the value of a monthly stipend. (Personal communications to the author in Bishkek, 1996.) In Kazakh and Kyrgyz newspapers of 1994-6 there have been several reports on rising levels of prostitution and other criminal activities carried out by women. See, for example, Gul'mira Arbabaeva, 'Na kollegii MVD otmechen rost zhenskoi prestupnosti', *Panorama* 29, 23 July 1994, p. 9; Kanapiia Gabdullina, 'Bezrabotitsa i zhenskimi litsom', *Dzhuma: Piatnitsa* 17, 20 October 1995, p. 2.
- 66 Personal communications to the author in Bishkek, Almaty and Tashkent, 1996.
- 67 Levels of natural increase (per 1,000 of the population) in the five republics in 1960/1987 respectively were as follows: Uzbekistan 33.8/30.1; Kazakhstan 30.6/18.0; Kyrgyzstan 30.8/25.3; Tadzhikistan 28.4/34.9; Turkmenistan 35.9/29.3. (Source: *Naselenie SSSR 1987*, Moscow: Finansy i

statistika, 1988, pp. 132-42.) The largest change was in Kazakhstan where the birthrate fell quite steadily in rural and in urban areas in 1980; thereafter it began to rise again. A similar pattern was observed in Kyrgyzstan. These two republics have long had large populations; the birthrate in these non-indigenous communities is significantly lower than amongst the titular peoples, hence the slower rate of increase. In Uzbekistan and Tadzhikistan the rate of increase is such that, according to some estimates, in the near future for every 100 people who leave the ranks of the working age group, some thirty-five will enter it (Viktor Perevedentsev, *Moskovskie novosti* 41, 11 October 1992, p. 9).

- 68 Meakin, *Russian Turkestan*, pp. 120-8, is one of the few writers to comment on this aspect of the lives of Central Asian women.
- 69 See, for example, the report on the 'Kazakhstan Queen of Clubs - 95' beauty contest, *Delovaia nedelia*, 11 August 1995. *Dzhuma: Piatnitsa*, published in Kazakhstan, is a typical new-style women's paper, full of advertisements for stylish lingerie, cosmetics and beauty treatments.
- 70 This phenomenon has been noted elsewhere. See, for example, Angela Gilliam, 'Women's equality and national liberation' in Chandra Mohanty et al. (eds.), *Third World women and the politics of feminism* (Bloomington, Ind.: Indiana University Press, 1991), pp. 215-50, especially p. 218; also Chandra Mohanty, *ibid.*, pp. 51-80, 'Under Western eyes: feminist scholarship and colonial discourses'.
- 71 Personal communication to the author by a member of the banned opposition party *Erk*, in Germany, 1995.
- 72 Cf. Gilliam, 'Women's equality', p. 227, where the question is posed: 'Which Third World Women speak for which Third World women?'